

# Eating disorders

## NICE quality standard

### Draft for consultation

March 2018

**This quality standard covers** assessment, treatment, monitoring and care for children, young people and adults with an eating disorder. It describes high-quality care in priority areas for improvement.

**It is for** commissioners, service providers, health, public health and social care practitioners, and the public.

This is the draft quality standard for consultation (**12 March 2018 to 9 April 2018**).

This is a second consultation because of the new statements suggested by the quality standard advisory committee. Please focus your comments only on the new statements 1, 5 and 6.

## Quality statements

[Statement 1](#) People with suspected eating disorders who are referred to an eating disorder service start assessment and treatment at the earliest opportunity.

[Statement 2](#) People with eating disorders have a discussion with a healthcare professional about their options for psychological treatment.

[Statement 3](#) People with binge eating disorder participate in a guided self-help programme as first-line psychological treatment.

[Statement 4](#) Children and young people with bulimia nervosa are offered bulimia-nervosa-focused family therapy (FT-BN).

[Statement 5](#) People with an eating disorder who are being supported by more than one service have a care plan that explains how the services will work together.

[Statement 6](#) People with an eating disorder who are moving between services have their risks assessed.

NICE has developed guidance and a quality standard on service user experience in adult mental health services (see the NICE pathway on [service user experience in adult mental health services](#)), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing eating disorder services include:

- [Transition from children's to adults' services](#) (2016) NICE quality standard 140
- [Diabetes in adults](#) (update, 2016) NICE quality standard 6
- [Diabetes in children and young people](#) (2016) NICE quality standard 125
- [Anxiety disorders](#) (2014) NICE quality standard 53
- [Depression in children and young people](#) (2013) NICE quality standard 48
- [Self-harm](#) (2013) NICE quality standard 34
- [Depression in adults](#) (2011) NICE quality standard 8

A full list of NICE quality standards is available from the [quality standards topic library](#).

## Questions for consultation

### *Questions about the quality standard*

**Question 1** Does the inclusion of the new statements accurately reflect the key areas for quality improvement?

**Question 2** Are local systems and structures in place to collect data for the proposed quality measures in the new statements? If not, how feasible would it be for these to be put in place?

**Question 3** Do you think each of the new statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

### *Questions about the individual quality statements*

**Question 4** For draft quality statement 1: For children and young people we have used the referral to assessment and treatment times as stated in the [Access and waiting time standard for children and young people with an eating disorder: commissioning guide](#) (NHS England, 2015). Are these referral to assessment and treatment times also achievable for adults? Please detail your answer.

## Quality statement 1: Early assessment and treatment

### ***Quality statement***

People with suspected eating disorders who are referred to an eating disorder service start assessment and treatment at the earliest opportunity.

### ***Rationale***

People with eating disorders who receive early intervention in eating disorder services have better recovery rates and a reduced risk of relapse. It may also reduce the need for hospitalisation, which has additional cost benefits. Delays in starting assessment and treatment can affect the response to treatment, and the longer the delay the greater the impact on outcomes.

### ***Quality measures***

#### **Structure**

Evidence of local arrangements to ensure that local referral pathways are in place for people with suspected eating disorders to start assessment and treatment at the earliest opportunity.

**Data source:** Local data collection, for example, service specifications. NHS England's [Access and waiting time standard for children and young people with an eating disorder: commissioning guide](#) (2015) includes details of referral to assessment and treatment times for children and young people with suspected eating disorders.

#### **Process**

a) Proportion of children and young people with suspected eating disorders who are classified as at high risk by an eating disorder service who have a face-to-face assessment within 24 hours.

Numerator – the number in the denominator who have a face-to-face assessment within 24 hours.

Denominator – the number of children and young people with suspected eating disorders who are classified as at high risk by an eating disorder service.

**Data source:** Local data collection, for example, local audit of patient records.

b) Proportion of children and young people with suspected eating disorders and classified as an urgent case who start treatment within 1 week of first contact with a designated healthcare professional.

Numerator – the number in the denominator who start treatment within 1 week of first contact with a designated healthcare professional.

Denominator – the number of children and young people with suspected eating disorders who are classified as an urgent case.

**Data source:** Local data collection, for example, local audit of patient records.

c) Proportion of children and young people with suspected eating disorders and classified as a non-urgent case who start treatment within 4 weeks of first contact with a designated healthcare professional.

Numerator – the number in the denominator who start treatment within 4 weeks of first contact with a designated healthcare professional.

Denominator – the number of children and young people with suspected eating disorders who are classified as a non-urgent case.

**Data source:** Local data collection, for example, local audit of patient records.

## **Outcome**

a) Recovery rate of people with eating disorders.

**Data source:** Local data collection, for example, local audit of patient records.

b) Relapse rate of people with eating disorders.

**Data source:** Local data collection, for example, local audit of patient records.

## ***What the quality statement means for different audiences***

**Service providers** (such as community eating disorder teams and secondary adult mental health services) ensure that referral pathways are in place for people with suspected eating disorders to access assessment and treatment services at the

earliest opportunity. Service providers should also ensure that healthcare professionals have training in assessment and treatment referral, and supervision with monitoring of competency.

**Healthcare professionals** (such as specialists within community eating disorder teams) assess people with suspected eating disorders who have been referred to an eating disorder service and start their treatment at the earliest opportunity.

**Commissioners** (such as clinical commissioning groups, NHS England and local authorities) ensure that they commission services with the capacity and expertise to deliver assessment for people with suspected eating disorders and start their treatment at the earliest opportunity.

**People with suspected eating disorders who are referred to an eating disorder service** have an assessment of their symptoms and risk factors and start treatment as soon as possible.

### ***Source guidance***

- [Eating disorders: recognition and treatment](#) (2017) NICE guideline NG69 recommendations 1.2.1 and 1.2.10
- [Access and waiting time standard for children and young people with an eating disorder: commissioning guide](#) (2015) NHS England

### ***Definitions of terms used in this quality statement***

#### **Suspected eating disorders**

The following signs, symptoms and risk factors should be taken into account when undertaking an initial assessment for an eating disorder:

- an unusually low or high BMI or body weight for their age
- rapid weight loss
- repeated self-induced vomiting or laxative misuse
- dieting or restrictive eating practices (such as dieting when they are underweight) or repeated distinct episodes of loss of control over eating that are worrying them, their family members or carers, or professionals
- family members or carers report a change in eating behaviour

- social withdrawal, particularly from situations that involve food
- other mental health problems
- a disproportionate concern about their weight or shape (for example, concerns about weight gain as a side effect of contraceptive medication)
- problems managing a chronic illness that affects diet, such as diabetes or coeliac disease
- menstrual or other endocrine disturbances, or unexplained gastrointestinal symptoms
- physical signs of:
  - malnutrition, including poor circulation, dizziness, palpitations, fainting or pallor
  - compensatory behaviours, including laxative or diet pill misuse, vomiting or excessive exercise
- abdominal pain that is associated with vomiting or restrictions in diet, and that cannot be fully explained by a medical condition
- unexplained electrolyte imbalance or hypoglycaemia
- atypical dental wear (such as erosion)
- whether they take part in activities associated with a high risk of eating disorders (for example, professional sport, fashion, dance, or modelling).

[Adapted from NICE's guideline on [eating disorders](#), recommendation 1.2.6]

### **Children and young people with suspected eating disorders who start treatment at the earliest opportunity**

Treatment for children and young people with suspected eating disorders should start within 4 weeks of first contact with a designated healthcare professional for non-urgent cases and within 1 week for urgent cases. For high-risk cases, the eating disorder service should undertake a face-to-face assessment within 24 hours.

[NHS England's [Access and waiting time standard for children and young people with an eating disorder](#) and expert opinion]

### ***Equality and diversity considerations***

In line with NICE's guideline on eating disorders, recommendation 1.1.2, equal access to services and treatment (including through self-referral) for people with an

eating disorder and their parents or carers (as appropriate) is important regardless of:

- age
- gender or gender identity (including people who are transgender)
- sexual orientation
- socioeconomic status
- religion, belief, culture, family origin or ethnicity
- where they live and who they live with
- any physical or other mental health problems or disabilities.

### ***Question for consultation***

For children and young people we have used the referral to assessment and treatment times as stated in the [Access and waiting time standard for children and young people with an eating disorder: commissioning guide](#) (NHS England, 2015).

Are these referral to assessment and treatment times also achievable for adults?

Please detail your answer.



## Quality statement 2: Discussion about psychological treatment options

### ***Quality statement***

People with eating disorders have a discussion with a healthcare professional about their options for psychological treatment.

### ***Rationale***

Discussing psychological treatment options with people with eating disorders (and their parents or carer as appropriate) enables healthcare professionals to tailor care to suit the person's individual needs and preferences. Patient choice is important during these discussions. However, for some people there may be an additional need for clinical opinion, for example, people with high-risk anorexia nervosa can have avoidant behaviour so may have difficulty deciding on their treatment.

### ***Quality measures***

#### **Structure**

Evidence of local arrangements to provide psychological treatments for people with eating disorders.

**Data source:** Local data collection, for example, service specifications.

#### **Process**

Proportion of people with eating disorders who have a documented discussion with a healthcare professional about their options for psychological treatment at diagnosis.

Numerator – the number in the denominator who have a documented discussion with a healthcare professional about their options for psychological treatment at diagnosis.

Denominator – the number of people diagnosed with eating disorders.

**Data source:** Local data collection, for example, local audit of patient records.

## ***What the quality statement means for different audiences***

**Service providers** (such as community eating disorder teams, primary care, secondary care, tertiary care and non-NHS units) ensure that pathways are in place for people with eating disorders to have a discussion with a healthcare professional about their options for psychological treatment. Service providers should also ensure that healthcare professionals have training in discussing these options and supervision with monitoring of competency.

**Healthcare professionals** (such as therapists specialising in eating disorders) discuss options for psychological treatment with people with eating disorders and support them in making a decision.

**Commissioners** (such as clinical commissioning groups, NHS England and local authorities) ensure that they commission services with the capacity and expertise to deliver options for psychological treatment for people with eating disorders.

**People with eating disorders** (such as anorexia nervosa, binge eating disorder, and bulimia nervosa and other specified feeding and eating disorders) talk about their options for psychological treatment with a healthcare professional. These options may also be discussed with their family members or carers if appropriate. Treatments aim to help people to manage their thoughts and feelings around food and to improve their mental wellbeing so that they can maintain their nutritional health and meet energy needs.

## ***Source guidance***

[Eating disorders: recognition and treatment](#) (2017) NICE guideline NG69 recommendations 1.3.4–1.3.17, 1.4.1–1.4.8 and 1.5.2–1.5.10]

## ***Definition of terms used in this quality statement***

### **Psychological treatments for people with eating disorders**

The NICE guideline for [eating disorders](#) gives details of psychological treatment options for children, young people and adults with anorexia nervosa, binge eating disorder and bulimia nervosa.

[NICE's guideline on [eating disorders](#), recommendations 1.3.4–1.3.17, 1.4.1–1.4.8 and 1.5.2–1.5.10]

### ***Equality and diversity considerations***

Patient choice is important during these discussions. However, for some people there may be an additional need for clinical opinion, for example, people with high-risk anorexia nervosa can have avoidant behaviour so may have difficulty deciding on their treatment.

Family therapy is not an appropriate psychological treatment option for children and young people who have been abused by family members or those who are in care.

## Quality statement 3: First-line psychological treatment for binge eating disorder

### ***Quality statement***

People with binge eating disorder participate in a guided self-help programme as first-line psychological treatment.

### ***Rationale***

Guided self-help programmes for adults, young people and children with binge eating disorder can improve recovery rates and reduce binge eating frequency. They can also have a long-term impact on physical and psychological health. If guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks, group eating-disorder-focused cognitive behavioural therapy (CBT-ED) can be provided as part of a stepped care approach.

### ***Quality measures***

#### **Structure**

Evidence of local arrangements to provide a guided self-help programme as first-line psychological treatment for people with binge eating disorder.

**Data source:** Local data collection, for example, service specifications.

#### **Process**

Proportion of people with binge eating disorder who participate in a guided self-help programme as first-line psychological treatment.

Numerator – the number in the denominator who participate in a guided self-help programme as first-line psychological treatment.

Denominator – the number of people diagnosed with binge eating disorder.

**Data source:** Local data collection, for example, local audit of patient records.

#### **Outcome**

a) Binge eating frequency for people with binge eating disorder.

**Data source:** Local data collection, for example, [Eating Disorder Examination Questionnaire](#) and local audit of patient records.

b) Relapse rates for people with binge eating disorder.

**Data source:** Local data collection, for example, [Eating Disorder Examination Questionnaire](#) and local audit of patient records.

### ***What the quality statement means for different audiences***

**Service providers** (such as community providers, primary, secondary and tertiary care and non-NHS units) ensure that they have teams in place to deliver a guided self-help programme as a first-line psychological treatment for people with binge eating disorder, and to monitor their response to treatment. They should also ensure that healthcare professionals have training in delivering these programmes, and supervision with monitoring of competency.

**Healthcare professionals** (such as non-specialist support workers) provide support for people using a guided self-help programme for binge eating disorder and monitor their response to treatment. They establish a good therapeutic relationship with the person and, if appropriate, with their family members or carers. They support and encourage the family to help the person to recover by self-monitoring binge eating behaviours and involvement in discussions.

**Commissioners** (such as clinical commissioning groups, NHS England and local authorities) ensure that they commission services with the capacity and expertise to deliver guided self-help programmes as first-line psychological treatment for people with binge eating disorder, and to monitor treatment response.

**People with binge eating disorder** take part in focused guided self-help programmes as the first psychological treatment. This includes working through a book about binge eating and having short sessions with a healthcare professional to check on progress. Usually there are between 4 and 9 sessions that last about 20 minutes each.

## **Source guidance**

[Eating disorders: recognition and treatment](#) (2017) NICE guideline NG69 recommendations 1.4.2 and 1.4.8

## **Definition of terms used in this quality statement**

### **Guided self-help programme for binge eating**

A guided self-help programme for binge eating should:

- use cognitive behavioural self-help materials
- focus on adherence to the self-help programme
- supplement the self-help programme with brief supportive sessions (for example, 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first)
- focus exclusively on helping the person follow the programme.

[NICE's guideline on [eating disorders](#), recommendation 1.4.3]

## **Equality and diversity considerations**

Self-help materials should be supplied in a format that suits the person's needs and preferences. They should be accessible to people who do not speak or read English, and should be culturally appropriate, age appropriate and gender appropriate.

People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's [Accessible Information Standard](#).

## Quality statement 4: Bulimia-nervosa-focused family therapy

### ***Quality statement***

Children and young people with bulimia nervosa are offered bulimia-nervosa-focused family therapy (FT-BN).

### ***Rationale***

FT-BN has a positive effect on remission, binge eating frequency and reducing hospitalisation rates.

### ***Quality measures***

#### **Structure**

Evidence of local arrangements to offer FT-BN to children and young people with bulimia nervosa.

**Data source:** Local data collection, for example, service specifications.

#### **Process**

Proportion of children and young people with bulimia nervosa who are offered FT-BN.

Numerator – the number in the denominator who are offered FT-BN at diagnosis.

Denominator –the number of children and young people diagnosed with bulimia nervosa.

**Data source:** Local data collection, for example, local audit of patient records.

#### **Outcome**

a) Binge eating frequency for children and young people with bulimia nervosa.

**Data source:** Local data collection, for example, [Eating Disorder Examination Questionnaire](#) and local audit of patient records.

b) Purging frequency for children and young people with bulimia nervosa.

**Data source:** Local data collection, for example, [Eating Disorder Examination Questionnaire](#) and local audit of patient records.

c) Recovery rates for children and young people with bulimia nervosa.

**Data source:** Local data collection, for example, [Eating Disorder Examination Questionnaire](#) and local audit of patient records.

### ***What the quality statement means for different audiences***

**Service providers** (such as community providers, primary, secondary and tertiary care and non-NHS units) ensure that they have teams in place to offer FT-BN for children or young people with bulimia nervosa, and to monitor treatment response. They should also ensure that healthcare professionals have training in offering this therapy and supervision with monitoring of competency.

**Healthcare professionals** (such as therapists) offer FT-BN for children or young people with bulimia nervosa and monitor their response to treatment. They establish a good therapeutic relationship with the child or young person and, if appropriate, with their family members or carers. They support and encourage the family to help the child or young person to recover by self-monitoring bulimic behaviours and involvement in discussions. Later and final treatment phases will also entail therapists supporting and encouraging family or carer involvement in plans for appropriate independence and relapse prevention.

**Commissioners** (such as clinical commissioning groups, NHS England and local authorities) ensure that they commission services with the capacity and expertise to offer FT-BN for children and young people with bulimia nervosa, and to monitor treatment response.

**Children and young people with bulimia** are offered a type of treatment called bulimia-nervosa-focused family therapy. It involves working with a practitioner (for example a therapist) to explore the effects of bulimia nervosa and how their family can support them to get better. Usually there are between 18 and 20 sessions that last for 6 months.



## **Source guidance**

[Eating disorders: recognition and treatment](#) (2017) NICE guideline NG69 recommendation 1.5.6

## **Definition of terms used in this quality statement**

### **Bulimia-nervosa-focused family therapy**

FT-BN for children and young people with bulimia nervosa should:

- typically consist of 18–20 sessions over 6 months
- establish a good therapeutic relationship with the person and their family members or carers
- support and encourage the family to help the person recover
- not blame the person, their family members or carers
- include information about:
  - regulating body weight
  - dieting
  - the adverse effects of attempting to control weight with self-induced vomiting, laxatives or other compensatory behaviours
- use a collaborative approach between the parents and the young person to establish regular eating patterns and minimise compensatory behaviours
- include regular meetings with the person on their own throughout the treatment
- include self-monitoring of bulimic behaviours and discussions with family members or carers
- in later phases of treatment, support the person and their family members or carers to establish a level of independence appropriate for their level of development
- in the final phase of treatment, focus on plans for when treatment ends (including any concerns the person and their family have) and on relapse prevention.

[NICE's guideline on [eating disorders](#), recommendation 1.5.7]

***Equality and diversity considerations***

Family therapy is not an appropriate psychological treatment option for children and young people who have been abused by family members or those who are in care.

## Quality statement 5: Coordinated care across services

### ***Quality statement***

People with an eating disorder who are being supported by more than one service have a care plan that explains how the services will work together.

### ***Rationale***

A lack of coordination can cause confusion, adds to the burden of the person and their family or carers, and has the potential to delay recovery. A care plan that explains how services will work together will ensure that healthcare professionals have a shared understanding of the person's care needs and their responsibilities for ongoing management. This will help to prevent treatment and support being compromised by poor coordination. Particular care should be taken when more than one healthcare service is involved because poor communication between services can lead to inconsistent messages and management approaches, as well as lack of clarity about clinical responsibilities.

### ***Quality measures***

#### **Structure**

Evidence of joint working arrangements, including regular liaison and meetings to discuss care plans, between eating disorder services and other services using formal processes of care planning such as the Care Programme Approach (CPA).

**Data source:** Local data collection, for example, contracts and service specifications. NHS England's [NHS standard contract for specialised eating disorders \(adults\)](#) (2013) includes details on care planning and collaborative working using the CPA.

#### **Process**

a) Proportion of people with an eating disorder who are supported by more than one service who have a care plan that explains how the services will work together.

Numerator – the number in the denominator who have a care plan that explains how the services will work together.

Denominator – the number of people diagnosed with an eating disorder who are supported by more than one service.

**Data source:** Local data collection, for example, local audit of patient records.

b) Proportion of people with an eating disorder being supported by more than one service who have CPA meetings to discuss their care plans.

Numerator –the number in the denominator who have a care plan that includes how the services will work together which is discussed at CPA meetings.

Denominator –the number of people diagnosed with an eating disorder being supported by more than one service.

**Data source:** Local data collection, for example, local audit of patient records.

### **Outcome**

a) Proportion of people with an eating disorder who are supported by more than one service who relapse.

**Data source:** Local data collection, for example, local audit of patient records.

b) Proportion of people with an eating disorder who are supported by more than one service who continue to engage with services using their care plan.

**Data source:** Local data collection, for example, local audit of patient records.

### ***What the quality statement means for different audiences***

**Service providers** (such as specialist inpatient and outpatient eating disorder services, community-based eating disorder teams, child and family services, general mental health teams, primary care or separate healthcare services treating a comorbidity) ensure that joint working arrangements are in place between eating disorder services and other services as detailed within the agreed care plan.

**Healthcare professionals** (such as a case manager or care coordinator within a specialist eating disorder services) are responsible for communicating the care plan with all the services involved in a person's care. This includes a combination of care planning meetings and regular written updates on the shared understanding of care

needs and how the services will work together to address this. Clear roles and responsibilities will need to be defined for all relevant healthcare professionals as well as to the person.

**Commissioners** (such as clinical commissioning groups, NHS England and local authorities) ensure that care plans on joint working arrangements can be developed, shared and delivered within and across the services involved.

**People with an eating disorder** who are supported by more than one service have a care plan that includes details of the person's needs, and explains how the services will work together to provide care and support. It explains clearly the roles and responsibilities of the healthcare professionals involved in the person's care.

### **Source guidance**

[Eating disorders: recognition and treatment](#) (2017) NICE guideline NG69 recommendation 1.1.18

### **Definition of terms used in this quality statement**

#### **Care plan**

This plan should be developed in collaboration with the person, their family members or carers (as appropriate), and the services involved.

It should include details of:

- joint working service arrangements
- a defined list of clinicians and services involved, and their roles and responsibilities
- preadmission care (including frequency and responsibility for monitoring medical and psychiatric risk)
- urgent or emergency admission (indications, procedure and location)
- defined clear objectives and outcomes for inpatient treatment
- how the person with the eating disorder will be discharged, how they will move back to community-based care, and what this care should be.

[Adapted from NICE's guideline on [eating disorders](#), recommendation 1.1.11 and NHS England's [NHS standard contract for specialised eating disorders \(adults\)](#)]

### ***Equality and diversity considerations***

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

Care plans should be supplied in a format that suits the person's needs and preferences. They should be accessible to people who do not speak or read English, and should be culturally appropriate, age appropriate and gender appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's [Accessible Information Standard](#).

## Quality statement 6: Coordinated care when moving between services

### ***Quality statement***

People with an eating disorder who are moving between services have their risks assessed.

### ***Rationale***

There are a number of reasons why people with eating disorders might need to move between services. They include transition from child and young people and adult services, between inpatient and outpatient services, between different geographical areas (common in the student population) or between different types of treatment, including back to primary care at the end of specialist treatment.

Particular care should be taken when people move between services because poor communication between services can lead to inconsistent messages and management approaches. Transition protocols including risk assessment and monitoring will ensure that treatment and support is not compromised and healthcare professionals have a shared understanding of the person's care needs and ongoing management.

### ***Quality measures***

#### **Structure**

a) Evidence of joint transition protocols between eating disorder services and other services using formal processes of care planning such as the Care Programme Approach (CPA).

**Data source:** Local data collection, for example, contracts and service specifications. NHS England's [NHS standard contract for specialised eating disorders \(adults\)](#) (2013) includes details of transition and care planning using the CPA.

b) Evidence of joint working arrangements, including regular liaison and meetings, to discuss risk assessment and monitoring at transition between eating disorder services and other services.

**Data source:** Local data collection, for example, contracts and service specifications. The Royal College of Psychiatrists' [MARSIPAN: Management of really sick patients with anorexia nervosa](#) (2014) and [Junior MARSIPAN: Management of really sick patients under 18 with anorexia nervosa](#) (2012) includes details of risk assessment and transfer between services.

### **Process**

Proportion of people with an eating disorder who are moving between services who have a care plan that includes a risk assessment on transfer.

Numerator – the number in the denominator who have a care plan that includes a risk assessment on transfer.

Denominator – the number of people diagnosed with an eating disorder who are moving between services.

**Data source:** Local data collection, for example, local audits on care plans.

### **Outcome**

Service user experience of eating disorder services.

**Data source:** Local data collection, for example, local audits on care plans.

### ***What the quality statement means for different audiences***

**Service providers** (such as specialist inpatient and outpatient eating disorder services, community-based eating disorder teams, children and adult services) ensure that processes are in place between eating disorder services and other services at transfer for risk assessment and monitoring, which is recorded in the agreed care plan.

**Healthcare professionals** (such as a case manager or care coordinator within a specialist eating disorder services) communicate the care plan at a recorded meeting with all the services involved at transfer and also the person and their family, if



appropriate. It is clear what will happen during and after the transfer of care, with clear roles defined to all relevant healthcare professionals as well as to the person. Risk assessment and monitoring will be highlighted as a key area of concern at transfer.

**Commissioners** (such as clinical commissioning groups, NHS England and local authorities) ensure that the services work together at transfer to deliver risk assessment and monitoring.

**People with an eating disorder who are moving between services** (including from children to adult services, inpatient to outpatient services, stepping up or down between intensity of treatments and moving between areas, for example from home to university) have a risk assessment at transfer that is explained at a meeting, recorded in their agreed care plan and monitored over time. Also clear roles and responsibilities are defined to all relevant healthcare professionals as well as to the person.

### ***Source guidance***

[Eating disorders: recognition and treatment](#) (2017) NICE guideline NG69 recommendation 1.1.18

## About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See [quality standard advisory committees](#) on the website for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the [quality standard's webpage](#)

This quality standard has been incorporated into the NICE pathway on [eating disorders](#), which brings together everything we have said on [eating disorders](#) in an interactive flowchart.

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and

Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

### ***Improving outcomes***

This quality standard is expected to contribute to improvements in the following outcomes:

- emergency readmissions of people with eating disorders within 30 days of discharge from hospital
- morbidity of people with eating disorders
- mortality of people with eating disorders
- length of hospital stay of people with eating disorders
- health-related quality of life of people with eating disorders
- service user experience of primary, secondary and outpatient care
- quality of life of family members and carers.

It is also expected to support delivery of the Department of Health's outcome frameworks:

- [NHS outcomes framework 2016–17](#)
- [Public health outcomes framework for England, 2016–19](#).

### ***Resource impact***

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [baseline assessment and resource impact tools](#) for the NICE guideline on eating disorders to help estimate local costs.

### ***Diversity, equality and language***

During the development of this quality standard, equality issues were considered and [equality assessments](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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