NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

NHS

Appendices and Helpful Resources for Inpatient and Intensive Day Care – Addendum to the Community Eating Disorder Guidance

Appendices and Helpful Resources for the Inpatient and Intensive Day Care – addendum to the community eating disorder guidance

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

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

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Appendix A: NICE-recommended care

A.1 Quality statements

The aim of the eating disorders pathway is to ensure children and young people access effective mental health care for an eating disorder in a timely manner. NICE guidelines and quality standards (see Section 2.2) provide the basis for defining evidence-based care and can be used to measure the provision of mental health care along the pathway. Each quality standard consists of a prioritised set of specific, concise and measurable statements, designed to support the improvement of care. This appendix contains the NICE quality statements and recommendations selected by the Expert Reference Group (ERG) as being most relevant to the pathway for eating disorders. NICE guidelines were reviewed and selected for relevance, along with their corresponding quality standard. Relevant quality statements were then selected from the standards.

Each quality statement should be measured through local data collection, feedback from children, young people and their families and carers on their experience of the quality of care provided by a service, and through the quality assessment and improvement programme (see Section 5.7.3 of the full implementation guidance), to determine whether a service is meeting the requirements of providing high-quality evidence-based care. Further information regarding the measurement of each quality statement can be found on the NICE webpage for the relevant quality standard.

Table 1: NICE quality statements

Quality statement (QS)
Medicines optimisation
QS 1. People are given the opportunity to be involved in making decisions about their medicines
QS 4. People who are inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission
QS 5. People discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued
Self-harm
QS 1. People who have self-harmed are cared for with compassion and the same respect and dignity as any service user
QS 2. People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide
QS 3. People who have self-harmed receive a comprehensive psychosocial assessment
QS 4. People who have self-harmed receive the monitoring they need while in the healthcare setting, in order to reduce the risk of further self-harm
QS 5. People who have self-harmed are cared for in a safe physical environment while in the healthcare setting, in order to reduce the risk of further self-harm

Quality statement (QS)
QS 6. People receiving continuing support for self-harm have a collaboratively developed risk management plan
QS 7. People receiving continuing support for self-harm have a discussion with their lead healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm
QS 8. People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition
Transition from children's to adults' services
QS 1. Young people who will move from children's to adults' services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children's services after school year 9
QS 2. Young people who will move from children's to adults' services have an annual meeting to review transition planning
QS 3. Young people who are moving from children's to adults' services have a named worker to coordinate care and support before, during and after transfer
QS 4. Young people who will move from children's to adults' services meet a practitioner from each adults' service they will move to before they transfer
QS 5. Young people who have moved from children's to adults' services but do not attend their first meeting or appointment are contacted by adults' services and given further opportunities to engage
Looked-after children and young people
QS 1. Looked-after children and young people experience warm, nurturing care
QS 2. Looked-after children and young people receive care from services and professionals that work collaboratively
QS 6. Looked-after children and young people who move across local authority or health boundaries continue to receive the services they need
QS 8. Care leavers move to independence at their own pace
Comorbid conditions
Alcohol-use disorders: diagnosis and management
QS 2. Health and social care staff opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice
Anxiety disorders
QS 2. People with an anxiety disorder are offered evidence-based psychological interventions
QS 3. People with an anxiety disorder are not prescribed benzodiazepines or antipsychotics unless specifically indicated
QS 4. People receiving treatment for an anxiety disorder have their response to treatment recorded at each treatment session
Depression in children and young people
QS 2. Children and young people with depression are given information appropriate to their age about the diagnosis and their treatment options
QS 5. Children and young people receiving treatment for depression have their health outcomes recorded at the beginning and end of each step in treatment

A.2 NICE-recommended care

Table 2: Eating disorders: recognition and treatment (NG69)

Delivery of the intervention	
Referral	
NICE reference numbers	
1.2.10	If an eating disorder is suspected after an initial assessment, refer immediately to a community-based, age-appropriate eating disorder service for further assessment or treatment.
Treating anorexia nervosa	
1.3.1	• Psychoeducation • Monitoring of weight, mental and physical health and risk factors • Multidisciplinary care coordinated between services • Involve the person's family or carers
Psychological treatment for anorexia nervosa in children and young people	
1.3.10	Consider anorexia-nervosa-focused family therapy (FT-AN), delivered as single- or a combination of single- and multi-family therapy
1.3.12	Consider support for family members who are not involved in the family therapy, to help them to cope with distress caused by the condition
1.3.13	Consider giving children and young people with anorexia nervosa additional appointments separate from their family members or carers
1.3.14	Assess whether family members or carers (as appropriate) need support if the child or young person with anorexia nervosa is having therapy on their own
1.1.15	If FT-AN is unacceptable, contraindicated or ineffective for children or young people with anorexia nervosa, consider individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN)
Dietary advice	
1.3.20	Only offer dietary counselling as part of a multidisciplinary approach
1.3.21	Encourage people with anorexia nervosa to take an age-appropriate oral multivitamin and multi-mineral supplement until their diet includes enough to meet their dietary reference values
1.3.22	Include family members or carers (as appropriate) in any dietary education or meal planning for children and young people with anorexia nervosa who are having therapy on their own
1.3.23	Offer supplementary dietary advice to children and young people with anorexia nervosa and their family or carers (as appropriate) to help them meet their dietary needs for growth and development (particularly during puberty)

Psychological treatment for binge eating disorder in children and young people	
Children and young people with binge eating disorder should be offered the same treatments recommended for adults with binge eating disorder.	
1.4.2	Offer a binge-eating-disorder-focused guided self-help programme
1.4.4	If guided self-help is unacceptable, contraindicated, or ineffective after four weeks, offer group eating-disorder-focused cognitive behavioural therapy (CBT-ED)
1.4.6	If group CBT-ED is not available or the person declines it, consider individual CBT-ED for adults with binge eating disorder
Psychological treatment for bulimia nervosa in children and young people	
1.5.6	Offer bulimia-focused family therapy (FT-BN)
1.5.9	If FT-BN is unacceptable, contraindicated or ineffective, consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) for children and young people with bulimia nervosa
Treating other specified feeding and eating disorders (OSFED)	
1.6.1	Consider using the treatments for the eating disorder it most closely resembles
Physical therapy for any eating disorder	
1.7.1	Do not offer a physical therapy (such as transcranial magnetic stimulation, acupuncture, weight training, yoga or warming therapy) as part of the treatment for eating disorders
Physical and mental health comorbidities	
1.8.1	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
1.8.2	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
Diabetes	
1.8.3	Eating disorder teams and diabetes teams should work collaboratively to manage the physical and mental health comorbidities
1.8.4	When treating eating disorders in people with diabetes: • explain to the person (and if needed their diabetes team) that they may need to monitor their blood glucose and blood ketones more closely during treatment • consider involving their family members and carers (as appropriate) in treatment to help them with blood glucose control
1.8.5	Address insulin misuse as part of any psychological treatment for eating disorders in people with diabetes
1.8.6	Offer people with an eating disorder who are misusing insulin an appropriate treatment plan
1.8.7	For people with suspected hypoglycaemia, test blood glucose at the recommended times

1.8.8	For people with suspected hyperglycaemia or hypoglycaemia, and people with normal blood glucose levels who are misusing insulin, healthcare professionals should test for blood ketones at the recommended times
1.8.9	For people with bulimia nervosa and diabetes, consider monitoring of: • glucose toxicity • insulin resistance • ketoacidosis • oedema
1.8.10	When diabetes control is challenging: • do not attempt to rapidly treat hyperglycaemia (for example with increased insulin doses), because this increases the risk of retinopathy and neuropathy • regularly monitor blood potassium levels • do not stop insulin altogether, because this puts the person at high risk of diabetic ketoacidosis.
1.8.11	For more guidance on managing diabetes, including on fluid replacement in children and young people with diabetic ketoacidosis, refer to the NICE guidelines on type 1 and type 2 diabetes in children and young people, type 1 diabetes in adults, and type 2 diabetes in adults.
Comorbid mental health problems	
1.8.12	In deciding how to approach treatment of comorbid conditions consider: • The severity and complexity of the eating disorder and comorbidity • The person's level of functioning • The person's preference and (if appropriate) those of their family and carers
1.8.13	Refer to the NICE guidelines on specific mental health problems for further guidance on treatment.
Medication risk management	
1.8.14	When prescribing medication for people with an eating disorder and comorbid mental or physical health conditions, take into account the impact malnutrition and compensatory behaviours can have on the effectiveness and the risk of side effects
1.8.15	When prescribing for people with an eating disorder and a comorbidity assess how the eating disorder will affect medication adherence (for example, for medication that can affect body weight)
1.8.16	When prescribing for people with an eating disorder, take account of the risks of medication that can compromise physical health because of pre-existing medical complications
1.8.17	Offer ECG monitoring for people with an eating disorder who are taking medication that can compromise cardiac functioning (for example, bradycardia below 50 beats per minute or a prolonged QT interval)

Substance or medication abuse	
1.8.18	For people with an eating disorder who are misusing substances, or over the counter or prescribed medication, provide treatment for the eating disorder unless the substance misuse is interfering with this treatment
1.8.19	If substance misuse or medication is interfering with treatment, consider a multidisciplinary approach with substance misuse services.

Growth and development	
1.8.20	Seek specialist paediatric or endocrinology advice for delayed physical development or stunted growth in children and young people with an eating disorder.
Conception and pregnancy for women with eating disorders	
1.9.1	Provide advice and education to women with an eating disorder who plan to conceive
1.9.2	Nominate a dedicated professional (such as a GP or midwife) to monitor and support pregnant women with an eating disorder during pregnancy and in the postnatal period
1.9.4	For guidance on providing advice to pregnant women about healthy eating and feeding their baby, see the NICE guideline on maternal and child nutrition.
Physical health assessment, monitoring and management for eating disorders	
1.10.1	Assess fluid and electrolyte balance in people with an eating disorder who are believed to be engaging in compensatory behaviours, such as vomiting, taking laxatives or diuretics, or water loading.
1.10.2	Assess whether ECG monitoring is needed in people with an eating disorder based on risk factors
1.10.3	Provide acute medical care (including emergency admission) for people with an eating disorder who have severe electrolyte imbalance, severe malnutrition, severe dehydration or signs of incipient organ failure
1.10.5	For people with an eating disorder and continued unexplained electrolyte imbalance, assess whether it could be caused by another condition
1.10.6	Encourage dental care for those with an eating disorder who are vomiting
1.10.7	Advise people with an eating disorder who are misusing laxatives or diuretics: • that laxatives and diuretics do not reduce calorie absorption and so do not help with weight loss • to gradually reduce and stop laxative or diuretic use
Assessment and monitoring of physical health in anorexia nervosa	
1.10.10	GPs should offer a physical and mental health review at least annually to people with anorexia nervosa who are not receiving ongoing treatment for their eating disorder
1.10.11	Monitor growth and development in children and young people with anorexia nervosa who have not completed puberty (for example, not reached menarche or final height)

Low bone mineral density in people with anorexia	
1.10.15	Consider a bone mineral density scan: • after 1 year of underweight in children and young people, or earlier if they have bone pain or recurrent fractures • after 2 years of underweight in adults, or earlier if they have bone pain or recurrent fractures
1.10.19	Do not routinely offer oral or transdermal oestrogen therapy to treat low bone mineral density in children or young people with anorexia nervosa
1.10.20	Seek specialist paediatric or endocrinological advice before starting any hormonal treatment for low bone mineral density. Coordinate any treatment with the eating disorders team
1.10.21	Consider transdermal 17-β-estradiol (with cyclic progesterone) for young women (13–17 years) with anorexia nervosa who have long-term low body weight and low bone mineral density with a bone age over 15women (13–17 years) with anorexia nervosa who have long-term low body weight and low bone mineral density with a bone age over 15.
1.10.22	Consider incremental physiological doses of oestrogen in young women (13–17 years) with anorexia nervosa who have delayed puberty, long-term low body weight and low bone mineral density with a bone age under 15
Inpatient and day patient treatment	
1.11.1	Admit people with an eating disorder whose physical health is severely compromised to a medical inpatient or day patient service for medical stabilisation and to initiate refeeding, if these cannot be done in an outpatient setting
1.11.2	Do not use an absolute weight or BMI threshold when deciding whether to admit people with an eating disorder to day patient or inpatient care
1.11.3	When deciding whether to use day patient or inpatient care, take the following into account: • the person's BMI or weight, and whether these can be safely managed in a day patient service • whether inpatient care is needed to actively monitor medical risk parameters. Refer to guidance 1 and 2 in junior MARSIPAN • the person’s current physical health and whether this is declining • whether the parents or carers of children and young people can support them and keep them from significant harm as a day patient
1.11.4	When reviewing the need for inpatient care as part of an integrated treatment programme for a person with an eating disorder: • do not use inpatient care solely to provide psychological treatment for eating disorders • do not discharge people solely because they have reached a healthy weight
1.11.5	For people with an eating disorder and acute mental health risk (such as significant suicide risk), consider psychiatric crisis care or psychiatric inpatient care
1.11.6	Children, young people and adults with an eating disorder who are admitted to day patient or inpatient care should be cared for in age-appropriate facilities. These should be near to their home, and have the capacity to provide appropriate educational activities during extended admissions
1.11.7	When a person is admitted to inpatient care for medical stabilisation, specialist eating disorder or liaison psychiatry services should:

	• keep in contact with the inpatient team to advise on care and management, both during the admission and when planning discharge • keep the person's family members or carers involved • consider starting or continuing psychological treatments for the eating disorder
1.11.8	Inpatient or day patient services should collaborate with other teams (including the community team) and the person's family members or carers (as appropriate), to help with treatment and transition

Refeeding	
1.11.9	Ensure that staff of day patient, inpatient, or acute services who treat eating disorders are trained to recognise the symptoms of refeeding syndrome and how to manage it
1.11.10	Use a standard operating procedure for refeeding that emphasises the need to avoid under-nutrition and refeeding syndrome. Refer to existing national guidance, such junior MARSIPAN
Care planning and discharge from inpatient care	
1.11.11	Develop a care plan for each person with an eating disorder who is admitted to inpatient care
1.11.12	Whether or not the person is medically stable, within 1 month of admission review with them, their parents or carers (as appropriate) and the referring team, whether inpatient care should be continued or stepped down to a less intensive setting
Medication	
Medication should not be used as the sole treatment for any eating disorder	
Using the Mental Health Act and compulsory treatment	
1.12.1	If a person's physical health is at serious risk due to their eating disorder, they do not consent to treatment, and they can only be treated safely in an inpatient setting, follow the legal framework for compulsory treatment in the Mental Health Act 1983
1.12.2	If a child or young person lacks capacity, their physical health is at serious risk and they do not consent to treatment, ask their parents or carers to consent on their behalf and if necessary, use an appropriate legal framework for compulsory treatment (such as the Mental Health Act 1983/2007 or the Children Act 1989)
1.12.3	Feeding people without their consent should only be done by multidisciplinary teams who are competent to do so

Note: BMI = body mass index; ECG = electrocardiogram; MARSIPAN = Management of Really Sick Patients with Anorexia Nervosa, QTc = corrected QT interval (which is, the period from the start of the Q wave to the end of the T wave: the duration of ventricular electrical activity); CBT-E = enhanced cognitive behavioural therapy

** This table includes recommendations from the latest NICE guidance on eating disorders, which is currently out for consultation. There may be further changes needed after the consultation process.*

Table 3: NICE-recommendations for transition between mental health settings and community or care home setting (NG53)

Intervention	Delivery of the intervention
Admission planning	Plan admission collaboratively with the person being admitted, their family members, parents or carers, community accommodation and support providers
	Allow more time and expert input to support people with complex, multiple or specific support needs to make transitions
	For planned admissions, offer people an opportunity to visit the inpatient unit before they are admitted. If this is not possible, consider using accessible online and printed information to support discussion about their admission
	During admission planning, record a full history
Crisis planning	Support those who have had multiple admissions to develop a crisis plan
	Start building therapeutic relationships as early as possible
	Refer to crisis plans and advance statements, advance decisions must be followed in line with the Mental Capacity Act 2005
	Offer all people access to appropriate advocacy services
	Those with cognitive difficulties should be made aware of why they have been admitted
	Discuss with the person any coping strategies they use and how they can continue with this on the ward
	Start discharge planning at admission or as early as possible when in crisis
	If admitted out-of-area, identify a named practitioner from the person's home area and from the ward they are admitted to. These practitioners should work together to ensure that the person's current placement lasts no longer than required. This includes reviewing the person's care plan, current placement, recovery goals and discharge plans at least every 3 months.
Legal status	Inform the person being admitted about their legal status at the point of admission, check they have understood the information given at admission, that they know they have a right to appeal, and that information and advocacy can be provided, that any changes to their legal status and treatment plans will be discussed as they occur
Observation	Inform the person what level of observation they are under, what this means, the reasons for it, how it will support recovery and treatment, how their preferences will be respected and how their rights to privacy and dignity will be protected, offer the person the opportunity to ask questions
Restrictions and access to personal possessions	Ensure restrictions are relevant and reasonable, take into consideration the safety of the person and others on the ward; are clearly explained as to why the restrictions are in place and under what circumstances they would be changed
	The following items should be made available: a toothbrush, hygiene products, nightwear

Intervention	Delivery of the intervention
Inform	Give the person verbal and written information about ward facilities and routines
	Discuss all medication and care needs with the person being admitted
	Discuss how to manage domestic and caring arrangements and liaise with the appropriate agencies
	Ensure people (particularly children and young people) know who they can talk to if they are frightened or need support
	Identify whether the person has any additional needs for support, for example with daily living activities
Family and carer support	Identify a named practitioner to make sure family, parents or carers receive support and timely information. Practitioners should start to build relationships with the person's family members, parents or carers during admission. Arrange for parents to have protected time at an early point in the process of admitting their child to discuss the process. Try to accommodate parents' or carers' working patterns and responsibilities. Throughout admission families, parents or carers should be given clear, accessible information (in line with patient confidentiality)
Carer's assessments	Take account of carer's needs. Identify carers who have recognisable needs. If desired, make a referral to the carer's local authority for a carer's assessment
Discharge	Discharge should be collaborative, person-centred and suitably-paced
Maintain community links	Keep links with life outside hospital, restart any activities before they are discharged, other phased leave, phased return to employment or education
Education	Children and young people under 18 years must have continued access to education and learning throughout their hospital stay. Before the child or young person goes back to school, identify a named worker from the education or training setting to be responsible for the transition, arrange a meeting between the named worker and the child or young person to plan their return
Psychoeducation	Consider psychoeducation sessions for all people as part of planning discharge. Consider group psychoeducation support for carers, this should include signposting on the specific condition of the person they care for
Peer support	Consider providing peer support to people with more than one previous hospital admission
Care planning	There should be a designated person responsible for writing the care plan in collaboration with the person being discharged and their carers where appropriate (see guideline for further information on care planning)
Assessment	Carry out a thorough assessment of the person's personal, social, safety and practical needs, including the risk of suicide. Carers should also be involved in the discharge plans
Follow-up support	Discuss follow-up support with the person before discharge. Consider booking a follow-up appointment with the GP to take place within two weeks of the person's discharge. Give the person a written record of the details. Follow up a person who has been discharged within seven days. Follow up a person who has been discharged within 48 hours if a risk of suicide has been identified
Discharge information	A discharge letter should be emailed to the person's GP within 24 hours of discharge. A copy should be given to the person and their community / specialist team where appropriate. Within 24 hours a copy of the person's latest care plan is sent to everyone involved in their care. Within a week, a discharge summary is sent to the GP and others involved in developing the care plan, subject to the person's agreement

Table 4: NICE-recommendations on hospital care from service user experience in adult mental health: improving the care for people using adult NHS mental health services (CG136)

Intervention	Delivery of the intervention
Assessment	Commence formal assessment and admission processes within 2 hours of arrival
Care coordination	Ensure overall coordination and management of care takes place at a regular multidisciplinary meeting
Daily one-to-one sessions	Daily one-to-one sessions lasting at least 1 hour
Regular consultant sessions	Regular (at least weekly) one-to-one sessions lasting at least 20 minutes
Medication	Should have an opportunity to meet with a mental health pharmacist to discuss medication choices and any risks and benefits
Activities	Ensure that service users have access to a wide range of meaningful and culturally appropriate occupations and activities seven days a week, not restricted to 9 a.m. to 5 p.m.
Access	Ensure access to internet and telephone
Staff training	All health and social care professionals who work in a hospital setting should be trained as a team to ensure the same person-centred approach to treatment and care
Community involvement	Service users should be routinely visited by health and social care professionals responsible for their community care
Advocacy	Ensure regular access to advocates
Food	Ensure hospital menus include a choice of foods, covering a range of ethnic, cultural and religious backgrounds and specific health problems
Discharge and transfer of care	Discharge and transfer of care should be managed collaboratively with the service user. Ensure that a 24-hour helpline is available to service users. Discuss arrangements with family or carers. Give service users clear information about all possible support options available after discharge. Give service users at least 48 hours' notice of the date of their discharge. Give them information about the local patient advice and liaison service (PALS)

Appendix B: Junior MARSIPAN risk assessment framework*

	Red (high risk)	Amber (alert to high concern)	Green (moderate risk)	Blue (low risk)
BMI and weight	Percentage median BMI <70% (below about the 0.4th BMI centile)	Percentage median BMI 70–80% (between about the 2nd and 0.4th BMI centile)	Percentage median BMI 80–85% (approx. 9th–2nd BMI centile)	Percentage median BMI>85% (approx. above 9th BMI centile)
	Recent loss of weight of >1 kg each week for 2 consecutive weeks	Recent loss of weight of 500–999g each week for 2 consecutive weeks	Recent weight loss of ≤500 g each week for 2 consecutive weeks	No weight loss over past 2 weeks
Cardiovascular health	Heart rate (awake): <40 bpm	Heart rate (awake): 40–50 bpm	Heart rate (awake): 50–60 bpm	Heart rate (awake): >60 bpm
		Sitting blood pressure: Systolic: <0.4th centile (84–98 mmHg depending on age and gender) Diastolic: <0.4th centile (35–40 mmHg depending on age and gender)	Sitting blood pressure: Systolic: <2nd centile (98–105 mmHg depending on age and gender) Diastolic: <2nd centile (40–45 mmHg depending on age and gender)	Normal sitting blood pressure for age and gender with reference to centile charts
	History of recurrent syncope; marked orthostatic changes (fall in systolic blood pressure of 20 mmHg or more, or below 0.4th–2nd centiles for age, or increase in heart rate of >30 bpm)	Occasional syncope; moderate orthostatic cardiovascular changes (fall in systolic blood pressure of 15 mmHg or more, or diastolic blood pressure fall of 10 mmHg or more within 3 minutes of standing, or increase in heart rate of up to 30 bpm)	Pre-syncopal symptoms but normal orthostatic cardiovascular changes	Normal orthostatic cardiovascular changes
	Irregular heart rhythm (does not include sinus arrhythmia)			Normal heart rhythm
			Cool peripheries; prolonged peripheral capillary refill time (normal central capillary refill time)	

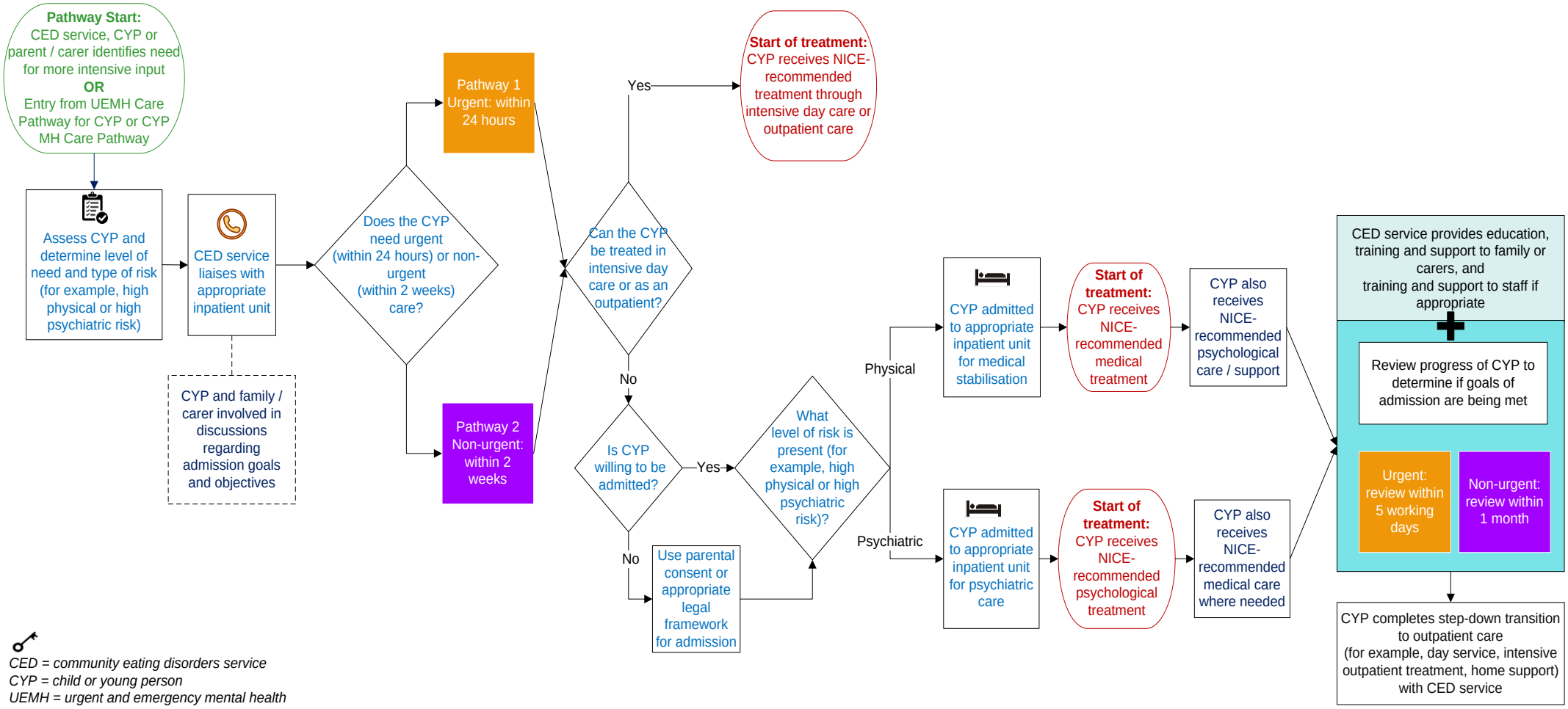
	Red (high risk)	Amber (alert to high concern)	Green (moderate risk)	Blue (low risk)
ECG abnormalities	QTc >460 ms (girls) or 400 ms (boys) with evidence of bradyarrhythmia or tachyarrhythmia (excludes sinus bradycardia and sinus arrhythmia); ECG evidence of biochemical abnormality	QTc>460 ms (girls) or 400 ms (boys)	QTc <460 ms (girls) or 400 ms (boys) and taking medication known to prolong QTc interval, family history of prolonged QTc or sensorineural deafness	QTc <460 ms (girls) or 400 ms (boys)
Hydration status	Fluid refusal: Severe dehydration (10%): reduced urine output, dry mouth, decreased skin turgor, sunken eyes, tachypnoea, tachycardia	Severe fluid restriction: Moderate dehydration (5–10%): reduced urine output, dry mouth, normal skin turgor, some tachypnoea, some tachycardia, peripheral oedema	Fluid restriction: Mild dehydration (<5%): may have dry mouth or not clinically dehydrated but with concerns about risk of dehydration with negative fluid balance	Not clinically dehydrated
Temperature	<35.5°C tympanic or 35.0°C axillary	<36°C		
Biochemical abnormalities	Hypophosphataemia, hypokalaemia, hypoalbuminaemia, hypoglycaemia, hyponatraemia, hypocalcaemia	Hypophosphataemia, hypokalaemia, hyponatraemia, hypocalcaemia		
Disordered eating behaviours	Acute food refusal or estimated calorie intake 400–600 kcal per day	Severe restriction (less than 50% of required intake), vomiting, purging with laxatives	Moderate restriction, bingeing	
Engagement with management plan	Violent when parents try to limit behaviour or encourage food or fluid intake, parental violence in relation to feeding (hitting, force feeding)	Poor insight into eating problems, lacks motivation to tackle eating problems, resistance to changes required to gain weight, parents unable to implement meal plan advice given by healthcare providers	Some insight into eating problems, some motivation to tackle eating problems, ambivalent towards changes required to gain weight but not actively resisting	Some insight into eating problems, motivated to tackle eating problems, ambivalence towards changes required to gain weight not apparent in behaviour
Activity and exercise	High levels of uncontrolled exercise in the context of malnutrition (>2 hours/day)	Moderate levels of uncontrolled exercise in the context of malnutrition (>1 hour/day)	Mild levels of uncontrolled exercise in the context of malnutrition (<1 hour/day)	No uncontrolled exercise

	Red (high risk)	Amber (alert to high concern)	Green (moderate risk)	Blue (low risk)
Self-harm and suicide	Self-poisoning, suicidal ideas with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide		
Other mental health diagnoses		Other major psychiatric co-diagnosis, for example OCD, psychosis, depression		
Muscular weakness – SUSS Test • Sit up from lying flat	Unable to sit up at all from lying flat (score 0)	Unable to sit up without using upper limbs (score 1)	Unable to sit up without noticeable difficulty (score 2)	Sits up from lying flat without any difficulty (score 3)
• Stand up from squat	Unable to get up at all from squatting (score 0)	Unable to get up without using upper limbs (score 1)	Unable to get up without noticeable difficulty (score 2)	Stands up from squat without any difficulty (score 3)
Other	Confusion and delirium, acute pancreatitis, gastric or oesophageal rupture	Mallory–Weiss tear, gastroesophageal reflux or gastritis, pressure sores	Poor attention and concentration	

Note: BMI = body mass index; ECG = electrocardiogram; MARSIPAN = Management of Really Sick Patients with Anorexia Nervosa, OCD = obsessive-compulsive disorder; SUSS = sit up – squat stand; QTc = corrected QT interval (which is, the period from the start of the Q wave to the end of the T wave: the duration of ventricular electrical activity).

**Junior MARSIPAN is currently undergoing revision, which may lead to changes with the risk assessment framework.*

Appendix C: The full eating disorders pathway for children and young people – inpatient and intensive day care



CED = community eating disorders service
CYP = child or young person
UEMH = urgent and emergency mental health

Helpful resources

This resource pack accompanies The Eating Disorders Pathway for Children and Young People: Inpatient and Intensive Day Care full implementation guidance, and provides commissioners and providers with appendices, examples of positive practice and helpful resources to support implementation.

Positive practice examples

Section 1 provides positive practice examples from children and young people's inpatient and intensive day care services for the treatment of eating disorders.

Helpful web-based resources

Section 2 provides a large number of links to helpful web-based resources including:

- national guidance
- NICE guidance
- mental health resources
- commissioning resources
- capacity, information sharing and safeguarding resources
- competence frameworks
- online/web-based tools for children and young people
- resources for families and carers
- other useful resources.

As noted in the implementation guidance, the Royal College of Psychiatrists Centre for Quality Improvement (CCQI) will be launching a quality assessment and improvement programme, which will be an ongoing source of helpful information and positive practice examples.

1 Positive practice examples

The following examples of positive practice have been included to illustrate how some inpatient, intensive day care and community services are achieving certain commissioning goals.

The Positive Practice in Mental Health Collaborative is a user-led, multi-agency collaborative of 75 organisations, including NHS Trusts, CCGs, third sector providers and service user groups. The aim of the organisation is to facilitate shared learning of positive practice in mental health services across organisations and sectors. The Positive Practice in Mental Health Collaborative provides a directory of positive practice in mental health services. 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.

1.1 Integrating medical care and access to paediatric beds with psychological interventions for eating disorders – joint working between CED services and paediatrics

The Cheshire and Merseyside Eating Disorder Service for children and adolescents is a community service with 4 inpatient beds. The team provides routine medical management with the option of transfer to a dedicated paediatric bed for up to 2 weeks of intensive medical management, with nasogastric feeding as required. This is undertaken as part of a service level agreement with the paediatric service in Chester, which provides 2 fortnightly clinics and 16 inpatient weeks per year for intensive medical management.

The Gloucestershire Eating Disorders Service has a shared protocol for working with paediatricians and the children's ward. The team supports paediatric colleagues by providing guidance during the admission. The team also provides teaching for doctors and nurses and a regular liaison meeting and rapid assessment of new cases admitted to the children's ward with frequent liaison throughout. When possible, the community home treatment team will in-reach to the ward to support patients with feeding.

The Exeter, East and Mid Devon Child and Adolescent Mental Health Services and Paediatric Service have developed a joint pathway to deliver care to children with restrictive eating disorders since 2012. The pathway enables the majority of young people with restrictive eating disorders to be maintained in the community throughout their treatment. The need for tier 4 admissions has been substantially reduced.

In moderate or high-risk cases, inpatient admission to the general paediatric ward is used urgently or semi-electively, to stabilise physical risk and re-establish intake of sufficient calories to achieve weight gain. This consists of a standardised 3 week supported feeding admission during which the child or young person is cared for with a strict care plan and a dietitian prescribed meal plan, with monitoring for refeeding syndrome. Compliance rates are good and nasogastric tube use is minimal.

"The key to success has been communication and joint working between professionals, and removal of the artificial divide between physical and mental health, medical and CAMHS teams."

Source: Exeter, East and Mid Devon CAMHS and paediatric service

Table 5: Outcomes for the Exeter, East and Mid Devon Service

Date	Admissions to general paediatric ward	Mean length of stay	Required NG feeding	Admitted to tier-4 inpatient unit
2008 - 2010	7	80	3	6
2012 - 2016	47	19.5	5	4

1.2 Providing intensive community-based treatment options to reduce number and length of hospital admissions

The Gloucestershire Eating Disorders Service home treatment programme was established in 2010 and is for children and young people at risk of hospital admission. This includes those who have been unable to halt weight loss with their parents; those who are stable but stuck at an unhealthy weight; and those that require a step-down to the community. The team intensively supports severely ill children, young people and parents in their homes. The treatment is normally for 6 weeks (3 weeks intensive and 3 weeks step down).

The Northumberland Tyne and Wear Eating Disorders Intensive Community Treatment service has developed a short term intensive treatment model for patients who have severe anorexia nervosa or who have not responded to family based therapy. The team identified 21 patients who met the criteria for inpatient treatment to trial this model, based on intensive family based treatment. Of these 21, only 2 subsequently required inpatient treatment, with the remaining 19 making significant progress, allowing continuation of outpatient care.

The South London and Maudsley Intensive Treatment Programme was developed by the Maudsley CED service for children and young people as an alternative to inpatient admission for individuals suffering from eating disorders who are unable to achieve consistent weight gain, establish regular eating or have a high level of maintaining factors hindering their recovery from an eating disorder. The intensive treatment programme involves working intensively with a group of children and young people, concurrently in small therapy groups and around mealtimes. Children and young people accepted on to the intensive treatment programme have an individual plan of attendance that can vary from 1 to 5 days per week. The service includes a multidisciplinary assessment incorporating a physical health examination by a medical doctor and regular physical monitoring, including consultation with the consultant paediatrician. The average duration of intensive intervention is 36 days. Evaluations show that the intensive treatment programme was an alternative to inpatient treatment for 40% of young people; approximately 90% of the children and young people offered the intensive treatment programme engage with treatment.

1.3 Ensuring optimal length of inpatient stay

The Great Ormond Street Hospital Eating Disorders Team is a national specialist service which has successfully reduced the length of inpatient stay through the introduction of step-up and step down care. Length of stay for young people with an eating disorder has reduced in the last 3 years from 253 days in 2013/14 to 64 days in 2016. Through working collaboratively with inpatient colleagues, the young person and their family determine admission goals with a focus on the minimal amount of change needed to continue care at a lower intensity. Goals of admission are reviewed weekly, with a full clinical review involving local teams within 3-6 weeks of admission to determine the level and location of care. Day patient care may be offered as a step down from inpatient treatment once risk is diminished, with an emphasis on maintaining continuity of care across the inpatient, day-patient and outpatient service. It should be noted that the setting of a specialist service within a children's hospital which has the capacity to provide for a complex level of medical care may have a role in minimising the length of stay and care for children and young people with co-existing medical conditions.

The Tees, Esk and Wear Eating Disorder Outreach Service (EDOS) was established

in 2015 as an addition to care provided by The Evergreen Centre inpatient unit**.** The goal of the EDOS team was to reduce the length of inpatient stay by providing intensive interventions within the patient's home environment. The EDOS team is now part of the care provision for every patient admitted to The Evergreen Centre. The team provides input and support from referral to discharge. This includes meal support at home, or input from the dietician, for example cooking with the family to illustrate correct portion sizes. If the patient is struggling on home leave, the EDOS team can provide intensive support. The team offers out-of-hours evening and weekend support. The team is also able to provide more 'crisis interventions', for example if a child, young person or their family is struggling at home. They also act as a liaison service between agencies which assists with discharge planning. There has been a notable reduction in the length of stay of patients since introducing EDOS.

Table 6: Service contacts

Service	Contact information	Key contact
Cheshire and Merseyside Eating Disorder Service	info@cwp.nhs.uk 01244393220	Simon Gowers
Gloucestershire Eating Disorders Service	2gnft.comms@nhs.net 01242 634242	Sam Clark-Stone
Exeter, East and Mid Devon Child and Adolescent Mental Health Services and Paediatric Service	01392 208600	Mel Nash
Great Ormond Street Hospital Eating Disorders Team	enquiries@gosh.nhs.uk 02078298679	Dasha Nicholls
Northumberland, Tyne and Wear NHS Foundation Trust Eating Disorders Intensive Community Treatment (EDICT)	NTAWNT.NoTCYPS@nhs.net 01434 612701	Jane Robb
South London and Maudsley Intensive Treatment Programme	020 3228 2545	Laura Baker Dianne Russell
Tees, Esk and Wear Eating Disorder Outreach Service (EDOS) (The Evergreen Centre)	tewv.enquiries@nhs.net 01642 529787	Craig Halpin

2 Helpful web-based resources

2.1 National guidance

Achieving Better Access to Mental Health Services by 2020

Care and Treatment Review: Policy and Guidance

Carers and Personalisation: Improving Outcomes

The Crisis Care Concordat

Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21

Equality Act (2010)

Future in Mind

Guidance for Reporting Against Access and Waiting Time Standards: Children and Young People with an Eating Disorders and 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)

Local Transformation Plans for Children and Young People's Mental Health and Wellbeing

Mental Capacity Act (2005)

Mental Health Act (1983)

Mental Health Act (2007)

Mental Health Act 1983: Code of Practice (2015)

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

2.2 NICE guidelines and quality standards

The Expert Reference Group considered that the following NICE guidelines and quality standards are directly relevant when treating a child or young person with an eating disorder:

2.2.1 Mental health guidelines

- Alcohol-use Disorders: Diagnosis and Management of Physical Complications (NICE clinical guideline 100)
- Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence (NICE clinical guideline 115)
- Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (NICE clinical guideline 192)
- Autism Spectrum Disorder in Under 19s: Support and Management (NICE clinical guideline 170)
- Bipolar Disorder: Assessment and Management (NICE clinical guideline 185)
- Borderline Personality Disorder: Recognition and Management (NICE clinical guideline 78)
- Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities Whose Behaviour Challenges (NICE guideline 11)
- Depression in Children and Young people: Identification and Management (NICE clinical guideline 28)
- Drug Misuse in Over 16s: Psychosocial Interventions (NICE clinical guideline 51)
- Drug Misuse Prevention: Targeted Interventions (NICE guideline 64)
- Mental Health Problems in People with Learning Disabilities: Prevention, Assessment and Management (NICE guideline 54)

- Obsessive-compulsive Disorder and Body Dysmorphic Disorder: Treatment (NICE clinical guideline 31)
- Post-traumatic Stress Disorder: Management (NICE clinical guideline 26)
- Self-harm in Over 8s: Short-term Management and Prevention of Recurrence (NICE clinical guideline 16)
- Self-harm in Over 8s: Long-term Management (NICE clinical guideline 133)
- Social Anxiety Disorder: Recognition, Assessment and Treatment (NICE clinical guideline 159)
- Transition Between Inpatient Mental Health Settings and Community or Care Home Setting (NICE guideline 53)
- Transition from Children's to Adults' Services for Young People Using Health or Social Care Services (NICE guideline 43)

2.2.2 Physical health guidelines

- Acute Kidney Injury: Prevention, Detection and Management (NICE clinical guideline 169)
- Chronic Kidney Disease: Managing Anaemia (NICE guideline 8)
- Diabetes (Type 1 and Type 2) in Children and Young People: Diagnosis and Management (NICE guideline 18)
- Intravenous Fluid Therapy in Children and Young People in Hospital (NICE guideline 29)
- Pressure Ulcers: Prevention and Management (NICE clinical guideline 179)

2.2.3 Other relevant guidelines

- Child Maltreatment: When to Suspect Maltreatment in Under 18s (NICE clinical guideline 89)
- Coeliac Disease: Recognition, Assessment and Management (NICE guideline 20)
- Fertility Problems: Assessment and Treatment (NICE clinical guideline 156)
- Looked-after Children and Young People (NICE public health guideline 28)
- Medicines Optimisation: The Safe and Effective Use of Medicines to Enable the Best Possible Outcomes (NICE guideline 5)
- Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings (NICE guideline 10)

2.2.4 Quality standards

- Acute Kidney Injury (NICE quality standard 76)
- Alcohol-use Disorders: Diagnosis and Management (NICE quality standard 11)
- Antenatal and Postnatal Mental Health (NICE quality standard 115)
- Antisocial Behaviour and Conduct Disorders in Children and Young People (NICE quality standard 59)
- Anxiety Disorders (NICE quality standard 53)
- Attention Deficit Hyperactivity Disorder (NICE quality standard 39)
- Autism (NICE quality standard 51)
- Bipolar Disorder, Psychosis and Schizophrenia in Children and Young People (NICE quality standard 102)
- Depression in Children and Young People (NICE quality standard 48)
- Diabetes in Children and Young People (NICE quality standard 125)
- Intravenous Fluid Therapy in Children and Young People in Hospital (NICE quality standard 131)
- Learning Disabilities: Challenging Behaviour (NICE quality standard 101)
- Looked-after Children and Young People (NICE quality standard 31)
- Medicines Optimisation (NICE quality standard 120)
- Self-harm (NICE quality standard 34)
- Transition from Children's to Adults' Services (NICE quality standard 140)

2.3 Mental health resources

Children and Young People's Health Rights in England: Shared Messages

Listening to Experience

Right Here, Right Now

2.4 Commissioning resources

Better Mental Health Outcomes for Children and Young People: A Resource Directory for Commissioners

Children and Young People's Mental Health and Wellbeing Profiling Tool

Commissioning for Effective Service Transformation: What We Have Learnt

Delivering Workforce Capacity, Capability and Sustainability in Child and Adolescent Mental Health Services

Good Mental Health Services for Young People – A joint report from the Faculty of Child and Adolescent Psychiatry and Faculty of General Adult Psychiatry

MINDSet

Supporting People with a Learning disability and/or Autism who Display Behaviour that Challenges, Including Those with a Mental Health Condition: Service Model for Commissioners of Health and Social Care Services

Values Based CAMHS Commission - What Really Matters in Children and Young People's Mental Health

YoungMinds Amplified Resources - Commissioned by NHS England, YoungMinds have developed a tool kit to support services to implement participation in all aspects of their work and service delivery.

2.5 Capacity, information sharing and safeguarding resources

Brief Guide: Capacity and Competence in Under 18s

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

The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: A Guide for Professionals

Working Together to Safeguard Children

2.6 Competence frameworks

Children and Young People's Improving Access to Psychological Therapies Programme National Curriculum

A Competence Framework for Liaison Mental Health Nursing

Core Competence Frameworks for Child and Adolescent Mental Health Services

Skills for Health Mental Health Core Skills Education and Training Framework

Skills for Health National Occupational Standards

2.7 Online/web-based tools for children and young people

Anorexia and Bulimia Care – A national eating disorders organisation providing information and support to anyone affected by eating disorders.

B-eat – The UK's eating disorder charity, providing information and support for everyone affected by eating disorders including helplines, message boards and online support groups.

Big White Wall - A 24/7 anonymous online service for people in psychological distress, where individuals are supported by other members to self-manage their own mental health.

ChildLine - Service for children and young people up to the age of 19 years, with options to speak with a counsellor via free call, online chat, or email. It also has message boards for young people to share their experiences and receive support from other young people in the same situation.

Men get EDs too – An eating disorder charity seeking to raise awareness of eating disorders in men and to support individuals, carers and their families.

Recovery Record – An eating disorder management app.

Student Minds – Provides support and information for students on looking after their mental health.

The Mix - Provides support for children and young people under the age of 25 years with a variety of means to access support, including phone, email, live message, peer to peer and counselling services, or online articles and video content.

The Seven Apps and Websites - Provides links to 7 websites or mobile applications developed by Innovation Labs for children and young people.

Youth Wellbeing Directory – Provides a list of local and national organisations and other information, for people up to the age of 25 years.

2.8 Resources for families and carers

Association for Young People's Health

MindEd for Families

NHS Choices: Eating Disorders - Advice for parents

Royal College of Psychiatrists: Eating Disorders Factsheet

Yorkshire Centre for Eating Disorders: An Information Pack for Carers 2016

2.9 Other useful resources

Anna Freud Centre: Mental health in Schools

Bringing Together Physical and Mental Health

Department for Education: Mental Health and Behaviour in Schools

King's College Eating Disorders Research Group

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.

Please contact **0300 311 22 33** or email **england.contactus@nhs.net**