Lincolnshire Partnership NHS
NHS Foundation Trust

Service/ care pathway/ Cluster	**Specialised Eating Disorder Services (Adults)**
Commissioner Lead	**[redacted s40(2)]**
Provider Lead	**[redacted s40(2)]**
Period	**24 months**
Date of Review	**Review April 2018**

1. Purpose

1.1 Aims and objectives

Key Service Outcomes

- **NHS Outcomes Framework domains and Indicators**

Domain 1	**Preventing People from dying prematurely** **Reducing premature death in people with serious mental illness**
Domain 2	**Enhancing quality of life for people with long-term conditions** **Ensuring that people feel supported to manage their condition** **Enhancing quality of life for people with mental illness**
Domain 3	**Helping people to recover from episodes of ill health or following injury** **Improving outcomes from planned treatments** **Improving outcomes from injuries and trauma**
Domain 4	**Ensuring people have a positive experience of care** **Friends and Family Test** **Improving peoples experience of out-patient care** **Improving access to primary care services** **Improving experiences of healthcare for people with mental illness**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm** **Patient Safety Incidents Reported** **Reducing the incidence of avoidable harm**

The service will seek to:

- Keep patients out of hospital
- Facilitate Early discharge
- Keep patients living well in the community
- Weight gain where relevant
- Reduction in abnormal eating behaviours
- Reduction in eating disordered cognitions
- Clarification of diagnoses
- Medical stabilisation
- Improved psychological functioning
- Improved quality of life and social functioning; people regain the skills required to live as independently as possible, as determined by the patient
- Liaison and provision of advice to referring mental health teams/primary care including signposting
- Improved community support (family and friends)

The aims of the service/s are to:

a) Limit the physical and psychiatric morbidity, social disability and mortality levels caused by eating disorders.
b) Effectively treat people with complex eating disorders and /or severe morbidity

The specification covers the specialised service that is provided in an outpatient and day patient setting for people with eating disorders.
Patients will have a diagnosable eating disorder according to DSM1V and/or ICD 10 or its successor who require treatment for weight restoration or stabilisation or management of abnormal weight control mechanisms.
The service will deliver the aim to improve both life expectancy and quality of life for adults with an eating disorder by:

- Making timely and accurate diagnosis
- providing appropriate treatment in line with best practice
- providing high quality proactive treatment and care
- ensuring smooth and managed transition from children's to adult care
- Support parents and families of adults with an eating disorder, as well as the affected adult.
- Support patients to manage their eating disorder independently in order that they can aspire to a life less hindered by their condition
- Ensuring effective communication between patients, families and service providers.
- Provide a personal service, sensitive to the physical, psychological and emotional needs of the patient and their family.

In brief community and day patient services include:

- Assessment
- Outpatient therapy
- Bespoke packages of intensive day treatment for individuals who would otherwise be admitted as an inpatient or as part of a discharge pathway Information and support for carers

Services are provided by a multi-disciplinary team with expertise in treating psychological and medical complications of eating disorders including re-feeding patients and achieving weight gain and ensuring the appropriate risk management arrangements necessary for such interventions are in place.

The specification covers male and female patients 17.5 years of age and over.

Where an individual has co-morbid problems or complex needs the service will work with other services and define roles and responsibilities.

1.2 National/ local context and evidence base

The majority of people with eating disorders fall into the following categories:

- Anorexia Nervosa
- Bulimia Nervosa and Atypical Eating Disorders (Eating Disorders not otherwise specified - EDNOS) including Binge Eating Disorder

It should be noted that there may be changes over time in the diagnostic presentation of individual sufferers.

Anorexia Nervosa

Individuals with Anorexia Nervosa restrict their food intake to a severe degree resulting in significant weight loss. This may be accompanied by other abnormal weight control mechanisms such as excessive exercise, self-induced vomiting, or laxative misuse. Sufferers are typically pre-occupied with a drive for thinness, a fear of fatness and distortion of their body image. Some people will not have these typical weight and shape concerns, and will express atypical over valued ideas, e.g. fear of feeling full, bowels not working and stomach distended, to explain their weight loss. Onset is typically in teenage years or early twenties. The majority of sufferers are women, although around 10% are men. Anorexia Nervosa is associated with significant physical and psychiatric co-morbidity. Mortality rates for the disorder increase with chronicity and aggregate mortality rates are estimated at 5.6% per decade (Sullivan 1995).
Arcelus J, Mitchell AJ, Wales J, Nielsen S. Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. Archives of general psychiatry. 2011;68(7):724-31. Epub 2011/07/06.

Severe Anorexia Nervosa is defined as an individual with a body mass index (BMI) of <15 (BMI – weight in kilograms divided by height in metres squared). In such cases there may be serious concern for, or a rapid deterioration in, the individual's physical state.

Mild/moderate Anorexia Nervosa is defined as an individual with a BMI of 15-17.5 where the condition is stable and low risk of rapid deterioration.

In the absence of validated modelling data, the best estimates of the prevalence of anorexia nervosa in the community are between 10-30 cases per 100,000 population, with an annual incidence of between 4-10 per 100,000. Whilst the peak age of anorexia nervosa is in the mid teens, most sufferers fall within the age range of adult services. Hoek et al 2006 in a review of literature concluded an overall annual incidence at least 8 per 100,000.

Bulimia Nervosa

Bulimia Nervosa is characterised by cycles of binge-eating, alternating with compensatory episodes of purging/over exercising/or food restriction. Binge eating is associated with a sense of loss of control, emotional distress and shame. Bulimia nervosa may be associated with significant physical risk including life threatening electrolyte disturbances – there are also a significant number of other physical sequalae associated with the condition. Bulimia nervosa is also associated with significant psychiatric co-morbidity, notably depression, and is often accompanied by many symptoms of wider physical and psychological discomfort and stress. Sufferers with bulimia nervosa tend to be of normal weight or in the overweight range.

In community-based studies, the prevalence of bulimia nervosa has been estimated between 0.5% and 1% in young women with an even social class distribution (Hay &Bacaltchuk, 2003).

Atypical Eating Disorders (Eating Disorders Not Otherwise Specified- EDNOS) and Binge Eating Disorder

Atypical Eating Disorders is the most common form of eating disorder. Sufferers may closely resemble people with Bulimia Nervosa and Anorexia Nervosa without fitting the criteria for the diagnosis exactly. Atypical eating disorders are disorders that may be as severe in presentation as that found in other diagnostic categories. Binge Eating Disorder is a specific sub set of Atypical Eating Disorders, whose sufferers tend to respond better to treatment. It is evenly distributed between males and females.

(The figures given for both prevalence and incidence should be treated with caution as they do not necessarily reflect the actual numbers of service users with the disorder presenting to services.)

Evidence base for Eating Disorders

Mental Health National Service Framework. DH 1999

NICE Guidelines for Eating Disorders Jan 2004. Guidelines reviewed in 2010 and no new guidance from new data given.

Local defined outcomes

Provide a local service to Lincolnshire patients with significant Eating Disorder.

To provide a timely service, with appropriate assessment and treatment options.

To prevent admissions to out of area units whenever possible.

2. Service Scope

2.1 Service Description

The service will be a Lincolnshire based provision that aims to:

- Limit the physical and psychiatric morbidity, social disability and mortality levels caused by eating disorders.
- Effectively treat people with complex eating disorders and /or severe morbidity
- Support people to remain at home during treatment and
- Promote health and wellbeing as part of a long term recovery focus

2.2 Any exclusion criteria

The service will not accept referrals for individuals who do not meet the eligibility criteria and who are not ordinarily resident in Lincolnshire or registered with one of the four Lincolnshire Clinical Commissioning Groups, unless otherwise pre-agreed

2.3 Geographic coverage/ boundaries

The service will be available to all patients who meet the eligibility criteria are registered with a GP practice in one of the 4 Lincolnshire CCG's. To Non-Lincolnshire patients at the direction of their GP and with prior funding consent only.

2.4 Whole System Relationships

Key relationships include, but are not limited to:

- The patient
- Carers and family members
- The referring ward or department staff
- Primary Care Services across the four Lincolnshire Clinical Commissioning Groups (CCGs) Secondary Physical health Care, including universal services
- All LPFT services
- Social Services

2.5 Interdependencies with other services (this list is not exhaustive)

- Primary Care
- Steps2Change
- Secondary Physical Health Care
- Specialist Eating Disorder Inpatient Units
- Perinatal Service
- Diabetes Nurse
- Dietetics
- Integrated Community Mental Health Teams
- Adult Psychology

2.6 Training/ education/ research activities

The Service will utilise specialist dieticians to improve nutritional state and weight restoration. A psychological approach tailored to individual learning and lifelong recovery.
Staff will utilise additional training opportunities to enhance the service offering where ever possible.

3. Service Delivery

3.1 Service model

Assessment

The service will:

- Assess referrals (see appendix 1)
- Clearly communicate to the service user, referrer, and GP the outcome of the assessment which may include recommendations to the referrer and advice about ongoing clinical management.
- Offer a service that maximises engagement.
- Offer carer assessments and involvement where appropriate.

Interventions etc

The service will:

- Provide a high quality intervention aimed at weight restoration or the reduction of severe or resistant behaviours associated with the eating disorder.

- Provide high quality psychological interventions, for example, Cognitive Behavioural Therapy, Interpersonal psychotherapy, Radically Open Dialectical Behavioural Therapy (RO-DBT) Group, Eye Movement Desensitisation Reprocessing (EMDR), Body Image Workshops, CBT Recovery Group
- Provide a high quality day programme (3 days a week) that offers opportunities for motivational enhancement, psycho-education, dietetic /nutrition psychoeducation, development of emotional coping skills, independent living skills, social skills, adaptive future lifestyle skills plus recreation and social activities Work with individuals to formulate and deliver their care plan.
- Utilise the Mental Health Act 1983 (amended 2007) where appropriate Work with other services as determined by the care plan.
- Work with carers in order to support individuals.
- Take carers needs into consideration as part of the treatment process.
- Provide advice and information in respect of eating disorders. Provide consultation and support around eating disorders issues to referring agencies.
- Provide a psychotherapeutic culture that provides structure and containment.
- Lincoln University Drop in
- Teaching to Nottingham University Doctorate Psychology Trainees adhoc
- Placement opportunities for trainees

3.2 Care pathways

See Appendix 1

3.3 Location(s) of service delivery

Services are delivered from existing LPFT estate and GP surgeries around the county in order to facilitate Patient access. The day program is provided out of the Carholme Court site, Lincoln.

3.4 Days/ hours of operation

Core hours of the Eating Disorder service are 9am – 5pm. Monday to Friday, excluding bank holidays.

3.5 Referral Criteria and sources

Anorexia Nervosa

- aged 17.5 or above (in line with Trust transition Policy)
- diagnosis of Anorexia Nervosa
- BMI (Body Mass Index) <17.5 or higher than 17.5 but rapid weight loss

Bulimia Nervosa and Atypical – Suitable for Tier 4

- Cluster 5 or above, i.e. complex plus
- Primary diagnosis of Bulimia Nervosa or Atypical Eating Disorder + BITE score above 20 for those presenting with Bulimia
- EDEQ score above the global normative range (four subscales) greater than 1.554
- Age 17.5 or above (in line with Trust transition policy) Plus one or more of:
- Electrolyte imbalance
- Significant physical sequelae of eating disorder
- Complex co-morbidity driving the Eating Disorder, e.g. PTSD

3.6 Referral processes

Referrals can be accepted from:

- Any health care professional

The referral information should include (as a minimum):

- Summary of presenting condition

- Detailed history
- Any significant psychiatric or physical co-morbidity

- Height, weight and BMI, rate of weight loss
- Results of diagnostic investigations e.g. ECG, blood, serological investigations, bone scans Any special needs
- Medication

3.7 Discharge processes

Service users should be fully communicated with and well prepared for discharge. The Trust will ensure effective clinical decision making around discharge is followed, as well as transition to other services where required.

Discharge will be initiated with one of the following:

- Evidence of successful outcome following sustained improvements in physical health and psychological wellbeing
- No evidence of physical and psychological change and lack of engagement after minimum of 6 sessions.
- No Patient confirmation of acceptance of assessment appointment
- Initial DNA and lack of response to 2 week follow up request
- Intermittent and repeated pattern of appointment cancellations Patient moves Out of Area

Discharges in all cases are with clinical discretion and made as part of an MDT discussion.

3.8 Response times and prioritisation

Following a request for an assessment the service will offer a timely assessment appointment. Urgent cases will be prioritised.

Urgent cases are defined as:

- Patient is severely physically compromised (low weight, electrolyte imbalance)
- Rapid weight loss over a short period of time
- Patient has Type 1 Diabetes
- Pregnancy (Anorexia Pathway)

Urgent cases will be contacted within 5 working days to arrange appointment to suit within 10 working days from receipt of referral.

Routine referrals will be contacted within 10 working days and offered an appointment within 28 days

Inappropriate referrals will be signposted accordingly and Referrer and Patient informed of the outcome.

4. Other

4.1 Assurance

Risk Assessment –
All assessments undertaken will include a risk assessment to the appropriate level of the individual in line with trust policy. The Risk assessment will be reviewed as and when required such as when the risks change or there is a change in circumstances and the risk profile has altered.

Safeguarding –
The Eating Disorder Service recognises its first priority should always be to ensure the safety, well-being and protection of vulnerable adults and children and all staffs have a responsibility to act on any suspicion or evidence of abuse or neglect, and report their concerns to a responsible person, manager or agency.

All Staff should be aware that they have an individual duty of absolute responsibility to ensure that they:

- Address the issue of parenting ability and flag-up any potential issues where a child may be in danger of abuse, be that physical, emotional, sexual or neglect.

- If a Service User discloses abuse of a physical, sexual or psychological nature, now or in the past, it is the staff member's responsibility to seek further details to ascertain if this is historic or current, in line with current safeguarding processes
- Identify what, if any, action has been taken and ascertain if the Service User requires support to report this to the relevant authorities.
- Inform the Service User that as staff they have a duty to report all abuse, however it is the clients choice whether they wish to take any further action, unless there is the possibility that other children may be in danger.
- Know where to locate safeguarding policies and procedures when necessary
- Complete a DATIX report detailing the abuse disclosure.

The Eating Disorder Service will carry out its clinical duties in accordance with legal frameworks such as (but not limited to) The Mental Health Act, The Mental Capacity Act and The Equality Act, as well as Trust policies such as Care Programme Approach and Safeguarding.

Untoward Incidents
Untoward incidents will be recorded using the Trusts approved mechanism for recording which includes identified risks to Service Users, staff, the service and the Trust. If it is clear that an incident has occurred where the above conditions are met then all staffs have a responsibility to ensure they complete an Untoward Incident report to record this.

Information
Staff will ensure that they comply with the Trust information policies.

Record Keeping
Record keeping will be accordance with the Records Management Policy. Each locality will have locked cabinet, within a lockable room, in which to keep Service User records.

Confidentiality
Confidentiality will be maintained in accordance with the Confidentiality Policy and the Information Sharing Protocol at all times. At the point of assessment Service Users will be verbally informed of the duty of confidentiality, including the limitations. This may include the need to share information with Criminal Justice, or other, agencies if involved.

In addition, all Service Users will be requested to sign a confidentiality statement, identifying the possible partnership agencies that information could be shared with. If the Service User declines to sign, this must be documented in the Practitioner records. This will not affect the duty to share information if the safety of the Service User or the safety of others is at risk (in accordance with the Common Law Duty of Confidence and the Data Protection Act 1998).

4.2 Monitoring and Evaluation

Management Supervision
To be held between the staff member and their line manager in accordance with the Supervision Policy.

Clinical Supervision
All clinical staffs are required to undertake clinical supervision in order to develop their clinical knowledge and skills needed to deliver high quality evidence based care and to ensure they have a supportive environment in which to reflect upon their clinical practice. This will be discussed and agreed in management supervision.

Service User Satisfaction
All people accessing the speciality are encouraged to use the Friends and Family test.

The Provider will supply monitoring data as agreed in 5 (Outcome and metric Reporting Requirements)

5. Outcome and metric Reporting Requirements

Outcome to be measured	*Benefit of the measure (service, patient and commissioner)*	*Evidence to be provided*	*Reporting type and frequency*	*Source of the data*

ED1 Patient and Carer Questionnaire	Service Quality is monitored from Patient and carer perspective	Qualitative narrative report from direct Patient Carer feedback	Monthly returns reported Quarterly	LPFT questionnaire data
ED2 Physical Health Care checks	Physical health, specifically weight is monitored as part of an holistic service	Electronic system check that Weight, height, BMI, is being monitored for each person accessing the service	Monthly returns reported Quarterly Showing % of patients who have improved their BMI (for those seen in the month)	LPFT Data Silverlink Report
ED3 Timeliness of the service. Measured separately for Anorexia and Bulimia pathways	Patients are offered access to the service as soon as appropriate	Excel report that shows: *Number of referrals in the month *Numbers waiting in the month (wait time profile) *Number of Discharges in the month (excluding inappropriate) *Mean wait from referral to Assessment *Mean wait from Assessment to treatment commencing	Monthly data reported quarterly	LPFT data Silverlink
ED4 Outcome measures	The service is effective	Report on OOAMHS giving patient scores . . . (This is currently in training for roll out in 2017)	Quarterly report showing monthly data Excel and narrative once training and OOAMHS embedded – To be initiated within 2017	LPFT service Myoutcomes web data

ED5 Activity information	Commissioners can see where activity is and identify any gaps	Number of referrals by *Service pathway (Anorexia, Bulimia, Day Program) *Source of referral *CCG *Primary Diagnosis *DNA's and reasons In Day Program (start and end) In groups (mid and end Mid treatment review In RO-DBT Group [Data sheet embed here]	Monthly returns reported Quarterly	LPFT data Silverlink
ED6 Outcome Measures	Quality of Life	EDEQ (Eating Disorders Examination Questionnaire	Monthly Data reported Quarterly	Service EDEQ results

6. Activity and staffing

6.1 Indicative Activity Plan

Anorexia Pathway

Based on activity data from 2015-16 the following Activity Plan is suggested for the current service capacity levels (Best practice infers no more than 4 average face to face contacts a day)

Activity	***Indicative* activity based on 2015-16 recorded activity**
Referrals	85 Annually
Interventions (face to face, verbal, written communications & group work)	800 face to face contacts annually per clinical WTE (1-3 groups per week)
Expected interventions per patient	Dependent on complexity of patient
Expected LOS per patient	15 - 18 Months

Bulimia Pathway

Based on activity data from 2015-16 the following Activity Plan is suggested for the current service capacity levels (Best practice infers no more than 3 average face to face contacts a day)

Activity	***Indicative* activity based on 2015-16 recorded activity**
Referrals	36 Annually
Interventions (face to face, verbal, written communications & group work)	504 face to face contacts annually per clinical WTE (1-2 group session per week)
Expected interventions per patient	Dependent on complexity of patient
Expected LOS per patient	9 – 12 Months

Anorexia Day Program (3 days per week)

Based on activity data from 2015-16 the following Activity Plan is suggested for the current service capacity levels

Activity	**Per Program**
Number of patients on the program	Maximum of 10 per day.
Expected interventions per patient	Up to 3 days per week during the program
Expected LOS per patient	12 week block of treatment (delivered over 14 weeks) may form part of longer term intervention in day prog

6.2 Staffing

In order to deliver the required outcomes, the service will employ staff which may include those from the following professions:

Consultant Psychiatrist
Consultant Psychologist
Team Co-ordinator/Nurse Specialist
Mental health Nurses
Community Support Worker
Community Support Worker

Medical Secretary
Team Secretary

7. Standards

7.1 Applicable national standards e.g. NICE, Royal College

The service should be registered with the CQC, Quality standards have been developed by the Royal College of Psychiatrists, Quality Network for Eating Disorders (QED). The service should meet all type 1 standards and the majority of type 2 standards.

The standards can be found at:
http://www.rcpsych.ac.uk/systempages/gsearch.aspx?cx=001100616363437152483%3aidnunf1yavs&cof=FORID%3a9&q=eating+disorder+quality+standards

The specification should be read in conjunction with and ensure compliance with:

- NICE 2004 Clinical Guideline CG9 - Eating Disorders, Core interventions in the treatment and management of Anorexia Nervosa, Bulimia Nervosa and related eating disorders.
- Mental Health Act 2007
- Mental Capacity Act 2005 & Deprivation of Liberty 2009
- The National Service Framework (NSF) for adults with mental health problems (1999)
- Mainstreaming Gender and Women's mental health – implementation guide 2003
- Mental Health and Social Exclusion (2004)
- Engaging and changing (2003) – Developing effective policy for the care and treatment of black and minority ethnic detained patients.
- *Refocusing the Care Programme Approach Policy and Positive Practice Guidance* (DH, March 2008).
- New Ways of Working.
- MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa (2010)
- Royal College of Psychiatrists Guidance on feeding in ED (new version in prep)

Appendix 1

1.Eating disorders clinical pathway.pdf