NICE National Institute for Health and Care Excellence

Putting NICE guidance into practice

Resource impact report:
Eating disorders: recognition and treatment (NG69)

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Summary

This report looks at the resource impact of implementing NICE's guideline on eating disorders: recognition and treatment in England. The guideline is a full update of NICE clinical guideline 9 (published January 2004) and will replace it.

NICE does not expect the guidance to have a significant impact on NHS resources, because the guideline does not recommend significant changes in practice. However, expert clinical opinion suggests that the 2004 guideline was not fully implemented across England. Areas that have not implemented the original guideline may need additional resources.

We prepared a resource impact template for completion at a local level. Organisations can input estimates into the resource impact template to reflect local practice and estimate the impact of implementing the guideline.

Areas which we highlight to be considered locally are:

- training and competencies
- psychological treatment for people with binge eating disorders
- inpatient and day patient treatments for people with eating disorders.

Eating disorders services are commissioned by NHS England, clinical commissioning groups (CCGs) and local authorities. Providers are community providers, primary care, secondary care, tertiary care and non-NHS units (funded by NHS commissioners).

1 Introduction

1.1 The guideline covers assessment, treatment, monitoring, and inpatient and day patient care for people with eating disorders. The guideline is a full update of NICE clinical guideline 9 (published January 2004) and will replace it.

1.2 This report discusses the resource impact of implementing the NICE guideline on eating disorders: recognition and treatment in England. It aims to help organisations plan for the financial implications of implementing this NICE guideline.

1.3 NICE does not expect the guideline to have a significant impact on NHS resources, because the guideline does not recommend significant changes in practice.

1.4 However experts suggest implementation of the 2004 guideline varies across England and there may be a resource impact for organisations that have not fully implemented the 2004 guideline.

1.5 A resource impact template accompanies this report to help with assessing the resource impact at a local level in England, Wales or Northern Ireland.

1.6 Separate assumptions should be used for children and young people aged up to 15 years old, and people aged 16 years or older. The template is designed to allow this.

1.7 Eating disorders services are commissioned by NHS England, clinical commissioning groups (CCGs) and local authorities. Providers are community providers, primary care, secondary care, tertiary care and non-NHS units (funded by NHS commissioners).

2 Background

2.1 Eating disorders typically develop in people during their late teens to mid-twenties, but can affect people of all ages. The three most

common eating disorders are anorexia nervosa, bulimia nervosa and binge eating disorder. The average age of onset is 16-17 years for anorexia nervosa and 18-19 years for bulimia nervosa (Eating disorders, July 2007. Parliamentary Office of Science and Technology 07/287).

2.2 People with an eating disorder experience physical and psychological complications and comorbidities, poor quality of life, disrupted relationships, emotional distress, social isolation and economic disadvantage. Young people may experience pubertal delay and also disruption to education.

2.3 Table 1 shows the prevalence of eating disorders in people aged 16 years or older by type of disorder.

Table 1 Estimated number of people aged 16 years or older with eating disorders in England

Description	Percentage of total population aged 16 years or older	Number of people
Total population in England aged 16 years or older		44,381,213
Prevalence of anorexia nervosa[a]	0.6	266,300
Prevalence of bulimia nervosa[a]	1	443,800
Prevalence of binge eating disorder[a]	3.2	1,398,000
Prevalence of other specified feeding and eating disorders[a]	3	1,309,000

[a] Solmi F, Hatch S L, Hotopf M, Treasure J and Micali N (2014) Prevalence and correlates of disordered eating in a general population sample: the South East London Community Health (SELCoH) study. Social Psychiatry and Psychiatric Epidemiology 49:1335–1346 and Solmi F, Hatch S L, Hotopf M, Treasure J and Micali N (2016) Eating disorders in a multi-ethnic inner-city UK sample: prevalence, comorbidity and service use. Social Psychiatry and Psychiatric Epidemiology 51 (3): 369-81.

3 Recommendations with potential resource impact

3.1 *Psychological treatment for binge eating disorder in adults*

The guideline recommends:

- Offer a binge-eating-focused guided self-help programme to adults with binge eating disorder. (1.4.2–3).
- If guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks, offer group cognitive behavioural therapy for eating disorders (CBT-ED). (1.4.4–5).
- If group CBT-ED is not available or the person declines it, consider individual CBT-ED for adults with binge eating disorder (1.4.6–7).
- For children and young people with binge eating disorder, offer the same treatments recommended for adults with binge eating disorder. (1.4.8).

Background

3.1.1 Experts suggest these recommendations would require a significant change to current practice in many areas. This is because many services do not provide treatment for binge eating disorder and where they exist they do not offer guided self-help, group CBT-ED or individual CBT-ED.

3.1.2 Providing treatment for binge eating disorder, and training healthcare professionals to do this, may have resource implications for primary and secondary care.

Costs

3.1.3 Potential costs will depend on the model of service and package of care and types of interventions discussed and agreed with the service user at a local level.

3.1.4 Organisations may use the 2017/18 National Tariff Payment System Annex C: Technical guidance for mental health clusters when agreeing local payment contracts.

3.1.5 Organisations can use the resource impact template (assumptions input worksheets, section A) to estimate the additional costs of providing psychological treatment for binge eating disorders. The template can also be used to estimate costs associated with psychological treatments for anorexia nervosa, bulimia nervosa and other specified feeding and eating disorders (OFSED) in both children and young people, and adults.

Benefits and savings

3.1.6 Using guided self-help as first-line treatment and group CBT-ED as second-line only is an efficient use of NHS resources.

3.2 *Inpatient and day patient treatment*

The guideline makes recommendations covering the criteria for admitting people to inpatient or day patient services (1.11.1–8), and on care planning and discharge from inpatient care (1.11.11–13).

Background

3.2.1 Experts suggest the recommendations are a change in practice in some areas as people may currently be admitted when they do not need to be.

3.2.2 In order to implement this recommendation training may be needed for healthcare professionals, to support community treatment rather than inpatient treatment.

Costs

3.2.3 Table 2 shows the 2015/16 annual NHS reference costs for specialist eating disorder services.

Table 2 NHS costs of specialised eating disorder services in 2015/16

Description	Activity (days)	Unit cost £	Cost £ (000)
Adult – admitted patient	87,146	455	39,653
Adult – community contacts	65,927	181	11,966
Adult – outpatient	51,596	148	7,646
Children – admitted patient	14,512	510	7,403
Children – community contact	32,522	191	6,202
Children – outpatient	38,801	262	10,171
Total	**290,504**		**83,041**
NHS reference costs 2015 to 2016: mental health specialist eating disorder services			

3.2.4 Organisations can use the resource impact template (assumptions input worksheets, section B) to estimate the additional costs or savings associated with inpatient treatments.

Benefits and savings

3.2.5 Using inpatient admissions only when needed is an efficient use of NHS resources. Organisations can use the guideline to review local inpatient services. Where recommendations 1.11.1 – 1.11.4 are not currently being implemented, resources may be able to be used more efficiently to free up inpatient capacity by following the recommendations.

3.3 *Training and competencies*

The guideline recommends that:

- Professionals who assess and treat eating disorder should be competent to do this for the age groups they care for (1.1.14).
- Health, social care and education professionals working with people with an eating disorder should be trained and skilled in:
  - negotiating and working with family members and carers
  - managing issues around information sharing and confidentiality
  - safeguarding

- working with multidisciplinary teams (1.1.15).

- Professionals who provide treatments for eating disorders should:
  - receive appropriate clinical supervision
  - use standardised outcome measures, for example the Eating Disorder Examination Questionnaire (EDE-Q)
  - monitor their competence (for example by using recordings of sessions, and external audit and scrutiny)
  - monitor treatment adherence in people who use their service (1.1.17).

Background

3.3.1 Experts suggest that there would be a need for additional training, monitoring and supervision in primary and secondary care.

3.3.2 Experts also suggest that more training and competency monitoring will be needed for professionals working with people with eating disorders.

Costs

3.3.3 Depending on current practice in services, there may be costs providing the staff training, monitoring or supervision recommended in the guideline. The exact costs would depend on the type of training needed, the number of staff that need training and the duration of training, and how the training is commissioned (internally, externally or online).

3.3.4 Organisations can use the resource impact template (assumptions input worksheets, section C) to estimate the additional costs of training staff.

Benefits and savings

3.3.5 Training healthcare professionals can improve their ability to recognise and treat eating disorders. This may lead to people

receiving prompt and appropriate care, and avoiding future, more expensive interventions.

3.3.6 Experts suggest that savings could also be achieved by stopping training in unproven therapies.

4 Other considerations

4.1 Others recommendations that need to be considered at a local level which may not have a significant cost but require additional GP time are:

- offer a physical and mental health review at least annually to people with anorexia nervosa who are not receiving ongoing treatment for their eating disorder
- use of dexa scans.

5 Implications for commissioners

5.1 Whilst the updated guideline does not recommend significant changes in practice from the 2004 guideline, commissioners need to consider how much progress has been made at a local level in implementing the initial guideline.

5.2 Care for children and young people under 18 is also covered in the commissioning guide Access and Waiting Time Standard for Children and Young People with an Eating Disorder.

5.3 Eating disorders services fall under programme budgeting category 5X: Other mental health disorders.

6 About this resource impact report

This resource impact report accompanies the NICE guideline on eating disorders: recognition and treatment and should be read in conjunction with it. See terms and conditions on the NICE website.