

Adult eating disorders: community, inpatient and intensive day patient care

Guidance for commissioners and providers



NATIONAL
COLLABORATING
CENTRE FOR
MENTAL HEALTH

Key statements

These statements were developed by people with experience of receiving treatment for an eating disorder, as well as their family members and carers. They reflect what people want and need from eating disorder services.

People with experience of an eating disorder

I will receive collaborative, person-centred treatment that is focused on my needs and not just my weight or BMI (body mass index), to help me recover mentally as well as physically.	I want professionals to show compassion, understanding and trust , while not making assumptions based on my diagnosis. Professionals who are working with me will understand how eating disorders can affect people differently, and how they might get in the way of people accepting help.
I want people involved in my care to communicate with me and be open and transparent , explaining why certain decisions. I want to be able to voice my opinion and to be fully informed throughout my treatment.	I want everybody involved in my care to communicate with each other . If I need inpatient treatment, then I want my inpatient and community team to work with each other. I want to stay connected to the 'real world' so I don't feel like I have to start afresh after being discharged. I need the right support to help me transition back to the community.
My treatment will always be based on the possibility of recovery and on helping me re-establish who I am, regardless of my past or the length of my illness. People won't give up on me.	I will be involved in creating my care plan , which will include information about any transitions I have to make (geographical, age-based or inpatient to community), what to do if I am in crisis, how I can stay well and what to do if I experience a relapse.
I have the right to nominate a person to support me and my wishes will be respected around who I would like to be involved in my care or not.	I want my community team to be trained and competent to offer evidence-based treatment , as well as a range of other therapies and groups.
I would like my community team to be made up of a range of professions and I would like to meet all the individuals involved in my care . I should know who my care coordinator is and who to contact if I find myself in distress.	I will be supported to make positive choices , but I will also be supported when I struggle to make these decisions for myself or I experience any setbacks.
I would like the inpatient unit to offer a structured treatment plan with regular groups and activities I can choose to attend no matter what weight I am, alongside individual therapy.	If I experience a relapse, I will be able to self-refer to the nearest eating disorder service and I will be seen as quickly as possible . I will not have to go back on to a waiting list or feel like I have to become worse to be seen.

Families and carers

As families, carers, partners, friends or support people, we will be able to access and receive support to help our loved ones with an eating disorder , regardless of whether they are getting treatment or not.	Services will understand that carers who are partners and carers who are parents may have different needs and will give them the right level of information and support.
Services will understand the distress we can experience and will help us to get support for our own mental and physical health .	

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1 Introduction

1.1 Background

There is increasing commitment across a range of stakeholders to improve both timely access to, and the quality of evidence-based treatment in, eating disorder services for adults and older adults. This has been strengthened following a report from the Parliamentary and Health Service Ombudsman (PHSO), '[Ignoring the Alarms: How NHS Eating Disorder Services are Failing Patients](#)'.¹ The report made a number of recommendations to improve access to effective, evidence-based treatment for adults and older adults. The current under-resourcing of community eating disorder services for adults leads to people experiencing delays in accessing evidence-based treatment (as outlined in the [eating disorders NICE guideline \(NG69\)](#)),² variability in the quality of care they receive and gaps in provision, particularly during transitions (geographical, age-based and inpatient to community transitions). Lack of consistent provision across the country results in people often being very unwell when they present for treatment. In addition, barriers to referral, limited services and lack of expertise mean that early intervention is not occurring, despite evidence suggesting that it can improve outcomes.³

In response to the PHSO report,¹ an Expert Reference Group (ERG) was convened by NHS England to address the specific recommendation to review the existing quality and availability of services to achieve parity with community eating disorder services for children and young people (CYP-CED). The National Collaborating Centre for Mental Health ([NCCMH](#)) was then commissioned to develop this guidance (see Section [7](#) for further information on this work).



Eating disorders can take a lot of your identity. You have to work out who you are again; chances are you have lost most of your life to this, so you need support to build life back up, to find out about yourself. To feel like a person again.

Service user

For genuine parity, adult eating disorder services should have the same access and waiting time standards from referral to treatment^a as children and young people's services: within 1 week for urgent treatment and 4 weeks for non-urgent treatment. As most eating disorders have a peak of onset between mid-teens to mid-twenties,⁴ establishing parity would prevent gaps in care, ensure better management of transitions and improve joint working across services. This requires increased investment to increase the workforce, skill mix and competence.

1.2 Improving adult eating disorder services

Recent funding and the implementation of [Access and Waiting Time Standards for Children and Young People with an Eating Disorder](#)⁵ led to an increase in referrals and demand on services. More importantly, it also led to a significant improvement in both the quality of care and its timely delivery (see [data](#) on waiting times from NHS England). However, adult services have not received the same amount of focus and funding, and the lack of a nationally mandated standard has led to disjointed services and variability in the quality of care provided.

Improving eating disorder services will require

^a Evidence-based treatment as outlined in the [Eating Disorders: Recognition and Treatment NICE Guideline \(NG69\)](#).²

commissioners across England to work together, including NHS England specialised commissioning, local authorities, voluntary, community and social enterprise sector (VCSE), local NHS trusts (including acute trusts), primary care networks, adult mental health services and clinical commissioning groups (CCGs). Commissioners and providers will need to consider both prevalence data and estimates of unmet need in local areas. This is particularly among people who may present with mild to moderate (or less complex) eating disorders but who may not receive treatment due to current thresholds and barriers to accessing care. Evaluating local need and the availability of local resources will help determine the potential additional investment required to enable services to meet the recommendations set out in this guide and, ultimately, improve care.

1.3 Co-production

The key to improving eating disorder services is to place the person at the heart of providing care. With this in mind, this guidance was developed with co-production as a central principle.

Co-production involves planning, developing, delivering and evaluating services together with people with experience of receiving treatment for an eating disorder, their families, partners, carers, friends and a wider [support network](#).^b People with experience of services were involved in the development of this guide as their perspectives are central to reducing inequalities in access and improving outcomes (see Section [7](#)).

To genuinely co-produce services, commissioners should develop and implement local plans in collaboration with:

- people with experience of using services (including families, partners and carers)
- service providers
- partner agencies, including VCSE organisations, primary care networks, local

hospital NHS trusts and education providers (such as schools, colleges and universities, to improve early identification and intervention).

The NCCMH is currently developing co-production guidance for commissioners.

1.4 Purpose and scope of this guidance

This guidance is for commissioners and providers of adult eating disorder services (age 18 years and above), as well as people who use services and those who support them. It focuses on the optimum model of delivery (see Section [2](#)), including the ideal skill mix and staffing of teams, to improve access to treatment, care and support. The guide will also be relevant to any other organisations or stakeholders that work with people who have an eating disorder. It will cover care provided in the community, as well as inpatient or intensive day patient treatment where required. Its aim is to support commissioners, providers and service users by setting recommendations against which all services should seek to measure themselves.

The guidance covers a range of eating disorders, as defined by the National Institute for Health and Care and Excellence (NICE): anorexia nervosa, bulimia nervosa, binge eating disorder and other specified feeding and eating disorders (OSFED). It will also concern adults who present across a very broad spectrum of both developmental and illness stages, with very different needs for treatment, care and support. This ranges from young people with a short duration eating disorder presenting for the first time, to people with a long-standing illness who have received multiple treatments. For children and young people with an eating disorder (up to age 18), please consult [Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning Guide](#),⁵ particularly in relation to managing transitions between services.

^b The term 'support network' will be used throughout the document to refer to people who provide emotional or practical support for a person with an eating disorder.

This guidance should be read alongside a number of other guides, including:

- [Eating Disorders: Recognition and Treatment NICE Guideline \(NG69\)](#)²
- [Eating Disorders Quality Standard \(QS175\)](#)⁶
- [MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa](#)⁷
- [Guidance for Commissioners of Eating Disorder services](#) from the Joint Commissioning Panel for Mental Health⁸
- The Eating Disorders Pathway for Children and

Young People: Inpatient and Intensive Day Care – an extension of the community pathway (NCCMH, forthcoming)

- A Framework for Community Mental Health Support, Care and Treatment for Adults and Older Adults (NCCMH, forthcoming).

2 Optimal model of service delivery

Clinical consensus indicates that the optimal model of service delivery for people with an eating disorder is a dedicated, multidisciplinary eating disorder service. Care should be delivered in the community, supported by intensive day patient or inpatient treatment for people with a high level of physical or psychiatric risk that cannot be managed safely in the community (see Section [3.9](#)). Eating disorder services should aspire to become all-age services, with no divide between children's and adult services, and one commissioner across the care pathway (see part 1 of Helpful Resources for an example).

A community eating disorder (CED) service should lead in providing care for a person with an eating disorder, regardless of where the person first presents (see Section [3.2](#)) or if they are receiving treatment as an inpatient or intensive day patient. A comprehensive CED service should ideally serve a wider geographical area (recommended 1 million or greater all-age population),⁹ with the skills and competences (see Section [4.2](#)) to provide care to a range of people. Those can include:

- people presenting for the first time
- people with long-term and enduring problems
- those with comorbid conditions (physical and mental health as well as drug and alcohol use), and
- young people transitioning from CYP-CED services.

2.1 Key functions of care

The core aim of a comprehensive CED service is to deliver timely, effective, evidence-based treatment that meets the needs of a person with an eating disorder. A CED service should:

- provide **evidence-based treatment, care and support** for the full range of eating disorder

diagnoses, including binge eating disorder and OSFED

- **accept all presentations** – from people who present for the first time to those with long-term problems, regardless of weight or BMI (body mass index)
- collaboratively use **routine outcome measurement** to support a person to identify and meet their goals for recovery (see Appendix E)
- have the **skills to provide care across the lifespan**, from younger people to older adults
- provide **medical monitoring** (see Section [3.8](#))
- offer **intensive community treatment**, or be able to support day patient treatment, to reduce unnecessary or inappropriate inpatient admissions
- be **proactive** in engaging people in treatment as soon as possible, as well as those who are returning to active treatment following a period of recovery
- **support and empower** families, partners, carers and the person's support network
- offer **advice, support and consultation** to other services involved in a person's care
- have clear protocols and joint working agreements with other services to ensure effective management of referral pathways and **provide coordinated care** (see [Section 2.5](#))
- work with other services to **reduce and prevent gaps in care** during service transitions (age-related, geographical or community to inpatient transitions)
- respond appropriately to issues relevant to competence, capacity, consent, safeguarding and information-sharing
- have **clear processes around managing risk and safety** as well as unattended appointments (including clear follow-up protocols to engage a person and prevent inappropriate discharge)

- provide **appropriate clinical supervision** to ensure professionals remain competent to deliver evidence-based treatment (see Section [4.3](#))
- **improve awareness** of the service in the community, the importance of early identification and reduce the stigma around eating disorders to increase help-seeking in the local population.

2.2 Delivery of care

A comprehensive, multidisciplinary CED service should have the skills and competences to deliver a range of functions and responsibilities, with appropriate staffing levels to cover staff absences. [Table 1](#) outlines the ideal staffing mix of a comprehensive CED service, based on clinical consensus. A member of the CED service should be allocated as the person’s main contact or care coordinator, with ongoing input from other professionals as needed. Further information on workforce is in Section [4](#).

Table 1: Ideal staffing mix of a comprehensive CED service

Profession	Responsibilities
Administrative staff	Provide administrative support to the service
Dietetician	Provide dietetic assessment, advice and treatment to patients and to staff; support staff to devise meal plans, manage risk related to refeeding; oversee the nutritional care plan and psychoeducation regarding nutrition, weight and food
Family therapist	Provide family therapy and support other clinicians within the team to work with people’s families, partners, carers and support network
Medical professionals (e.g. clinical nurse consultant, GP, physician)	Medical monitoring, blood tests, electrocardiograms (ECGs); liaise with other medical professionals (e.g. gastroenterologists and primary care; see Section 3.8)
Nursing staff	Initial patient contact, facilitate engagement, assessments, deliver evidence-based individual and family psychological interventions, liaise with wider network
Occupational therapists	Support and develop people’s lives outside of an eating disorder (e.g. meal preparation, life skills training, social skills training, sensory processing) and provide anxiety, assertiveness and anger interventions
Peer support workers (see Appendix G)	Support the recovery model, act as a mentor, assist in the delivery of peer support groups as well as eating disorder training, education and awareness (with appropriate training and clinical supervision)
Psychiatrists	Provide biopsychosocial assessment, medical and psychological treatments and coordination of care, including assessment, diagnosis and management of comorbidities, and monitoring and managing of physical and psychological risks, especially for people with complex needs. Psychiatrists also have medico-legal responsibilities around using the Mental Health Act ¹⁰ and Mental Capacity Act, ¹¹ if needed
Psychologists	Assessment, formulation and delivering evidence-based psychological interventions
Social workers	Provide individual, couple and family support; facilitate support groups and link to other community resources
Support workers (including assistant psychologists)	Provide interventions and support for individuals or groups (with appropriate supervision and training); work with clinicians to collect and analyse outcomes and feedback

The CED service may be delivered as one team from a central location, or through a hub and spoke model, operating via a network of smaller teams of eating disorder clinicians in neighbouring areas that come together as part of a comprehensive service. [Figure 1](#) outlines the components of a comprehensive CED service and how this may be delivered.

CED services should have extended working hours (where possible) or flexible provision, with appointments available outside of the 9–5 working hours where needed. Delivering a hub and spoke model of care will require clear processes outlining how the service will function as one team, including management of risk and safety, joint case meetings and staff supervision. Commissioners and providers will need to determine how the ideal model of service delivery may be adapted to fit the local population's needs. The service will require a clear leadership and governance structure to ensure the delivery of high-quality care. (See part 1 of [Helpful Resources](#) for examples of staffing arrangements across different services).

2.3 Assessing the needs of the local population

An effective CED service requires commissioners and providers to have a firm understanding of local demand through an assessment of local need. This should be based on a clear definition of 'need' that considers the whole range of needs, beyond just direct medical or psychological treatment for an eating disorder, and should not simply be based on current or historical referral rates. CED services will need to consider the resources required to provide care and support for people who present with an eating disorder but may not be ready to start medical or psychological treatment.

Current data indicate a 6% point prevalence rate for the full range of eating disorders, in both

genders across the adult years.^c The [Public Health Fingertips](#) tool provides local prevalence estimates to assist in the planning and commissioning of services. However, commissioners and providers should be aware that prevalence data can be an underestimate of the actual needs of the local population, as most research typically focuses on females with complex needs.

Increasing awareness of available services and the removal of barriers to accessing care can lead to a significant increase in demand for services, which may then require adjustments to local prevalence estimates. Commissioners and providers should work with local VCSE and other non-statutory organisations who provide services for people with an eating disorder, to gain further information regarding local need and demand.

Providers will need to have processes in place for managing an increase in demand, which is likely to occur following improved access to services, although this will vary across local areas. Managing increased demand may require working with commissioners, other services and people who have experience of using services to put strategies in place to ensure the capacity and capability of the workforce.

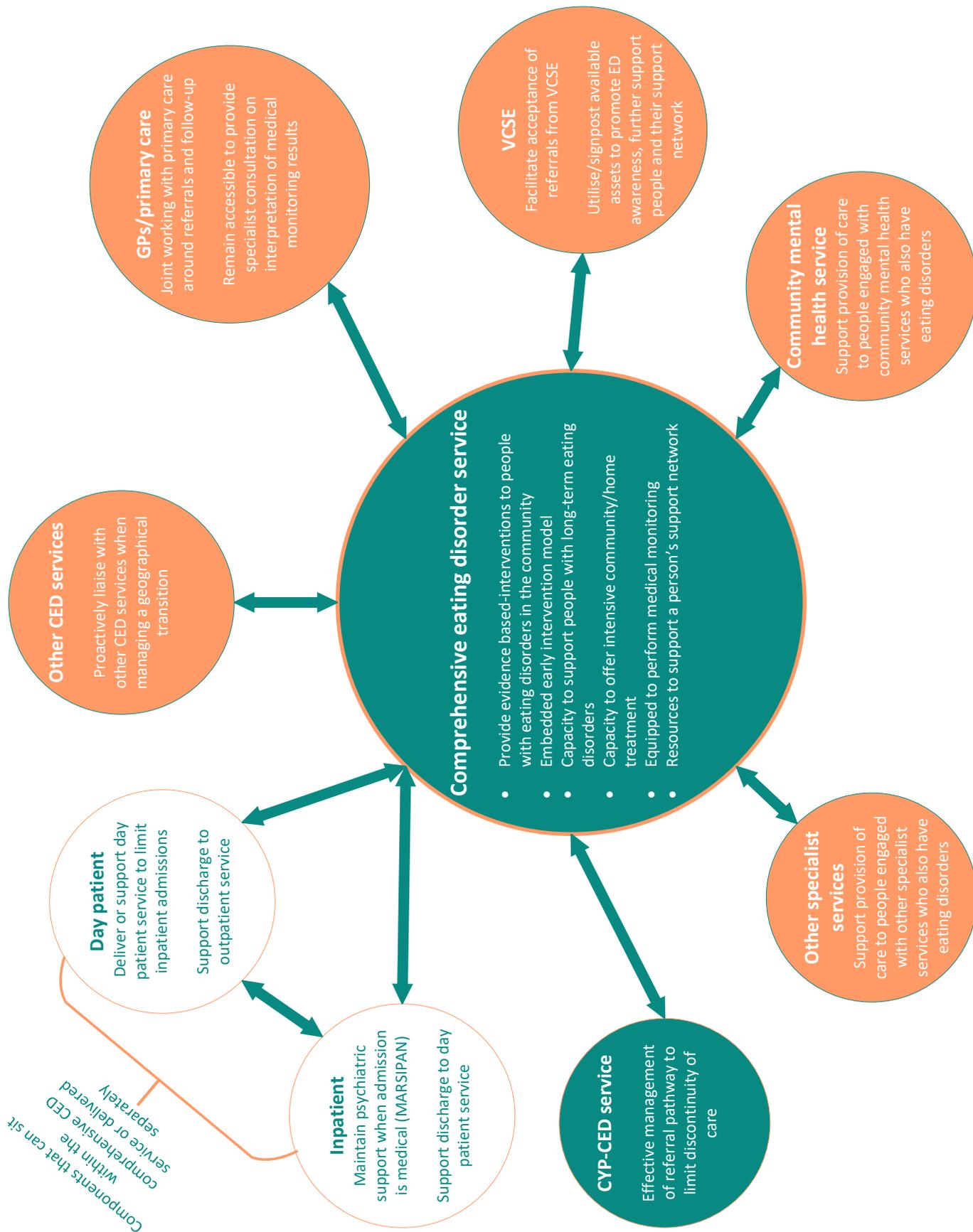
2.4 Establishing and developing an adult eating disorder service

Based on the assessment of local need and demand, commissioners and providers will determine current eating disorder service provision, identify any gaps, and create a plan to improve delivery of services using updated local prevalence data. Workforce development, skill mix, competences, training and recruitment will be key to improvements in this area (see [Section 4](#)).

When commissioning a CED service, or ensuring an existing service is providing adequate care, commissioners will need to consider:

^c This figure was determined by consensus from academics and researchers internationally and was agreed by the Expert Reference Group.

Figure 1: The core functions of a comprehensive adult CED service across a joint care network



- the size of population to be served (recommended 1 million or greater all-age population)
- the general level of coexisting mental health and physical health problems and how these will be or are currently managed, including joint delivery of care across services
- the capacity and effectiveness of current services to deliver both early intervention and long-term care
- the anticipated impact of new or proposed services in meeting the need
- developing a local model of care delivery, including care pathways, based on local needs and resources (including the local availability of inpatient or intensive day patient options)
- clarifying (within the service and the CCG) the responsibilities for commissioners and providers, especially in terms of links with inpatient units and funding for beds
- overall workforce requirements, including location of multidisciplinary teams (whether they will be co-located or can form a virtual team with regular meetings) and differential skillsets required for particular presentations
- education and training for other clinicians and professionals across health care, social care and education sectors
- improving general awareness and understanding in the wider community of eating disorders and common associated comorbidities.

To create a viable CED service that can cover a wider geographical area, commissioners will need to decide: whether to commission a service for a single CCG or share the commissioning with other CCGs; how the service will be delivered geographically; and the responsibilities of each commissioner or CCG. The balance between anticipated need, service size/cost, access and waiting times and available funding will need to be achieved through a strategy shared and agreed among all partners involved. If two or more CCGs are to share a service, then a 'lead' CCG needs to be identified and a shared agreement created on what will be commissioned and how the contract will be managed.

NHS England has [published resources](#) for commissioners to guide the implementation of mental health services within a wider joint strategy. This will require local commissioners agreeing on a shared commissioning process and strategy to work towards integration and collaboration with local providers, and developing service specifications that support these ambitions.

Challenges and solutions. A number of challenges may arise when establishing and developing a CED service. These are outlined in Appendix D, alongside potential solutions that can be put into practice.

2.5 Joint working across services

Coordinated care and good communication across services is essential to ensuring that people with an eating disorder receive the care they need (see [NICE Quality Statement 5](#)).⁶ The CED service will need to have strong working relationships across a number of services and organisations, which may vary depending on local resources and the needs of individuals accessing the service. The CED service will also need to have links across a range of services, including: primary care, community mental health services, IAPT (Improving Access to Psychological Therapies), CYP-CED services, liaison mental health services, older adult services, perinatal services, dental or oral health services, VCSE organisations, local authorities (including social care), education providers, acute care trusts, drug and alcohol services, homeless services, diabetes teams, neurodevelopmental services, services for those with complex needs associated with a diagnosis of personality disorder, occupational and employment services, crisis services and provider collaboratives in tertiary mental health ([New Care Models](#)). This is to ensure clear access and referral pathways so that all services can work together to prevent gaps in provision and deliver the right care for the person.

While the CED service will lead in providing care, as well as support other services as needed, integrated care arrangements across services are essential and should:

- be based on clear and effective communication
- include regular liaison and joint working meetings, including coordinated review meetings, joint training and education opportunities
- be based on a care plan that is co-produced (developed and written with a person and their family, partner or carers; see Section [1.3](#) and [3.5](#))
- set clear parameters around working relationships, including clear protocols regarding referrals, assessments, access to treatments, and possible inpatient admissions or intensive care

- be locally determined based on available resources and support
- have clearly established processes for when someone is not ready to engage or refuses treatment (see Section [3.4](#))
- identify barriers and solutions to providing care or discharge
- use joint record systems (digital records) where possible.

The CED service should ensure they can link across to other referral pathways and services, such as the [Perinatal Mental Health Care Pathway](#),¹² [Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults](#),¹³ [early intervention in psychosis services](#),¹⁴ and the Framework for Community Mental Health Support, Care and Treatment for Adults and Older Adults (forthcoming).

3 Delivering evidence-based treatment, care and support

3.1 Person-centred care

Person-centred care is the foundation of all care provided by a CED service: the needs of the person rather than the needs of the service should be the focus. Person-centred care involves shared decision-making and working collaboratively with the person, their family, partner, carers and support network (as appropriate). The focus of care should always be on the person's needs and progress towards positive change. People should be given clear information on the service, including how to access an advocate, getting a second opinion, how to make a complaint and how to provide feedback.

Professionals should refer to the [Service User Experience in Adult Mental Health guideline](#)¹⁵ and [Service User Experience in Adult Mental Health Services quality standard](#)¹⁶ on improving people's experience of mental health services.



We need to be seen as an individual with individual struggles, rather than the illness or just another one in the service.

Service user

Informed choice. Informed patient choice is integral to all discussions, particularly regarding options for psychological treatment (see [NICE Quality Statement 2](#)).⁶ Some people who may be at high risk may need additional clinical support to understand the need for appropriate treatment to ensure their safety at all times. Where possible, a person should be given a choice of the treatment they receive, its format (such as face to face or via digital platforms), who provides it and where



Trust and the therapeutic relationship should be the priority for care, at the core of all treatment.

Service user and carer group

they can receive it. If a choice is not possible, then this should be discussed with and explained to the person. It is the CED service's responsibility to ensure a choice is informed by making the service user aware of all relevant information. NHS Improvement provides information for service users regarding [choice in mental health](#), while NHS England provides guidance for commissioners and providers on people's legal rights to [choice in mental health care](#).

3.2 Accessing treatment, care and support

Access. All CED services should be accessible to people who require care for an eating disorder, with **no thresholds or barriers to receiving treatment**. Weight or BMI should not be a barrier to accessing or receiving treatment. Services should offer multiple access points to meet the needs of different populations, with self-referral (or partner/family referral) a key element. These access points include online forms, telephone or text options, face to face, or through clear referral pathways via primary care, VCSE organisations, community or inpatient mental health services, social care, education providers, mental health crisis services, occupational health or employment services, and acute care services. Section [3.14](#) outlines further considerations for commissioners and providers to advance equality in accessing services.

As people with an eating disorder may present in various settings, the CED service needs to work with other services. This is to improve

their awareness and ability to identify an eating disorder and establish clear pathways to make sure a person is referred as soon as an eating disorder is suspected. If a person is receiving treatment from another service (e.g. for a physical health problem) and it becomes apparent that they have a comorbid eating disorder, then that service should immediately contact the CED service and follow their advice and recommendations. Referrals from another service should be actively followed up by the CED service, rather than waiting for the person to contact them to make an appointment. The referrer should be informed about the outcome of the referral.

Access to care should be equal regardless of whether a person is presenting for the first time or with a long-term condition. When re-presenting, a person should be able to access a CED service at the first sign of a relapse to receive care as soon as possible. Decisions on accepting referrals and discharge should never be made based solely on a person's BMI, weight, or frequency of bingeing and purging episodes ([NICE guideline section 1.2.8](#)),² but should incorporate the person's goals for treatment and recovery. For example, obesity in the presence of an eating disorder should not prevent a person from receiving support from a CED service.¹⁷

If a person is moving to another area and requires ongoing care, then their CED service should proactively contact the CED service in that area to ensure continuity of care. Registration with a GP should not be an essential criterion to access a CED service; if someone presenting to a CED service is not registered with a local GP, then facilitating this should be included in their care plan.

Timeframe. People should receive treatment, care and support as soon as possible. For instance, if a person presents to their GP with a suspected eating disorder, the GP should immediately contact the CED service for advice and follow their recommendations ([NICE guideline section 1.2.10](#)).² **Referral standards**

for adults with an eating disorder should be the same as for children and young people: receiving evidence-based treatment within 1 week of presentation in urgent cases and 4 weeks in non-urgent cases. In cases of emergency, the CED service should be contacted to provide support within 24 hours. An initial assessment of the person's needs will be required to determine the level of care they receive. While a person is waiting for treatment, services should consider whether to involve or signpost to VCSE organisations or draw on online resources, local groups or telephone helplines for additional support (see Helpful Resources, part 2).

Location. Care should be provided in the most appropriate setting to meet a person's needs and should be as accessible as possible. CED services based in rural areas should consider the needs of people who may need to travel to receive care and whether this can be safely and effectively delivered by an outreach team or in an alternative setting. This may be a private room in a primary care practice or community service; through digital technologies such as Skype; or additional support with transport to access the service may be required.

The environment of the service itself should be welcoming, comfortable and non-judgemental. It should provide the person with a feeling of safety.

3.3 Identification of needs

An appropriate and comprehensive assessment across physical health, mental health and social factors should be completed by an experienced clinician within the CED service. It should cover relevant environmental factors, social support and adverse life experiences. The CED service should liaise with referring agencies who may have done initial or additional assessments already, to ensure these are not unnecessarily repeated.

An assessment should not be based on single measures (such as BMI alone; [NICE guideline section 1.2.8](#));² rather, it should identify the relevant symptoms and behaviours of an eating

disorder, determine any additional needs, including comorbidities, and identify and address any risks or safety concerns, including physical frailty, which can present in both younger and older adults. The CED service should also routinely discuss with people with eating disorders the use of social media, including benefits and potential harms, and how they can support a person to interact with social media in a positive way, or make use of apps or digital resources.

The outcome of an assessment should be a formulation or a shared understanding of the presenting problem or needs. It should be carried out with the person to allow for a collaborative decision about how to effectively address their needs, and should result in the development of an agreed care plan. Professionals should refer to NICE guidance ([NICE guideline section 1.2](#))² for further criteria for identification and assessment of an eating disorder.

3.4 Engagement

Always follow up with people; never give up on them.

Service user

Engagement with a CED service is a two-way process, requiring the person and the professional to be engaged and invested in treatment.

Initial engagement. Once a person is identified as requiring treatment for an eating disorder, the CED service needs to consider whether the person is ready to engage in treatment. Responsibility for outreach, follow-up and engaging with people who are reluctant to receive treatment lies with the CED service.

The CED service should be prepared to be met with ambivalence or reluctance to engaging in treatment on the part of a person, but should nevertheless make every reasonable effort to engage them, particularly when there is evidence of recent deterioration or severe risk. Time

should be taken to explore, understand and help people overcome their anxieties or fears related to treatment or weight gain, provide relevant information on eating disorders and on what the service offers, and discuss treatment options and benefits. In some cases, the CED service may deliver support indirectly by engaging with the person's family, partner, carer or a member of their support network. Peer support workers can also bolster engagement in treatment among adults with eating disorders.¹⁸

Liaising with other services, such as primary care, VCSE organisations or education settings, may assist in supporting people until they are ready for treatment. Setting clear timeframes for follow-up by the CED service to check people's readiness for treatment may also be useful. For some people, starting treatment can shift their perspective towards a readiness to engage.

Clinicians may need to use supervision or case review meetings to discuss whether non-engagement may be a sign that a different approach is required, whether the formulation or care plan needs changing, or if the person may benefit from seeing a different clinician.

Ongoing engagement. There are other elements of engagement between a CED service and the person.

- Providing consistent care throughout the person's time with the service; this includes seeing the same clinician where possible and all professionals following the same care plan (see Section [3.5](#)).
- Focusing on a person's recovery, encouraging them to be empowered through their treatment, but also recognising that people have the right to not get better as defined by professionals and still be engaged with the service. Alternative support options (such as through VCSE organisations) may need to be

Knowing what to expect as much as possible before you go would help; it's the fear of the unknown that stops people getting in the door.

Service user

discussed with a person if treatment through the CED service appears not to be helping them towards recovery.

- Services being open and honest with a person about what they can and cannot provide to them, with other support options offered. If, for some reason, they cannot offer them an appointment, they should explain why, emphasising that this is not based on any doubt regarding their level of need.
- Setting realistic expectations with a person that are in line with their goals, keeping treatment at the person's pace, as appropriate, and addressing any fears or concerns they have regarding recovery. Regularly reviewing the person's goals will help balance engagement with the need for progress.
- Communicating with a person at all stages of their treatment.
- Validating a person's experience and not making them feel they need to become 'more unwell' to access the service.



The key to recovery is finding something else to live for more than the eating disorder.

Service user

3.5 Care plans

Following the assessment and identification of a person's needs, a care plan should be developed to address those. This should be done in collaboration with the person, their family, partner or carer (as appropriate), and with any other services involved. Every person that presents to the CED service should receive a written care plan; this may range from a brief care plan for guided self-help and a follow-up appointment, to a more detailed plan involving multiple services that may reflect a higher level of complexity. The care plan may include:

- details of all healthcare professionals and services involved, with their roles and responsibilities, including the person's main care coordinator

- how services will work together to provide treatment, care and support
- how the person's family, partner, carer or support network may be involved in their care
- the person's goals for treatment and recovery, including how progress towards these will be measured, and strategies to prevent relapse
- all options for treatment, care and support, such as type of treatment offered, number of sessions expected and where they will receive treatment
- social or environmental factors that are important to the person, such as support for work or education, or engaging in meaningful activities or hobbies
- medical monitoring (blood samples, ECGs), including frequency, plans if the person does not attend tests when expected, the professional responsible for obtaining and acting on the results, and a clear plan for medical monitoring on discharge
- timeframe for reviewing the care plan to determine whether the person's needs are being met or any changes to treatment required
- what the service will do if the person does not attend an appointment (e.g. make a phone call, send a text message or email, visit the person at home or talk to their family, carers or friends)
- how the person can access treatment out of hours (if they experience a mental health or physical health emergency)
- how any transitions will be managed
- any requirements for advance care planning where needed (see the [Decision-making and Mental Capacity NICE guideline \(NG108\)](#)).¹⁹

If a person requires inpatient or intensive day patient treatment, their care plan might also



Services need to work with the person around managing risk and relapse together – this includes being open and honest, with positive communication, and empowering the person throughout their care.

Service user and carer group

include (see [NICE Quality Statement 5](#)):⁶

- preparing for admission (including frequency and responsibility for monitoring medical and psychiatric risk)
- defined clear objectives and outcomes for inpatient treatment, including potential length of stay
- how a person will be discharged from inpatient care, how they will move back to community-based care, and what this care should look like.

Care plans need to be explicit about the person's warning signs of deterioration, clearly outlining strategies for relapse prevention. This is particularly important if a person is vulnerable to subsequent relapse, especially following a transition.¹ People who have been in a period of recovery but need to return to active treatment should be able to do so without delay and should have this outlined in their care plan.

3.6 Support for families, partners, carers, friends and support networks

Empowering and supporting a person's family, partner, carer, friends and their wider support network is an integral part of service provision, particularly when the person is not ready to receive active treatment. Proactively reaching out to the support network through linking them with resources in the community, or holding open support groups, can improve their quality of life, reduce risk and help create an environment that may lead the person with an eating disorder to seek treatment. When a person receiving treatment does not want their family involved in their care, CED services should still provide the family with general information on eating disorders and signpost them to appropriate support, resources and services.

Support for families, partners, carers, friends and the wider support network includes:

- valuing and recognising the important role they

- play in the person's treatment and recovery
- education and information on eating disorders (including links to online resources such as [MindEd](#)) and on how they can help a person; this may include training or skills workshops
- providing information on [carer assessments](#) so that they can attend to their own needs (see [NICE guideline section 1.1.10](#))²
- CED services implementing the principles of the [Triangle of Care](#)
- helping them maintain their own mental health, physical health and wellbeing
- working with or signposting to local and national organisations, support networks, recovery colleges and VCSE organisations (see [Helpful Resources](#) for further links)
- empowering them to be part of a person's care and recovery, and including them in meetings (where appropriate)
- appropriate levels of information-sharing, with consent from the person
- having clear discussions about, and making them aware of, the issues around confidentiality.



If you know how to help them, that is a way forward. Families need support to help support their loved one.

Carer

Services should consider:

- the definition of [carer](#), particularly for adults, where a partner, spouse, sibling or close friend may have caring responsibilities
- the support needs of a person who may not have any family members or carers involved, or those who may receive support from friends or others
- the varying needs of people throughout the lifespan, as younger adults will be more dependent on their family for care, whereas older adults may live independently and may not wish their family to be involved.

Further resources for carers and support networks are listed in the [Appendices](#) section.

3.7 Receiving evidence-based treatment, care and support

Once a care plan has been developed, with a clear timeframe for the delivery of actions within the plan as well as clear treatment goals and outcomes, the person should be allocated to the appropriate care pathway within the service to receive evidence-based treatment, care and support in line with the [eating disorders NICE guideline \(NG69\)](#).² Appendix A has further information on NICE recommendations and quality statements.

People should receive evidence-based treatment as soon as possible (early intervention demonstrates more effective outcomes; see [NICE Quality Statement 1](#)).^{6,20,21} Services should:

- ensure continuity of care for the person through shared care planning and joint working
- prevent further deterioration and other eating disorders developing (e.g. bulimia nervosa arising in a person recovering from anorexia nervosa)
- review with a person their care plan and outcomes regularly at appropriate timepoints
- work with a person on building their identity outside of their eating disorder, through developing their life skills, engaging them in meaningful activities and linking them with community groups and resources
- involve the person's family, partner, carer or support network, as appropriate
- link the person, their family or their support network with support groups or peer support workers
- offer flexible appointment times for people who are working or in education
- support a person to have a named GP (if they do not already have one; this may include helping them to understand their [right to a GP](#)); CED services should work closely with primary care throughout a person's treatment
- consider the needs of particular populations (see Section [3.14](#))

- make adjustments required for overweight or obese people with an eating disorder (e.g. the size of chairs, group rooms, blood pressure cuffs and weight capacity of scales)
- prepare a person for discharge from the service and establish links with other services, particularly primary care, to ensure ongoing management, monitoring and review.

Receiving care after hours. CED services should have clear processes in place to ensure people can receive appropriate treatment, care and support after hours if they experience a mental health crisis or physical health emergency. This may require:

- making sure this is covered in a person's care plan
- linking with inpatient, day patient, urgent and emergency mental health services, or local out-of-hours care pathways to provide additional support
- liaising with VCSE organisations that may provide online or telephone support after hours.

This process should then be communicated to other services as part of an integrated joint working agreement. Detailing this in a person's care plan will ensure other professionals, such as the person's GP, know what support to provide or who they can signpost to.



Managing endings is really important; people need therapeutic relationships to end in a supportive way to manage their expectations, prepare them for greater independence, and help them to be ready for discharge.

Service user and carer group

Changes to treatment. CED services need to have processes in place for making changes to treatment if a person is not responding to the proposed treatment plan, or if they feel that the treatment they are receiving is not working for them. A clinician should have regular, open discussions with a person about their progress and whether they feel a particular psychological

approach is working for them. A person should be given the choice (where appropriate and available) to switch to a different psychological treatment or therapist, to increase or decrease the intensity of the treatment they receive or choose the way treatment is delivered. Alternative options should always be explored before a person is discharged (with monitoring or follow-up from primary care).

Long-term presentations. Commissioners and providers should consider the needs of people with a long-term eating disorder, as the treatment, care and support they receive may differ from those for other presentations. People presenting with a long-standing eating disorder should receive evidence-based treatment, however, for those who have experienced multiple treatments over time a different approach may be appropriate. Ongoing input from a CED service may be appropriate for those who remain at high medical risk or have ongoing high psychiatric need. However, this should be reviewed regularly to ensure an effective balance between engagement and progress. In some instances, treatment that remains purely supportive may reduce a person’s motivation to take up treatment that focuses on change or progress. It may be more effective for the person to be discharged to primary care with a strong encouragement to return to the CED service for evidence-based treatment when they are ready. In other instances, low-level psychosocial support from the CED service (including peer worker support) can be the minimum necessary to sustain stability and should be continued. The balance between these two positions requires careful assessment, regular review and clear discussions with the person. Clinicians will also need to remember that

duration of illness is not necessarily a predictor of outcome, as people who experience multiple relapses or inpatient admissions may demonstrate progress, albeit at a slower rate.

3.8 Medical monitoring

The ability to comprehensively monitor and manage the physical health of all people with an eating disorder (across all diagnoses and presentations) is an essential function of a CED service (see [NICE guideline section 1.10²](#) and Appendix A). A CED service must be sufficiently equipped to conduct a full medical assessment, including blood tests and ECGs, and receive same-day results to facilitate same-day clinical decision-making. This may be delivered by a medical professional with expertise in eating disorders, who is then able to liaise with other medical professionals if required.

Medical monitoring needs to be based on local medical monitoring agreements clearly established across the CED service and primary care network, with one consistent protocol agreed on by local commissioners. The protocol should be developed in collaboration with primary care services and clearly outline the responsibilities for each service ([Table 2](#)). A shared care pathway for medical monitoring should be produced. The decision on who is responsible for the medical monitoring of a person should be informed by their level of medical risk and ability to effectively engage with physical health monitoring.

When responsibility for medical monitoring is assumed by primary care, the limitations of this need to be recognised and mitigated. For instance, specialist eating disorder knowledge

Table 2: Responsibility for medical monitoring

CED service	Primary care
<ul style="list-style-type: none"> Person is at high medical risk and/or unable to reliably adhere to physical health monitoring in a primary care setting 	<ul style="list-style-type: none"> Person is at moderate risk but recognises their need for health care and seeks it Person is at low medical risk Person is discharged from the CED service

may be necessary to correctly interpret the results of medical monitoring tests. The CED service should be accessible to provide specialist consultation to primary care to ensure results are interpreted correctly, regardless of whether a person is currently engaging with the CED service. To ensure that the CED service has capacity to reliably provide this consultation, opportunities for upskilling other staff members (such as nurses) should be explored. A CED service that is accessible for consultation will facilitate GPs' safe acceptance of discharges from the CED service and reduce demand on the CED service's resources.

King's College London has published [guidance](#)²² on conducting and interpreting medical risk assessment for people with eating disorders, which may provide important insights for GPs and other medical professionals who do not specialise in eating disorders.

3.9 Intensive community treatment

Intensive community treatment focuses on treating the person in their community as an alternative to an inpatient admission. It can also help reduce length of inpatient stay and inpatient costs overall.²³ 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:

- a brief period of outreach support provided by the CED service
- increased frequency of community treatment to maintain momentum towards progress, including supervised mealtimes and support for families around meals, provided by the CED service for an agreed period of time.

If a person requires intensive community treatment, their care plan should be updated, with an agreed timeframe for review with the intention to decrease the intensity of treatment. CED services will need to consider their resources and capacity to provide this level of care.

Commissioners and providers may need to liaise with established mental health intensive home treatment teams concerning further training or support that may be required by the CED service.

3.10 Inpatient and intensive day patient treatment

Clinicians working across CED, inpatient and intensive day patient services should have a good working knowledge of the key requirements around the management and treatment of people in inpatient and intensive day patient treatment. This should include risk assessment, as set out in the [MARSIPAN](#)⁷ and the [eating disorders NICE guideline](#).² Issues around capacity and consent (see Section [3.15](#)), including use of the [Mental Health Act 1983](#)²⁴ (revised [2007](#)),¹⁰ should be managed appropriately and with empathy, working in collaboration with the person or their family and carers at all times.

Inpatient treatment. The decision to admit should be made according to clinical need and the person's safety rather than diagnosis (see [NICE guideline section 1.11](#)),² and should consider available inpatient or community resources.⁸ An admission should be as close to home as possible, with clear goals and objectives (including goals for discharge) agreed and set beforehand, and regular reviews to assess whether inpatient care should be continued or stepped down to a less intensive setting.

The CED service should establish joint working protocols across medical and mental health inpatient units to ensure they can provide input and support inpatient staff during an admission. For continuity of care, the CED service should usually remain the lead in providing care, working closely with inpatient staff from the start of the admission to ensure the person receives the appropriate level of treatment, with psychological and social components incorporated into their care.

The type of unit or ward will depend on the person's needs, which setting can effectively meet

those and the availability of beds. If there is a high medical risk or comorbid physical health problem, a person may be admitted to a general medical ward, with clear input from the CED service. People who present with high psychiatric risk may be admitted to an adult mental health unit or psychiatric intensive care unit.

Intensive day patient treatment. This provides step-down care from inpatient treatment or an alternative to admission.^{25,26,27,28} It may be provided by either an inpatient unit or a CED service, at least four to five times a week, and should include support around main meals as well as encouraging people to learn skills and engage in activities that contribute towards their recovery. As people make progress, the frequency of day patient treatment should be reviewed and decreased to ensure an appropriate step-down to community treatment. Integrated working across day patient and CED services can help support people to live in the community and prevent relapse or readmission.

Commissioners and providers should refer to [NHS England's service specifications for adult eating disorders for inpatient and intensive day patient treatment](#)²⁹ (these do not cover community eating disorder services commissioned by CCGs).

3.11 Managing transitions

The PHSO report¹ highlighted the challenges involved when a person with an eating disorder transitions between services, either between geographical locations or from children's to adult services. Young people attending university for the first time are particularly vulnerable (see Appendix F for recommendations on supporting students). Consequently, effective management of transitions across services needs to be a critical part of joint working arrangements and coordinated care.

Transition protocols (see [NICE Quality Statement 6](#))⁶ should be in place to ensure good communication between services to avoid inconsistent messages or management

approaches. Effective management of transitions should be based on a transition plan that includes risk assessment and monitoring, and an agreed next appointment with the CED team or with the person's allocated care coordinator.

For geographical transitions, CED services should work closely with primary care providers, CED services in other areas and university mental health services to remove gaps in care and delays in treatment that tend to occur when a person moves to a new area and needs to register with a new GP. Transitions should be seamless, with no gaps in support or quality of provision. People should be seen by the new CED service without delay.

For age-based transitions, the CED service should work with the CYP-CED service for a minimum of 6 months before the planned transition to ensure a seamless care pathway (see NICE guidance on [Transition from Children's to Adult's Services](#)).³⁰ The parents or carers should be provided with information and advice around the young person's transition, given the change in their rights and role when a young person enters adult services. When a person first presents to a CYP-CED service within 6 months of typical transition age, the CED service should be involved in their initial assessment. The Royal College of Psychiatrists' report, [Managing Transitions When the Patient has an Eating Disorder](#)³¹ also provides guidance on coordinating care, planning for transitions and joint working across services, particularly when a young person transitions from CYP-CED services.

For further information on transitions, commissioners and providers should refer to NICE guidance on [Transition Between Inpatient Mental Health Settings and Community or Care Home Settings](#),³² [MARSIPAN](#)⁷ and [NHS England's service specifications for adult inpatient and day patient eating disorder services](#).²⁹ NHS England has also published a mandatory national [Transition CQUIN Indicator for 2017/2019](#) on transitions from CYP to adult mental health services, primary care and other relevant CCG-commissioned services.

3.12 Managing comorbid conditions

When managing comorbid mental health and physical health problems, the CED service will need to work with the person to identify their goals for treatment and collaborate with other services to provide integrated care (see [NICE guideline section 1.8](#)).² The person's level of need may require input from multiple services at the same time. An integrated rather than sequential approach should be taken, with careful thought given to which service should be the lead in this process to ensure continuity of care.

Management of comorbid conditions should consider the severity and complexity of the eating disorder and the comorbidity, the person's level of functioning and their treatment preference.² A person should be able to receive treatment for comorbid mental or physical health problems at the same time; having a comorbid condition should not be a reason for delaying or rejecting someone for treatment. Continued community treatment for specific conditions, based on the relevant NICE guidance, should always be the aim.

Diabetes. Diabetes is a significant comorbid physical health problem that needs to be monitored and treated appropriately, with collaborative input from diabetes teams. Staff working across both CED and inpatient or intensive day patient services may require further training and upskilling to support people with diabetes effectively.

“Diabulimia”. Diabulimia is a condition where people with diabetes and an eating disorder restrict their insulin intake to lose weight. This is a serious and emerging problem that in the most severe cases can be life-threatening. [NHS England recently announced](#) (February 2019) pilot services that will provide joined-up treatment for diabetes and mental health.

Mental health problems. Comorbid mental health problems, such as depression and anxiety, are common in people with eating disorders;

obsessive–compulsive disorder may be more prevalent in those with anorexia nervosa.³³ Consideration of other comorbid conditions, such as autism, borderline personality disorder or substance misuse is also necessary, as there may be ongoing risk issues and a need to adapt treatment. A person should be able to access CED services regardless of the comorbidity.

3.13 Routine measurement of progress and outcomes

Routine outcome measurement should be in place consistently across CED and inpatient or intensive day patient services on three levels.

1. **Individual level:** helps to empower the person, inform on progress towards their goals, monitor their symptoms and inform clinical practice
2. **Service level:** used to assess people's experience of care to monitor service provision and quality of care
3. **Population level:** can be used to monitor the uptake of the service in the area, add to local prevalence data and compare to national data.

Outcome measures should always be used on a session by session basis with the person and their family, partner or carers, as part of a collaborative process to identify the person's needs and reflect on their progress towards treatment goals and experience of care. Professionals need to ensure that person-focused outcomes are based on the person's goals, their subjective experience of feeling better and improved functioning in other areas of life, and not solely on improvements in the symptoms or behaviours of the eating disorder.

Outcome measures are also a useful tool for review meetings, multidisciplinary team discussions and clinical supervision sessions. Aggregate information from outcomes can inform service improvements and delivery. (See Appendix E for further information on using outcome measures, including a list of measures for CED services.)

3.14 Advancing mental health equality

Reducing inequalities in access and improving outcomes for people with an eating disorder is central to the development of services. It is best achieved through: co-production (see Section 1.3); specific training and supervision for staff; and the collaboration of national, regional and local commissioners. Commissioners and providers across settings should work together to ensure that services are inclusive and accessible to all people with an eating disorder. It is important to remember that protected characteristics (defined by the [Equality Act 2010](#))³⁴ may affect the presentation of mental health problems and have an impact on the delivery of assessment and interventions.

A person may feel particularly vulnerable when accessing care. Certain populations may have a varying experience of access and care, such as:

- males
- people who are transgender
- people who identify as non-binary
- people from socio-economically deprived areas
- black and Asian minority ethnic communities
- people with comorbidities
- as well as those who present with obesity and an eating disorder.

For example, eating disorders in males and transgender individuals may not be recognised or clearly identified, which may lead to difficulties or delays in accessing appropriate treatment.

Professionals may require specific training and supervision focusing on mental health equality issues to ensure all people receive effective care.

CED services can advance mental health equality by:

- improving access to services and providing more flexibility in how care is delivered (including flexible appointment times, location of care delivery and outreach support)

- improving people's experience of care through ongoing training, education and supervision for staff on equality, diversity and culturally informed treatment
- providing information in a format that suits the person's needs and preferences (see NHS England's [Accessible Information Standard](#))
- enabling easy access to a translator or advocate if needed
- implementing more diverse staffing and recruitment policies, to reflect the local population
- ensuring facilities and provision of care are gender neutral, to respect the needs of males, people who are transgender and who identify as non-binary (including the use of appropriate gender pronouns)
- recognising that transgender and non-binary people may experience body dysmorphic issues that are related to their gender identity rather than their eating disorder,³⁵ and being mindful of and sensitive to this distinction (see Appendix H).

Local commissioners should be able to demonstrate the way they meet the duties placed on them under the [Equality Act 2010](#)³⁴ and the [Health and Social Care Act 2012](#).³⁶

Service design and communications should be appropriate and accessible to meet the needs of diverse communities and ensure that service provision is commissioned across the full range of complexity. Commissioners should refer to the [Guidance for Commissioners on Equality and Health Inequalities Legal Duties](#)³⁷ for further information on how to improve health outcomes and the experience of individuals, communities and the workforce.

The NCCMH is also undertaking a project focused on advancing mental health equality. This will support commissioners and service providers to identify and work towards reducing inequalities and advancing equality across the mental health care system.

3.15 Information-sharing, capacity, consent, safeguarding and confidentiality

Clinicians should have sufficient knowledge of the specific issues and legislation relevant to competence, capacity, consent, safeguarding and information-sharing. This encompasses the [Mental Health Act 1983](#)²⁴ (revised [2007](#)),¹⁰ the [Mental Capacity Act](#),¹¹ the [Mental Health Act 1983: Code of Practice](#),³⁸ the [Mental Capacity Act 2005: Code of Practice](#)³⁹ as well as the NICE guideline for [decision-making and mental capacity](#)¹⁹ (see also [NICE guideline section 1.12](#)).²

The Social Care Institute for Excellence (SCIE) has produced [resources and information for professionals on safeguarding](#) for both adults and young people. Services should have clear processes around these issues and staff should receive regular training and supervision to maintain their knowledge and competence in this area. (See part 2 of the Helpful Resources.)

4 Workforce and staffing

4.1 Workforce planning

A CED service should be a multi-skilled, multidisciplinary team with significant knowledge, competence and experience in the assessment, risk management and treatment of people with eating disorders. CED services need to be resourced appropriately to provide care, including community outreach work, for the full range of eating disorders, including binge eating disorder and OSFED, and to meet the needs of different populations. Actual staffing levels and skill mix will depend on the needs of the local population and other prevalence data (as set out in Section 2.4), but should be sufficient to cover staff absences and ensure appropriate clinical supervision. The Helpful Resources document provides examples of services and their staffing mixes (part 1).

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

Leadership and governance. The PHSO report¹ highlighted the critical role of system leaders in providing necessary oversight to services and the leadership and management required to transform the existing adult eating disorder workforce. Commissioners and providers will need to



You can see the staff that genuinely care and want to be there. Some can be amazing and literally save your life. Staff are the people who will make the difference.

Service user

develop clear governance plans and structures to ensure clinical accountability is clear across the CED service.

Staff wellbeing. The CED service should actively support and promote staff wellbeing. This may be through providing access to support services, appropriate clinical supervision, monitoring staff sickness, assessing and implementing strategies to improve morale, and encouraging staff feedback on the service. Opportunities for diversity in workload, professional development and career progression are also important elements. Commissioners and providers should review [Thriving at Work](#),⁴⁰ which sets out recommendations for organisations to improve mental health in the workplace, while NHS England has published a [framework for employers](#) to support their employees' health and wellbeing.

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

The [Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning Guide](#)⁵ set out a [workforce calculator](#) to assist commissioners and providers in determining the correct mix of skills and staff for their local area. Commissioners of adult services may find it useful, but will need to consider additional staffing for inpatient or day patient services. Further guidance on workforce

requirements, service distribution, service development and training is available in the Royal College of Psychiatrists' report on [eating disorders in the UK](#).⁹

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



Peer support workers or people with experience of using services can help staff 'truly get it', to understand what it is like to live with an eating disorder and to be mindful of how they talk about food and their own bodies, and the effects this can have.

Service user and carer group

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

4.2 Competences

All members of the CED service should be competent in assessing and treating eating disorders (see [NICE guideline section 1.1.14 to 1.1.17](#)).² Different team members will be required to contribute different skills consistent with their professional background, eating disorder-specific training and level of expertise. Professionals within the CED service should be skilled to meet

a number of competence frameworks, such as the ESCaSS guide (forthcoming) and the [Self-harm and Suicide Prevention Competence Framework](#). They should have the relevant competences in:

- psychiatric assessment for people who present with an eating disorder throughout the lifespan (from younger adults to older adults)
- medical assessment and physical health monitoring
- refeeding or tube feeding in inpatient settings
- rapid response to referrals to provide early intervention
- assessing and managing risk and safety
- delivering evidence-based treatment, care and support to people who present across the full range of eating disorders, including those who present for the first time, as well as those who present with comorbidities or complex and long-term problems
- understanding the behaviours and symptoms of eating disorders, including how this can affect people's ability to engage with services and accept help
- working effectively within a multidisciplinary team, including care coordination
- working effectively across service interfaces to deliver collaborative care
- providing support to inpatient and day patient settings
- empowering family members, partners and carers to further support the person and delivering family-based interventions where appropriate
- managing issues around information-sharing, confidentiality and safeguarding
- monitoring treatment adherence in people receiving care
- using routine, standardised measures of progress and outcome.

The CED service should support other professionals across primary care, community mental health services, education, social care, public health, VCSE and other agencies to improve their knowledge and understanding of eating disorders, particularly around recognition and referral to the CED service. Professionals

within primary care will need skills and competences in ongoing medical management (as part of integrated care and on long-term follow-up after discharge from the CED service). Community mental health services may need to improve the general skills and knowledge within the team, however, it may also be useful for a member of the team to have specialist skills in working with eating disorders, to ensure closer collaboration with the CED service. Staff in inpatient units will need the appropriate knowledge and competences on inpatient treatment of eating disorders. Further joint training and learning opportunities across services are an ideal way to develop multi-agency relationships and facilitate ongoing support.

4.3 Supervision

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

4.4 Training

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

offering training for carers and family members as part of the support they provide.

Training should aim to:

- upskill members of a CED service to meet a range of needs and ensure they have excellent communication and interpersonal skills; this includes training to support young people transitioning from children's to adult services
- ensure staff have the appropriate working knowledge of relevant legal requirements associated with information-sharing, capacity and consent ([NICE guideline section 1.12](#))²
- build in flexibility at a local level given geographical differences in workforce and recruitment
- give people with experience of using services the skills to hold peer support or peer mentor roles.

Commissioners and providers will need to consider how training for emerging CED services may differ from upskilling existing CED services. Web-based training (see Helpful Resources, part 2) may be an option for upskilling practitioners and increasing the availability of psychological treatments, as it has demonstrated positive effects on therapist competence, particularly in enhanced cognitive-behavioural therapy (CBT-E) over a wide geographical area.^{41,42,43,44}

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

The PHSO report¹ recommended that the General Medical Council (GMC) conduct a review of training for all junior doctors in eating disorders towards improving understanding, and that Health Education England review its current education and training to address the gaps in provision of eating disorder specialists. These and further efforts to bolster the recognition and management of eating disorders among primary care services will be invaluable to the development and operation of integrated CED services.



Primary care professionals need better training to recognise, identify and work with people who have an eating disorder, including helpful ways of discussing eating disorder symptoms and behaviours. They need to be able to link the person directly with the CED service when they first present.

Service user and carer group

5 Ensuring a quality service

People's experiences of treatment, care and support, and feedback from other services such as primary care, are central to measuring the quality of services and determining priorities for improvement. Regular measurement of the quality of services will help provide consistent, evidence-based treatment and support across England and will ensure people with an eating disorder know what to expect from a service.

Commissioners and providers will need to ensure they deliver care in line with the [eating disorders quality standard](#)⁶ (see Appendix C) and the Care Quality Commission's (CQC's) [framework](#) for delivering safe, effective, caring, responsive and well-led services. NICE has developed [tools and resources](#) to support services in improving the quality of care they provide.

A [quality improvement approach](#) should be used to underpin implementation of the recommendations in this guide. Each area should create its own theory of change (e.g. a driver diagram) and a measurement strategy for improvement. Ideas should be tested and allowed to fail as well as succeed, with both failures and successes contributing to learning and improvements. This approach will ensure that staff and people with eating disorders are fully involved in developing services, and that services know whether they are



A good quality service has staff with the right training, skills, awareness and knowledge to help someone meet their needs. Continuity of care, communication and choice are all critical factors to empowering people throughout their care, giving them a voice, and making sure they are listened to. Thinking about the whole person, being creative and proactive in providing treatment and supporting them to be motivated can help the person re-build their sense of identity and establish a life focused on recovery and not the eating disorder.

Service user and carer group

improving or not through the use of data tracked over time (e.g. by using run charts).

5.1 Data collection

CED services should routinely collect data on service use to inform and support their continuous improvement. National datasets will provide routine, consistent measurement of local services' performance to support quality, improve people's experience of care and reduce unwarranted variation in service provision and outcomes. The Mental Health Services Data Set ([MHSDS](#)) is a secondary uses dataset which enables collection, measurement and reporting of service data. Many process measures for mental health services are already captured in the [MHSDS](#). Collecting the right data in the right parts of the system at the right time is crucial,⁴⁵ as it helps identify where improvements are needed.

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

Commissioners and providers should:

- invest in and maintain the necessary IT systems that facilitate 'real-time' in-session feedback for the person and the professional to inform clinical practice

- support data collection and reporting of outcomes for use in evaluating the impact of service delivery, both locally and nationally
- set out clear processes to implement feedback from people with experience of using services and data from outcomes collected to improve service delivery and performance
- consider and include data collection in workforce planning
- ensure the appropriate collection and handling of data to comply with data governance.

5.2 Quality improvement networks

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

The QED is currently developing standards of accreditation for community eating disorder services, which incorporate the [eating disorders NICE guideline \(NG69\)](#),² the PHSO report¹ and recommendations from this guide. They have also developed [Standards for Adult Inpatient Eating Disorder Services](#)⁴⁶ to support accreditation.

5.3 What commissioners and providers should do

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

- Ensure all people in their local area have access to a dedicated CED service with the appropriate referral pathways in place
- Ensure services have clear information available on their website, including their location, treatments they provide, and what a person can expect
- Collaborate with people who have experience of using services, as well as their support network, to regularly evaluate and improve the care they provide
- Commission eating disorder services with the appropriate capacity and skill mix that can meet the mental health, physical health and social needs of people with an eating disorder, and the needs of their families, partners, carers or support network
- Commission services to support greater integration across services and provider organisations; this may require collaborative working with other commissioners
- Recognise the difference between treatment failure and relapse – just because a person is accessing the service after having treatment before does not mean they would not benefit from being treated again
- Ensure clear joint working policies are in place across services to support coordination and continuity of care, and prevent gaps or delays in treatment
- Ensure that clear transition processes and agreements are in place, particularly around risk assessment and monitoring, with effective coordination when care spans multiple organisations
- Facilitate robust medical monitoring agreements with local primary care networks
- Ensure staff have the competence, capacity and skills to deliver evidence-based treatment, with the appropriate level of supervision and access to training and professional development
- Monitor quality of provision of care for people with eating disorders
- Ensure routine outcome measurement across services
- Consider how digital technologies can be used to support developing services, delivering care, training and supervision

6 Definitions of terms and abbreviations

Table 3: Abbreviations

Abbreviation	Full term	Abbreviation	Full term
BMI	Body mass index	MARSIPAN	Management of Really Sick Patients with Anorexia Nervosa
CCG	Clinical commissioning group	MHSDS	Mental Health Services Data Set
CCQI	College Centre for Quality Improvement	NCCMH	National Collaborating Centre for Mental Health
CED	Community eating disorder(s)	NICE	National Institute for Health and Care Excellence
CYP-CED	Children and young people's eating disorder (services)	OSFED	Other specified feeding and eating disorders
ECG	Electrocardiogram	PHSO	Parliamentary and Health Service Ombudsman
GMC	General Medical Council	VCSE	Voluntary, community and social enterprise sector
GP	General practitioner		

Table 4: Definitions of terms

Term	Definition
Carer	Anyone who cares for a partner, family member, friend or other person in need of support and assistance with activities of daily living. Carers may be paid or unpaid, and include those who care for people with mental health problems, long-term physical health conditions and disabilities.
Person-centred care	Flexible care based on the need of the person rather than the service. A person is: treated with dignity, compassion and respect; offered coordinated and personalised support, care or treatment; and supported to recognise and develop their strengths and abilities, to enable them to live as independent and fulfilling a life as possible.
Support network	A group of people, an organisation or a person who provides emotional and/or practical support to someone in need. A support network can be made up of the person's partner, nominated person, friends, family members, parents, siblings, peers, volunteers, health and social care professionals or supportive online forums and social networking sites.
Transition	The planning process around and handling of transfers of care between care settings and/or location, including the initial planning, the transfer itself and the support provided throughout.
Urgent	When a person may be at high risk (physical or mental health risk that threatens their life, long-term health or the safety of others) and they require an immediate response from services.

7 How was this guide developed?

In response to the PHSO report,¹ an Expert Reference Group (ERG) was convened by NHS England to address the specific recommendation for NHS England to review the existing quality and availability of services to achieve parity with children and young people's eating disorder services. The National Collaborating Centre for Mental Health (NCCMH) was then commissioned to develop this guidance. The ERG included people with expertise in the area of eating disorders, including those with experience of using services, and those from clinical, academic and commissioning backgrounds. A separate reference group was convened with people with experience of receiving treatment for an eating disorder to further develop the recommendations within this guide.

The recommendations in this guidance were developed based on NICE guidelines and quality standards, evidence of positive practice from published literature and existing services, and consensus from the ERG.

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