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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

ABUHB Response to Eating Disorders Service Review 2018

Introduction

The Minister's letter of 25th September 2019 calling for Health Boards to consider incremental change aimed at improving access to care and support for people with Eating Disorders in Wales was very welcome. The Health Board fully supports the 2018 Review's aspirations to improve services in Wales and would welcome the opportunity to be an early adopter to meet the ambitious aims of the Review. The Review's focus on: reconfiguring services towards earlier intervention, working towards achieving the NICE 2018 quality standards on Eating Disorders within two years, single point of access, self-referral and achieving a four week waiting time across adult and child services as well as developing plans for 0-25 age group service is ambitious, but we believe deliverable in Aneurin Bevan University Health Board (ABUHB). We aim to build on our current investments in Eating Disorders Services in Child and Adolescent Mental Health Service (CAMHS) where we offer a single point of access, self-referral and four week wait times from assessment, extending this incrementally into Adult Mental Health Services (AMHS) without destabilising current provision. We believe these incremental developments could be developed and supported by building an infrastructure within the Health Board that included service users, carers and partnerships with the third sector.

We plan to work closely with our colleagues in Powys and other neighbouring Health Boards to implement strategic initiatives to meet the NICE Quality Standards and Review's Recommendations as well as aligning with the Reviews aim for Health Boards to work together.

Contained in this document is feedback from clinical staff and service users on the 2018 Review. The current configuration of adult eating disorders services within the Health Board along with baseline data on service provision. The unmet need that we forecast in our population and our plans as a Health Board for key incremental phased changes to ensure that long term planning is aligned with the Review's vision as well as the key infrastructure changes that will be required to support these changes.

CAMHS and Adult Mental Health Clinicians Feedback on the Eating Disorders Service Review 2018

Feedback from service users, carers and clinicians across the Health Board fully supported the 6 underlying principles of the Review. Responses from service users and staff also welcomed the assessment that current services are underfunded. The Minister's commitment to increasing the resources to eating disorder services who will need significant investment in order to move toward the objectives outlined in the 2018 Review was very well received. (Please see **Appendix 1** for a full summary of Review Feedback).

Service users and staff believe that the nation of Wales should have access to eating disorders services aimed at prevention and early intervention. They would agree that outcomes for eating disorders services should have national application with equity of access and service but be delivered locally by Health

Boards. There was a great deal of enthusiasm for the Health Board to deliver the outcomes with increased resources rather than via a reconfiguration to a national eating disorder service.

An all age ED service with a single point of access is an ambitious target but we believe that with the right investment of resources it is achievable in Gwent. We currently have excellent joint working relationships across Adult Eating Disorder Services and CAMHS colleagues who collaborate on a number of clinical, training and schools initiatives.

How are Services are Being Configured toward Earlier Intervention?

ABUHB SCAMHS have already reconfigured their service in developing SPACE (Single point of access for children's emotional wellbeing) which is inclusive of self-referral and requires collaboration with agencies across Gwent. Including:

- Families First
- Flying Start
- Youth Service
- Primary Care Mental Health Support Service
- Education
- Community Psychology
- Platform 4YP
- Youth Offending Service

Our aim with the new SPEED funding in CAMHS is to link in with the SPACE referral meetings to develop early identification and assessment, as well as offer assessment and interventions for cases of Avoidant Restrictive Food Intake Disorder (ARFID). The new SPEED team will develop links and interfaces to ensure all young people presenting with eating difficulties will be offered an assessment or consultation with other health professional i.e. school nurses.

The Adult Specialist Eating Disorders Service would welcome the opportunity to develop an early intervention and treatment model based on the Maudsley's First Episode Rapid Early Intervention for Eating Disorders Service (FREED). Details of this proposal are outlined in our phase 2 proposal for Early Intervention in Eating Disorders for Emerging Adults aged 16-25.

The Whole School Approach provides strategy and structure to enhance opportunities for early intervention and prevention of eating disorders. Two ABUHB CAMHS clinicians are currently seconded into school projects, this is a generic CAMHS approach but does include modules on eating disorders.

Adult Specialist Eating Disorders Service developed a project for schools in 2018 which was piloted in Caerphilly called Team 'T:EaM health' is an abbreviation of Toolkit: (for) Emotional and Mental and Emotional health. The project aimed to raise an awareness of eating disorders so that staff and pupils alike are more confident in talking about, and dealing with, eating disorders in schools.

As a Health Board we aim to collaborate with weight management services, local organisations and third sector groups with the aim of developing programmes for schools. This piece of work would be undertaken in conjunction with full

funding for the SPEED and FREED teams as outlined in Phase 1 of funding for CAMHS and Phase 2 for AEDS.

How are Services Working towards Four Week Waiting Times Across Adult and Children's Services Within 2 Years?

Four weeks from assessment to treatment in routine presentations is the current standard for CAMHS in ABUHB who are currently 80% compliant. The new SPEED team will maintain compliance with the 4 week target, addressing the increase in referrals by providing early assessments for children presenting with ARFID.

For Adult services the current wait time is 10 weeks for a routine assessment within a CMHT. With a further 4-6 week wait to be allocated a care co-ordinator and commence treatment. Psychology waiting lists in secondary care can be up to a year. It is rare for anyone presenting with Bulimia Nervosa or Binge Eating Disorder and no other psychiatric co-morbidity to be taken on in AMHS. The proposals for adult services contained in this document at phase 1 and 2 aim to address this issue within 2 years.

How are Services Working toward Achieving the NICE Quality standards on Eating Disorders within 2 years?

ABUHB CAMHS generic community teams and specialist Tier 3 Intensive Treatment Programme (ITP) have adopted the principles of the Maudsley Family Based model to underpin our clinical practice. Staff have also had training in the model provided by the Tier 4 SCEDS team based at Ty-Lydiard.

CAMHS are delivering a version of ITP, through the re-organisation of their Tier 3 service. In order to fully implement, they require further funding for 3 x band 6 CAMHS specialists. . Community staff who see those young people presenting with more moderate presentations have not received adequate training in Family Based Treatment (FBT). A specialist ED team would allow the opportunity for more focussed therapy and support for young people and their families. Further training in all eating disorders evidence based therapies is required across the service, with a robust supervision framework to ensure standards and quality of practice.

For adults NICE quality standards 2018 would be met within the Specialist Eating Disorders Tier 3 service (SEDS). However a person with an eating disorder at Tier 2 in AMHS is highly unlikely to receive a NICE 2017 compliant psychological intervention for their eating disorder unless they are referred to SEDS. The proposals for adult services contained in this document at phase 1 and 2 aim to address this issue within 2 years.

Outline Plans for Health Boards working co-operatively with each other.

Currently Health Boards work co-operatively with one another in a number of national forums, including the All Wales Specialist Eating Disorder Special Interest Group and its management team, as well as the Eating Disorders sub-group of the CAMHS network. ABUHB plan to set up an Eating Disorders Steering group to share learning, best practice and all-age model advancement at national and regional level with other Health Boards to help address gaps in service provision.

Current ABUHB Adult Eating Disorders Service Provision:

The ABUHB Specialist Eating Disorders Service (SEDS) was set up following funding from Welsh Government to implement the Eating Disorders Framework for Wales 2009. The framework explicitly reinforces the roles of primary care teams, generic psychiatric and physical health services in identifying, assessing, intervening, treating and monitoring people who have an eating disorder.

Currently, Aneurin Bevan University Health Board's Mental Health and Learning Disabilities Division provides early intervention and treatment via Community Mental Health Teams (CMHT) and Primary Mental Healthcare Teams (PMHT). PMHT accept referrals from GPs and Community Mental Health Teams and provide assessment and short term treatment for low to medium risk eating disorder sufferers and monitoring for chronic and enduring eating disorders. CMHTs, receive referrals from GPs, Primary Mental Health Teams and self-referrals as described in Part 3 of the Mental Health Measure 2012. Due to the increasing demand and level of acuity seen in CMHTs, many ED patients do not meet threshold for treatment, but present with difficulties that are too complex for Primary Care. Young people transitioning from Child and Adolescent Mental Health Services (CAMHS) also experience long waits to be seen by Adult Mental Health Services (AMHS) or do not meet the threshold levels of risk and acuity for AMHS. These patients frequently present at a later date to CMHT's when their physical and psychological health has deteriorated and their level of risk has increased. Service users, parents and carers often feel ignored and isolated by the response of adult mental health services.

PMHTs do not have the requisite skills, training or remit to deliver treatment to patients with an eating disorder. Clinicians in Primary Care are aware that patients with less severe eating disorders are unlikely to meet criteria for secondary mental health care services unless they are severely unwell and so don't refer them. Clinicians in CMHTs often feel unskilled at assessing and delivering treatments in line with NICE 2017 recommendations. The current wait time is 10 weeks for a routine assessment within a CMHT. With a further 4-6 week wait to be allocated a care co-ordinator and commence treatment. Psychology waiting lists in secondary care can be up to a year. . Usually the person would have to present with another co-morbidity such as personality disorder, suicidal ideation, depression or self-harm. Once accepted into AMHS it is highly unlikely that the patient would receive a NICE 2017 compliant psychological intervention for their eating disorder unless they are referred to SEDS. Minimal dietetic and physical health monitoring is available in AMHS at secondary care with GPs becoming increasingly reluctant to carry out physical health checks on psychiatric patients. Due to the high threshold for treatment in the CMHT patients presenting to services at Primary Care do not get referred to Secondary Mental Health. These patients are too complex for Primary Care but don't meet the criteria for Secondary Mental Health. Inevitably this leave these patients either deteriorating until they meet the criteria, increasing their physical and psychological difficulties whilst worsening their prognosis, or disappearing from services which they experience as unable to help them.

With this in mind current service numbers are likely to significantly underestimate the demand in Primary and Secondary care. For example the numbers of patients who are coded as having an eating disorder intervention on ABUHBs electronic data system (Epex) have on average since 2011-2019 varied between 98-108 in secondary care and 26-34 in SEDS.

Using the eating disorders charity Beat's calculation of numbers of people with an eating disorder (**Appendix 2**) and extrapolating this onto the population data of Gwent from StatsWales would yield:

5,807 cases of Eating Disorders not otherwise specified (EDNOS) in Gwent.

Taking the figures for Anorexia and Bulimia Nervosa (EDNOS is largely seen within Adult Weight Management Services in Gwent) would indicate a total of **2351** possible cases in Gwent. It is widely thought that up to **30%** of people with Anorexia and Bulimia do not present to services and are not receiving a service that they might wish to access.

Proposal for Adult Services at Tier 2 phase 1:

This proposal would align with the recommendations from the Eating Disorders (ED) Service Review 2018 commissioned by Welsh Government in which ED services across Wales, service users, carers and the third Sector are involved. The plan is based on the Minister's request for key incremental changes that could be made, to ensure that longer term planning will align with the vision set out in the review. It will also meet the reviews six underlying principles of: early detection and intervention, inclusivity, person centred, relationship based, recovery focused and trauma informed.

That ABUHB SEDS employ a Psychiatrist for 3 sessions per week, 1 Band 7 and 5 Band 6 Specialist Clinicians, 2 Health Care Support Workers and 1 Band 3 Administrative assistant. These staff would provide an early intervention and treatment service for people with Eating Disorders across Gwent who are referred from Primary Care. Specialist Clinicians would assess all referrals to AMHS from Primary Care suspected of having an eating disorder. These clinicians would offer treatment within 4 weeks for routine referrals. ED Clinicians would care co-ordinate and undertake Care and Treatment Planning for those people with a primary diagnosis of an eating disorder. The Specialist Clinicians would provide support to Primary Mental Health Care Clinicians who currently see young people aged 16 and above, providing assessment and treatment interventions as per NICE 2017 guidance and where appropriate work across CAMHS and AMHS to provide a seamless transition taking on care co-ordination for those young people requiring transition to adult services. Specialist ED Clinicians will be co-located within borough CMHTs.

Aims:

- To provide early identification, specialist assessment and treatment as per NICE 2017 guidance for those people presenting with an ED in ABUHB in Primary or Secondary care in order to improve prognosis, reduce morbidity and mortality associated with ED. (*ED Review 2,4,5,7,11 improving recognition, early intervention and treatment in Primary Care*)

- People with suspected eating disorders who are referred to the eating disorder service start assessment and treatment within 4 weeks or 1 week if urgent. (*NICE QS 1. ED Review 9*)
- People will be offered a range of psychological interventions as per NICE 2017 guidance. (*ED Review 10 offering a range of NICE concordant psychological therapies*).
- People with eating disorders have a discussion with a healthcare professional about their options for psychological treatment. (*NICE QS 2 offering people a choice in therapies*)
- To enable those patients with an ED that currently do not meet threshold for care co-ordination by the CMHT to have access to specialist treatment ensuring safe and effective management of the psychological, physical and social aspects of their ED. (*ED Review 2,4,7,11 improving recognition, early intervention treatment and prognosis*)
- Specialist ED clinicians will co-ordinate the care plan of the person with an eating disorder ensuring that those who are being supported by more than one service have a care plan that explains how the services will work together. (*NICE QS 5. ED Review 20 clinical collaboration and care planning to meet a person's complex needs*)
- Specialist ED Clinicians will undertake the physical health checks of those patients within the service who require intense physical health monitoring with support from medical and psychiatric teams involved in the patients care. (*ED Review,4,7,11 prioritising the medical needs of ED patients improving early intervention, treatment and prognosis*)
- To ensure seamless transitions between services and for young people requiring adult services ensuring a risk assessment and management plan is in place. (*NICE QS 6,risk assessments for those people moving between services*)
- To support Primary Care Clinicians when working with young people aged 16 and above who have an ED. (*ED Review 4,5,7,11 improving recognition, early intervention treatment and prognosis*)
- To improve access to clinical expertise in ED at the point of entry and local to the patients home. (*NICE QS 2. ED Review 2,4,7 improving recognition, early intervention treatment and prognosis*)
- To develop and strengthen the ED workforce. (*ED review 10, 11 ongoing clinical training to ensure expertise in assessment and treatment.*)
- With increased access to physical health monitoring and supervision more people will have good physical health monitoring, and better management of the many physical complications associated with ED. (*ED Review 4,5,11 detection and early, effective care of eating disorders at Primary Care*)

NICE QS refers to NICE Quality Standard 175 2018. <https://www.nice.org.uk/guidance/qs175>

ED Review refers to Welsh Eating Disorders Review 2018. <https://gov.wales/eating-disorders-service-review-2018>

Objectives:

The above aims will be achieved by the following objectives:

- To undertake a comprehensive timely assessment for those patients presenting in ABUHB to CMHTs including engagement, motivational enhancement and psycho education.

- To provide and support early identification and treatment as per NICE 2017 recommendations for people presenting at Primary and Secondary care to improve prognosis.
- To improve the rate and probability of full recovery from an ED by access to appropriate and timely evidence based treatment interventions.
- Those patients with an ED that currently do not meet threshold for care co-ordination by the CMHT and are currently falling between services will have access to specialist treatment.
- ED services taking the lead in ensuring that MARSIPAN 2014 and NICE 2017 guidelines are implemented across ABUHB, leading to a reduction in the morbidity and mortality associated with ED.
- Increased early availability of specialist ED services will ensure safe and effective management of the psychological, physical and social aspects of ED.
- To ensure that ED patients have access to the level of treatment they require depending on their need wherever they are being seen within ABUHB.
- Specialist Clinicians will provide care co-ordination and Care and Treatment Planning for those patients who have a primary diagnosis of an ED as well as relapse prevention and monitoring.
- Working collaboratively with Tier 3 Specialist Eating Disorders Service and referring as appropriate patients to Tier 3.
- Managing transitions across services such as CAMHS, PMHTs and CMHTs and between other services such as University or out of area provision.
- Provide good quality information to patients and carers.
- Increase efficiency, effectiveness, cost-effectiveness and quality of service provision
- Specialist support workers would undertake the physical health checks of all patients with an ED in a timely manner and as clinically indicated.
- Physical health checks would be monitored and acted upon by those staff involved in the patients care.
- Care co-ordinators and the Responsible Clinicians would have timely access to the patient's physical health results.
- Specialist support workers would be able to undertake physical health checks in locations that would ensure the patient's compliance in this notoriously difficult to engage and highly ambivalent patient group.

Strategic Alignment:

This proposal is consistent with the aims of the following Welsh Government Strategy documents:

- Together for Mental Health
- Mental Health (Wales) Measure 2012
- MARSIPAN 2014
- The Wellbeing of Future Generations Act 2015
- Framework for Wales (refresh) 2016
- Prosperity for All.2017
- NICE guidance on Eating Disorders 2017
- A Healthier Wales 2018
- ED Service Review 2018
- NICE Quality Standard 175 September 2018

Review

It is envisaged that 12 months into the project, the service will complete an evaluation and audit in November 2020 against the NICE Quality Standards 2018 and the Eating Disorders Review 2018. In conjunction with this evaluation, the project will have been working closely with colleagues in other Health Boards to share knowledge and learning aimed at meeting the Quality Standards and Review's Recommendations. For example, implementation across South Powys may look different to that in Gwent but would be aimed at delivering the required outcomes as specified in the Minister's guidance.

Cost Breakdown to support FREED model:

	Band	WTE	2020/21 Rate	Cost £
Consultant Psychiatrist	Medical	0.3	125,607	37,682
1 Band 7	Band 7	1.00	56,072	56,072
5 Band 6s	Band 6	5.00	47,559	237,795
2 Band 4s	Band 4	2.00	29,884	59,768
1 Band 3.	Band 3	1.00	26,002	26,002
Total Pay Costs				417,319
Travel				5,400
Phone purchase				1,500
Phones rental				2,160
IT				5,000
Training/Equipment				15,000
Total Non Pay Costs				29,060
Total Costs				446,379

Proposal for CAMHS Service at Early Intervention and Prevention phase 1:

The SPEED team will develop an early intervention strategy aiming to address eating / body image issues within primary / secondary education, within GP surgery's and primary care providers. A training strategy to address the above aims will be developed in order to achieve these objectives.

The SPEED team will also collaborate with the Adult Eating Disorder Team for transition and develop the FREED model of assessment for those ages 16 plus if deemed appropriate.

An audit tool inclusive of outcomes measures, user / carer feedback, training competencies for staff will demonstrate effectiveness of the service.

Key Milestones:

A planning and operationalisation phase of 3 months from approval to establish a health, educational and social care training programme working with the SPEED team to provide pathways for prevention, recognition, early assessment and intervention. This will involve negotiations with schools, school health nurses, GP's, paediatric services, sufferers and carers. From 3-9 months there will be an implementation phase with training across services & school workshops. After the 1st year evaluation tools & outcomes measures will inform a review of the service and adjustments made in line with the evidence collated.

Delivering a training programme covering prevention, recognition, referral and interventions for a range of health, education, social care and primary care services. This training will have different aims, levels and competencies based on need.

At the end of the first year workshops on: awareness raising days on eating disorder, improving self-esteem and body image confidence within schools will have been delivered across Gwent.

Cost Breakdown to support SPEED model:

	Band	WTE	2020/21 Rate	Cost £
3 Band 6s	Band 6	3.00	47,559	142,677
Total Pay Costs				142,677
Non Pay costs				
Travel				3,000
Phone purchase				900
Phones rental				900
IT				2000
Training/Equipment				3000
Total Non Pay Costs				9,800
Total Costs				152,477

Establishment of an Eating Disorders Steering Group Phase 1.

Oversight for the development of Eating Disorders Services within the Health Board will take place via an Eating Disorders Steering Group set up by the Health Board. This group will be established within the Health Board involving service users and services in Gwent. Membership of the steering group would be driven by the need for a whole system approach. Membership to include, service users and carers, clinicians from paediatric services, gastroenterology, Primary Care, CAMHS, AMHs, school nurses, school/college counsellors, Teachers and Higher Education, multiple agencies across Gwent including Families First, Flying Start, Beat, etc. It is envisaged that the Steering Group would also co-opt expertise as required to ensure deliver of the key objectives of the Review

The Steering Group will continue to develop the proposals ensuring that stakeholders are engaged at every stage as the services progress incrementally to meet the Reviews recommendations. The Health Board will have oversight and accountability of the Steering Group which will also feed into the Regional Partnership Boards ensuring a whole system approach to the prevention and treatment of eating disorders.

The Steering Group's aim will be to implement an all-age eating disorders pathway that will improve access and outcomes for eating disorder patients. The additional resources will support the creation of the capacity required to incrementally:

1. Develop an all-age single point of access for eating disorders support and intervention.
2. Address the current gaps in provision at each level of Eating Disorders service delivery in accordance with NICE guidelines.
3. Share learning, best practice and all-age model advancement at national level with other Health Boards to help address gaps in provision.

The Steering Group would ensure that the Reviews recommendation 2 which urged working in partnership with other agencies across the region to support a whole systems approach for delivery of equitable, accessible world class eating disorders service for the people of Wales is met.

Early Intervention in Eating Disorders for Emerging Adults 16-25 year olds phase 2.

This proposal would align with the recommendations from the Eating Disorders (ED) Service Review 2018 creating a service specifically for those aged 16-25 with a single point of entry for accessing ED services where service users could self-refer. The proposal is based on the Minister's request for key incremental changes that could be made, to ensure that longer term planning will align with the vision set out in the review and is timed to follow on from the establishment of AEDS at Tier 2. It will meet the reviews six underlying principles of: early detection and intervention, inclusivity, person centred, relationship based, recovery focused and trauma informed.

The 2018 Review's recommendations highlighted the need for early intervention particularly with regard to the age at which eating disorders tend to emerge 16-25 years old. The Review has proposed the FREED model standing for: First Episode Rapid Intervention for Eating Disorders. This model helps young people to access specialised evidence-based treatment quickly. ABUHB believe that this is a model whose principles could work well for Gwent. The goal is for treatment to start within 4 weeks of referral to an eating disorder service and is being piloted in other areas including Birmingham, Bristol and Leeds in England. The following text outlines this model and is taken from FREED's website:

Clinical, biological and neurobiological studies have shown that the first three years of illness provide a critical window for early effective intervention in eating disorders. There are three main reasons for this:

1. For anorexia nervosa in particular, illness duration is a key predictor of treatment outcomes. Outcomes are best with duration of illness < 3 years.
2. Growing evidence suggests that eating disorders are associated with significant structural and functional brain changes. Eating disorder behaviours are initially rewarding, then habitual, and then neurocognitively engrained.
3. Because eating disorders typically develop in adolescence and young adulthood, when the brain is still developing, these brain changes have potential to disrupt brain maturation.

Eating disorders tend to persist over time. The longer a young person is unwell, the more likely it is that brain changes will occur and persist. In addition, they are more likely to experience disruptions to social, educational and emotional development.

Early intervention is consistent with a stage of model illness, for which there is considerable support for anorexia nervosa in particular and all eating disorders to some degree

FREED operates as a 'service within a service'. It complements, rather than replaces, existing eating disorder services and treatments. FREED also attends to the specific needs of young people in the early stages of an eating disorder. It emphasises early, pro-active engagement; early symptom change; family involvement; attention to the effects of eating disorders on the brain; attention to social media use; and attention to transitions (out of school, to university, into work) and 'emerging adulthood'.

Key to early intervention is the concept of 'Duration of an Untreated Eating Disorder' (DUED). This is the time between onset of an eating disorder and starting eating disorder treatment. There are several major barriers to shortening DUED and providing early intervention:

- Patient and family-related barriers (e.g. not realising there is a problem, not wanting to change, being skeptical of health care services).

- Primary-care based barriers (e.g., lack of GP awareness, knowledge or skills, or uncertainty about how to refer to specialist treatment).
- Service-related barriers (poor access to services, waiting times within services, and poor transitions between services).

Recent data from Germany and the UK report an average duration of DUED of between 25 to 41 months for first episode eating disorder cases. This suggests that many people only access treatment after the critical window of the first 3 illness years.

FREED aims to address each set of barriers but was developed to overcome service-related barriers in particular. In ABUHB we would see this as a component of our eating disorders service in early intervention via self-referral offering a single point of access to eating disorders services.

Emerging adulthood has been proposed as a new way of thinking about the developmental period from roughly age 18 to 25 years. This period is distinct in terms of demographic characteristics, subjective experiences, and identity formation and exploration. Five key characteristics of emerging adulthood include:

- Identity exploration
- Instability
- Self-focus
- Feeling 'in between'
- Possibilities

Most eating disorders will develop in adolescence or emerging adulthood. Eating disorders can heighten a sense of instability, an uncertain identity and feeling 'in between'.

Emerging adults with eating disorders may need help navigating major transitions in their lives (e.g., in education, work, living circumstances, relationships) and to form an identity and adult life separate to their eating disorder.

Proposal for an All Age Single Point of Access:

It is proposed that ABUHB employ a Band 8a team lead, 1 Band 7 and 4 Band 6 Specialist Clinicians, 1 Band 4 and 1 Band 3 administrator to deliver the FREED model support the single point of access in Gwent. These staff would provide single point of access for an early intervention and treatment service for people with Eating Disorders across Gwent, who are referred from Primary Care or who self-refer. Specialist Clinicians would offer an assessment and treatment within 4 weeks for those with an eating disorder including anorexia nervosa, bulimia nervosa binge eating disorder or another eating disorder. The service will provide single point of access for ED services, self-referral and treatment for BED.

Aims:

- To provide early identification, specialist assessment and treatment as per NICE 2017 guidance for those people presenting with an ED in ABUHB in order to improve prognosis, reduce morbidity and mortality associated with ED. (*ED Review 2,4,5,7,11 12,improving recognition, early intervention and treatment in Primary Care*)
- People with suspected eating disorders who are referred to the eating disorder service start assessment and treatment within 4 weeks or 1 week if urgent. (*NICE QS 1. ED Review 9*)
- People will be offered a range of psychological interventions as per NICE 2017 guidance. (*ED Review 10 offering a range of NICE concordant psychological therapies*).
- People with eating disorders have a discussion with a healthcare professional about their options for psychological treatment. (*NICE QS 2 offering people a choice in therapies*)
- To enable those people with an ED that currently do not meet the threshold to enter services currently to have access to specialist treatment ensuring safe and effective management of the psychological, physical and social aspects of their ED. (*ED Review 2,4,7,11,12 improving recognition, early intervention treatment and prognosis*)
- Specialist ED Clinicians will undertake the physical health checks of those patients within the service who require intense physical health monitoring with support from medical and psychiatric teams involved in the patients care. (*ED Review,4,7,11 12 prioritising the medical needs of ED patients improving early intervention, treatment and prognosis*)
- To ensure seamless transitions between services and for young people requiring adult services ensuring a risk assessment and management plan is in place. (*NICE QS 6,risk assessments for those people moving between services*)
- To provide a service to those people who wish to self-refer aged 16 and above who have an ED offering a single point of access into ED services in the Health Board. (*ED Review 4,5,7,11 12 improving recognition, early intervention treatment and prognosis*)
- To expand the remit of Welsh ED services to include BED. (*ED Review 12 detecting and treating people with BED*)
- To provide a single point of access to Eating Disorders services and the option of self-referral. (*ED Review 6,7 single point of access and as per FREED model*)
- To improve access to clinical expertise in ED at the point of entry and local to the patients home. (*NICE QS 2. ED Review 2,4,7 improving recognition, early intervention treatment and prognosis*)
- To develop and strengthen the ED workforce. (*ED review 10, 11 ongoing clinical training to ensure expertise in assessment and treatment.*)
- With increased access to physical health monitoring and supervision more people will have good physical health monitoring, and better management of the many physical complications associated with ED. (*ED Review 4,5,11 12 detection and early, effective care of eating disorders at Primary Care*)

NICE QS refers to NICE Quality Standard 175 2018. <https://www.nice.org.uk/guidance/qs175>

ED Review refers to Welsh Eating Disorders Review 2018. <https://gov.wales/eating-disorders-service-review-2018>

Strategic Alignment:

This proposal is consistent with the aims of the following Welsh Government Strategy documents:

- Together for Mental Health
- Mental Health (Wales) Measure 2012
- MARSIPAN 2014
- The Wellbeing of Future Generations Act 2015
- Framework for Wales (refresh) 2016
- Prosperity for All.2017
- NICE guidance on Eating Disorders 2017
- A Healthier Wales 2018
- ED Service Review 2018
- NICE Quality Standard 175 September 2018

Costs to support All Age Single Point of Access

	Band	WTE	2020/21 Rate	Cost £
1 Band 8a	Band 8A	1.00	64,203	64,203
1 Band 7	Band 7	1.00	56,072	56,072
1 Band 4s	Band 4	1.00	29,884	29,844
1 Band 3.	Band 3	1.00	26,002	26,002
Total Pay Costs				176,121
Travel				5,500
Phone purchase				1,500
Phones rental				2,160
IT				5,000
Training/Equipment				8,000
Total Non Pay Costs				22,160
Total Costs				198, 281

Appendix 1.

ABUHB CAMHS and AMH Professionals response to the Eating Disorders Review's 2018 recommendations.

ABUHB Professionals Group response was drawn from medical, nursing, health professionals and strategic managers with a strong Eating Disorders patient / carer involvement to ensure a soundly based patient-focussed consideration to the Review's recommendation on improvements to Eating Disorders services and outcomes. The Minister asked us to consider the Review's proposal for a National Eating Disorder Service, based on a hub and spoke model. This is an area where service users and staff felt particularly strongly that Health Board based augmentation of local services would be far more preferable than the reconstruction of national or regional centres. Service users and staff believe that the nation of Wales should have access to eating disorders services aimed at prevention and early intervention. They would agree that outcomes for eating disorders services should take a whole nation approach with equity of access and service delivered by Health Boards who could be resourced to provide the range of services to meet a person's needs locally.

Recommendation 1 – 'Significant investment for eating disorders'

Staff and service users welcome the Review's recommendation of the current Welsh eating disorder services are severely under-resourced with respect to recommendations for services.

Recommendation 2 – 'Major re-organisation of, and investment in, the ED services across Wales'

Staff and Service users were supportive of a major investment in the eating disorder services across Wales to align it with a clear set of principles with equity of access delivering equitable, accessible and world class eating disorder service to all people in Wales who need it. However, there was no support for a major reorganisation of existing services along national lines. The proposal to deliver ED services in a national model would sit at odds with the NHS model in the rest of Wales. In fact the idea of a major re organisation along the model described in the Review for national and regional services was perceived very negatively. There was a real concern that Health Boards that had invested locally in eating disorders services would be penalised for this investment, with a result that service users would be left with a poorer service than previously. Local reorganisation would be welcome to develop existing services building on what is currently available, augmenting and building services to meet the outcomes of the Review.

The group unanimously agreed on the 6 underlying principles of the Review, but expressed concerns regarding the new proposed national model as follows:

- Difficulties with geography, travel, accessibility, finance of families.
- If there was a central hub, would this remove service's already doing well and de-stabilise services / teams.

- Depletion of staff, working across health boards, across boundaries, how this would align with other services, will it become isolated.
- Logistical issues such as care co-ordination, risk management, will Health Boards pull together to provide a service or create new barriers to access.
- Appears to be a replication of current services e.g. trauma work, DBT, is this "another CAMHS" or a Health Board, a mini mental health service.
- The Group are committed to developing eating disorder services but wanting to maintain their current position within the Health Board rather than developing National Service with specific hubs.

Recommendation 3- 'HB's should be held to previous agreements to match fund'

The recommendation that Health Boards should be held to their previous agreements to match fund Welsh Government contributions to specialist eating disorder services was thought to be unrealistic given the current financial situation in which all Health Boards are either overspent or struggling to breakeven financially.

Recommendation 4&5- 'Detection and early intervention with GP'S / Primary Care'

Detection and early, effective care of eating disorders at primary care are essential. Feedback was clear that GP services feel under enormous pressure and are reluctant to take on more work in the field of eating disorders. In primary care it was felt that ED clinicians should be present to ensure early detection and intervention. This would reduce the burden on primary care and GPs as they can be seen and assessed by the ED specialist quickly.

It was felt that improvement in the recognition, assessment and treatment of eating disorders in primary care did not only rest with Royal college of General Practitioners and that all royal colleges, and professional bodies should be involved

Recommendation 6 - 'Single point of access for all referrals'

The recommendation that eating disorder service should accept referrals from all sources, including self-referral, without removing the involvement of general practitioners. CAMHS in ABUHB have achieved this via a single point of access known as SPACE (Single point of access for children's emotional wellbeing), inclusive of self-referral. Our aim with the new SPEED funding in CAMHS is to link in with the SPACE referral meeting to develop early identification and assessment as well as cases of ARFID.

Adult services would welcome the ability to have single point of access and self-referral but this would require major investment in order to achieve this.

Recommendation 7 - 'The SPEED early intervention model should be implemented and FREED for Adults'

Early intervention model was very welcome and again would require major investment to re-organise services to achieve this. SPEED* model will be implemented within ABUHB CAMHS. Full implementation of SPEED requires further investment for psychiatry and paediatric time. First Episode Rapid Early Intervention for Eating Disorders Service (FREED) (model could be implemented in alignment with AMH ED Service with further investment and this would fit with the development of a 16-25 age group service model.

Whilst welcoming the need for strategies aimed at prevention and early intervention feedback also noted that all age Eating Disorder services need to meet the needs of older adults with a Severe and Enduring Eating Disorders (SEED).

the name of the model "SPEED" was questioned, with its connotation indicating the street name for amphetamine

Recommendation 8 – 'Develop and deliver Whole School Approach (WSA)'

The principles of a WSA have been agreed in ABUHB CAMHS as part of the Gwent Regional CAMHS Transformational agenda/plan. WSA principle is fully supported with ABUHB CAMHS staff already seconded into generic school projects inclusive of some Eating Disorders work i.e. mental health first aid training for teachers which has an Eating Disorders module. Further work to be supported by SPEED team.

Recommendation 9 – 'Waiting time of 1 week from referral to treatment for urgent cases and 4 weeks for routine'

This is the current standard for CAMHS in ABUHB and currently we are 80% compliant. The new SPEED team will address this shortfall, although the number of referrals will increase as we will be providing early assessments for children presenting with ARFID.

Adult ED services are extremely keen to meet this recommendation which would require major investment to re-organise services to achieve these targets as per phase 1. We have submitted a bid for funding which we believe would facilitate meeting these outcomes and is contained in the main body of this document.

Recommendation 10 - 'NICE guidelines require that ED staff are fully trained in a range of Therapies'

The NICE 2017 guidelines require that the eating disorder service staff are fully trained and able to identify and assess eating disorders as well as to deliver a range of NICE-concordant therapies to children, young people and adults. The Adult Specialist Eating Disorders Service is fully compliant with NICE guidance however this is not the case across the all the tiers of mental health services.

In addition, the Review's recommendation that eating disorder clinical staff should be trained in treating common co-morbid mental health problems. All clinical staff in the ED service apart from the dietitians have formal mental health qualifications and experience of working with psychiatric co-morbidity.

Recommendation 11 – ‘Funding for consultant eating disorder psychiatrist, paediatricians, physicians and general practice’

Extensive agreement that there should be prioritisation of the medical needs of people with eating disorders delivered locally within the Health Board.

Recommendation 12 -- ‘Expand remit to include Binge Eating Disorders (BEDs)’

Currently BEDs would be seen in child and adolescent weight management services such as CONNECT or the Adult Weight Management Service. ED services would be happy to work with weight management services to support the delivery of treatment to those people with BED.

Recommendation 13- ‘Telehealth’

The recommendation that the eating disorder service should be one of the early adopters on a national basis of extensive and integrated use of telehealth for communication and for delivery of treatment was felt to be very ambitious given the current state of infrastructure and technical ability to support such an innovation. This recommendation was very unpopular with service users. Telehealth was seen as more appropriate for motivated service users in Primary Care.

Recommendation 14- ‘The third sector / advocacy’

The Third Sector is very limited in eating disorder services in Wales but would be very welcome in being more actively involved across Wales in supporting patients and families.

Recommendation 15 &16 ‘National protocols for patients with Eating Disorders & diabetes’

Whilst agreeing with the need to work across specialities in ED and Diabetes services locally. The proposal for a national multidisciplinary subspecialist team within the national eating disorder service which has dual expertise in diabetes and eating disorders was widely thought to be extremely challenging on a national/regional scale.

Recommendation 17- ‘National protocols for patient with ASD working collaboratively’

Whilst agreeing with the need to work across specialities in ED and Autism services locally. The proposal for a national multidisciplinary subspecialist team within the national eating disorder service which has dual expertise in autism and eating disorders was widely thought to be extremely challenging on a national/regional scale.

Recommendation 18 – ‘Carer consultants x 2’

The group felt that the needs and perspectives of families of both children and young people and adults with eating disorders are considered in eating disorders service’s in ABUHB. We weren’t clear how national Leads for Wales would work

and what outcomes were expected from these posts, there was a preference for a network of local leads.

Recommendation 19 – ‘Addressing equality and diversity issues with respective national leads/teams’

The recommendation that there should be national leads and teams for males and for Welsh speakers, left clinicians somewhat mystified as to how this would work. The feeling was that males and Welsh speakers should be an integral part of service provision delivered locally by Health Boards rather than separated off nationally.

Recommendation 20 – ‘Strong links and working relationships with other specialist / local / generic services, to collaborate to meet complex needs that arise from comorbid mental health issues’

Broad agreement that we currently work to this recommendation in ABUHB. As eating disorder clinicians the Professionals Group develop and maintain strong links and working relationships with other specialist and local generic services, so as to collaborate to meet the complex needs that arise from comorbid mental health issues. The recommendation that ED services also provide treatments for co-morbidities would mean a duplication of service provision away from the specialists in mental health. The implications were felt to be that ED specialist services would transform into generic mental health services losing expertise and effectiveness. In effect diluting the ED service of the expertise the Review intends to concentrate. Services instead could cooperate/collaborate more as the links are already there, separating the services will only create barriers.

Recommendation 21 – ‘Quality improvement lead / research lead’

There was agreement in principle but some members of the Professionals Group were unclear what the function of these posts was and would have liked more detail on this area. Recommendation of local was preferred to the Reviews emphasis on national specialist teams and leads.

Recommendation 22 – ‘Significant investment for eating disorders’

Some ED patients require inpatient admission to specialist units which are located some distance from patient’s home. Service users and carers constantly question why there is no inpatient unit in Wales. They were disappointed that the 2018 review did not consider the option of an inpatient unit as part of its remit, preferring to “review in 5 years’ time when the situation has stabilised”. The view that inpatient numbers will stabilise in 5 years seems at odds with data from NHS England inpatient admissions for eating disorders in England which have more than doubled from 7,260 in 2010-11 to 16,023 in the year to April 2018.

ABUHB CAMHS and AMH Professionals Group summary

Recommendations:

1. Public consultation was undertaken as part of the Review but consultation with professionals working in eating disorders services to determine whether there is support for a national service was experienced as lacking. Had they been consulted, the Group would have preferred to see a range of options for services with clearly defined outcomes and models of design for deliver.
2. There was a general feeling/consensus from the Group that quality could be driven up through peer reviews to enhance delivery of eating disorders services and expertise without a national approach to service delivery. Peer reviews similar to the one now being undertaken within CAMHS can allow for improved performance and practice across Eating Disorders services. The Health Board has supported the Adult Eating Disorders Service to be part of the Royal College of Psychiatry's Quality in Eating Disorders (QED) pilot project to develop standards for community eating disorders services. QED is a peer review project which includes ED services in all countries of the United Kingdom. Through peer support, quality can be driven up regionally and nationally with Health Boards sharing examples of best practice and supporting one another in implementing innovation and change.
3. A new way of working where best practice is shared nationally will bring with it overall improvements in quality of service delivery nationally. ABUHB eating disorder services have shown a great improvement in the quality of delivery of services. This has been largely due to the support of the Health Board (with funding from Welsh Government) in joint working locally across tiers, age ranges and the third sector. A national model would disrupt established joint working arrangements.
4. Pathways need to be optimised for the definitive care of eating disorders patients. A stepped model of each stage of the pathway will bring out improved care and outcomes.
5. In ABUHB we are developing a coordinated continuum of Eating Disorders provision with the newly designed SPEED service in the community, Intensive support team in CAMHS and an active, effective transition plan that is managed through to Adult Specialist Eating Disorders Services. We would welcome the resources to collaborate and further integrate services to meet the aspirations for services outlined in the review.
6. Ongoing care, at present, can be disjointed and/or poorly coordinated. The general support at Adult CMHT level needs to be improved to ensure appropriate identification and support at an early opportunity. With this provision available at Tier 2, the transfer of serious cases to the Specialist Eating Disorders Adult team will be timely and consistent. (Outlined in developments in Phase 1 of the project).

Appendix 2.

Beat Data on Eating Disorders in the UK

(<https://www.beateatingdisorders.org.uk/how-many-people-eating-disorder-uk>)

How Many People Have an Eating Disorder in the UK?

We estimate that around **1.25 million people** in the UK have an eating disorder. While there have been some significant and well-designed studies conducted in the UK in recent years, overall there has not been sufficient research to draw firm conclusions about the prevalence of eating disorders in the UK. Therefore, our estimate is based predominately on research carried out in other countries (primarily other western European countries, Northern European countries, the USA and Australia). Of course, this is not ideal, given the different social and cultural contexts and access to treatment between countries.

We will revise this estimate as new data becomes available. We are in the process of attempting to obtain unpublished data that would reduce the uncertainty in this estimate.

How did we arrive at this estimate?

To calculate the most accurate estimate with the data available to us, we looked at a series of studies that investigated prevalence of eating disorders among different genders, age ranges, and diagnoses, and sought to combine these into one total. We have broken these categories down below.

Females

To determine the percentage of sufferers among girls aged 5 – 10, we took the prevalence rate for eating disorders estimated in the last national study of the prevalence of mental health conditions in children and adolescents conducted in the UK [1].

- 0.2% of females aged 5 – 10. (4,689)

For those aged 11 – 34, we used the average prevalence rates for Anorexia and Bulimia reported in the last major academic review [2]. The paper cited reports

these estimates as relating to “*young women*”. We applied them to under-35s based on the ages of the participants who took part in the studies they reviewed.

- 0.3% for Anorexia (29,267)
- 1% for Bulimia (97,557)

For those aged 11 – 24 with Eating Disorders Not Otherwise Specified (EDNOS), we used the prevalence rate from a large study of high school students in Portugal [3].

- 2.37% for EDNOS (125,871)

For those aged 35 and over with Anorexia, we applied an estimate derived from a review of studies on the outcome of Anorexia Nervosa [4], which suggested that 20% of patients develop a chronic condition. Therefore, we applied this ratio to the estimate of 0.3% for females aged 11 – 34:

- 0.075% for Anorexia (14,410)

For those aged 35 and over with Bulimia, we applied estimates derived by comparing the difference in prevalence of Bulimia as age increases, which we calculated from some major US studies [5].

- 1.05% for those aged 35 – 44 (43,955); 1.05% for those aged 45 – 59 (70,586); 0.26% for those aged 60 and over with Bulimia (21,580).

For those over 25 with EDNOS, we applied estimates derived by comparing the difference in prevalence of Binge Eating Disorder (BED) as age increases, which we calculated from some major US studies [5].

- 2.74% for those aged 25 – 29 (61,347); 2.16% for those aged 30 – 34 (47,621); 2.16% for those aged 35 – 44 (90,645); 2.94% for those aged 45 – 59 (198,495); 1.57% for those aged 60 or over with EDNOS (129,463).

Males

To determine the percentage of sufferers among boys aged 5 – 10, we took the prevalence rate for eating disorders estimated by the last national study of the prevalence of mental health conditions in children and adolescents conducted in the UK [1].

- 0.5% of males aged 5 – 10 (12,296)

For those aged 11 – 34 with Anorexia, we assumed that males account for 25% of cases [6]. We applied this ratio to the estimate for females with Anorexia aged 11 – 34, which is 0.3%.

- 0.1% of males aged 11 – 34 with Anorexia (10,054)

For those aged 11 – 34 with Bulimia, we assumed that males account for 25% of cases [6]. We applied this ratio to the estimate for females with Bulimia aged 11 – 34, which is 1%:

- 0.33% males aged 11 – 34 with Bulimia (33,515)

For those aged 11 – 24 with Eating Disorders Not Otherwise Specified (EDNOS), we assumed that males account for 25% of cases [6]. We applied this ratio to the estimate for females with EDNOS aged 11 – 24, which is 2.37%:

- 0.79% of males aged 11 – 24 with EDNOS (44,084)

For 35-year-olds and over with Anorexia, we assumed that males account for 25% of cases [6]. We applied this ratio to the estimate for females aged 35+ with Anorexia of 0.075%.

- 0.025% for males aged 35+ with Anorexia (4,452)

For 35-year-olds and over with Bulimia, we applied estimates derived by comparing the difference in prevalence of Bulimia as age increases which we calculated from some major US studies [5].

- 0.34% for males aged 35 – 44 (14,293); 0.34% for males aged 45 – 59 (22,619); 0.09% for males aged 60+ with Bulimia (6,107).

For 25-year-olds and over with EDNOS, we applied estimates derived by comparing the difference in prevalence of Binge Eating Disorder (BED) as age increases which we calculated from some major US studies [5].

- 0.9% for males aged 25 – 29 (20,549); 0.71% for males aged 30 – 34 (15,609); 0.71% for males aged 35 – 44 (29,447); 0.97% for males aged 45 – 69 (63,547); 0.52% for males aged 60+ with EDNOS (36,604).

When applied to recent data about the UK population [7], this leads to a total estimate of 1,248,663 ~ **1.25 million**.

The studies reviewed to create this estimate calculated prevalence using the diagnostic definitions of DSM-IV. There is still relatively little evidence about the prevalence of eating disorders in the community based on the new DSM-5 diagnostic categories, which no longer include the umbrella of EDNOS, but instead include Binge Eating Disorder as a separate diagnosis, and OSFED (Other Specified Feeding or Eating Disorder) where a patient's symptoms do not exactly match the expected criteria for Anorexia, Bulimia, or Binge Eating Disorder.

An alternative calculation based on the DSM-5 criteria using estimates derived from Machado et. al. (2013), Micali et. al. (2017) and Conceicao et. al. (2017) resulted in a similar total of **1.37 million**. However, these three studies do not, when taken together, cover the entire age range, and so assumptions had to be made that their estimates were valid beyond the ages of the samples they recruited.

References:

- [1] Unfortunately, this study only assessed for the prevalence of anorexia or bulimia, and did not report separate prevalence rates by diagnosis. Source: Green et. al., 2005
- [2] Smink, van Hoeken and Hoek, 2012
- [3] Machado et. al., 2007
- [4] Steinhausen (2002)
- [5] Swanson et. al. (2011); Hudson et. al. (2007)
- [6] Based on a review of community-based prevalence studies by Sweeting et. al. (2015).
- [7] ONS (2017)

**Appendix 3
Evaluation and Audit**

Description of Indicator	Current State	Expected Future State	Data will be collected on an ongoing basis and is likely to include the following markers of change
<p><u>Workforce Development:</u> Strengthen and Improve competence, confidence and delivery of services to service users experiencing an Eating Disorder.</p>	<p>Variable levels of skills in staff assessing and treating ED across PMHT and CMHT. ED patients with less severe presentations don't meet threshold for CMHT intervention but are too complex for PMHT. CMHTs struggling to manage caseloads with the available resources. CMHTs feel ill-equipped to treat those presenting with an ED.</p> <p>Physical health monitoring for those in Specialist Eating Disorders service undertaken by Primary Care who don't believe they have the specialist skills for the task.</p>	<p>All patients presenting to CMHT with an ED will be assessed by an ED clinician. ED clinicians will undertake specialist treatment within the patient's local area within 4 weeks. ED Clinicians will provide care co-ordination for those patients whose primary diagnosis is an eating disorder, including those transitioning from CAMHS. ED Clinicians will support PMHTs through liaison, consultation, supervision and advice. All physical health checks to be carried out by Specialist Eating Disorders Service for those patients in the Tier 3 service in line</p>	<p>Training, support and supervision arrangements for staff; standardised measures of staff perception of knowledge, skills and attitudes. Audit of Service user and carer feedback. Focus groups with PMHT and CMHTs.</p>

		with best clinical practice.	
<p><u>Clinical Gains:</u> Improved access to Specialist Clinicians delivering evidence based treatments at point of access. Those patients with an ED that currently do not meet the threshold for CMHTs will have access to specialist treatment. Improvement in the rate and probability of full recovery from an ED by access to appropriate and timely evidence based treatment interventions.</p> <p>.</p> <p>Improved access to physical health and psychological wellbeing of ED service users.</p>	<p>ED presentations unlikely to be seen by CMHT unless severe and or complex. ED patients unlikely to receive a NICE 2017 recommended psychological intervention in PMHT or CMHT. ED patients add to the waiting list for psychological interventions. ED patients falling between the thresholds for tiered services. ED CAMHS patients may not be seen until they are over 18 if at all.</p> <p>Physical health monitoring currently carried out by GP's who are unlikely to continue with medical monitoring in the near future. ED patients don't have access to physical health monitoring in a timely manner or as clinically indicated.</p>	<p>ED patients able to access specialist physical and psychological intervention in a timely manner and as clinically indicated. ED patients and their families have access to specialist services on entry to CMHT. All ED presentations in ABUHB will have access to NICE 2017 recommended treatment intervention. Direct support to PMHTs in assessing and treating ED patients. ED CAMHS transitions care co-ordinated by Specialist Clinicians.</p> <p>ED patients able to access physical health monitoring in a timely manner and as clinically indicated.</p>	<p>Self-Reported Outcome measures specific to ED: CIA, EDE-Q as well as CORE 34. Audited against standards of 1000+Lives intelligent targets. Audit of Service user and carer feedback</p> <p>Access to physical health checks and monitoring as clinically indicated. Reduction in the numbers of patients requiring admission for refeeding as physical monitoring will enable safer treatment in the community.</p>

<p><u>Risk Reduction:</u> Increased early availability of specialist ED services will ensure safe and effective management of the psychological, physical and social aspects of risk related to ED. A reduction in physical health risk behaviour. Improvement in the management of physical risk leading to a reduction in morbidity and mortality rates.</p>	<p>ED service users presenting risks to self as they may not reach threshold for treatment in services. Delays in being seen and assessed in CMHTs leading to deterioration in presentations. Variable level of expertise and interest in ED in PMHT and CMHT leading to delays in treatment. Variable quality of treatment available in PMHTs and CMHTs ED service users presenting risks to self via poorly monitored and managed physical health. Primary care reluctant to administer physical health checks as often as clinically indicated.</p>	<p>Specialist assessment to determine level of physical risk. Timely access to evidence based treatment reducing the risk of physical and psychological deterioration, morbidity and mortality. Service user, family and professionals better able to manage physical and psychological risks associated with ED. Service user, family and professionals better able to manage physical and psychological risks associated with ED. Health checks and monitoring administered for all patients including those who are highly ambivalent.</p>	<p>Improvement across adverse reporting data. Reduction in morbidity and mortality. Earlier intervention to ameliorate physical and psychological consequences of ED.</p>
<p><u>Recovery focus:</u> Increased early availability of specialist ED services will ensure safe and effective management of the psychological, physical and</p>	<p>Variable quality of treatment available in PMHTs and CMHTs. Prolonged waits can lead to deterioration in condition and</p>	<p>Specialist ED clinical interventions will improve adherence to treatment. Early intervention will improve prognosis.</p>	<p>Clearly outlined CTP documents that are underpinned by a recovery focus. Evidence of recovery oriented service provision and that service users are active</p>

<p>social aspects of ED. Increased early availability of Specialist treatment will lead to an improvement in prognosis.</p>	<p>result in poorer outcomes. Severity of ED liable to increase without treatment.</p>	<p>ED patients receiving specialist treatment will reduce the length of time in services and optimise recovery as the focus. Physical health monitoring and supervision carried out by specialist staff will improve adherence to treatment and provides an opportunity for psychoeducation and motivational enhancement. Opportunity for relatives and carers to have training in supporting their loved one.</p>	<p>partners in their own care.</p>
<p><u>Cost-Effectiveness:</u> Increased efficiency, effectiveness and quality of service provision.</p>	<p>Costs of clinicians in CMHT currently borne by local MH teams. Resources in PMHT may not be utilised effectively.</p>	<p>Effective assessment and treatment across PMHT and CMHTs leading to increased compliance with care plan, reducing length of time in services. Early intervention and management of consequences of severe malnutrition, psychological and social effects of ED.</p>	<p>Provision of NICE 2017 and MARSIPAN 2014 concordant, effective, high quality interventions at the earliest opportunity Admission rates, and bed days. Reduced resource implications for CMHTs and PMHTs.</p>