SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service name	Adult Specialist Eating Disorder Inpatient Services **CRG – All-Age Eating Disorders**		
Service specification number		**Date Approved**	**Review Date**
Status	Draft		
Population and/or geography to be served: Adults resident in the United Kingdom			

Commissioner responsibility/lead [2021 – Mar 2023]:

NHS England

Commissioner responsibility/lead [from April 2023 onwards]:

Integrated Care Boards via NHS-led Provider Collaboratives

Population covered:
This service specification covers intensive treatments (inpatient, intensive day-patient, and intensive community treatment) for eating disorders. There is no expectation that every provider will necessarily provide all these interventions, but where they are commissioned to do so by NHS England, they should comply with this specification. Some outpatient work is included under the definition of 'outreach' specified below (see Section 2.2.14).

It does not cover community eating disorder services or less intensive day services which are commissioned by Integrated Care Systems (ICSs). This specification is only part of the patient pathway, and joined-up care pathways with the ICS-commissioned services and provider collaboratives are vital for improved outcomes. This specification needs to be incorporated into working arrangements and pathways within provider collaboratives.

The service outlined in this specification is for patients ordinarily resident in England or who are otherwise the commissioning responsibility of the NHS in England as defined in "Who Pays?: Determining which NHS commissioner is responsible for commissioning healthcare services" and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges.

Eating Disorder Population:
Patients will have a diagnosable eating disorder according to 'The International Statistical Classification of Diseases and Related Health Problems version 11 (ICD 11)' or its successor who require intensive treatment:

- Anorexia Nervosa
- Bulimia Nervosa
- Atypical Anorexia Nervosa

- Atypical Bulimia Nervosa
- Avoidant Restrictive Food Intake Disorder (ARFID)
- Binge Eating Disorder (BED)
- Unspecified Eating Disorder

Avoidant Restrictive Food Intake Disorder (ARFID) and Binge Eating Disorder (BED) are described in DSM-5 and ICD-11 and were included in the categories of atypical and unspecified eating disorders in ICD-10. They are included in this specification when specialist eating disorder services are the most appropriate service to treat the patient's eating and weight difficulties in the context of moderate to severe risk and where the patient's needs are not met appropriately by another service.

Exclusion criteria:

- Patients who have weight issues in the absence of a diagnosed eating disorder
- Patients who are under 17 years of age
- Patients with Pica

Services must not exclude patients purely on the basis of BMI, comorbidity, or the presence of learning disability or autism. However, the optimal treatment setting should be carefully considered with the patient, their carers, and the local services available based on the needs of the individual patient.

Patients should be admitted as close to home as possible to maintain their support networks.

For the purposes of this specification, intensive treatment includes inpatient treatment; day patient treatment as defined by section 2.2.2; and intensive community treatment defined by section 2.2.15, which will increasingly be developed by provider collaboratives within the framework of new models of care for eating disorders.

1. Service aims and desired outcomes

1.1 Service aims

The aims of the service/s are to:

- Assess and implement appropriate treatment.
- Deliver flexible programmes of care that are patient-centred and can adapt to individualised goals.
- Reduce the physical and psychosocial morbidity and disability associated with eating disorders, with a focus on full recovery whenever possible.
- Improve the physical and psychosocial functioning and prevent disability associated with eating disorders, with a focus on full recovery as defined by the individual whenever possible, with a core focus on improving quality of life and encouraging engagement in activities that are meaningful to the individual.
- Reduce deaths from eating disorders.
- Improve quality of life and encourage engagement in meaningful activity.

Objectives of the service are to:

- Work alongside community eating disorder services to provide coherent and robust care pathways to meet the needs of people with severe eating disorders.
- Provide a comprehensive multi-disciplinary assessment including diagnosis and formulation.

- Provide high-quality care and treatment informed by current evidence.
- Work in partnership with patients, families, and carers to optimise engagement and ensure support tailored to individual needs.
- Provide specific psychological therapies as appropriate to the patients' needs.
- Provide interventions to improve occupational and psychosocial functioning and quality of life.
- Ensure smooth and managed transitions, including those from children and young people's services to adult services, across different levels of treatment, and across geographical boundaries.
- Ensure smooth and effective transitions for students going away to university whose treatment often needs to cross two geographical areas (Royal College of Psychiatrists 2017). Treatment should not be tied exclusively to the area where they are registered with a GP, and there should be close liaison between eating disorders services and GPs in their stable place of residence (usually the family home) and their place of residence while studying.
- Ensure effective communication and coordination of care across the care network, including patients, families, and carers, community eating disorder providers, and the broader health and social care network.
- Support and actively engage families and carers as a resource for improved wellbeing and recovery goals.
- Provide an individualised, patient-centred service sensitive to the cultural, emotional, physical, and psychological needs of the patient and their family or carers.
- Provide consultation and advice to acute providers and other services involved in the eating disorder care pathway.
- Each provider collaborative must have arrangements in place for obtaining second opinions and for providing others with second opinions when needed. This should be both within and across Provider Collaboratives.
- Commit to an annual review of outcome and quality metrics. This addition ensures continuous improvement and accountability, allowing for regular assessment and refinement of services based on stakeholder feedback and emerging best practices.

1.2 Outcomes

Routine outcome measures should be completed on admission and discharge. These measures can be used to inform individual treatment and evaluate service provision. The following range of outcome measures should be used:

- BMI
- Eating Disorder Examination Questionnaire (EDE-Q 6.0): Measures the range and severity of eating disorder symptoms and behaviours.
- Clinical Impairment Assessment (CIA) questionnaire: Measures the severity of psychosocial impairment due to eating disorder features.
- Health Questionnaire (PHQ-9): Used to facilitate the recognition and identification of depression.
- Generalised Anxiety Disorder Assessment (GAD-7): Used to assess the severity of anxiety.
- Patient experience/satisfaction measure.
- Carer experience/satisfaction measure.

NHS Outcomes Framework Domains & Indicators

Domain	Indicator
1	Preventing people from dying prematurely
2	Enhancing quality of life for people with long-term conditions
3	Helping people to recover from episodes of ill-health or following injury
4	Ensuring people have a positive experience of care
5	Treating and caring for people in a safe environment and protecting them from avoidable harm

1.3 Service Defined Outcomes/Outputs

No	Indicator	Data source	Domains	CQC Key Question (Regulation Number)
1	Improvement in BMI of patients on discharge	QNT Metrics report	1, 2, 3, 4	9, 10, 11, 12, 14
2	Reducing delays to discharges	QNT Metrics report	1, 2, 3, 4, 5	9, 10, 11, 12, 13
3	All patients to have a completed EDE-Q 6* both on admission and on discharge	QNT Metrics report	1, 2, 3, 4, 5	9, 10, 11, 12, 14, 15, 17, 18
4	Improvement in EDE-Q 6* score between admission and discharge	QNT Metrics report	1, 2, 3, 4, 5	9, 10, 11, 12, 14, 15, 17, 18
5	Average length of stay comparative to the median for all units	QNT Metrics report	1, 2, 3, 4, 5	9, 10, 11, 12, 14, 15, 17, 18
6	Percentage of discharged patients where there is a completed patient satisfaction survey (using POEM) relative to other units	QNT Metrics report	2, 4	9, 10, 12
7	Improvement in patient satisfaction results or maintaining a high-level quarter to quarter (POEM) - median score.	QNT Metrics report	2, 4	9, 10, 12
8	Percentage of discharged patients where there is a completed carer/partner/parent satisfaction survey	QNT Metrics report	2, 4	9, 10, 12
9	Improvement in or maintenance of high rating in carer/partner/parent satisfaction quarter to quarter – median score.	QNT Metrics report	2, 4	9, 10, 12
10	All patient deaths to be notified to commissioning body within 24hrs.	QNT Metrics report	1, 2, 3, 4, 5	20

11	Number of patients who die while under the care of the Provider	QNT Metrics report	1, 2, 3, 4, 5	9, 10, 12, 15, 20
12	All eligible staff have received clinical supervision	QNT Metrics report	1, 2, 3, 4, 5	13, 18, 19
13	All staff have received annual Safeguarding Children training	QNT Metrics report	1, 2, 3, 4, 5	13, 18, 19
14	All staff have received annual Safeguarding Vulnerable Adults training	QNT Metrics report	1, 2, 3, 4, 5	13, 18, 19
15	Increase access for male patients through the measurement of percentage of male admissions to monitor	QNT Metrics report	1, 2, 3, 4, 5	9, 10, 12
16	Percentage of patients treated under MHA for any part of their admission.	QNT Metrics report	1, 2, 3, 4, 5	9, 10, 11, 12, 13, 14, 15, 17, 18, 19
17	Number of patients receiving at least 1 NG feed.	Self-reporting by units	1, 2, 3, 4, 5	9, 11, 12, 14, 15, 17, 18, 19
18	During the quarter the number of patients on the ward who have received at least one NG feed as a percentage of all patients on the ward.	QNT Metrics report	1, 2, 3, 4, 5	9, 11, 12, 14, 15, 17, 18, 19
19	During the year the number of patients on the ward who have been enterically fed for more than 28 days as a percentage of all patients on the ward.	QNT Metrics report	1, 2, 3, 4, 5	9, 11, 12, 14, 15, 17, 18, 19
20	Percentage of patients who have been discharged under a CTO	QNT Metrics report	1, 2, 3, 4, 5	9, 12, 17
21	Percentage of patients recalled under a CTO	QNT Metrics report	1, 2, 3, 4, 5	9, 12, 17
22	All patients have all the following recorded on admission: Gender identity and whether this is different to that assigned at birth, Sexual orientation, Ethnicity, Learning Disability/Autism spectrum conditions status, All other disabilities, Comorbidities	QNT Metrics	4	9, 10, 12, 13
23	Proportion of patients who have had a sensory screening tool administered at admission	QNT Metrics report	1, 2, 3, 4, 5	10, 13, Equality and Diversity
24	Number of patients and occasions where restraint has been applied – Reduction in the use of restraint	QNT Metrics report	4, 5	9, 10, 12, 13

25	Reduction in restrictive practices	QNT Metrics report	4, 5	9, 10, 12, 13
26	Reduction in seclusion and segregation	QNT Metrics report	4, 5	9, 10, 12, 13

2. Service Description

2.1 Service Model

Indications for Admission to Intensive Treatment:

Patients with eating disorders who require specialist intensive treatment generally fall into one of four categories:

- High or deteriorating medical risk.
- Outpatient psychological treatment has not been sufficient to effect improvement in someone with moderate to severe risk. Consideration of admission should not be delayed if outpatient treatment is ineffective.
- Those at low weight with significant functional impairment who require weight stabilisation or modest weight restoration.
- Patients may occasionally be admitted for assessment, for example, when there is uncertainty about diagnosis or to assess the effectiveness of intensive treatment.

Decisions about which of intensive community treatment, day patient, or inpatient care is the most appropriate intervention should consider:

- Medical and psychiatric risk
- The patient's goals and preferences based on individual formulation and appropriateness of treatment settings depending on the nature and degree of the risk.
- Decision making capacity of the patient with respect to treatment
- Quality and quantity of support available from family/carers.

2.2 General Characteristics of Services:

It is recognised that specialist intensive treatment services will differ somewhat in their organisation and staffing depending on the approach to treatment interventions offered and population served. This diversity is considered a strength as it increases the range of treatment options for patients and allows a degree of matching of treatment to individual need. However, all services will be expected to meet the minimum standards set out in this specification.

Some specialist intensive treatment services may also provide services which are additional to those covered in this specification. These may either be specified separately or added to this specification.

2.3 Referral Processes and Sources:

Provider collaboratives will establish referral and admission pathways within their collaborative. Individual providers will also need to establish pathways for patients referred from out of area.

Each specialist intensive treatment service should develop a care pathway model which includes referral and discharge procedures integrated with community treatment pathways. Referrals must come from the community eating disorder service. Referral pathways should not delay admission in an emergency.
The community and specialist intensive treatment team should be involved in any admissions to a medical bed in accordance with the local MEED protocol or national MEED guidance.

The referrer should complete the national eating disorder admission form and send it to the relevant inpatient unit and any other stakeholders as dictated by local admission arrangements. All areas of the form should be completed to ensure relevant information is communicated and prevent any delays in the assessment process.

Following receipt of the eating disorder admission form, a pre-admission assessment may take place to consider the goals of admission, any potential risks/benefits, and whether the person's needs could be better met by alternative, less intensive services.

Referrers should be involved in the decision to admit and the development of a care and treatment plan for patients that are offered admission. Provider collaboratives are expected to establish clear referral to admission pathways.

Responsibility for the care of the patient remains with the referring service until the point of admission, and the processing of referrals should not be delayed because of issues relating to establishing commissioning responsibility or ordinary residence status.

2.4 Response to Referrals:
Referrals must go through the agreed Provider Collaborative bed management or referral processes.

The Provider Collaborative should have processes in place to review the urgency of a referral. Providers should respond to the referrer with an indication of when (or if) a bed is likely to be available. Responses should be shared with the referrer within the following timeframes:

- Emergency referral - response within one working day (Monday – Friday).
- Urgent referral - response within one week.
- Routine/planned referral - response within 2 weeks.

The specialist service will decide (in collaboration with the community team) whether a pre-admission assessment is appropriate. The specialist inpatient/day patient unit will offer advice to the referrer on immediate management, including the use of the Mental Health Act.

2.5 Access to Admission:
Providers of specialist intensive services will work closely with local community ED services to ensure timely admissions, prioritising according to risk and clinical need. It is good practice to provide patients with information about the ward (for example, in the form of a leaflet or by arranging a visit to the ward prior to admission).

Admission to a medical bed is indicated for the treatment of high-risk medical complications that cannot be safely delivered in a specialist eating disorder unit (e.g. needing cardiac monitoring or intravenous treatment). Adult patients with eating disorders should not routinely be admitted to a medical bed for the treatment of their eating disorder or for low weight alone.

2.6 Co-Working with Other Inpatient Psychiatric Services:
When there are serious psychiatric co-morbidities, the decision about the most appropriate unit to which to admit the patient should be guided by a personalised formulation and assessment of need.

Presence of a co-morbid psychiatric disorder should not exclude the person from admission to an eating disorder service. Equally, the presence of an eating disorder should not exclude the patient from admission to other types of unit/services such as an acute psychiatric ward.

There is an expectation that services will work closely together to meet the needs of patients.

2.7 Age of Admission:
This specification covers specialist intensive services for women and men 18 years and above. Those who are between ages 17-18 years will usually be admitted to child and adolescent services. However, flexibility to admit 17 to18 year-olds to adult specialist intensive treatment services is present if it is developmentally and clinically appropriate.

This should be agreed with the individual, family/carers, and community services in advance of admission. There should be arrangements in place for advice and joint working with CAMHS services, and a specific developmental and safeguarding risk assessment should be undertaken.

Any adult eating disorders service admitting 17-year-olds will need to be able to provide developmentally appropriate family interventions specifically focused on the eating disorder and should facilitate access to education.

To note, there is no requirement for under 18s admitted to an adult unit to be automatically placed on one-to-one observations. The level of observations should be determined by an individualised assessment of risk.

2.8 Composition of the Multidisciplinary Clinical Team:
Treatment in specialist inpatient and day patient units should be provided by a suitably trained and experienced multidisciplinary clinical team (MDT). Core professions which should be represented in the MDT are:

- Psychiatrists
- Nurses
- Occupational therapists
- Dietitians
- Psychologists (Counselling or Clinical)
- Psychological therapists (including family therapist where possible)

- Social Worker
- Family workers and peer support workers

Other professionals (e.g. physiotherapists) may also have an important role to play.

3. Interventions

3.1 Inpatient Services:
Inpatient services must include:

- 24-hour service
- A multi-disciplinary team with appropriate expertise.
- Ward staffing consistent with safer staffing nursing guidelines and adequate to provide necessary interventions e.g. feeding under restraint.
- Ability to treat patients detained under the Mental Health Act 1983 (amended 2007).
- Skills and facilities required to provide nasogastric (NG) feeding.
- Skills and facilities required for management of medically unstable patients
- Skills and facilities required for management of pressure sores
- Skills and facilities required for understanding and responding to behavioural challenges
- Evidence-based psychological treatment based on the patient's formulation (including trauma work if appropriate)
- NICE approved treatment to manage physical and psychiatric comorbidities
- Understanding of sensory environments and the impact these have on autistic, neurodivergent, or otherwise sensorily hypo/hyper-sensitive people, with reasonable adjustments as a requirement in services.

3.2 Intensive Day Patient Services:
Intensive day patient services can provide step-down care from inpatient treatment or an alternative to admission. They should be able to provide the same range of interventions as inpatient services, except for management of medically unstable patients, NG feeding, management of challenging behaviour, and treatment of pressure sores.

Intensive day treatment service should be able to provide treatment at least 5 days a week and ideally 7 days. The length of the day should be sufficient to provide at least 2 main meals where necessary with sufficient support to patients and carers to be able to engage with a full meal plan on and off the unit. There should be flexibility to reduce the intensity of treatment according to clinical need/progress.
Step-down from inpatient to day patient services should be seamless.

3.3 Interventions Common to Inpatient/Day Patient Services:
All interventions will be provided by suitably qualified staff who are supervised by senior professionals with wide experience in eating disorders.

Staff are supported to deliver high-quality intervention through access to both supervision of their work as an individual and team-based psychological/systemic supervision (e.g. reflective practice).
General:

- An MDT with expertise in treating psychosocial, psychological, nutritional, and medical aspects of eating disorders and their comorbidities.
- An MDT with training and experience in autism and learning disability and their effect on presentation, behaviour, and their management.
- Assessment including full risk assessment.
- Appropriate risk management arrangements
- Treatment tailored to individual need which aims to optimise length of stay and balance benefits against the longer-term effects of institutionalisation.
- A psychotherapeutic culture that provides safety, structure, and containment.
- Multidisciplinary expertise in the prevention and management of challenging behaviour.
- Provide the option of advocacy services to all patients.
- Intensive eating disorder treatment programmes are often highly restrictive (e.g., lots of rules and restrictions on behaviour). Whilst some restrictions are necessary, those which are in place should be explained to the patient and reviewed regularly.
- Collaborate with other teams (including the community ED team) and the person's family members or carers (as appropriate) to help with treatment and transition.
- Work with local community services and third sector organisations that can promote recovery and enhance quality of life, including education, voluntary, social, and leisure.

Nutritional:

- Interventions to improve nutrition and normalise eating behaviours and support weight restoration supported by a dietitian.
- Provide expert management of refeeding that addresses the need to avoid undernutrition and overnutrition and is consistent with national guidance. Some units may choose to adopt a standard operating procedure for refeeding.
- Staff are trained to recognise the risks, signs, and symptoms of refeeding syndrome, and how to manage these.
- Less restrictive options such as oral feeding and liquid nutritional supplements (sip feeds) should be considered before NG feeding.
- Staff that are trained and supervised in support for oral and NG re-feeding.
- Prolonged NG feeding, particularly under restraint, is a specific intervention without an evidence base that requires regular review. The pros and cons of persisting with a highly restrictive practice must be carefully considered: review and re-formulation is strongly recommended. When daily restraint is required to facilitate NG feeding, a second opinion should be considered after a month and must be sought at 3 months.

Physical & Medical Healthcare:

- Full assessment of physical health needs.
- Investigations and treatment for physical conditions as required.
- Intensive medical monitoring e.g., ability to do daily blood tests with access to results same day and ECGs when required.
- Frequent physical (vital) observations.
- Management of abnormal weight control behaviours (for example - water loading, excessive exercising, self-induced vomiting, and laxative abuse)
- Treatment of pressure sores and access to tissue viability services
- Staff must be trained in immediate life support.
- Units should facilitate access to a comprehensive range of healthcare services where appropriate.

- Develop referral pathways to secondary healthcare services within timescales according to DH guidelines or good clinical practice.
- Units should have good liaison with specialist secondary care services such as Gastroenterology, Cardiology, Women's health, and dentistry.
- The unit should be able to provide medication monitoring and prescribing expertise to meet the needs of patients with Eating Disorders and associated co-morbidities.
- Implement all appropriate age and gender-specific screening and vaccinations in line with Department of Health (DH) guidance where these are required.
- Provide general health promotion activities including access to national screening programmes, dietary advice, sexual health, advice on drug/alcohol use, and the opportunity to exercise (with appropriate supervision).
- Provide targeted programmes on smoking cessation as appropriate.

Therapeutic:

- High-quality evidenced-based psychological and family interventions focused on the eating disorder. These will be provided by suitably qualified staff who are supervised by a senior professional with wide experience in eating disorders.
- A high-quality Mon-Friday daily group programme. This should be coordinated by a professional qualified in providing group interventions. The group programme should provide evidence-based interventions and offer opportunities for motivational enhancement, psychoeducation, and nutritional education. It should promote the development of skills in the areas of independent eating, self-catering, emotional coping, psychological wellbeing, social interaction, lifestyle, independent living, and recreation.
- Services open over weekends should facilitate recreational or social activities.
- Units should ensure they have clear and easily accessible visiting arrangements which should include providing a suitable environment for children who may be visiting their family member.
- Patients should have access to planned visits and therapeutic leave as part of their therapeutic programme.

3.4 Enhanced Observation and Engagement:

Enhanced observations provide a level of supervision and engagement above routine observations. The level/frequency is determined by the needs of the patients and with the patient.

Needs may include reduction of risk from harm to self, harm to others, self-neglect for safeguarding as well as supporting reduction of eating disorder behaviours. Enhanced observations will in normal circumstances be considered to be part of the contracted level of general care.

All eating disorder services must:

- Develop and implement a policy for enhanced observations in the day/inpatient element.
- Deliver enhanced observations in line with good clinical practice.
- Review enhanced observations at least once a day and reduce at the earliest opportunity.
- Undertake enhanced observations using staff members who are familiar with the care needs of the patient.

3.5 Therapeutic Leave:
Therapeutic leave from the unit may be helpful to support generalising behaviour change to home. Leave should be carefully planned with the patient and their support network, depending on risks and benefits in preparation for discharge.

If there is a clinical requirement that results in a patient needing to have more than 5 nights leave, the provider must complete a leave notification form. Once completed, the leave notification should be submitted to the originating area case manager as soon as is possible so that any queries can be raised with the service.

No payment shall be made by the commissioner for leave beds unless the leave notification process is followed.

3.6 Carer & Family Support and Intervention:
Support and intervention for carers, families, and friends should be offered and provided even if the patient does not want them involved in care at any given time.
Carers, families, and friends should have access to:

- Information and support for carers; this may take the form, for example, of individual support or provision of a carers' support group.
- Skills-based carer training.
- Support to patients and family/carers whilst patients are on therapeutic leave when appropriate as part of the care plan.
- Carer's assessment when required.
- Signposting to third sector carer support services.

3.7 Managing Aggression, Violence & Self-Harm:
All staff should have basic training in:

- Management of complex emotional needs (personality disorder) including de-escalation skills and basic Dialectical Behaviour Therapy (DBT) skills.
- Autism Spectrum Disorders (ASD) and de-escalation skills specific to the needs of those with ASD.
- Techniques for safe physical restraint (e.g. PMVA) and patient debrief after restraint.

3.8 Second Opinions:
Second opinions to other units should be provided through reciprocal arrangements coordinated by provider collaboratives.

The aim of second opinions is to provide an independent review of care and treatment to support reformulation, further care planning, and intervention. It is not specifically to assess for transfer to another unit, although on occasions that may be agreed.

Where there is suspected or recognised autism, a second opinion from an autism specialist should be considered as potentially more helpful to the patient than a second eating disorder opinion.

3.9 Care Planning:

Develop clear individualised treatment objectives and outcomes for the admission.
Care plans should be developed in collaboration with the person, their family members or carers (whenever possible and appropriate), the community-based eating disorder service, and other services (e.g. general mental health teams).

Care and treatment plans must reflect mental, physical, and social healthcare needs. Consideration must be given to holistic needs including finance/benefits; housing; social connections; work and leisure activities; religious needs, etc.

Care planning must include the needs of carers (see section 3.9) e.g., individual or group support; psychoeducation; carer's assessment; skills-based training.
Review regularly – particularly if needs are changing or the care plan is not effective.
Robust discharge care planning starting from admission - setting out indicators for discharge, how the patient will move back to community-based care, and what this care should be. Include relapse prevention, contingency, and crisis planning.

3.10 Review of Care & Treatment:
Whether or not the patient is medically stable, within 1 month of admission, review with them, their family/carers (when appropriate), and the referring team whether care should be continued or stepped down to a less intensive setting. As part of the review:

- Assess whether enough progress has been made towards the objectives agreed at admission.
- If there is insufficient progress towards goals, the care and treatment plan must be reformulated, and the potential benefits and risk of ongoing inpatient treatment reviewed. Options for stepping up treatment (including use of MHA) or stepping down treatment should both be considered.
- Consider the risk that people with an eating disorder can become institutionalised by a long admission and that a lack of change in their condition could indicate that inpatient treatment is harmful.
- Agree a schedule for further reviews with reviews happening at least monthly (involving the community team and family/carers). Note that a review does not have to follow the format of a CPA review.
- Consider seeking an independent second opinion if healthcare professionals have different views about the benefit of continued inpatient care.
- Long length of stay: if an admission is likely to extend beyond 6 months, consideration should be given to reformulation and second opinion/consultation. For admissions exceeding a year, a second opinion/consultation should be sought.
- Where discharge is indicated because risks of admission are assessed as outweighing benefits, community teams will need to work with specialist intensive treatment providers to accept discharge and plan management of risk in the community.
- Where there is disagreement about best interest assessment for a patient lacking capacity who is at high risk and not making progress with intensive treatment, the case can be referred to the Court of Protection.
- For those who are autistic and/or have a learning disability, the Care and Treatment Review (CTR) process should be included.

3.11 Discharge Planning:

The purpose of discharge planning is to anticipate the patient's needs on discharge in a range of domains (e.g. social needs, housing, and physical health). This process should start in pre-admission planning (or as soon as possible after admission when pre-admission hasn't been possible) to ensure the necessary actions are taken to address these needs prior to discharge and minimise the chance of delayed discharge.

The discharge care plan will be jointly developed and agreed with the patient, the inpatient service, the specialist community eating disorder team, and other relevant services. Care coordination should generally be carried out by the community eating disorder team.

The discharge care plan should clearly define the treatment to be provided in the community and its goals. The care plan should include a plan for managing and monitoring the service user's physical and psychiatric health and any associated risk factors.

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

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

3.12 Discharge Arrangements:
Discharge is appropriate when treatment goals have been met. However, discharge is also likely to be indicated if progress is poor and the risks of admission outweigh benefits.

Prolongation of ineffective treatment may worsen rather than improve outcomes because of institutionalisation, continued exposure to high expressed emotion, and demoralisation of patient and staff. Factors to be considered in deciding on discharge include:

- Improvement in physical health
- Improvement in psychiatric co-morbidity and optimisation of treatment
- Improvement in social functioning
- Provision of appropriate housing and social support
- Provision of appropriate support from local eating disorders services
- Provision of appropriate support from general mental health services if required

The rationale, timescale, and preparation needed for discharge should be agreed with the local service through the CPA process. Collaborative discharge planning should take place as early as possible in conjunction with local services.

Where an individual has co-morbid problems or complex needs, the specialist intensive treatment service will work with other services through the CPA process to agree an appropriate package/pathway of care with an identified care coordinator and defined roles and responsibilities for all services and staff involved.

Specialist intensive treatment services should be prepared to offer training and support to community carers to establish an effective discharge. This should be available to a broad range of carers, including hostel staff, family, and friends.

A discharge notification (including medication and prescribing needs, medical monitoring requirements, crisis, and contingency plans) must be sent to the GP and community team within 24 hours of discharge.

A full discharge summary should be sent to the patient, GP, ED community team, and any other services involved within 10 working days of discharge. The summary should include a multidisciplinary assessment, diagnosis, formulation, treatment received, progress made, ongoing needs, and care plans.

3.13 Delayed Discharges:
Inpatient units should have procedures in place to address delayed discharges.

3.14 Outreach/Community Services:
In most cases, further treatment following discharge should be provided by the local community eating disorder service. However, where the community service is unable to meet the treatment needs of the patient, some follow-up and continued treatment in the outpatient setting may be provided by agreement with the specialist intensive treatment service which has been treating them.

This might be required, for example, to complete a time-limited therapy begun during admission or to reduce the risk of relapse and re-admission. Decisions about community treatment should be guided by the best interests of the patient and agreed by all the services involved through the process of CPA.

Discharge planning and discharge summary should be completed at discharge from outpatient services as described in section 3.11 above (discharge planning).

3.15 Intensive Community Treatment:
Intensive community treatment may be funded by provider collaboratives and is therefore included in this specification.

Intensive community treatment focuses on treating the patient in their community as an alternative to inpatient admission. It can also help reduce the length of inpatient stay and inpatient costs overall through early supported discharge. It should be considered instead of inpatient or intensive day patient treatment or for step-down support following an admission.

Intensive community treatment may include community outreach and increased frequency of community contact including supervised mealtimes and support for families around meals alongside ongoing evidence-based therapy for an agreed period of time.

4. Equity of Access

4.1 Access to Services
The service will uphold equality and diversity legislation and should not discriminate based on the following characteristics:

- Ethnicity
- Legal status (e.g., asylum seekers)

- Disability
- Gender
- Age
- Sexuality
- Religion
- Other disadvantaged communities, including people who are excluded due to education or skills levels, unemployment, or where they live

Services should be proactive about understanding and improving access (for example, through work with local community groups) for people with these protected characteristics who may experience obstacles to accessing services.

If any patients are deaf, the service must meet their communication needs and any interventions must be adapted to account for their deafness. Specialist deaf mental health services should be contacted to provide additional support and adaptation.

Communities who are proportionately underrepresented within our services (such as men and trans people) should be offered unrestricted access to all specialist intensive treatment services without discrimination, and measures put in place to ensure that people who fall within these groups receive inclusive and culturally sensitive care.

4.2 Male Beds:
There is evidence of unequal access to eating disorders services for men; prevalence of eating disorders in men is up to 25% in community samples (Hudson et al 2007), yet only 5% of admissions are male.

NHS Digital data shows that some specialist intensive services within the UK have not admitted any men in several years, whilst others cap numbers of male beds. This is unacceptable, and it is essential that male patients are not denied admission based on gender.

Inpatient units must comply with the CQC/NHS/I joint statement on male admissions (QC Admission of Male Patients to Eating Disorders Units: Guidance for Commissioners 2020).

- *Please see links at end of specification to review in line with the above or refer directly to the CQC website.*

4.3 Interfaces with Other Services:
Specialist intensive treatment services should provide advice, guidance, and support to medical and psychiatric wards. Guidance and advice should also be provided to primary care colleagues caring for people with eating disorders.

Specialist intensive treatment providers are expected to take a leadership role in the MEED networks within their local catchment area.

Specialist intensive treatment services must have established pathways with a local acute hospital to support the medical care of inpatients.

4.4 Pathways:

Pathway Descriptors

Pathway	Description
Discharge	Outlined in section 2.2.12
Referral	Outlined in section 2.1.2
Assessment	Outlined in section 2.2.9
Treatment	Outlined in sections 2.2.1 - 2.2.15
MDT	Outlined in section 2.1.7

4.5 Networks:

There is a requirement for providers of this service and their clinical teams, alongside neighbouring commissioned providers, to work as a defined clinical network coordinating patient pathway to ensure equitable access to high-quality care in line with the standards set within this specification.

5. Essential Service Components

5.1 Other Exceptional Requirements:

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

A Quality Network for Eating Disorders (QED) has been developed by the Royal College of Psychiatrists. Services should be accredited by QED.

5.2 Training Materials and Resources for Staff:

To ensure the provision of high-quality care, all staff involved in the treatment of patients with eating disorders must have access to appropriate training and resources. The following components should be included:

Initial Training:

- Comprehensive induction program covering the nature and treatment of eating disorders, tailored to the specific roles within the MDT.
- Training on understanding and supporting co-morbid conditions such as autism, learning disabilities, and complex mental health needs.
- Training on the use of sensory screening tools and the impact of sensory environments on patients with sensory sensitivities.

Ongoing Professional Development:

- Regular updates on evidence-based treatments and new research findings in the field of eating disorders.
- Training sessions on managing medical and psychiatric emergencies specific to eating disorders.
- Workshops on enhancing communication skills and therapeutic engagement with patients and their families/carers.

Specialised Training:

- Training in the use of nasogastric (NG) feeding, including management of refeeding syndrome.
- Techniques for safe physical restraint and de-escalation strategies.

- Specific modules on managing aggression, violence, and self-harm.

Supervision and Support:

- Access to individual and team-based psychological/systemic supervision.
- Peer support groups and reflective practice sessions to promote staff well-being and resilience.
- Support from senior professionals with extensive experience in eating disorders.

Resources:

- Access to relevant literature, guidelines, and protocols on eating disorder management.
- Online training modules and e-learning platforms for continuous learning.
- Availability of advocacy services and information to help staff support patients effectively.

5.3 Links to Other Key Documents:

This specification should be read in conjunction with and ensure compliance with the following documents:

- Admission of Male Patients to Eating Disorders Units: Guidance for Commissioners 2020. CQC. (Appendix 1)
- Adult Eating Disorders: Community, Inpatient, and Intensive Day Patient Care – Guidance for commissioners and providers (Aug 8, 2019). NHS England: Available at: https://www.england.nhs.uk/publication/adult-eating-disorders-community-inpatient-and-intensive-day-patient-care-guidance-for-commissioners-and-providers/
- Guidance on safe nurse staffing levels in the UK. Royal College of Nursing (2010). Available at: https://www.nmc.org.uk/about-us/policy/position-statements/safe-staffing-guidelines/
- Ignoring the alarms: How NHS eating disorder services are failing patients. Parliamentary and Health Service Ombudsman [PHSO] (2017). Available at: Ignoring the alarms: How NHS eating disorder services are failing patients (publishing.service.gov.uk)
- Managing transitions when the patient has an eating disorder. Royal College of Psychiatrists: (CR208 Nov 2017). Available at: https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2017-college-reports/managing-transitions-when-the-patient-has-an-eating-disorder-cr208-nov-2017
- Medical Emergencies In Eating Disorders. Royal College of Psychiatry (CR233) Available at: Medical emergencies in eating disorders (MEED): Guidance on recognition and management (CR233) (rcpsych.ac.uk)
- Mental Health Act (2007) Legislation.gov.uk. 2015. Available at: http://www.legislation.gov.uk/ukpga/2007/12/part/1/chapter/1/crossheading/mental-disorder
- Mental Capacity Act (2005) Available at: Mental Capacity Act 2005 (legislation.gov.uk)
- Naso-Gastric Tube feeding under restraint: Best Practice Guidelines for Dietitians. A joint statement from the British Dietetic Association and the Irish Nutrition & Dietetic Institute (2019).

- NHS Mental Health Implementation Plan 2019/20 – 2023/24 (NHS England 2019) Available at: NHS Mental Health Implementation Plan 2019/20 – 2023/24 (longtermplan.nhs.uk)
- NICE guideline NG69 (23 May 2017) Eating disorders: recognition and treatment. Full guideline. Available at: Overview | Eating disorders: recognition and treatment | Guidance | NICE
- Position statement on early intervention for eating disorders PS03/19. Royal College Psychiatry (May 2019) Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps03_19.pdf?sfvrsn=b1283556_2
- Reducing Restrictive Practice. National Collaborating Centre for Mental Health Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/reducing-restrictive-practice/programme-documents/reducing-restrictive-practice---learning-from-the-collaborative.pdf?sfvrsn=cac1a1b1_2
- Refocusing the Care Programme Approach Policy and Positive Practice Guidance (DH March 2008). Available at: https://proceduresonline.com/trixcms/media/1116/refocusing-the-care-programme-approach.pdf
- Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers (June 2022). Available at: B1578i-who-pays-2022-june-2022.pdf (england.nhs.uk)

Appendix 1

ADMISSION OF MALE PATIENTS TO EATING DISORDERS UNITS

Guidance for Commissioners

Elimination of mixed sex accommodation is a priority for the National Health Service and mental health inpatient units need to comply with the requirements of the Department of Health and the revised Mental Health Act Code of Practice. NHS commissioners and the Care Quality Commission have a responsibility to ensure that these requirements are met.

However, the small number of inpatient eating disorders units and the relatively small proportion of male admissions make it very difficult to provide completely segregated wards for male and female patients and it is essential that male patients are not denied admission based on gender.

The guidance below is consistent with the standards referred to above. It has been agreed with the Care Quality Commission and Mat Kinton, National MHA Policy Advisor at the CQC, has confirmed that it conforms to the advice given to their inspectors.

Admission of a male patient to an eating disorders unit which accommodates female patients is acceptable provided the following conditions are met:

1. A risk assessment has been carried out to ensure that the male patient does not pose a specific risk to female patients.

2. There is an agreement in place with NHSE commissioners on the admission of male patients and the admission is consistent with this agreement.

3. Appropriate arrangements have been put in place to ensure that female patients do not feel unsafe or compromised in terms of privacy and to ensure an appropriate and timely response if such a situation should arise.

4. Male patients are accommodated in single bedrooms with en suite bathroom and toilet facilities, if possible.

5. If this is not possible, male patients occupy a single room with use of male-only bathroom and toilet facilities. Male bedrooms and bathroom facilities are grouped together as much as possible.

6. Patients do not have to walk through a sleeping or bathroom area occupied by another sex to reach toilets or bathrooms.

7. A women-only day room is available.

It is acceptable for patients of different genders to share corridor spaces. In exceptional, emergency situations, it may be justified to admit a male patient without the above conditions being met.

When a patient's survival or recovery depends on rapid admission, the requirement for full segregation clearly takes a lower priority. In these situations, clinical need must be judged for each individual patient and the final placement decision should weigh the benefits and disadvantages of each available option. Wherever possible, the patient or their family should be consulted.

Where mixing is unavoidable, transfer to an appropriate male bed should take place as soon as possible. Only in the most exceptional circumstances should this be delayed beyond 24 hours.

Organisations providing NHS-funded care must agree with their commissioners how they will determine whether a particular episode of mixed sleeping accommodation is justified and therefore not in breach of the guidance.