

# **Appendices and Helpful Resources for Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care**

# Appendices and Helpful Resources for Adult eating disorders: community, inpatient and intensive day patient care

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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

This guidance can be made available in alternative formats, such as easy read or  
large print, and may be available in alternative languages, upon request. Please  
contact by emailing [england.adultmh@nhs.net](mailto:england.adultmh@nhs.net)

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## Appendix A: NICE guidance

NICE guidelines and quality standards provide the basis for defining evidence-based care and can be used to measure the standard of mental health care within a service. Further information regarding the recommendations in each guideline can be found on the [NICE webpage](#).

### Appendix A.1: Key NICE guidelines

[Eating Disorders: Recognition and Treatment \(NG69\)](#)

[Patient Experience in Adult NHS Services: Improving the Experience of Care for People using Adult NHS Services \(CG138\)](#)

[Service User Experience in adult Mental Health: Improving the Experience of Care for People using Adult NHS Mental Health Services \(CG136\)](#)

[Transition between Inpatient Mental Health Settings and Community or Care Home Settings \(NG53\)](#)

[Transition from Children's to Adults' Services for Young People using Health or Social Care services \(NG43\)](#)

#### Appendix A.1.1: NICE guidelines for mental health comorbidities

[Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance \(CG192\)](#)

[Antisocial Personality Disorder: Prevention and Management \(CG77\)](#)

[Bipolar Disorder: Assessment and Management \(CG185\)](#)

[Borderline Personality Disorder: Recognition and Management \(CG78\)](#)

[Coexisting Severe Mental Illness \(Psychosis\) and Substance Misuse: Assessment and Management in Healthcare Settings \(CG120\)](#)

[Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services \(NG58\)](#)

[Common Mental Health Problems: Identification and Pathways to Care \(CG123\)](#)

[Depression in Adults: Recognition and Management \(CG90\)](#)

[Generalised Anxiety Disorder and Panic Disorder in Adults: Management \(CG113\)](#)

[Mental Health Problems in People with Learning Disabilities: Prevention, Assessment and Management \(NG54\)](#)

[Obsessive-Compulsive Disorder and Body Dysmorphic Disorder: Treatment \(CG31\)](#)

[Post-traumatic Stress Disorder \(NG116\)](#)

[Preventing Suicide in Community and Custodial Settings \(NG105\)](#)

[Psychosis and Schizophrenia in Adults: Prevention and Management \(CG178\)](#)

[Self-harm in Over 8s: Long-term Management \(CG133\)](#)

[Social Anxiety Disorder: Recognition, Assessment and Treatment \(CG159\)](#)

### Appendix A.1.2: NICE guidelines for physical health comorbidities

[Acute Heart Failure: Diagnosis and Management \(CG187\)](#)

[Acute Kidney Injury: Prevention, Detection and Management \(CG169\)](#)

[Acute Upper Gastrointestinal Bleeding in Over 16s: Management \(CG141\)](#)

[Acutely ill Adults in Hospital: Recognising and Responding to Deterioration \(CG50\)](#)

[Chronic Heart Failure in Adults: Diagnosis and Management \(CG106\)](#)

[Chronic Kidney Disease \(Stage 4 or 5\): Management of Hyperphosphataemia \(CG157\)](#)

[Chronic Kidney Disease in Adults: Assessment and Management \(CG182\)](#)

[Chronic Kidney Disease: Managing Anaemia \(NG8\)](#)

[Hypertension in Adults: Diagnosis and Management \(CG127\)](#)

[Intravenous Fluid Therapy in Adults in Hospital \(CG174\)](#)

[Multimorbidity: Clinical Assessment and Management \(NG56\)](#)

[Osteoporosis: Assessing the Risk of Fragility Fracture \(CG146\)](#)

[Pressure Ulcers: Prevention and Management \(CG179\)](#)

[Type 1 Diabetes in Adults: Diagnosis and Management \(NG17\)](#)

[Type 2 Diabetes in Adults: Management \(NG28\)](#)

### Appendix A.1.3: Other relevant NICE guidelines

[Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence \(CG115\)](#)

[Attention Deficit Hyperactivity Disorder: Diagnosis and Management \(NG87\)](#)

[Autism Spectrum Disorder in Adults: Diagnosis and Management \(CG142\)](#)

[Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities Whose Behaviour Challenges \(NG11\)](#)

[Community Pharmacies: Promoting Health and Wellbeing \(NG102\)](#)

[Decision-Making and Mental Capacity \(NG108\)](#)

[Drug Misuse in Over 16s: Psychosocial Interventions \(CG51\)](#)

[Medicines Adherence: Involving Patients in Decisions about Prescribed Medicines and Supporting Adherence \(CG76\)](#)

[Medicines Optimisation: The Safe and Effective Use of Medicines to Enable the Best Possible Outcomes \(NG5\)](#)

[Obesity: Identification, Assessment and Management \(CG189\)](#)

[People's Experience in Adult Social Care Services: Improving the Experience of Care for People Using Adult Social Care Services \(NG86\)](#)

[Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals \(SG1\)](#)

[Violence and Aggression: Short-Term Management in Mental Health, Health and Community Settings \(NG10\)](#)

[Transition Between Inpatient Hospital Settings and Community or Care Home Settings for Adults with social Care Needs \(NG27\)](#)

## **Appendix A.2: NICE quality standards**

NICE quality standards consist of a prioritised set of specific, concise and measurable statements, designed to support the improvement of care. Further information regarding the measurement of each quality statement can be found on the [NICE webpage](#) for the relevant quality standard.

### Appendix A.2.1: Key quality standards

[Eating Disorders \(QS175\)](#)

[Patient Experience in adult NHS Services \(QS15\)](#) – to be updated in March 2019

[Service User Experience in Adult Mental Health Services \(QS14\)](#) – to be updated in March 2019

[Transition between Inpatient Mental Health Settings and Community or Care Home Settings \(QS159\)](#)

[Transition from Children's to Adults' Services \(QS140\)](#)

### Appendix A.2.2: Quality standards relevant for mental health comorbidities

[Antenatal and Postnatal Mental Health \(QS115\)](#)

[Anxiety Disorders \(QS53\)](#)

[Bipolar Disorder in Adults \(QS95\)](#)

[Depression in Adults \(QS8\)](#)

[Personality Disorders: Borderline and Antisocial \(QS88\)](#)

[Psychosis and Schizophrenia in Adults \(QS80\)](#)

[Self-harm \(QS34\)](#)

### Appendix A.2.3: Quality standards relevant for physical health comorbidities

[Acute Heart Failure \(QS103\)](#)

[Acute Kidney Injury \(QS76\)](#)

[Acute Upper Gastrointestinal Bleeding in Adults \(QS38\)](#)

[Chronic Heart Failure in Adults \(QS9\)](#)

[Chronic Kidney Disease in Adults \(QS5\)](#)

[Diabetes in Adults \(QS6\)](#)

[Intravenous Fluid Therapy in Adults in Hospital \(QS66\)](#)

[Multimorbidity \(QS153\)](#)

[Obesity: Clinical Assessment and Management \(QS127\)](#)

[Osteoporosis \(QS149\)](#)

[Pressure Ulcers \(QS89\)](#)

### Appendix A.2.4: Other relevant quality standards

[Alcohol-Use Disorders: Diagnosis and Management \(QS11\)](#)

[Attention Deficit Hyperactivity Disorder \(QS39\)](#)

[Autism \(QS51\)](#)

[Drug Use Disorders in Adults \(QS23\)](#)

[Learning Disabilities: Challenging Behaviour \(QS101\)](#)

[Learning Disabilities: Identifying and Managing Mental Health Problems \(QS142\)](#)

[Medicines Optimisation \(QS120\)](#)

[Promoting Health and Preventing Premature Mortality in Black, Asian and Other Minority Ethnic Groups \(QS167\)](#)

[Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs \(QS136\)](#)

[Violent and Aggressive Behaviours in People with Mental Health Problems \(QS154\)](#)

## Appendix B: Evidence-based psychological interventions

This is a high-level summary of evidence-based psychological interventions from the [eating disorders NICE guideline \(NG69\)](#). Please refer to the guideline for detailed recommendations on how to provide treatment.

| Recommendation   | Detail  | NICE reference |
|--|---|----------------|
| <b>Anorexia nervosa – adults</b>   |   |                |
| Individual eating disorder-focused cognitive-behavioural therapy (CBT-eating disorder)   | Typically consists of up to 40 sessions over 40 weeks, with twice-weekly sessions in the first 2 or 3 weeks   | 1.3.5          |
| Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)  | Typically consists of 20 sessions weekly sessions for the first 10 weeks and a flexible schedule after this, up to 10 extra sessions for people with complex problems | 1.3.6          |
| Specialist Supportive Clinical Management (SSCM)   | Typically consists of 20 or more weekly sessions (depending on severity)  | 1.3.7          |
| If individual CBT-eating disorder, MANTRA or SSCM is unacceptable, contraindicated or ineffective for adults with anorexia nervosa, consider: <ul style="list-style-type: none"> <li>one of these 3 treatments that the person has not had before or</li> <li>eating-disorder-focused focal psychodynamic therapy (FPT)</li> </ul> | FPT: typically consists of up to 40 sessions over 40 weeks  | 1.3.8          |
|  |   |                |
| <b>Anorexia nervosa – all</b>  |   |                |
| Only offer dietary counselling as part of a multidisciplinary approach   |   | 1.3.20         |
| Do not offer medication as the sole treatment  |   | 1.3.24         |
| <b>Binge eating disorder</b>   |   |                |
| Offer a binge eating disorder-focused guided self-help programme   | Guided self-help programmes can improve recovery rates and reduce binge eating frequency  | 1.4.2          |
| If guided self-help is unacceptable, contraindicated or ineffective after 4 weeks, offer group CBT-eating disorder   | 16 weekly 90 minute group sessions over 4 months  | 1.4.4          |
| If group CBT-eating disorder is not available or the person declines it, consider individual CBT-eating disorder for adults with binge eating disorder   | 16 - 20 sessions  | 1.4.6          |



| <b>Bulimia nervosa – adults</b>   |   |        |
|---|---|--------|
| Consider bulimia nervosa-focused guided self-help for adults with bulimia nervosa   | Use CBT self-help materials for eating disorders; supplement with brief supportive sessions (4 - 9 sessions lasting 20 minutes each over 16 weeks, weekly at first) | 1.5.2  |
| If bulimia nervosa-focused guided self- help is unacceptable, contraindicated or ineffective after 4 weeks of treatment, consider individual CBT-eating disorder  | Up to 20 sessions over 20 weeks; consider twice weekly sessions in the first phase  | 1.5.4  |
| <b>Bulimia nervosa – all</b>  |   |        |
| Do not offer medication as the sole treatment   |   | 1.5.11 |
| <b>Other specified feeding and eating disorders</b>   |   |        |
| For people with other specified feeding and eating disorders (OSFED), consider using the treatments for the eating disorder it most closely resembles   |   | 1.6.1  |
| <b>Comorbidities</b>  |   |        |
| Eating disorder specialists and other healthcare teams should collaborate to support effective treatment of physical or mental health comorbidities in people with an eating disorder   |   | 1.8.1  |
| When collaborating, teams should use outcome measures for both the eating disorder and the physical and mental health comorbidities, to monitor the effectiveness of treatments for each condition and the potential impact they have on each other |   | 1.8.2  |

Commissioners and providers should consider how the eating disorder treatment pathway could be enabled through the use of evidence-based technologies (such as self-management apps, telehealth or digitally-enabled models of therapy). Further information can be found on: <https://www.nice.org.uk/about/what-we-do/our-programmes/evidence-standards-framework-for-digital-health-technologies>

## Appendix C: Measuring quality

The [eating disorders quality standard \(QS175\)](#) covers assessment, treatment, monitoring and care for children, young people and adults with an eating disorder. Each quality statement should be measured through local data collection and feedback from people who use the service, and their families and carers, on their experience of the quality of care provided, to determine whether a service is meeting the requirements of providing high-quality evidence-based treatment.

| Statement   | Structure   | Process   | Outcome   |
|---|---|---|---|
| <p><a href="#">Statement 1</a><br/>People with suspected eating disorders who are referred to an eating disorder service start assessment and treatment within 4 weeks for children and young people or a locally agreed timeframe for adults</p> | <p>Evidence that local referral pathways are in place for adults to start assessment and treatment within a locally agreed timeframe</p> <p><b>Data source:</b> local data collection, such as service specifications</p> | <p>Proportion of adults with suspected eating disorder who are assessed and treated within locally agreed timeframes</p> <p><b>Data source:</b> local data collection such as audit of electronic records</p> | <ul style="list-style-type: none"> <li>Length of time from referral to assessment and start of treatment at an eating disorder service for adults with suspected eating disorders</li> </ul> <p><b>Data source:</b> local data collection such as audit of electronic records</p> <ul style="list-style-type: none"> <li>Rate of recovery for people with eating disorders</li> </ul> <p><b>Data source:</b> local data collection through outcome measures such as the Eating Disorder Examination Questionnaire (EDE-Q)</p> |

| Statement  | Structure  | Process  | Outcome   |
|--|--|--|---|
| <p><a href="#">Statement 2</a><br/>People with eating disorders have a discussion with a healthcare professional about their options for psychological treatment</p> | <p>Evidence of local arrangements to provide psychological treatments for people with eating disorders</p> <p><b>Data source:</b> local data collection, such as service specifications</p>  | <p>Proportion of people with eating disorders who have a documented discussion with a healthcare professional about their options for psychological treatment at the point of diagnosis</p> <p><b>Data source:</b> local data collection such as audit of electronic records</p> |   |
| <p><a href="#">Statement 3</a><br/>People with binge eating disorder participate in a guided self-help programme as first-line psychological treatment</p>           | <p>Evidence of local arrangements to provide a guided self-help programme as a first-line psychological treatment for people with binge eating disorder</p> <p><b>Data source:</b> local data collection, such as service specifications</p> | <p>Proportion of people with binge eating disorder who participate in a guided self-help programme as first- line psychological treatment</p> <p><b>Data source:</b> local data collection such as audit of electronic records</p>   | <ul style="list-style-type: none"> <li>• Binge eating frequency for people with binge eating disorder</li> <li>• Rate of relapse for people with binge eating disorder</li> </ul> <p><b>Data source:</b> local data collection through outcome measures such as the EDE</p> |

| Statement   | Structure  | Process  | Outcome  |
|---|--|--|--|
| <p><a href="#">Statement 5</a><br/>People with eating disorders who are being supported by more than one service have a care plan that explains how the services will work together</p> | <p>Evidence of joint working arrangements, including regular liaison and meetings to discuss care plans, between eating disorder services and other services, using formal processes of care planning</p> <p><b>Data source:</b> local data collection, such as contracts and service specifications</p>   | <p>Proportion of people with eating disorders supported by more than one service who have a care plan that explains how the services will work together</p> <p><b>Data source:</b> local data collection such as audit of electronic records</p>   | <ul style="list-style-type: none"> <li>Rate of relapse for people with eating disorders who are supported by more than one service</li> </ul> <p><b>Data source:</b> local data collection through service user experience of eating disorder services</p>   |
| <p><a href="#">Statement 6</a><br/>People with eating disorders who are moving between services have their risks assessed</p>   | <ul style="list-style-type: none"> <li>Evidence of joint transition protocols between eating disorder services and other services, using formal processes of care planning</li> <li>Evidence of joint working arrangements, including regular liaison and meetings, to discuss risk assessment and monitoring at transition between eating disorder services and other services providing care for people with eating disorders</li> </ul> | <ul style="list-style-type: none"> <li>Proportion of people with eating disorders moving between services who have a care plan that includes a risk assessment before and after transfer</li> </ul> <p><b>Data source:</b> local data collection such as audit of electronic records or care plans</p> | <ul style="list-style-type: none"> <li>Proportion of people with eating disorders who have moved between services and did not attend their first meeting or appointment</li> <li>Relapse rate of people with eating disorders who move between services</li> <li>Service user experience of eating disorder services</li> </ul> <p><b>Data source:</b> local data collection through local audits of electronic records and surveys to measure</p> |

**Data source:** local data collection, such as contracts and service specifications

service user experience of eating disorder services

## Appendix D. Implementation challenges and solutions

Below are some of the challenges that clinicians, service manager and experts by experience have highlighted in relation to community-based eating disorder services for adults, along with potential solutions and evidence that these solutions are working effectively.

| Issue or Challenge  | Suggested solution  | Evidence of implementing solution   |
|---|---|---|
| <b>People with experience of using eating disorder services</b>   |   |   |
| <p>Balance around discharge– people should not be discharged too soon and left without any care</p>                           | <ul style="list-style-type: none"> <li>• Appropriate therapeutic management of endings (especially when discharged from a CED service)</li> <li>• Clinicians need to explain the rationale behind discharge and encourage re-access if the person feels they need it</li> <li>• Self-referral back to services available and promoted to people using CED services, their families or carers</li> <li>• Expectation should be established at the outset that this will be a time-limited treatment and the person should be sufficiently prepared for the ending</li> </ul> | <ul style="list-style-type: none"> <li>• Service User experience surveys or feedback</li> <li>• Re-referral rate</li> </ul> |
| <p>Exclusion of patients: Being excluded from mental health services if also presenting with a comorbid disordered eating</p> | <ul style="list-style-type: none"> <li>• Mental health services should liaise with CED services to clarify a possible diagnosis of an eating disorder; they should jointly come up with an agreed plan of where the person can receive the most effective treatment</li> <li>• Requires improvements in joined up working facilitated by sustainability</li> </ul>  |   |

|   |  |   |
|---|--|---|
|   | and transformation partnership (STP) level governance structures   |   |
| Parents/carers/support network may not have access to information around the person's care under adult services | <ul style="list-style-type: none"> <li>• Carer's assessment should be offered</li> <li>• Services should be proactive in reaching out to parents and carers, and offering them general information about eating disorder services</li> <li>• Clinicians need to take a developmental perspective and encourage people to involve their family; discuss ways in which it can be beneficial; and reassure them about any concerns they may have</li> <li>• Accessible information in multiple formats and languages</li> </ul>                 | <ul style="list-style-type: none"> <li>• Carer experience survey</li> <li>• Evidence of service protocols or processes providing parents, carers or members of the support network with information</li> </ul>  |
| Lack of clarity on medical monitoring arrangements  | <ul style="list-style-type: none"> <li>• Medical monitoring needs to be as easy as possible for the person</li> <li>• A CED service agrees a care plan and discharge plan with a person; the plan should cover medical monitoring arrangements</li> <li>• Person and GP have a copy of the care plan and the discharge plan</li> <li>• GP local enhanced service to support funding and primary care training</li> <li>• Consider primary care leads – either at GP practice level or primary care network level as these develop</li> </ul> | <ul style="list-style-type: none"> <li>• Sample audit of care plans or discharge plans (for inclusion of medical monitoring)</li> <li>• Person and primary care spot audit – clear medical monitoring instructions</li> <li>• Service user/carer surveys or feedback</li> </ul> |

|   |   |  |
|---|---|--|
| Lack of high-quality information on local CED services – what they offer and what to expect | <ul style="list-style-type: none"> <li>• Up-to-date website</li> <li>• Accessible information in multiple formats</li> </ul>  | <ul style="list-style-type: none"> <li>• Evidence of website, accessible information in multiple formats</li> </ul>  |
| Lack of support, education, training for families, partners, carers and the support network | <ul style="list-style-type: none"> <li>• Ensure access to, or information on, carers groups, training, skills workshops</li> <li>• Supported signposting to carers' assessment (through the local authority)</li> </ul>   | <ul style="list-style-type: none"> <li>• Number of carer assessments</li> <li>• Evidence of joint working with other services to support families and carers</li> <li>• Evidence of carer protocols within the CED service</li> <li>• Evidence of CCG-commissioned carers' services</li> </ul> |
| <b>Commissioners and Providers</b>  |   |  |
| Lack of joined up working across services   | <ul style="list-style-type: none"> <li>• Clinical networks can be helpful in improving collaboration between services in some areas</li> <li>• Locate the eating disorder teams of all ages together to aid mutual support and learning as well as promoting better communication</li> <li>• Joint training between eating disorder and other mental health service staff</li> <li>• Contracts/service specifications to include requirement for joint working</li> <li>• Governance/delivery structures to focus on integration of services</li> </ul> | <ul style="list-style-type: none"> <li>• Service user experience survey or feedback</li> <li>• Staff experience survey or feedback</li> </ul>  |
| Challenges of transforming CED service with new models or ways of working                   | <ul style="list-style-type: none"> <li>• Best practice examples to be shared to offer guidance on potential models</li> </ul>   | <ul style="list-style-type: none"> <li>• Evidence of service protocols or agreements to support new ways of working</li> </ul>   |



|   |  |   |
|---|--|---|
|   | <ul style="list-style-type: none"> <li>• Close working between commissioners and providers to transform services in line with the assessed needs of their local population</li> <li>• Use contractual mechanisms to support transformation (e.g. service delivery improvement plan – SDIP)</li> <li>• Consider how new care models now NHS- led provider collaboratives can be used to create efficiencies which could be used to fund the service (e.g. to increase funding into CED service). An overarching need should be to improve the quality of the CED service</li> </ul> | <ul style="list-style-type: none"> <li>• Evidence of completing a needs assessment of the local population and using the data to inform service specifications</li> </ul> |
| Multiple commissioners using the same provider – commissioning different service levels | <ul style="list-style-type: none"> <li>• Needs to be a lead commissioner for local services</li> <li>• STP hold commissioners to account</li> <li>• Aim to create parity between CYP and adult eating disorder services</li> <li>• Outcome-based commissioning at population level</li> <li>• Commissioners should work with providers to agree what processes need to be in place to deliver care in line with guidelines and improve access to evidence-based treatment</li> </ul>   | <ul style="list-style-type: none"> <li>• Monitor eating disorder patient outcomes at STP level</li> <li>• Commissioners to evidence service provision</li> </ul>          |
| Managing the relationship between voluntary,  | <ul style="list-style-type: none"> <li>• Contracting processes (e.g. alliance contracting)</li> </ul>  | <ul style="list-style-type: none"> <li>• Surveys/feedback at organisation level</li> </ul>  |

|   |   |  |
|---|---|--|
| <p>community and social enterprise (VCSE) sector and statutory services</p>   | <ul style="list-style-type: none"> <li>• Partnership working supported via mental health care delivery governance processes</li> <li>• Joint meetings and training opportunities, to improve relationships and mutual understanding</li> </ul>  | <ul style="list-style-type: none"> <li>• Protocols to support partnership working</li> </ul>   |
| <p>Acute hospitals – lack of clarity on pathway to access acute medical services when required and joint working with CED services</p>  | <ul style="list-style-type: none"> <li>• Pathway agreed between acute hospitals and CED services: on how to access acute medical care if required and protocol for joint working</li> <li>• Achieving this will require joint working at commissioning level between mental health and acute hospital commissioners</li> </ul>  | <ul style="list-style-type: none"> <li>• Evidence of clear pathway to access medical care when required and protocol for joint working between acute hospitals and eating disorder services</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Local authority – lack of clear pathway for carer’s assessments/support</li> <li>• Lack of clarity on eating disorder carer provision or local offer of support</li> </ul> | <ul style="list-style-type: none"> <li>• Clear pathway for carers’ needs assessment included within eating disorder pathway</li> <li>• Clear local authority (LA) information on offer to carers (e.g. carer training, assessments, support options)</li> <li>• The mental health governance structure should support the inclusion of the LA in the eating disorder pathway</li> </ul> | <ul style="list-style-type: none"> <li>• Number of carer assessments</li> <li>• Evidence of clear information on carer support</li> <li>• Evidence of clarity on pathway to access carer assessment within overall eating disorder pathway</li> <li>• Evidence that system mental health governance structure includes LA</li> </ul> |
| <p><b>CED services</b></p>  |   |  |
| <p>Poorly managed transitions from CYP – need a clear purpose and aims for transition</p>   | <ul style="list-style-type: none"> <li>• Flexibility around whether someone remains in CYP care if they are benefitting from care being provided, or is able to enter adult services when presenting</li> </ul>   | <ul style="list-style-type: none"> <li>• FREED protocol (engaging with young people about to transition and accepting young people who are near transition age at first presentation)</li> </ul>   |

|   |   |  |
|---|---|--|
|   | <p>for the first time before the age of 18 if this avoids an imminent transition</p> <ul style="list-style-type: none"> <li>• Flexible criteria around accessing eating disorder services (e.g. age related)</li> <li>• Joint working between CYP and adult services (e.g. dedicated 16+ workforce, jointly funded between CYP and adult services) to provide a seamless care pathway</li> <li>• Transition coordinators to support patients to transition</li> </ul> | <ul style="list-style-type: none"> <li>• Patient experience</li> <li>• Staff experience</li> <li>• Evidence of transition protocols</li> </ul>   |
| Staffing and recruitment                          | <ul style="list-style-type: none"> <li>• Being flexible with workforce – skill mix and using supervision (e.g. of assistant psychologists)</li> <li>• Recruiting for competences rather than only to professional group</li> <li>• Having a clear workforce strategy to match the needs and make-up of the local population</li> </ul>  | <ul style="list-style-type: none"> <li>• Evidence of competences outlined in job descriptions</li> <li>• Workforce plans to include skill mix, competences and responsibilities</li> </ul>                         |
| Managing “did not attend” rates and cancellations | <ul style="list-style-type: none"> <li>• DNA rates can be a function of waiting times – the longer a person is kept on a wait list, the more likely they are to not show up to their first appointment</li> <li>• Manage wait list more effectively to reduce waiting times</li> <li>• Appointment reminder service by text or email</li> <li>• Good information available about the</li> </ul>   | <ul style="list-style-type: none"> <li>• Evidence of waiting times and wait list management strategies</li> <li>• Fall in DNA and cancellation rates</li> <li>• Data on impact of appointment reminders</li> </ul> |

|  |   |  |
|--|---|--|
|  | <p>assessment appointment and what it entails</p> <ul style="list-style-type: none"> <li>• Assertive follow up by the CED service when a person does not turn up (e.g. by telephone) to offer an alternative appointment</li> <li>• Support for people on waiting lists through VCSE organisations or guided self-help (where appropriate)</li> </ul>   |  |
| Removing access criteria may increase waiting lists                          | <ul style="list-style-type: none"> <li>• Waiting lists need to be monitored and discussed jointly with commissioners and providers and action plans to manage any increase should likewise be developed jointly</li> <li>• Upskill practitioners in the wider care network to support people with mild to moderate needs</li> <li>• Services need to transform to deliver the most efficient care that they can in line with NICE guidance</li> </ul> | <ul style="list-style-type: none"> <li>• Waiting list data</li> <li>• Evidence of plans to manage increase in demand</li> </ul>                              |
| <b>Primary care</b>  |   |  |
| Identifying early signs of an eating disorder, identifying and managing risk | <ul style="list-style-type: none"> <li>• Joint working with a CED service</li> <li>• Primary care training</li> <li>• Primary care eating disorder awareness campaign – local, regional and national levels</li> <li>• CEDs engaging in partnerships with VCSE organisations to deliver training to primary care staff on spotting the early signs of eating disorders</li> </ul>   | <ul style="list-style-type: none"> <li>• Primary care feedback/survey</li> <li>• Numbers of primary care staff attending eating disorder training</li> </ul> |

|   |   |  |
|---|---|--|
|   | and the importance of immediate referral for specialist assessment  |  |
| Lack of expertise in interpreting medical monitoring results  | <ul style="list-style-type: none"> <li>• Specialists in the CED service to be accessible for consultation with GPs to interpret results correctly</li> <li>• Primary care training – as above</li> <li>• Brief primary care medical monitoring guideline</li> </ul>   | <ul style="list-style-type: none"> <li>• GP feedback/survey</li> <li>• CED staff feedback/survey</li> <li>• Number of serious incidents related to medical monitoring</li> </ul> |
| Lack of clarity on the local service offer for people with an eating disorder, to enable management of expectations     | <ul style="list-style-type: none"> <li>• Clear eating disorder pathway and sources of information (e.g. service user leaflets, website)</li> </ul>  | <ul style="list-style-type: none"> <li>• Primary care feedback/survey</li> <li>• Service user feedback/survey</li> </ul>   |
| Lack of clarity on primary care medical monitoring responsibilities and funding arrangements                            | <ul style="list-style-type: none"> <li>• Commissioned medical monitoring pathway/protocol – clarity on responsibilities of primary care, funding in place</li> </ul>  | <ul style="list-style-type: none"> <li>• Evidence of commissioned medical monitoring pathway</li> </ul>  |
| <b>Advancing equality</b>   |   |  |
| Considering and meeting the needs of a range of people, including males, transgender and binary people (see Appendix H) | <ul style="list-style-type: none"> <li>• Ensure appropriate facilities are provided for all genders and people of other identities (including those who are transgender and who identify as non-binary)</li> <li>• Appropriate staffing</li> <li>• Staff trained in how to deliver culturally informed treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Service user feedback</li> </ul>  |

## Appendix E. Outcome measures

When deciding on an approach to routinely measuring progress and outcomes in people with an eating disorder, several factors should be considered in relation to the methodology and the tools and measures to be used:

- **psychometric properties:** tools should be valid and provide a reliable measure of change over time
- **clinical utility:** measures should have clinical value and be central to the delivery of care, with progress and outcomes discussed with the person as part of their treatment
- **staff competence:** staff should be trained and competent in using and supervising the use of outcome measures, including knowledge of when (and when not) to use them, their strengths and limitations, and how to integrate outcomes to guide clinical decisions and interventions
- **timeframe:** progress and outcomes should be measured on a session-by-session basis throughout treatment, based on discussion and agreement with the person.

The following table outlines a range of outcome measures that should be used with people who present with an eating disorder.

| Domain   | Measure   | Description   | Completed by                   |
|--|---|---|--------------------------------|
| <b>Eating disorder symptoms and behaviours</b> | Eating Disorder Examination Questionnaire ( <a href="#">EDE-Q 6.0</a> )                               | Measures the range and severity of eating disorder symptoms and behaviours  | Person with an eating disorder |
| <b>Progress</b>                                | Goal-Based Outcome ( <a href="#">GBO</a> ) Tool   | Method to measure progress and outcomes of an intervention  | Person with an eating disorder |
| <b>General functioning</b>                     | Clinical Impairment Assessment ( <a href="#">CIA</a> ) questionnaire                                  | Measures the severity of psychosocial impairment due to eating disorder features  | Person with an eating disorder |
|  | Health of the Nation Outcome Scales ( <a href="#">HoNOS</a> ) – adapted for use with eating disorders | Measures behaviour, impairment, symptoms and social functioning. The Royal College of Psychiatrists' Faculty of Eating Disorders Psychiatry has produced <a href="#">guidance</a> for using | Clinician                      |

|                       |   |   |                                |
|-----------------------|---|---|--------------------------------|
|                       |   | the HoNOS with people who have an eating disorder   |                                |
| <b>Other symptoms</b> | Patient Health Questionnaire ( <a href="#">PHQ-9</a> )            | Used to facilitate the recognition and identification of depression                                 | Person with an eating disorder |
|                       | Generalised Anxiety Disorder Assessment ( <a href="#">GAD-7</a> ) | Used to assess the severity of anxiety  | Person with an eating disorder |
| <b>Other measures</b> | WHO Quality of Life measure ( <a href="#">WHOQOL</a> )            | Developed by the World Health Organization to measure the improvement in a person's quality of life | Person with an eating disorder |

Appropriate outcome measures should be used when people present with a comorbid mental health or physical health problem. This will enable monitoring the effectiveness of treatment and the potential impact of comorbidities (see [NICE guideline section 1.8](#)). Services should also measure the person's experience of care in accordance with the [Service User Experience in Adult Mental Health Services quality standard \(QS14\)](#).

## Appendix F: Support for students in higher education

Students in higher education (HE/FE Colleges) are a potentially vulnerable group, with high rates of eating disorders. Starting university or other forms of HE presents young people with multiple challenges, including but not limited to: living independently for the first time, being away from established supports such as family and friends, managing academic demands, making new friends, negotiating relationships and caring for themselves, including shopping, cooking and managing their health and health care<sup>1</sup>. Eating disorders may newly arise in this context and pre-existing eating disorders can easily deteriorate without this being detected and treated in a timely fashion.<sup>2</sup>

The following issues need to be considered, especially in relation to people with severe current or recent eating disorders: (1) fitness to study; (2) helping students to prepare for starting or returning to university; and (3) managing transitions of care between home and university.

### **Fitness to study/return to studies**

Helpful guidance exists regarding fitness to study for students with severe eating disorders (Higher Educational Occupational Physicians/Practitioners – HEOPS; <http://www.heops.org.uk/guide.php>). This guidance should be used collaboratively by CED services to facilitate optimal decision making and planning between a CED service, the person and their family, in liaison with other relevant parties (such as university health and wellbeing staff, academic staff, home and university GPs, as appropriate). In interpreting HEOPS guidance, careful thought needs to be given to the balance between actual or potential benefits or harms of continuing or taking a break from studies as well as the supports available for studying and recovering in the home or university setting. Any such assessment is likely to take time. Decisions will need to be reviewed over time and adjusted according to the person's response to treatment and any change in circumstances.

- Assessment and treatment planning for any students newly presenting to CED services with an eating disorder needs to consider their fitness to continue to study in discussion with the student and other relevant parties and needs to make clear recommendations, including an action plan.
- Where the person has not yet started university or is currently taking time out to focus on their recovery, the CED service needs to be proactive and start collaborative discussions about fitness to study or return to studies. This needs to involve all relevant parties well in advance of the start of the academic year and should aim to have a jointly agreed care plan in place before the person can start or return to university.
- Special considerations apply for students in regulated professions, such as the NHS – if a CED service is concerned that a student may not be fit to practise, they may need to report them to the appropriate authorities (when a student is not willing to do so themselves).



## Helping students prepare for starting and returning to university/HE

This includes helping students prepare for: (a) the challenges that all young people starting university/HE face; (b) the challenges that people with eating disorders face (such as shopping, cooking, budgeting by themselves, eating in halls, social eating, etc.); and (c) helping them access services and supports at their university.

To address normative and eating disorder-related challenges associated with starting university, a CED service should:

- consider running university starter or return groups; protocols for these exist as part of FREED ([FREEDfromED.co.uk](http://FREEDfromED.co.uk))
- provide a person with relevant information (such as the [FREED Preparing for University guide](#)), help them discuss their concerns and anxiety, and problem-solve or trouble shoot around them.

## Planning for and managing care and transitions of care

Many students regularly move forwards and backwards between home and university accommodation. For all students with a current or past eating disorder who are studying away from home, careful thought needs to be given as to how best to ensure well-coordinated, timely, responsive and supportive care.

- Students need to have the option of having named GPs in both places (home and university) and a CED service may need to be involved in both places.
- There will need to be clear written agreements between home and university health services that should cover:
  - who is responsible for what aspects of care
  - how any changes are going to be communicated and to whom
  - indicators of risk, deterioration and relapse and how to respond to them
  - what should happen in a crisis.
- These plans should usually be shared with the student's family or carers (as appropriate and with the student's consent). Home CED services of a person with an eating disorder who is moving away to start university should usually keep the person open to their service at least until the end of the first year of study, as they may be best placed to deal with any initial adjustment difficulties.
- Consideration should be given to having some ongoing contact between the person and the home CED service while they are settling into university life and are getting known to services at university. This contact may include reviews during university holidays, phone calls or Skype or email check-ins.
- In some cases, young people who have received treatment for an eating disorder from their local CYP-eating disorder (CYP-CED) service, will be transferred to an adult CED service on or after their 18<sup>th</sup> birthday. A CED service may then immediately have to refer them on to university-based services, before being able to get to know them, let alone build a

relationship with them. In these cases, it is best practice for the CYP-CED service to provide advice and support to the person during their transition to university.

- CEDs should be open to accepting referrals from GPs and other CEDs outside of their area to facilitate a safe transition. Not being registered with a GP in the same area as the new service should not preclude a student from accessing the CED while at their university address. Instead, the CED should support them in registering with a GP at their university address as part of their care plan.

## Appendix G: Peer support

Research evaluating peer support workers (PSWs) in eating disorder services is sparse, and that which is available is of limited quality. Consequently, NICE guidance on eating disorders has recommended research evaluating the effectiveness of peer support interventions for people with eating disorders and their families or carers.<sup>3</sup>

Peer support workforces have been championed in the [Five Year Forward View for Mental Health](#),<sup>4</sup> and the limited research which is available, anecdotal evidence from service users and the consensus of the Expert Reference Group all support the notion that PSWs can be valuable members of a CED service workforce.

The guidance on PSWs detailed both here and in the main guide has been informed by the consensus of the Expert Reference Group.

- **Training** programmes specifically for PSWs in a CED service are yet to be developed. Guidance for implementing PSWs in mental health services from [Implementing Recovery through Organisational Change](#) indicates that training should empower PSWs to support recovery by equipping them with core skills in communication, active listening, mutual problem solving and personal recovery planning. Ongoing training opportunities should be available for PSWs to further develop their skills and aid career progression.
  - Established training courses for PSWs in mental health services are delivered by [Nottinghamshire Healthcare NHS Trust](#), [Cambridgeshire & Peterborough NHS Foundation Trust](#) and [Central and North West London NHS Foundation Trust](#)
- **Supervision** is critical to the successful incorporation of PSWs into a CED service workforce. A PSW should have an identified line manager and regular supervision, which should provide the opportunity for reflection on working practice.
  - A vital function of regular supervision is to ensure that the PSW's own recovery is not compromised by their undertaking of the role.
  - Supervision will also play an important role in managing risk<sup>5</sup> by facilitating reflection on maintaining appropriate boundaries in the mentoring relationship, circumstances where reporting of information disclosed by a person with an eating disorder is necessary and how to handle risks specific to the person (such as absconding, self-harm etc).

Both training and supervision should be guided by the core principles of peer support in mental health services, as set out in the [Implementing Recovery through Organisational Change](#) initiative:

- mutual
- reciprocal
- non-directive
- recovery focused
- strengths-based
- inclusive
- progressive
- safe.

Beyond peer support for people with an eating disorder, hiring people with lived experience of caring for someone with an eating disorder can be a valuable addition to the CED workforce when it comes to providing support services for families, carers and extended support networks.

### **Peer support resources**

- [Peer Support Workers: a practical guide for implementation](#) – a joint briefing from the Centre for Mental Health and the Mental Health Network NHS Confederation detailing guidance for implementing peer support workers in mental health services.
- [Experts by Experience](#) – guidelines from the Scottish Recovery Network on the development and implementation of peer support workers in the mental health sector.
- [Beat's Echo Peer Coaching](#) – a service for carers to access peer advice from other carers, or train to become peer advisers themselves.

## Appendix H. Equality considerations

### Transgender and non-binary people

The available evidence suggests that there are specific factors to consider for people who present with an eating disorder and identify as transgender and non-binary.

- People who identify as transgender and non-binary have been reported to engage in compensatory behaviours at a greater frequency than cisgender\* individuals.<sup>6</sup>
- Disordered eating and striving for thinness among people who identify as transgender or non-binary may be related to a desire to either highlight or suppress features of their biological sex in order to better align their physique with their gender.<sup>7</sup>
  - In some cases, the process of medical gender transition has been reported to alleviate symptoms of an eating disorder.<sup>8</sup>
- Hormone therapy that a person who identifies as transgender or non-binary may be undertaking in order to physically transition can induce weight gain, which may lead to distress and introduce further complexity in providing treatment for an eating disorder.<sup>7</sup>
- People with an eating disorder who identify as transgender or non-binary may experience body dysmorphic issues that are related to discordance between their biological sex and gender identity, rather than their eating disorder. For this reason, a treatment approach that places significant emphasis on body positivity may be perceived as dismissive of the distress they experience around unwanted aspects of their physiology.<sup>9</sup>

Staff in a CED service providing care to people with eating disorders who identify as transgender or non-binary should make efforts to understand the person's feelings around transition, as this may offer insights into the aetiology of their eating disorder, the distinction between body dysmorphic issues, and the likelihood of facing complicating factors. All such information has the potential to be highly valuable when developing a formulation and delivering appropriate, effective care.

Importantly, all staff interacting with people who identify as transgender or non-binary should be respectful of the person's preferred pronouns and be mindful of the detrimental effects that dismissing someone's gender identity or mis-gendering them can have on treatment and recovery.

\* 'Cisgender' denotes someone whose sense of personal identity and gender corresponds with their birth sex.

## Appendix I. Workforce and Staffing

### Appendix I.1 Workforce planning

A CED service should be a multi-skilled, multidisciplinary team with significant knowledge, competence and experience in the assessment, risk management and treatment of people with eating disorders. CED services need to be resourced appropriately to provide care, including community outreach work, for the full range of eating disorders, including binge eating disorder and OSFED, and to meet the needs of different populations. Actual staffing levels and skill mix will depend on the needs of the local population and other prevalence data (as set out in Section 2.3 of the main guide) but should be sufficient to cover staff absences and ensure appropriate clinical supervision.

#### **The following considerations are key to effective workforce planning**

**Recruitment:** This should consider and reflect the diversity of the local population, as well as the overall capacity requirements of the service, and be done in conjunction with people who have experience of services. Services will need to find a balance between professional background (see Section 2.1 of the main guide) and skill sets and competences, which may vary depending on the local area and ability to recruit to certain vacancies. Commissioners and providers need to consider how the existing workforce can be further trained and used more innovatively to improve capacity, as well as the impact on workloads and staff capacity of active engagement with people who are not ready to start treatment.

**Leadership and governance.** The PHSO report<sup>2</sup> highlighted the critical role of system leaders in providing necessary oversight to services and the leadership and management required to transform the existing adult eating disorder workforce. Commissioners and providers will need to develop clear governance plans and structures to ensure clinical accountability is clear across the CED service.

**Staff wellbeing.** The CED service should actively support and promote staff wellbeing. This may be through providing access to support services, appropriate clinical supervision, monitoring staff sickness, assessing and implementing strategies to improve morale, and encouraging staff feedback on the service. Opportunities for diversity in workload, professional development and career progression are also important elements. Commissioners and providers should review [Thriving at Work](#),<sup>10</sup> which sets out recommendations for organisations to improve mental health in the workplace, while NHS England has published a [framework for employers](#) to support their employees' health and wellbeing.

**Staffing guidance.** The forthcoming Effective, Safe, Compassionate and Sustainable Staffing (ESCaSS) guide for mental health services outlines a comprehensive model for workforce planning that supports its development and sustainability. Commissioners and providers should refer to ESCaSS alongside this guide when determining the workforce required for a dedicated CED service.

The [Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning Guide](#) set out a [workforce calculator](#) to assist commissioners and providers in determining the correct mix of skills and staff for their local area. Commissioners of adult services may find it useful but will need to consider additional staffing for inpatient or day patient services. Further guidance on workforce requirements, service distribution, service development and training is available in the Royal College of Psychiatrists' report on [eating disorders in the UK](#).<sup>11</sup>

**Peer support.** Peer support workers (see Appendix G) employed within a CED service should be adults with previous experience of an eating disorder. Families and carers can also provide valuable peer support for other carers and members of a person's support network. The peer support role should be a professional, paid role within the CED service, with a clear job description, appropriate training, supervision, employment rights and opportunities for career progression.

It is critically important to ensure that a peer support worker has achieved stable recovery from their eating disorder. To ensure that their own recovery is not compromised by the role, peer support workers should have regular supervision and the ability to access clinical support when necessary. The relationship that peer support workers develop with a person should have clearly defined boundaries in terms of frequency and modes of contact.

## Appendix I.2 Competences

All members of the CED service should be competent in assessing and treating eating disorders (see NICE guideline section 1.1.14 to 1.1.17).<sup>3</sup> Different team members will be required to contribute different skills consistent with their professional background, eating disorder-specific training and level of expertise. Professionals within the CED service should be skilled to meet a number of competence frameworks, such as the ESCaSS guide (forthcoming) and the [Self-harm and Suicide Prevention Competence Framework](#). They should have the relevant competences in:

- psychiatric assessment for people who present with an eating disorder throughout the lifespan (from younger adults to older adults)
- medical assessment and physical health monitoring
- refeeding or tube feeding in inpatient settings
- rapid response to referrals to provide early intervention
- assessing and managing risk and safety
- delivering evidence-based treatment, care and support to people who present across the full range of eating disorders, including those who present for the first time, as well as those who present with comorbidities or complex and long-term problems
- understanding the behaviours and symptoms of eating disorders, including how this can affect people's ability to engage with services and accept help
- working effectively within a multidisciplinary team, including care coordination

- working effectively across service interfaces to deliver collaborative care
- providing support to inpatient and day patient settings
- empowering family members, partners and carers to further support the person and delivering family-based interventions where appropriate
- managing issues around information-sharing, confidentiality and safeguarding
- monitoring treatment adherence in people receiving care
- using routine, standardised measures of progress and outcome.

The CED service should support other professionals and other agencies to improve their knowledge and understanding of eating disorders, particularly around recognition and referral to the CED service. Professionals within primary care will need skills and competences in ongoing medical management (as part of integrated care and on long-term follow-up after discharge from the CED service).

It may also be useful for a member of the community mental health services team to have specialist skills in working with eating disorders, to ensure closer collaboration with the CED service. Staff in inpatient units will need the appropriate knowledge and competences on inpatient treatment of eating disorders.

### Appendix I.3 Supervision

Staff within the CED service and other services should receive appropriate clinical supervision from appropriately qualified senior clinicians and support to maintain ongoing competence, reflective practice, clinician performance and professional development. Cases should be reviewed and progress discussed in supervision on a regular basis (depending on the person's frequency of treatment) to ensure an outcomes- focused approach to treatment.

### Appendix I.4 Training

Commissioners and providers will need to work with CED services to assess and determine the training needs for each team and to fill in any gaps to ensure all professionals within the service have the competences required to deliver evidence-based treatment for adults with an eating disorder. Whole-team training can enhance collaborative working across staff from different professional backgrounds, while training modules may be an option for services to shape training to fit their staff. Services should also consider offering training for carers and family members as part of the support they provide.

Training should aim to:

- upskill members of a CED service to meet a range of needs and ensure they have excellent communication and interpersonal skills; this includes training to support young people transitioning from childrens' to adult services
- ensure staff have the appropriate working knowledge of relevant legal requirements associated with information-sharing, capacity and consent



- (NICE guideline section 1.12)<sup>3</sup>
- build in flexibility at a local level given geographical differences in workforce and recruitment
  - give people with experience of using services the skills to hold peer support or peer mentor roles.

Commissioners and providers will need to consider how training for emerging CED services may differ from upskilling existing CED services. [Web-based training](#) may be an option for upskilling practitioners and increasing the availability of psychological treatments, as it has demonstrated positive effects on therapist competence, particularly in enhanced cognitive-behavioural therapy (CBT-E) for eating disorders over a wide geographical area.<sup>12,13,14,15</sup>

Commissioners and providers of eating disorder services should consider how to work with VCSE organisations, commissioners and providers of other health and social care services, particularly primary care, community mental health services and acute services, to ensure that eating disorder-specific training for other professionals is delivered effectively. Training for other services needs to be tailored and may range from general information on eating disorders to improve overall awareness (such as within education settings), to specific information on the symptoms and behaviours of eating disorders to ensure appropriate identification and referral to the CED service (such as for primary care).

The PHSO report<sup>2</sup> recommended that there is a review of training for all junior doctors in eating disorders to improve the recognition and management of eating disorders in primary care services. This will be invaluable to the development and operation of integrated CED services.

## Appendix J. Ensuring a Quality Service

People's experiences of treatment, care and support, and feedback from other services such as primary care, are central to measuring the quality of services and determining priorities for improvement.

Commissioners and providers will need to ensure they deliver care in line with the eating disorders quality standard<sup>16</sup> (see Appendix C) and the Care Quality Commission's (CQC's) framework for delivering safe, effective, caring, responsive and well-led services. NICE has developed tools and resources to support services in improving the quality of care they provide.

A quality improvement approach should be used to underpin implementation of the recommendations in this guide.

### Appendix J.1 Data collection

CED services should routinely collect data on service use to inform and support their continuous improvement. National datasets will provide routine, consistent measurement of local services' performance to support quality, improve people's experience of care and reduce unwarranted variation in service provision and outcomes.

The Mental Health Services Data Set (MHSDS) is a secondary uses dataset which enables collection, measurement and reporting of service data. Many process measures for mental health services are already captured in the MHSDS.

Providers should collect and submit data regularly, while commissioners will need to ensure delivery and data quality. Commissioners should check that providers have made the necessary updates to their electronic care record system to enable clinicians to enter the data required to monitor performance against the recommendations in this guide. Local collection of data should inform the development of services and the integration of pathways for both CED services and inpatient/intensive day patient services. Services should also collect data to improve local prevalence estimates, including age at onset, to improve early intervention approaches and public awareness campaigns. Commissioners and providers should:

- invest in and maintain the necessary IT systems that facilitate 'real-time' in-session feedback for the person and the professional to inform clinical practice
- support data collection and reporting of outcomes for use in evaluating the impact of service delivery, both locally and nationally
- set out clear processes to implement feedback from people with experience of using services and data from outcomes collected to improve service delivery and performance
- consider and include data collection in workforce planning
- ensure the appropriate collection and handling of data to comply with data governance.

## Appendix J.2 Quality improvement networks

The [Quality Network for Eating Disorders](#) (QED) at the College Centre for Quality Improvement (CCQI) works with services to assure and improve the quality of care through setting standards, engaging services in an accreditation system, and using these to measure and improve the quality of care. The QED works with providers, users and commissioners to raise standards of care that people with mental health needs receive. The CCQI uses national clinical audits, surveys and peer-review visits to collect and centralise information from service users, families, carers and staff about standards of care, thereby improving accessibility and validity of data.

The QED is currently developing standards of accreditation for community eating disorder services, which incorporate the [eating disorders NICE guideline \(NG69\)](#)<sup>3</sup>, the PHSO report<sup>2</sup> and recommendations from this guide. They have also developed [Standards for Adult Inpatient Eating Disorder Services](#)<sup>17</sup> to support accreditation.

## Appendix J.3 What commissioners and providers should do

Commissioners and providers have a number of responsibilities to improve quality of care provided to people with an eating disorder.

- Ensure all people in their local area have access to a dedicated CED service with the appropriate referral pathways in place
- Ensure services have clear information available on their website, including their location, treatments they provide, and what a person can expect
- Collaborate with people who have experience of using services, as well as their support network, to regularly evaluate and improve the care they provide
- Commission eating disorder services with the appropriate capacity and skill mix that can meet the mental health, physical health and social needs of people with an eating disorder, and the needs of their families, partners, carers or support network
- Commission services to support greater integration across services and provider organisations; this may require collaborative working with other commissioners
- Recognise the difference between treatment failure and relapse – just because a person is accessing the service after having treatment before does not mean they would not benefit from being treated again
- Ensure clear joint working policies are in place across services to support coordination and continuity of care, and prevent gaps or delays in treatment
- Ensure that clear transition processes and agreements are in place, particularly around risk assessment and monitoring, with effective coordination when care spans multiple organisations

- Facilitate robust medical monitoring agreements with local primary care networks
- Ensure staff have the competence, capacity and skills to deliver evidence-based treatment, with the appropriate level of supervision and access to training and professional development
- Monitor quality of provision of care for people with eating disorders
- Ensure routine outcome measurement across services
- Consider how digital technologies can be used to support developing services, delivering care, training and supervision

## Helpful resources

This resource pack accompanies the full guide and provides commissioners and providers with examples of positive practice and helpful resources to support implementation of adult eating disorder services.

### Positive practice examples

[Part 1](#) provides positive practice examples from eating disorder services.

### Helpful web-based resources

[Part 2](#) provides links to helpful web-based resources, including:

- national guidance
- eating disorder resources
- commissioning resources
- co-production resources
- capacity, information sharing and safeguarding resources
- competence frameworks
- resources for families and carers
- other useful resources.

### References

[Part 3](#) provides the references used for this guide.

## Part 1: Positive practice examples



The following examples of positive practice have been included to illustrate how some adult eating disorder services are improving access to and delivering evidence-based care.

The NCCMH is working together with the [Positive Practice in Mental Health Collaborative](#) to identify and share examples of positive practice in mental health across England. The Collaborative is a user-led, multi-agency initiative linking 75 organisations, including NHS trusts, CCGs, third-sector providers and service user groups. The aim of the Collaborative is to facilitate shared learning of positive practice in mental health services across organisations and sectors. They have created a [directory](#) of examples of positive practice in mental health services.

## 1. CONNECT – Yorkshire

CONNECT: The West Yorkshire and Harrogate Adult Eating Disorders Service is a new service, part of Leeds and York Partnership NHS Foundation Trust (LYPFT), which has been developed through a New Care Models initiative for adult eating disorders. Development of this new service has involved the expansion and tailoring of existing eating disorders services to significantly reshape both inpatient and community care for adults with eating disorders across the West Yorkshire and Harrogate Health and Care Partnership (HCP) area.

CONNECT provides outpatient, intensive home-based, early intervention, outreach and inpatient treatment for adults (18 years and older) with eating disorders. The service aims to provide:

- a consistent and integrated pathway of care which spans a number of services including specialist adult community-based eating disorder services and specialist adult eating disorders inpatient beds (ward 6, Yorkshire Centre for Eating Disorders, Leeds)
- an improved, joined-up approach to the care and treatment of adults with eating disorders across the West Yorkshire and Harrogate health system and wider services, resulting in improved outcomes and experience, and improved transitions between services
- a multidisciplinary team (MDT) approach to delivering high-quality treatments as recommended by the National Institute for Health and Care Excellence (NICE) guidelines on eating disorders, to facilitate positive change in people who have an eating disorder
- a consistent, coordinated and strengthened approach to the delivery of 'Management of Really Sick Patients with Anorexia Nervosa' (MARSIPAN) in partnership with acute hospital partners across the region
- a reduction of the length of stay within inpatient services and out-of-area placements, with admission occurring only when clinically necessary.

Since going live in April 2018, CONNECT has led to:

- a 24% reduction in hospital bed stays
- repatriation of all pre-existing out-of-area placements
- no new out-of-area placements
- development and implementation of five regional MARSIPAN pathways covering all acute hospital providers across the region.

The staffing model for the CONNECT community and outreach service and the inpatient service is outlined in the table below.

| <b>CONNECT community and outreach staffing model</b>               |              |                              |
|--|--------------|------------------------------|
| <b>Role</b>  | <b>Band</b>  | <b>Whole-time equivalent</b> |
| Consultant psychiatrist  | Consultant   | 1                            |
| Specialty doctor   | Band 7 to 8d | 1                            |
| Consultant psychologist  | Consultant   | 0.5                          |
| Clinical nurse lead  | 8a           | 0.5                          |
| Psychologist   | 8a           | 1                            |
| Clinical trial manager   | 7            | 1                            |
| Therapist  | 7            | 1                            |
| Dietician  | 7            | 0.5                          |
| Social worker  | 6            | 0.5                          |
| Mental health practitioner   | 6            | 5                            |
| Dietician  | 6            | 1                            |
| Health support worker  | 3            | 3                            |
| Peer support worker  | 3            | 1                            |
| Admin support worker   | 3            | 2                            |
| <b>The Yorkshire Centre for Eating Disorders inpatient service</b> |              |                              |
| <b>Role</b>  | <b>Band</b>  | <b>Whole-time equivalent</b> |
| Consultant psychiatrist  | Consultant   | 1                            |
| Psychologist   | 8b           | 1                            |
| Junior doctor (FY2/CT rotation)                                    | 7            | 1                            |
| CTM  | 7            | 1                            |
| Allied health professional lead                                    | 7            | 1                            |
| Advanced practitioner  | 7            | 1                            |
| Occupational therapist   | 6            | 1                            |
| Dietician  | 6            | 1                            |
| Nurse  | 6            | 4                            |
| Occupational therapist (rotation)                                  | 5            | 1                            |
| Nurse  | 5            | 9.5                          |
| Admin lead   | 4            | 0.8                          |
| Health support worker  | 3            | 11                           |
| Dietetic assistant   | 3            | 1                            |
| Admin support worker   | 2            | 0.8                          |

For more information on the CONNECT service and the treatments provided, please see <https://www.leedsandyorkpft.nhs.uk/our-services/services-list/connect-west-yorkshire-harrogate-adult-eating-disorders-service> or contact Dr William Rhys Jones, consultant psychiatrist and clinical lead, at [r.jones9@nhs.net](mailto:r.jones9@nhs.net)



## **2. The FREED model at South London and Maudsley – early intervention service**

The First Episode & Rapid Early Intervention for Eating Disorders (FREED) model is an evidence-based, specialist service model for 16- to 25-year-olds with an eating disorder of less than 3 years' duration.

Its central focus is reducing the duration of an untreated eating disorder (DUED) and the model places significant emphasis on rapid access to assessment and treatment. All referrals to the CED service which meet FREED criteria are managed by a dedicated FREED champion (band 7). This has decreased DUED by up to 6 months and led to a reduction in waiting times for assessment and treatment of 32% and 41% respectively.

The FREED care package adapts existing evidence based-treatments to better meet the specific developmental needs of young people presenting with a recent-onset eating disorder. A greater emphasis is placed on early psychoeducational change and family involvement; informing people about social media use as a potential illness maintaining factor; and transitions that may interfere with recovery from eating disorders (such as progressing from children's to adult services or moving to university) are carefully managed. Engagement of FREED service users is promoted through flexibility around appointment times and methods of contact.

Overall, this approach has improved treatment outcomes. By 12 months, 70% of FREED patients achieved symptom scores below clinical thresholds; 60% of FREED patients with anorexia achieved a healthy weight, compared with 17% of treatment-as-usual group. The model also decreased inpatient or day-patient care requirement by 35%. These differences were maintained at a 2-year follow-up.

FREED operates as a 'service within a service' and can be embedded into a broader, comprehensive community eating disorder service. For example, CONNECT employ the FREED model in the delivery of early intervention care.

### **Staffing**

In line with a model that can be embedded into an existing service, FREED is not staffed separately from the CED service, but by expanding upon the existing workforce. An additional band 7 clinician is employed as a FREED champion, working 0.6 WTE for every 100 FREED referrals per year. Of this 0.6 WTE, the FREED champion will spend 1 day per week overseeing the implementation of FREED, with the remaining 2 days spent performing clinical work with FREED patients.

See <https://freedfromed.co.uk> or contact Professor Ulrike Schmidt, consultant psychiatrist ([ulrike.schmidt@kcl.ac.uk](mailto:ulrike.schmidt@kcl.ac.uk)), for more information on the model.

### 3. Hampshire Community Eating Disorder Service – April House

The Hampshire CED service operates as a hub and spoke model from bases across Portsmouth, Basingstoke and Southampton. The last – April House in Southampton – functions as the central hub. Regardless of their working base, all staff are part of one MDT team, with dedicated time at April House. That configuration allows staff to come together for shared assessment meetings, risk management and reflective practice.

Assistant psychologists within the MDT are trained to deliver a brief, evidence-based form of CBT-eating disorder, which is delivered on a 1:1 basis. This therapy was developed and first tested within this service (collaboratively with others), to enhance service user benefit. Using CBT-eating disorder allows the service to see a greater number of people and reduce waiting times substantially, without compromising on care and recovery rates. CBT-eating disorder delivery is supported by weekly clinical supervision from senior clinical psychologists, who retain overall clinical responsibility.

Assistant psychologists co-facilitate group interventions (e.g. carer support groups). They are also responsible for collating and analysing all service-related outcome data, including service user and referrer feedback. Upskilling assistant psychologists to enable the delivery of low-intensity psychological interventions as part of a stepped care pathway has allowed the service to increase its treatment capacity while maintaining clinical effectiveness and patient satisfaction.<sup>18,19</sup>

The service's day support program (DSP) is also based at April House, though it serves the whole catchment area of the service. Its location at the CED service hub allows for integrated care packages when required and facilitates smooth transitions between day-patient and outpatient care. DSP is open for extended hours, during which a person can access a full programme of meal support and therapeutic groups, while continuing to live at home. Links with local transport services make DSP accessible to the whole catchment area. Qualitative feedback suggests that people with eating disorders value and benefit from the opportunity to access intensive support close to home.

See <https://www.southernhealth.nhs.uk/services/mental-health/specialist-mental-health-services/eating-disorders-service/> or contact Dr Hannah Turner, consultant clinical psychologist ([hannah.turner@southernhealth.nhs.uk](mailto:hannah.turner@southernhealth.nhs.uk)), for more information about the service.

| <b>April House DSP staff breakdown</b> |             |                              |
|--|-------------|------------------------------|
| <b>Role</b>                            | <b>Band</b> | <b>Whole-time equivalent</b> |
| Eating disorder therapist<br>OR        | 8           | 0.1                          |
| Nurse                                  | 7           | 0.6                          |
| Dietician                              | 7           | 1.0                          |
| Occupational therapist                 | 6           | 0.8                          |
| Mental health practitioner             | 6           | 1                            |
|  |             |                              |
| Health care support worker             | 3           | 4.8                          |

#### 4. Dorset Eating Disorder Service

Dorset Eating Disorder Service operates as an all-ages service, having integrated CYP and adult eating disorder services. Although it is staffed by a single workforce, some practitioners still work exclusively with specific age ranges and a dedicated group of staff work with young adults. This has eradicated the need for transitions from one service to the other. Across 2018/2019, 14 people engaged with the integrated service celebrated their 18<sup>th</sup> birthday. As no transition needed to occur, the typical workload associated with planning and managing a transition was not necessary, making valuable time and staff resources available throughout the rest of the service. Most importantly, none of these 14 were lost from treatment during this period.

Prior to the integration of CYP and adult eating disorder services, a dedicated transition team would engage with young people aged 16+ in CYP-CED services to support their eventual transition into adult services and remain engaged with them beyond the age of 18.

Dorset Eating Disorder Service have established advantageous working practices with local primary care providers. Clinical nurse specialists spend time embedded in GP practices to support early identification and intervention of eating disorders in primary care. Dorset Eating Disorder Service staff also deliver training in primary care settings for school nurses, GPs and others. Feedback from practitioners who undertake this training indicates that it has led to valuable improvements in basic understanding of eating disorders, advancing knowledge of signs and symptoms, causes and risks, recovery, treatment approaches and available support in primary care.

This close working with primary care extends to a further major aspect of Dorset Eating Disorder Service's work – significant outreach to university students. The service operates a university clinic, embedded in the campus medical centre, offering evidence-based treatment delivered by a clinical nurse specialist. Students are referred and offered treatment very quickly. There is no barrier to travelling to an eating disorder unit, which is located 5 miles away. Students who access with service while at university are retained by Dorset Eating Disorder Service when they return home out of university term dates and continue to be supported via the phone, in order to avoid complications around geographical transitions that may result in disengagement. The service also hosts an annual week of events based at the university to raise awareness of eating disorders and the support services available, and Dorset Eating Disorder Service staff teach food-, weight- and shape-related modules of undergraduate psychology and nursing courses.

For more information about Dorset Eating Disorder Service, please refer to: <https://www.dorsethealthcare.nhs.uk/patients-and-visitors/our-services-hospitals/mental-health/eating-disorders> or contact Dr Ciarán Newell, consultant nurse ([C.newell@nhs.net](mailto:C.newell@nhs.net)) and Jess Griffiths, counsellor and eating disorders practitioner ([office@jessgriffiths.co.uk](mailto:office@jessgriffiths.co.uk)).

## Part 2: Helpful web-based resources

### National guidance and reports

- [Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning Guide](#)
- [Care Act 2014](#)
- [Carers and Personalisation: Improving Outcomes](#)
- [Eating Disorders in the UK: Service Distribution, Service Development and Training \(CR170\)](#)
- [Equality Act 2010](#)
- [Guidance for Reporting Against Access and Waiting Time Standards: Children and Young People with an Eating Disorders, Early Intervention in Psychosis](#)
- [Guidance to Support the Introduction of Access and Waiting Time Standards for Mental Health Services in 2015/16](#)
- [Health and Social Care Act 2012](#)
- [Ignoring the Alarms: How NHS eating Disorder Services are Failing Patients](#)  
– report from the Parliamentary and Health Service Ombudsman
- [Managing Transitions When the Patient has an Eating Disorder \(CR208\)](#)
- [MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa \(2nd edition\)](#)
- [Mental Capacity Act 2005](#)
- [Mental Capacity Act 2005: Code of Practice](#)
- [Mental Health Act 1983](#)
- [Mental Health Act 1983: Code of Practice \(2015\)](#)
- [Mental Health Act 2007](#)
- [Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies](#)

### Eating disorder resources

- [Academy for Eating Disorders \(AED\)](#) – a global professional association committed to leadership in eating disorders research, education, treatment and prevention
- [Anorexia and Bulimia Care \(ABC\)](#) – a national UK eating disorders organisation that provides ongoing care, emotional support and practical guidance for people affected by eating disorders
- [Beat](#) – The UK's eating disorder charity, providing information and support for everyone affected by eating disorders. They offer helplines and online support groups, and some of their published resources include:

- [Seeking Treatment for an Eating Disorder?](#) – a resource for service users, or anyone supporting them and GPs; highlights key NICE guidance
- [Emotional Overeating: The Facts and Where to Find Support](#) – produced by Beat in line with Department of Health and Social Care information standards
- [Centre for Clinical Interventions](#) – provides resources for clinicians, people with an eating disorder and their support network
- [Guidance on Medical Risk Assessment for Eating Disorders](#), King's College London
- [Male VoicED](#) – an organisation supporting men with eating disorders
- [National Eating Disorders Association \(NEDA\)](#) – an organisation supporting individuals and families affected by eating disorders
- [National Eating Disorders Collaboration \(NEDC\)](#) – a collaboration of people and organisations with an expertise and/or interest in eating disorders; based in Australia
- [Recovery Record](#) – an eating disorder management app
- [British Eating Disorders Society \(BREDS\)](#) – a multidisciplinary network of professionals

## Commissioning resources

- [A Framework for Collaborative Commissioning Between Clinical Commissioning Groups](#)
- [Guidance for Commissioners of Eating Disorder services](#) from the Joint Commissioning Panel for Mental Health
- [Guidance on managing transfers of care](#)
- [Guidance for NHS Commissioners on Equality and Health Inequalities Legal Duties](#)
- [Influencing Mental Health Services – A Guide to Values-Based Commissioning](#)
- [Integrated Commissioning for Better Outcomes: A Commissioning Framework](#)
- [Mental Health in Primary Care – A briefing for Clinical Commissioning Groups](#)
- [Mental Health And Wellbeing Profiling Tools](#)
- [Modelling the Interface between Primary Care and Specialist Mental Health Services](#)
- [NHS benchmarking](#)
- NHS England's [Accessible Information Standard](#)
- NHS England's [resources for commissioners](#) to guide the implementation of mental health services within a wider joint strategy
- NHS England's [service specifications](#) for adult eating disorders for inpatient and intensive day patient treatment (does not include community services)
- [NHS Standard Contract](#)
- [Prevention concordat for better mental health](#)
- [Public Health England resources to address social and wider determinants of health](#)
- [The Collaborating Centre for Values-Based Practice in Health and Social Care](#)

- [Transition CQUIN Indicator for 2017/2019](#)
- Information on [commissioning beat](#) to work with a CED service
- [Universities UK Framework](#) – useful information for improving joint up working with universities

### **Co-production resources**

- [A Co-production Model: Five Values and Seven Steps to Make This Happen in Reality](#)
- [Co-Production in Social Care: What It is and How to Do It](#)
- [Embedding Co-production in Mental Health: A Framework for Strategic Leads, Commissioners and Managers](#)
- [Progressing Transformative Co-production in Mental Health](#)

### **Capacity, information sharing and safeguarding resources**

- [Caldicott Principles on Information Sharing](#)
- [Centre of Excellence for Information Sharing – safeguarding resources and case studies](#)
- [Information Sharing: Advice for Practitioners Providing Safeguarding Services to Children, Young People, Parents and Carers](#)
- [Information Sharing and Suicide Prevention Consensus Statement](#)
- [Social Care Institute for Excellence \(SCIE\)](#) – resources and information for professionals on safeguarding

### **Competence frameworks**

- [National Mental Capacity Act Competency Framework](#)
- [Self-harm and Suicide Prevention Competence Framework](#)
- [Skills for Health Mental Health Core Skills Education and Training Framework](#)
- [Skills for Health National Occupational Standards](#)

### **Resources for families and carers**

- [Beat – Support for carers](#) – information for carers and links to support services
- [Eating Disorders: A Guide for Friends and Family](#) – produced by Beat in line with Department of Health and Social Care information standards
- [Carers' Assessments – Help for Parent Carers](#)
- [Carers UK Assessment factsheet](#) – looks at the different ways caring can affect life, including physical, emotional and mental health, as well as work, leisure, education and wider family and friend relationships
- [Families Empowered and Supporting Treatment of Eating Disorders \(FEAST\)](#) – an international organisation for parents and carers of people with an eating disorder
- [Information leaflets and guidance on working with carers](#) – compiled and developed by CAUSE

- [MindEd for Families](#) – a free learning resource about the mental health of children, young people and older adults
- [The Triangle of Care](#) – a guide to best practice in mental health care in England (developed by the [Carers Trust](#))
- [The Triangle of Care for Young Carers and Adult Carers](#)
- [Yorkshire Centre for Eating Disorders: An Information Pack for Carers 2016](#)

### Other useful resources

- [Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services](#)
- [Bringing Together Physical and Mental Health](#)
- [Choice in Mental Health Care](#)
- [The Compassionate Mind Foundation](#) – training and resources around applying a compassionate approach
- [Developing Peer Support in the Community: A Toolkit](#)
- [Inequality among Lesbian, Gay Bisexual and Transgender Groups in the UK](#) – A review of evidence concerning inequalities concerning LGBTQ+ people, including mental health
- [King's College London Eating Disorders Research Group](#)
- [Mental Health Five Year Forward View Dashboard](#)
- [Mental Health Pack](#) – a symbol communication tool for mental health assessments, in psychiatric or physical health care settings, for use with individuals who may have communication or language difficulties
- [Referral to Treatment Consultant-Led Waiting Times: Rules Suite](#)
- [Royal College of Psychiatrists Faculty of Eating Disorders Psychiatry](#)
- [The Point of Care: Measures of Patients' Experience in Hospital: Purpose, Methods and Uses](#)
- [Quality Network for Eating Disorders](#) (QED) within the College Centre for Quality Improvement (CCQI)



## Part 3: References

- 1) The Royal College of Psychiatrists. The Mental Health of Students in Higher Education. 2011.
- 2) Parliamentary and Health Service Ombudsman. Ignoring the Alarms: How NHS Eating Disorder Services are Failing Patients. London: Parliamentary and Health Service Ombudsman; 2017.
- 3) National Institute for Health and Care Excellence. Eating Disorders: Recognition and treatment. NICE guideline 69. London: NICE; 2017.
- 4) Mental Health Taskforce. The Five Year Forward View for Mental Health. London: NHS England; 2016.
- 5) Holley J, Gillard S, Gibson S. Peer Worker Roles and Risk in Mental Health Services: A
- 6) Qualitative Comparative Case Study. Community Mental Health Journal. 2015; 51: 477– 490.
- 7) Diemer EW, Grant JD, Munn-Chernoff MA, Patterson DA, Duncan AE. Gender Identity, Sexual Orientation, and Eating-Related Pathology in a National Sample of College Students. Journal of Adolescent Health. 2015; 57: 144–149.
- 8) Ålgars M, Alanko K, Santtila P, Sandnabba NK. Disordered Eating and Gender Identity Disorder: A Qualitative Study. Eating Disorders. 2012; 20: 300–311.
- 9) Connolly MD, Zervos MJ, Barone CJ, Johnson CC, Joseph CLM. The Mental Health of Transgender Youth: Advances in Understanding. Journal of Adolescent Health. 2016; 59: 489–495.
- 10) Duffy ME, Henkel KE, Earnshaw VA. Transgender Clients' Experiences of Eating Disorder Treatment. Journal of LGBT Issues in Counseling. 2016; 10: 136–149.
- 11) Stevenson D, Farmer P. Thriving at Work: The Stevenson/Farmer Review of Mental Health and Employers. London: Department for Work and Pensions, Department of Health and Social Care; 2017
- 12) The Royal College of Psychiatrists' Section of Eating Disorders. Eating Disorders in the UK: Service Distribution, Service Development and Training. London: Royal College of Psychiatrists; 2012.
- 13) O'Connor M, Morgan KE, Bailey-Straebl S, Fairburn C, Cooper Z. Increasing the availability of psychological treatments: A multinational

- study of a scalable method for training therapists. *Journal of Medical Internet Research*. 2018;20:e10386.
- 14) Cooper Z, Bailey-Straebler S, Bohn K, de Vries D, Murphy R, O'Connor ME, et al. Assessing therapist competence: Development of a performance-based measure and its comparison with a web-based measure. *Journal of Medical Internet Research Mental Health*. 2017;4:e51.
  - 15) Cooper Z, Bailey-Straebler S, Morgan KE, O'Connor M, Caddy C, Hamadi L, et al. Using the internet to train therapists: Randomised comparison of two scalable methods. *Journal of Medical Internet Research*. 2017;19:e355.
  - 16) Fairburn CG, Allen E, Bailey-Straebler S, O'Connor ME, Cooper Z. Scaling up psychological treatments: A countrywide test of the online training of therapists. *Journal of Medical Internet Research*. 2017;19:e214.
  - 17) National Institute for Health and Care Excellence. *Eating Disorders. Quality Standard 175*. London: NICE; 2018.
  - 18) Clarke H, Gardner M. *Standards for Adult Inpatient Eating Disorder Services: Second Edition*. London: College Centre for Quality Improvement; 2017.
  - 19) Waller G, Tatham M, Turner H, Mountford VA, Bennetts A, Bramwell K et al. A 10-session cognitive-behavioral therapy (CBT-T) for eating disorders: Outcomes from a case series of nonunderweight adult patients. *International Journal of Eating Disorders*. 2018; 51: 262–269.
  - 20) Hoskins JI, Blood L, Stokes HR, Tatham M, Waller G, Turner H. Patients' experiences of brief cognitive behavioral therapy for eating disorders: A qualitative investigation. *International Journal of Eating Disorders*. 2019. doi:10.1002/eat.23039.

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

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