

Addendum - Inpatient and Intensive Day Care Extension to the Community Eating Disorder Guidance

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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The pathway values statement

This guidance represents a commitment to ensuring that mental health care is delivered to children and young people, and their families and carers, in a **person-centred**, **compassionate** and **supportive** way, promoting **safety** and **wellbeing** at the forefront. Delivery of mental health care should be **needs-led**, **responsive** and provided in a way that **empowers** children and young people to build on their strengths, promotes **recovery**, supports their **families and carers**, and ensures **equality and fairness** for all.

1. Aims of this document

1.1 The aim of this document is to extend the community eating disorders pathway to include inpatient and intensive day care. This is to support the delivery of integrated care by dedicated CED services and inpatient or intensive day care services, to provide effective mental health care in the right place at the right time. The ambition is to improve access to high-quality mental health care and support for children and young people with an eating disorder and co-existing physical and mental health problems and reduce unwarranted variation in service provision and outcomes. Children and young people should be treated as close to home as possible, at the earliest opportunity, to substantially reduce the need for admission and length of stay.

1.2 This guidance supports local commissioning and service improvements by recommending quality benchmarks against which all services should seek to measure themselves. National datasets will provide routine, consistent measurement of local services' performance against these benchmarks, supporting quality, improving children and young people's experience of care and reducing unwarranted variation. The evidence is clear that prompt access to effective treatment aids recovery, prevents relapses and reduces burden on the young person, family and NHS costs.

1.3 This guidance was developed in 2017 to inform an extension to the published community eating disorder pathway. The aim is to help improve integration between the community eating disorder services and episodes of care in day or inpatient settings. Throughout the pathway, the community eating disorder service should take a lead role in providing care both in the community and if they require inpatient or intensive day care.

Inpatient and intensive day care services include:

- inpatient medical children's wards or age-appropriate general wards
- child and adolescent mental health inpatient or day patient services.

1.4 Ensuring equal access to mental health care and reducing health inequalities for all children and young people with an eating disorder as well as their families/carers is best achieved through co-production at every level, including training and supervision for staff, as well as collaboration with national, regional and local commissioners. Local commissioners should be able to demonstrate the way they meet the duties placed on them under the Equality Act 2010 and the Health and Social Care Act 2012. Service design and communications should be appropriate and accessible to meet the needs of diverse communities.

2. Updated policy and strategic context

2.1 From 2015, the Government made an additional £1.4 billion in funding to improve access to high-quality mental health support (including crisis care). This included £30 million recurrent funding for eating disorders in CCG baselines.

2.2 In 2019-20, the £30 million for enhancing CYP CED services was increased to £41million, with a further boost committed from 2020/21 over the course of the [NHS Long Term Plan](#).

2.3 NHS England is currently working with 12 sites nationally to test approaches that could feasibly deliver a four week waiting time for access to NHS support, ahead of introducing new national waiting time standards for all children and young people who need specialist mental health services. The pilots will test not only what it takes to achieve and maintain a four-week waiting time, but also how best to define and measure this access to specialist children and young people's mental health services. This will enable NHS England to set more robust standards as part of the [Interim Review of Clinical Standards](#) .

2.4 New Care Models programme, now referred to as NHS-Led Provider Collaborative, includes delegating specialised commissioning budgets for adult eating disorder inpatient services to provider led collaboratives. The collaboratives will have the power to re-invest funds to enhance pathways of care and maximise access to dedicated community-based provision to reduce the need for admissions and length of stay, delivering care closer to home.

By April 2020 our ambition is to have Provider Collaboratives for the majority of specialised mental health services covering 75% of the population. By 2022/23 we expect Provider Collaboratives to cover 100% of the population, and to have expanded across all other appropriate specialised mental health, learning disability and autism services.

2.5 In 2016, NHS England undertook a review of all inpatient child and adolescent mental health service (CAMHS) beds, including those for eating disorders, to improve their distribution across the regions. Regional specialised commissioning teams are implementing the review's recommendations to improve children and young people's outcomes and experience by:

- eliminating inappropriate out of area placements
- improving local bed availability aligned with community services
- eliminating inappropriate under-18 placements in adult beds
- ensuring a sufficient national bed stock for surge management
- integrating and collaborating with local commissioners and providers
- developing service specifications that support these ambitions.

Key recommendations of the inpatient CAMHS review include ending the practice of sending people out of area by 2020/21, investing in dedicated CED services and introducing national clinical quality benchmarks to help reduce the unwarranted variation in quality and efficiency in the mental health system across England.

2.6 This supports two of the four clinical priorities set out in [Next Steps on the Five Year Forward View](#) (urgent and emergency care and mental health) and the ambitions set out in the [NHS Long Term Plan](#), as well as the national priority for local NHS hospitals, community services and councils to work together in the coming years to free up hospital beds and ensure access to care in the most suitable setting for children and young people.

3. Key statements: what should good eating disorders care look like in an inpatient or intensive day care setting?

These statements were developed in collaboration with young people with experience of receiving mental health care for an eating disorder in an inpatient or intensive day care setting. The statements reflect what they want and need from commissioners and providers.

“I will be treated with kindness, respect and dignity.”

“I will be treated as an individual and not just according to my diagnosis.”

“I expect professionals to listen to me and my family or carers and to respect and encourage our input.”

“There will be someone available to talk to me when I am in distress.”

“If I need urgent treatment I will be assessed and given care and support that meets my needs within 24 hours of presenting to the team. I will receive:

- **clear details of my further care and support, and**
- **more intensive treatment in the community, or**
- **admission to an appropriate service, which may be a local paediatric unit.”**

“If I need an admission, I will be treated as close to home as possible.”

“If I am admitted, the ward routine and rules will be explained to me beforehand so I can prepare for what it will be like. A unit guide pack is really useful when someone first arrives.”

“My community team will stay involved with my treatment throughout my admission. They will be in regular contact with me, my family or carers and the inpatient team.”

“On admission I will have a comprehensive assessment during which we will decide on treatment goals and a discharge plan. I will be given a provisional discharge date.”

“During admission, the food will be of good quality and reflect the food that I will be eating in the community.”

“I will be offered regular psychological treatment and support from the outset of my admission.”

“I will be supported to continue with my studies during an admission.”

“I will have regular reviews during my treatment. If I am not making progress, alternative options will be discussed with me and my family or carers.”

“I will gradually have more home leave towards the end of admission, before I am discharged.”

4. Benefits of extending the eating disorders pathway for children and young people

There are many significant **benefits** to delivering integrated care for eating disorders across CED and inpatient or intensive day care services. See the table below for further detail.

Benefits of extending the eating disorders pathway for children and young people

Children, young people, their families and carers will benefit from:

- improved delivery of evidence-based treatment to promote recovery, reduce relapse and improve long-term outcomes
- continuous care to meet children and young people's needs, with an integrated, collaborative care package, without multiple referrals to services
- improved access to appropriate treatment that is closer to home
- reduced response times for inpatient or intensive day care
- reduced need for transfer to adult mental health services
- shorter inpatient admissions with fewer delayed discharges
- improved quality of life and overall functioning for the child or young person, including better educational outcomes and social connections
- children and young people being able to access their own support networks, which will cause less disruption to their social development
- families and carers receiving greater support and education on how to care for their child at home, while also maintaining their own mental health
- a clear understanding about what to expect from inpatient or intensive day care.

Commissioners and providers will benefit from:

- greater continuity of care leading to more effective and efficient treatment
- improved knowledge and skills for community and inpatient staff, leading to a more skilled and competent workforce that can deliver person-centred, collaborative, outcome-focused and evidence-based care, and manage high demand on services while improving outcomes.

Economic and financial benefits include:

- appropriate and timely access to integrated eating disorder treatment may decrease long-term health costs by:
 - decreasing the number of admissions that occur
 - reducing length of stay
 - reducing relapse
 - reducing the need for referrals to other services
- increased ability of services to match local demand with capacity, leading to overall reduced bed usage.

5. Quality benchmarks for inpatient and intensive day care for eating disorders

High-quality care

5.1 The recommended approach to treating an eating disorder is NICE-recommended care in the community with a CED service, supported by intensive day care or brief inpatient management for addressing acute complications. The CED service should act as the lead in providing care for children and young people presenting with an eating disorder, even if they are also receiving inpatient or intensive day care.

5.2 NICE-recommended care is defined by the [Eating Disorders NICE guideline](#) and available in Appendix B of the [appendices and helpful resources](#).

When a child or young person requires inpatient or intensive day care, either urgent or non-urgent, the CED service and the inpatient or intensive day care team should work together to make sure care is provided in a collaborative way. In line with the [Eating Disorders NICE guideline](#) (Section 1.11), an inpatient admission should be brief in duration, and as close to the child or young person's home as possible.

5.3 Some CED services are able to offer intensive community, home treatment or day care provision. However, there are instances when the intensity of treatment required cannot be provided in the community, such as when:

- There is a significant physical risk that requires medical stabilisation
- There is a significant psychiatric risk that cannot be managed safely in the community (for example, suicidality)
- The child or young person has not responded to intensive treatment in the community or their needs cannot be addressed effectively in the community, and there continues to be a physical and/or psychiatric risk that requires a period of inpatient or intensive day care.

5.4 If the child or young person does require an admission, the CED service should provide oversight, support and consultation throughout the pathway, including during episodes of inpatient or intensive day care. There should be clear joint working arrangements between the inpatient and CED service to ensure continuity of care during an admission, with clear relapse prevention planning and discharge arrangements.

"...Giving the local CED [service] clinical oversight is extremely important. During my second admission, my CED [service] had clinical oversight, my home consultant visited the hospital, and my home therapist came to give me therapy. I felt like I was in control of my treatment, that it wasn't something being 'done to me'."

Young person, 2017

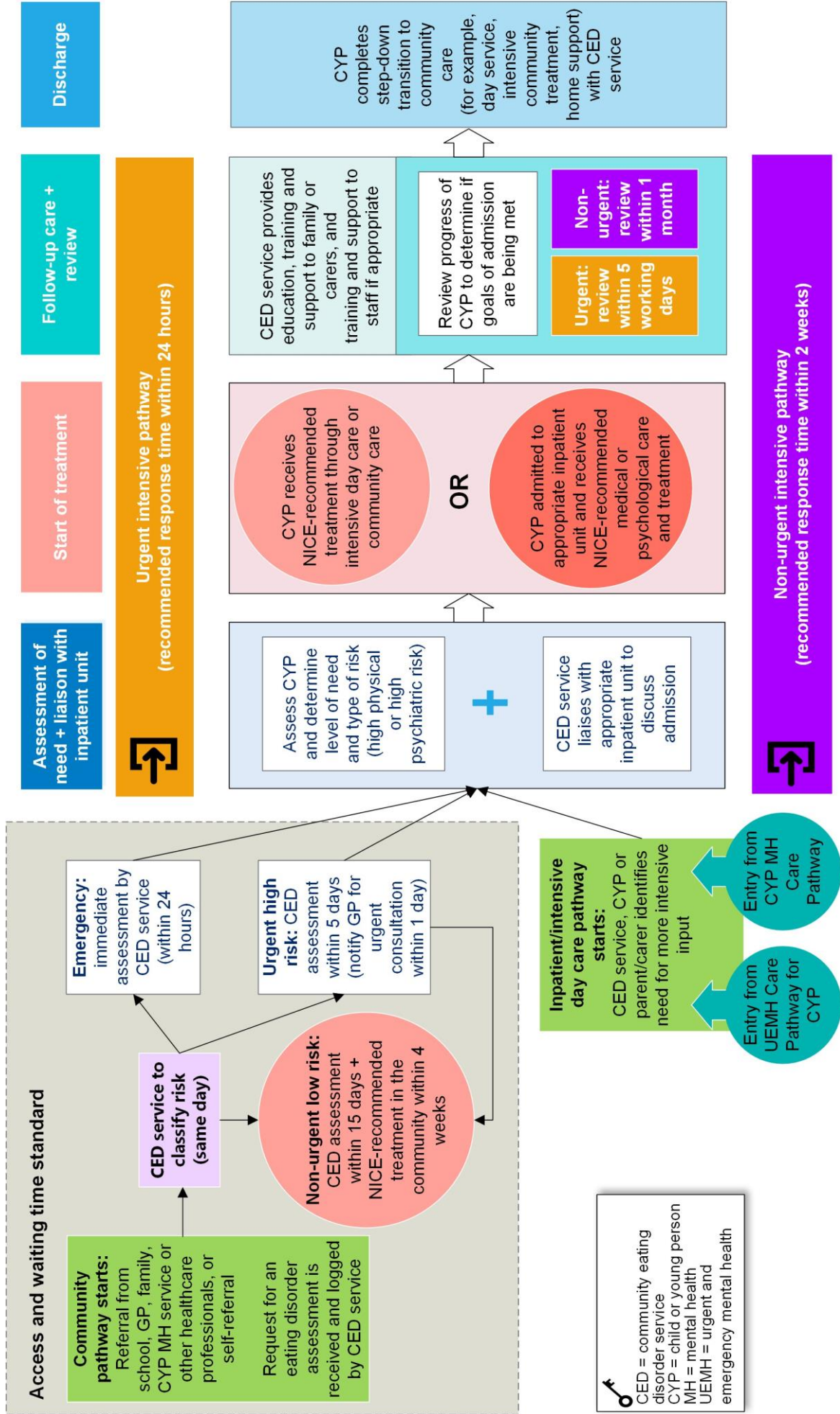
5.5 The pathway sets out the recommended actions from the point at which a child or young person with an eating disorder is identified as needing inpatient or intensive day care, to the time when they start receiving NICE-recommended care in that setting to meet their needs. See the diagram on the next page for an overview of the pathway.

Appendix B of the [appendices and helpful resources](#).

For examples of how some inpatient, intensive day care and community services are achieving specific commissioning goals, please see the **positive practice examples** in the [appendices and helpful resources](#).

The **diagram** on page 10 summarises the eating disorder pathway for children and young people incorporating inpatient and intensive day care.

The eating disorders pathway for children and young people — summary diagram



- 5.6 The following factors underpin the provision of mental health care for children and young people:
- the care setting
 - education, social and cultural considerations
 - mental capacity and consent
 - information sharing
 - safeguarding
 - changes to care
 - managing comorbid conditions
 - the diverse needs of population groups
 - considerations for vulnerable populations.

Timely access

5.7 Children and young people should be able to access help as quickly as possible. The benchmarks and recommended response times were developed based on NICE guidelines and quality standards, evidence of positive practice from published literature and existing services, consensus from an Expert Reference Group comprising a wide range of stakeholders, and through engagement with children, young people, and their families and carers, to reflect a reasonable timeframe to receive help. Data will be collected through the [Mental Health Services Dataset](#) to provide transparency on current performance and allow commissioners and providers to compare themselves and reduce unwarranted variation.

5.8 When a child or young person requires an urgent or non-urgent admission, and they have been receiving NICE-recommended care in the community, they should continue to receive this during their admission to ensure continuity of care.

Key pathway principles

- 5.9 Several guiding principles should be applied when providing care to children and young people with an eating disorder across all care settings:
- ensuring prompt access to treatment
 - early access to evidence-based care in the community as soon as an eating disorder is suspected
 - collaboration and supportive engagement with the child or young person
 - involving and supporting families and carers
 - informed and shared decision-making
 - integrated, multi-agency approach to care, including effective management of transitions
 - focusing on the needs of the child or young person and their family or carers rather than the needs of the service.

Key pathway functions

5.10 There are a number of **key functions** of inpatient and intensive day care that should be provided to meet the needs of the child or young person with an eating disorder and their family or carers. These functions should be delivered jointly by the CED and inpatient or intensive day care service, with the CED service leading the overall provision of care:

Advice and liaison: skilled, competent and experienced professionals should be available to provide consultation and support to other services.

Assessment: assessments for admission should involve a collaborative response between physical and mental health professionals.

“Promote shared decision-making. Even if there is something that must happen, there should always be a conversation about how it happens. If you include us, you will empower us.”

Young person, 2017

Care plans: should be collaboratively developed with the child or young person, and their family or carers if appropriate, and be individually tailored to meet their physical, psychological and social needs.

Provision of inpatient care: the provision of NICE- recommended care should also include:

- an orientation to the inpatient unit, including written information
- good quality, individually tailored meal programmes that support transition back to the community
- physical or medical care
- psychological interventions.

Provision of intensive day care: NICE- recommended care that is equivalent to inpatient care (with some exceptions, such as nasogastric tube feeding) should be provided at least four to five days a week, with the ability to provide at least three main meals where necessary.

Support, education and training for families and carers: the additional psychological, social or financial needs (particularly if care of their child impacts on employment) of families and carers should be considered and addressed. They should be involved in treatment plans, have their own mental health needs assessed, and be given information, education, training and/or therapy as needed.

Transitions: these should be based on the needs of the child or young person, and their family or carers, with clear discharge planning from the start of admission, and a focus on the readiness of the child or young person for community treatment. Changes in care should be made in a coordinated manner with clear consideration of relapse prevention and the need for multi-agency review. NICE guidance on [transitions from an inpatient to community setting](#) and [transitions from children's to adults' services](#), should be followed.

The CED service should play a key role in working with families and carers to provide support, education and information, particularly on how they can support the child or young person during periods of home leave, and once they have been discharged.

Reviews

5.11 A formal review should occur within **one month** of non-urgent intensive input (or sooner if necessary) and should include the inpatient or intensive day care team, the CED service, the child or young person, their family or carers and any other relevant agency involved in their care.

5.12 For urgent intensive input, a review should occur within **five working days of admission**. Follow-up reviews should then occur at regular intervals (recommended weekly), with a maximum of four weeks between reviews.

Outcomes measures

5.13 Outcomes measures should be used consistently across CED and inpatient or intensive day care services. They should always be used with the child or young person and their family or carers as part of a collaborative process to identify their needs, gauge their progress and reflect their experience of care. Outcomes measures are also a useful tool for review meetings, multidisciplinary team discussions and clinical supervision sessions.

Appendix B in [the eating disorders pathway for children and young people: community care guidance](#) for further detail.

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