National Audit of Eating Disorders: Service Mapping Report 2025

This report details data provided about services in England between January 2025 and May 2025

HQIP
Healthcare Quality Improvement Partnership

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NAED
NATIONAL AUDIT OF EATING DISORDERS

Publication date December 2025

The National Audit of Eating Disorders (NAED) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England as part of the National Clinical Audit and Patient Outcomes Programme.

This report has been produced by the NAED Team and its clinical, service user, and carer advisors. Input on the report content and design was also sought from the NAED Service User and Carer Advisory Group (SUCAG) which includes 10 experts by experience recruited by Beat, and a Steering Group comprising clinicians, commissioners, NHS England staff, charities, and Royal Colleges.

Thank you to everyone who has supported this audit.

NAED Project Team

Philippa Nunn (Programme Manager)
Rachel Davies (Deputy Programme Manager)
Marcelina Halatyn (Project Officer)
Kashish Janiani Tulsiyani (Project Officer)
Richard Olowu (Project Officer)
Dr Alan Quirk (Head of Clinical Audit and Research)
Prof Dasha Nicholls (Clinical & Strategic Director, CCQI)

NAED Advisors

Prof Ulrike Schmidt OBE (Clinical Advisor)
Dr Karina Allen (Clinical Advisor)
Rebecca Regler (Service User Advisor)
Vicky James (Carer Advisor)

NAED Service User and Carer Advisory Group (SUCAG)

The Service User and Carer Advisory Group (SUCAG) is made up of people who have lived experience of eating disorders services, either as a patient or a carer for someone who has used an eating disorders service. The group is coordinated and facilitated by our partnering eating disorders charity, Beat.

The SUCAG works in parallel to the Steering Group and with our Service User and Carer Advisors to provide collective feedback on key decisions in the audit to ensure these reflect issues of importance to patients with eating disorders and their families/carers.

December 2025

Foreword

We are excited to share the first findings from the new national audit of eating disorder services, which brings together people with lived experience, clinicians, academics and implementation specialists to take an objective, in-depth look at the care provided to people with eating disorders in England. Eating disorders affect people from all walks of life and of all ages, genders and ethnicities. Some are visible, others completely hidden. All cause substantial emotional and physical pain, with impacts on the well-being of families, partners and friends.

As NAED Advisors we have, in our different ways, spent much of our lives advocating for people with eating disorders to be able to access timely high-quality evidence-based treatment and care, which we know makes a tangible difference to clinical and other outcomes. Skilled multi-disciplinary teams, competent in working with individuals and families and in assessing and managing psychological and physical risks, are needed to achieve this. Sign-up for the audit has been phenomenal, highlighting the commitment of teams up and down the country in contributing to and learning from the national picture that emerges.

All reports from the audit are designed to be accessible to patients and their carers and supporters, so they can relate service provision to their personal circumstances. We hope the audit will drive improvements in access and quality of care for all patients with eating disorders and their supporters, for which this mapping of eating disorders provision is a starting point.

Dr Karina Allen, Vicky James, Rebecca Regler, Prof Ulrike Schmidt

Contents

Key Findings

Participation of Teams

- **209 eligible services** in England were identified, comprised of **297 teams**
- **97% of teams registered** to take part in the audit

NHS England and Private Provision

- **78%** of all eating disorders teams are **NHS-delivered**
- **42% of adult** and **27% of CYP inpatient** services are delivered by **private providers**

Provision across ICBs

- **100%** of ICBs have at least one team delivering **CYP** and **adult community care**
- **Inpatient services** are specially commissioned and typically delivered across multiple ICBs

Children and Young People (CYP) and Adult Team Provision

- **93 CYP community** teams and **69 adult community** teams identified in England
- **54 inpatient CYP teams** – mostly based in general adolescent units – and **33 inpatient adult teams** located in dedicated eating disorder inpatient units, identified in England
- Nationally, **adult community** teams have **1.89** people on their caseload for every **1** patient open to **CYP** teams. This means **adult community** teams face an **89% higher demand***

Access and Waiting Times

- The national median wait for **CYP community care** is **14 days for assessment** and **4 days for treatment**, with **waiting times of up to 450 days**
- The national median wait for **adult community care** is **28 days for assessment** and **42 days for treatment**, with **waiting times of up to 700 days**
- **15%** of community adult teams **accept self-referrals** compared to **62%** of CYP teams

Provision for Eating Disorder Diagnoses

- **Binge eating disorder (BED)** is treated by **63%** of CYP teams, **55%** of adult teams, and **94%** of all age teams
- **Avoidant restrictive food intake disorder (ARFID)** is treated by **48%** of CYP teams, **29%** of adult teams, and **25%** of all age teams

Shared Care Protocols

- **36%** of teams have **shared care protocols** for **psychiatric comorbidities** and **35%** for **physical comorbidities**

NICE-Recommended Psychological Therapies in Community Teams

- **85%** of CYP and **90%** of adult teams offer cognitive behavioural therapy for eating disorders (CBT-ED)
- **86%** of **CYP teams** offer **family therapy** for eating disorders (FT-ED)
- **62%** of **adult teams** offer **guided self-help**

* This number is not adjusted for population or team size.

Introduction

Eating disorders are an escalating public health issue. Prevalence of all eating disorders was estimated at **6%** of the population in the UK in 2019, and **7.5%** in 2025. Contemporary UK prevalence data for each eating disorder is not available; however, existing evidence indicates that Bulimia Nervosa and Binge Eating Disorder are more prevalent than Anorexia Nervosa. Eating disorders carry a substantial burden, often leading to long-term physical and psychological consequences if not treated early and effectively. A 2025 report by the All-Party Parliamentary Group on eating disorders highlighted the stark mismatch between rising demand and service capacity, calling for a coordinated national response to address these gaps and ensure equitable access to care.

The **National Audit of Eating Disorders (NAED)** is a new initiative designed to support this response. It brings together people with lived experience, clinicians, academics, and implementation specialists to take an objective, in-depth look at service provision across England. The audit aims to improve identification, management, and overall quality of care for people with eating disorders, including children and young people, adults of working age, and older adults.

In its first year, the audit focused on mapping services to understand the breadth and depth of current provision. Teams were invited to complete **two** comprehensive surveys covering service types, disorders treated, staffing, pathways, protocols, joint working, outcomes, interventions, referrals, waitlists, and discharge processes. The data presented in this report were collected between January and May 2025 and are shown at national, regional, Integrated Care Board (ICB), NHS Trust, and service-type levels.

Quotes from people with lived experience and clinicians are included to highlight the real-world impact of the findings. Quotes from service users and carers were gathered through the NAED SUCAG and quotes from clinicians are from Kat Novogrudsky et al's qualitative investigation of eating disorder clinicians' experiences in England (2025). A glossary of key terms and abbreviations can be found in Appendices A & B.

The audit and this report are designed to be accessible to patients, carers, and supporters, offering insights into service provision relevant to their personal circumstances. Importantly, the audit transcends traditional boundaries between providers (NHS, voluntary, private), service types (child, adult), and settings (community, inpatient).

Following this initial mapping, the core audit is scheduled to begin in summer 2026, using routinely collected patient-level data (e.g. via the Mental Health Services Dataset). These data will be analysed against **12** audit metrics covering access, waiting times, interventions, and outcomes. Aggregated data will be made available to teams via a dashboard, and a **State of the Nation Report** is planned for publication in 2027.

We hope this report will be a valuable resource for commissioners, clinicians, service users, carers, and all those working to improve care for people with eating disorders.

Inclusion criteria

Eating disorder services in England that are:

- NHS commissioned services, including those commissioned by specialised commissioning and ICBs/ICSs and Provider Collaboratives
- Services delivered in partnership with and by the voluntary, community and social enterprise (VCSE) sector that are commissioned by the NHS
- Inpatient and community eating disorder services
- All general adolescent units where eating disorders are not explicitly excluded

Exclusion criteria

- NHS funded non-eating disorder services that provide eating disorder treatments
- Eating disorder services in England that are not NHS funded e.g. non-NHS funded independent sector
- Services treating co-morbid conditions other than eating disorders
- Services that provide primary care and acute care.

Methods

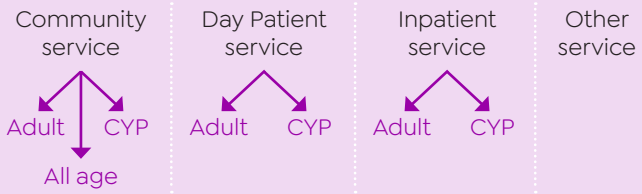
DATA COLLECTION

Eligible services were identified through:

1. **NHS England regional leads**
2. **RCPsych Quality Networks: QED, QNIC, QNCC**
3. **Mental Health Trust Medical Directors and CEOs**

Eligible services were asked to register each team within their organisation. These teams were then categorised according to the type of service they provide to make sure that data are comparable across the different types of service.

Types of services



Registered **teams** were invited to complete **two** surveys.

Survey 1
captured team-level data on type of service and EDs treated

Survey 2
captured team-level details on staffing, caseloads, pathways, outcomes, accreditation, discharge, interventions and wait lists

DATA CLEANING

Data from the completed survey were exported from Snap Survey into a spreadsheet for analysis.

Discrepancies or incomplete responses were identified and, where necessary, queries sent to the relevant teams to review and amend their responses.

Returned amendments were made and checked by the NAED team, to ensure accuracy and consistency of the dataset.

PARTICIPATION

209 eligible services were identified

96% (200/209) of eligible services, comprised of **97% (288/297)** of eligible teams, registered for the audit (Appendix C)

96% (277/288)
of registered teams completed at least **one** of the surveys

91% (262/288)
of registered teams completed **both** survey 1 and survey 2

DATA ANALYSIS

Data were aggregated and descriptive statistics were run at five different levels:

1. **National**
2. **Regional**
3. **Service Type**
4. **Integrated Care Board**
5. **NHS Trust**

Analysed data breakdowns are available in the appendices and slide set.

Overview of Eating Disorders Provision in England

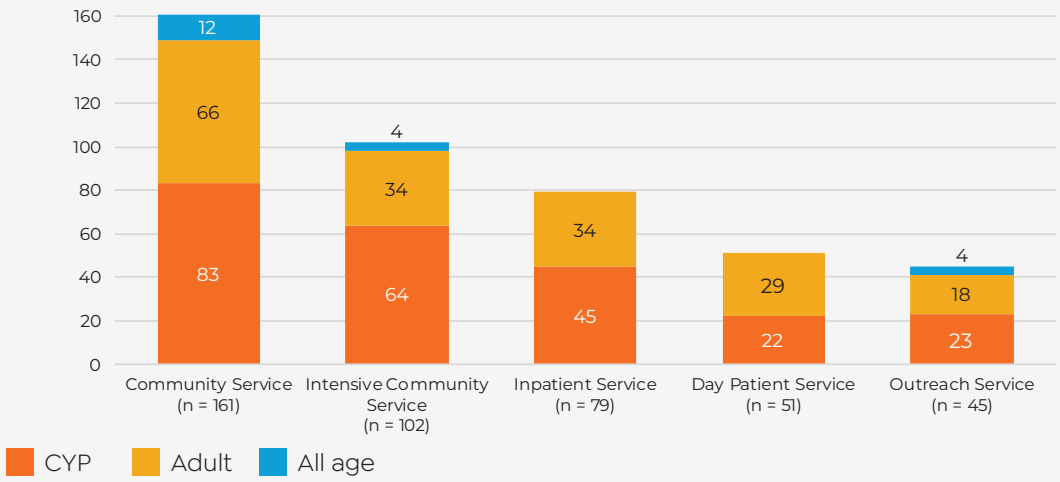
Types of Service

Nationally, there are more teams for children and young people (CYP) than for adults. As part of the initial mapping, prior to registration, we identified **93 community** teams supporting CYP compared to **69**[1] for adults, and **54 inpatient** teams for CYP compared to **33 adult**. Most inpatient CYP teams are general adolescent units, while adult inpatient teams are typically specialist eating disorder units. This distinction contributes to the higher number of inpatient teams available for CYP.

According to data reported on the NHS Futures Eating Disorder Dashboard, at the time of data collection there were **15,230 adults** and **10,890 CYP** on the caseload of community teams (NHS England, 2025). This means that adult community teams face an **89%**[2] higher demand per team than CYP teams, indicating a substantial disparity in service pressure.

Survey 1 was completed by **96%** of the **288** registered teams, and the data presented throughout this report is based on their responses. While community care was widely available, other services were less universal, with outreach services the least common (Figure 1). Many teams provide multiple types of care, such as both community and intensive community, or inpatient and day patient, while others offer only one.

Figure 1: Number of eating disorder teams providing each type of service based on Survey 1 responses



Provision at an Integrated Care Board (ICB) Level

- All ICBs have at least **one** team delivering CYP and adult community care.
- **Intensive community care** (e.g. home treatment) is more widely available for CYP (**88%**) than adults (**62%**) (Figure 2).
- Day patient teams show more limited coverage (Figure 2): **38%** of ICBs have day patient services for CYP; **48%** for adults.

Inpatient team coverage could not be analysed at an ICB level, as these services are specially commissioned and typically delivered across multiple ICBs – often through NHS-led Provider Collaboratives. However, the national coverage of inpatient teams is shown in Figure 2.

Structure of Provision

Teams were asked whether they deliver eating disorder care in **one** of **three** ways: through specialist eating disorder teams, within a general service with a dedicated pathway, or within a general service without a dedicated pathway.

- **Community-based provision (including intensive support)** is delivered by specialist teams in over **90%** of cases.
- **Day patient care** is provided by specialist teams in **78%** of services; **20%** operate within a general service pathway, and **2%** without a dedicated pathway.
- **Inpatient care** has the lowest specialist provision: **60%** by specialist teams, **32%** via a pathway in general services, and **8%** without a dedicated pathway.

Further breakdowns, including by age, are available in Appendix D.

[1] 4 of these teams are nationally commissioned Type 1 diabetes with disordered eating (T1DE) services, with two based in acute trusts.
[2] This number is not adjusted for population or team size.

Figure 2: Map of the distribution of eating disorder day patient and inpatient provision across England

Overview of Eating Disorder Service Providers

Around **three quarters** (**78%**) of eating disorder teams are NHS-delivered (Figure 3). Private providers deliver **11%** of NHS-funded services, mainly inpatient care:

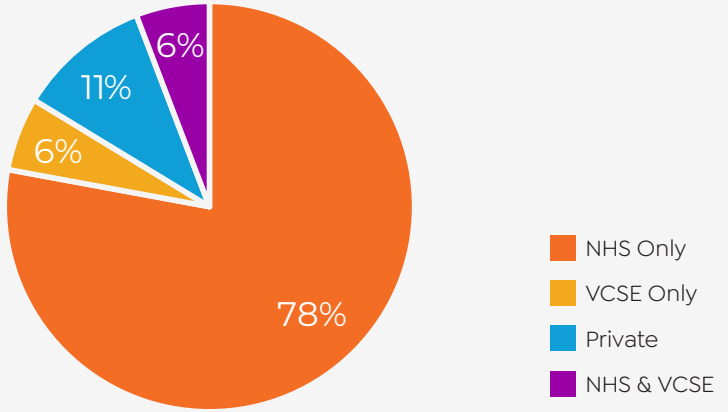
- **42%** of adult and **27%** of CYP inpatient services are delivered by private providers admitting NHS patients.
- On average, **93%** of patients treated in these services were NHS-funded last year.

Voluntary, Community and Social Enterprise (VCSE) providers account for **6%** of NHS-funded services, **rising to 11%** when including NHS partnerships. These mainly support community care:

- **27%** serve all ages
- **17%** are adult-only
- **11%** are CYP-only

Further breakdowns by region and service type are in Appendix E.

Figure 3: Percentage of eating disorder teams whose services are delivered by private or public providers (n=276)



Eating Disorders Treated

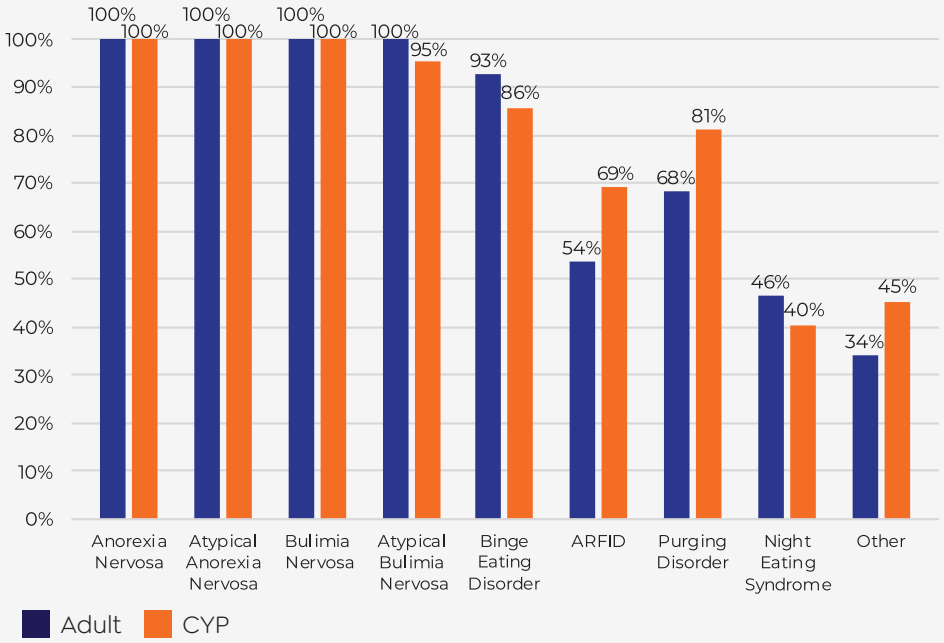
Eating Disorders Treated Across ICBs

At least **one** adult and CYP team within each ICB offers treatment for Anorexia Nervosa, Atypical Anorexia Nervosa, Bulimia Nervosa, and Atypical Bulimia Nervosa (Figure 4).

Binge Eating Disorder (BED) is treated in **93%** of ICBs for adults, and **86%** for CYP, though only **35%** of all teams have a documented care pathway for it. Notable gaps remain for Avoidant/Restrictive Food Intake Disorder (ARFID) (**54%** for adults and **69%** for CYP) and Night Eating Syndrome (NES) (**46%** for adults and **40%** for CYP).

The number of participating teams per ICB ranges from **1 to 18**.

Figure 4: Percentage of Integrated Care Boards that have at least one team providing treatment for each type of eating disorder in adults and CYP*



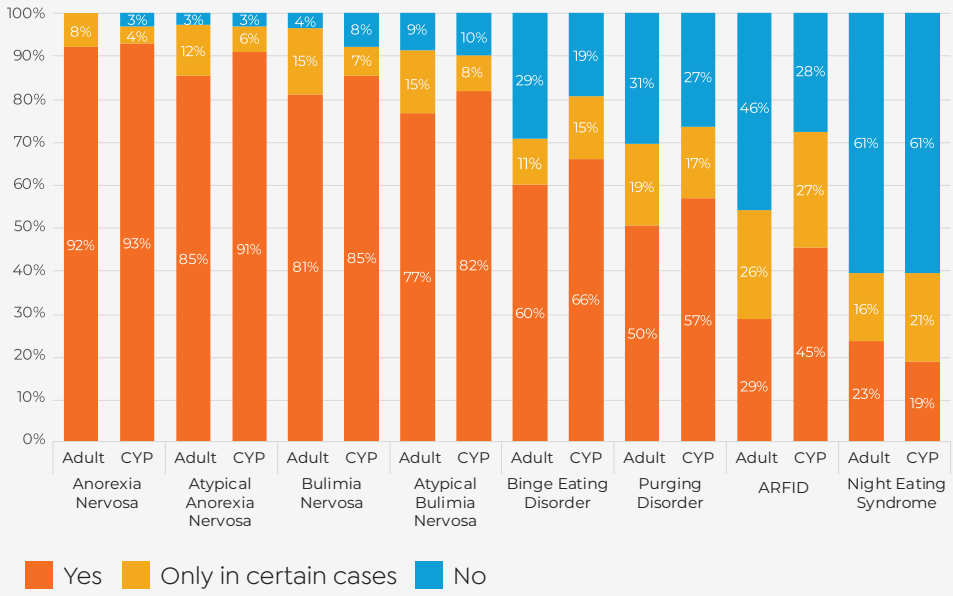
Eating Disorders Treated Across Teams

- Teams most commonly treat: Anorexia Nervosa (**92%** adults, **93%** CYP), Atypical Anorexia Nervosa (**85%** adults, **91%** CYP), Bulimia Nervosa (**81%**, adults, **85%** CYP), Atypical Bulimia Nervosa (**77%** adults, **82%** CYP)
- Less consistent: BED (**60%** adults, **66%** CYP)
- Lowest provision: ARFID (**29%** adults, **45%** CYP) and NES (**23%** adults, **19%** CYP)

These figures show that treatment for Anorexia Nervosa is more widespread, likely due to the greater risks to life from being severely underweight. However, the prevalence of Bulimia Nervosa and Binge Eating Disorder are greater, highlighting gaps in treatment availability (Figure 5).

Further breakdowns by region and service type are in Appendix F.

Figure 5: Percentage of eating disorder teams that treat each type of eating disorder in adults and CYP*



* All age teams are included in both the adult and CYP categories.

Spotlight on ARFID Provision

Current NICE guidelines for the management of eating disorders (National Institute for Health and Care Excellence, 2017) do not include ARFID, as at the time they were written there was little research evidence on which to base recommendations. Consequently, ARFID was excluded from initial commissioning guidance for ED services, resulting in variable treatment access across England (Figure 6).

Our data highlights large regional differences in ARFID treatment. For example:

- In London, **69%** of teams treat all people with ARFID (**48%** adult, **52%** CYP).
- In the North East and Yorkshire, only **26%** do (**15%** adult, **77%** CYP, **8%** all-age).

Service type also influences treatment availability:

- Only **15%** of adult, **31%** of CYP, and **27%** of all age community teams treat all people with ARFID
- Whereas **58%** of adult and **76%** of CYP inpatient teams do

All regional and service type breakdowns are in Appendix F.

Nationally, **35%** of CYP teams, **30%** of adult teams, and **19%** of all age teams report having a documented ARFID care pathway. The audit has also identified several early adopters of ARFID-specific care:

- **4** teams registered for NAED focus solely on ARFID
- **3** teams provide an ARFID programme as part of broader services
- **2** teams have run or are running pilot ARFID programmes.

Why this matters

"My son has ARFID. We were only referred because we ended up in their local hospital... Even when you get into a service there is no particular pathway. In the past 5 years we have been in **three** different teaching hospitals in London which have all taken a very different approach." Carer

Figure 6: Map of the distribution of teams providing ARFID treatment across England

Referrals

Community Teams

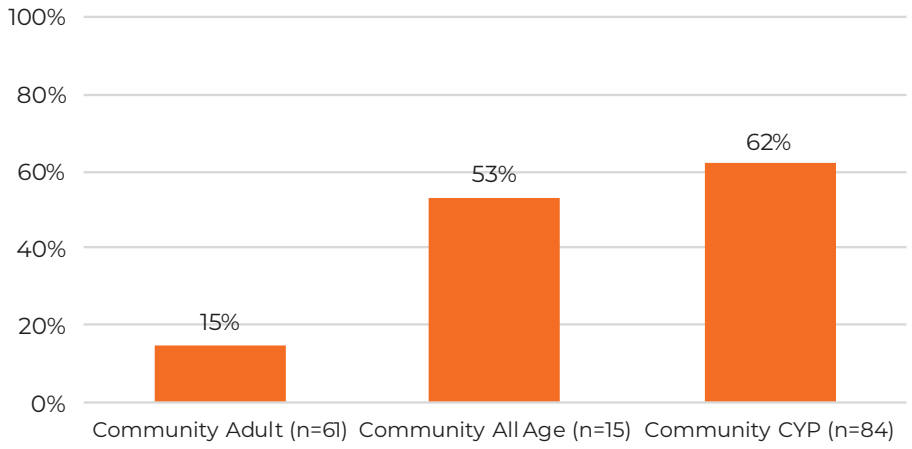
The most frequently reported referral pathways for adult teams are via Community Mental Health Teams (CMHTs), medical wards, and GPs (**>80%**). For CYP teams, referral routes mirror those of adult services, with CYP Mental Health Services (CYPMHSs) replacing CMHTs. CYP teams also frequently receive referrals from educational institutions (**77%**) (Appendix G).

Self-referrals, which enable direct service access and early intervention (NHS England, 2015), are accepted inconsistently across teams, with notable disparities between age groups (Figure 7) (Appendix G).

Day Patient and Inpatient Teams

The most commonly reported referral pathway is via Community Eating Disorder Services (CEDS) for both adult (**>70%**) and CYP teams (**>80%**). CYP inpatient teams also frequently receive referrals from CYPMHSs (**77%**) and inpatient psychiatric units (**56%**).

Figure 7: Percentage of eating disorder community teams that accept self-referrals



Why this matters

"I self referred to CAMHS on the Monday back to school after Christmas and we were seen on Friday – that was great but equally a function of how ill my son was." Carer

First Episode Rapid Early Intervention for Eating Disorders (FREED)

FREED offers rapid, evidence-based treatment for 16- to 25-year-olds with an eating disorder of less than **three** years' duration. It aims to reduce delays in assessment and intervention, supporting early recovery and better outcomes for young people.

It has been rolled out to all **54** eligible Trusts, with **51%** of eligible audit teams reporting an active FREED pathway.

Prioritisation of Referrals

Most teams prioritise referrals by clinical urgency, based on defined criteria such as clinical severity or risk of harm.

Whilst age is a criterion for FREED eligibility, it is not used to determine priority. Referral source is the least commonly reported prioritisation criteria (**<6%**).

Exclusion Criteria

The most common exclusion criterion for services was geographical location (**52%**), followed by psychiatric or physical comorbidities requiring separate treatment (**41%**). **19%** of teams reported having exclusion criteria based on Body Mass Index (BMI). For example:

- **12%** inpatient teams had upper BMI exclusion criterion
- **30%** of VCSE teams had lower BMI exclusion criterion

A full breakdown of exclusion criteria by service type is available in Appendix H.

Restrictions Based on Gender

3% of teams reported restrictions in service access or delivery based on gender. These were found in:

- **3** adult and **2** CYP inpatient teams: Limited male bed availability, **2** female-only wards (including **one** low-secure ward)
- **3** CYP community teams: All/majority female clinicians, reducing patient choice for male service users

Access and Waiting Times

Number of People on Waiting Lists

At the time of data collection, **3,855** people were waiting for an initial assessment and **4,537** for treatment in community teams.

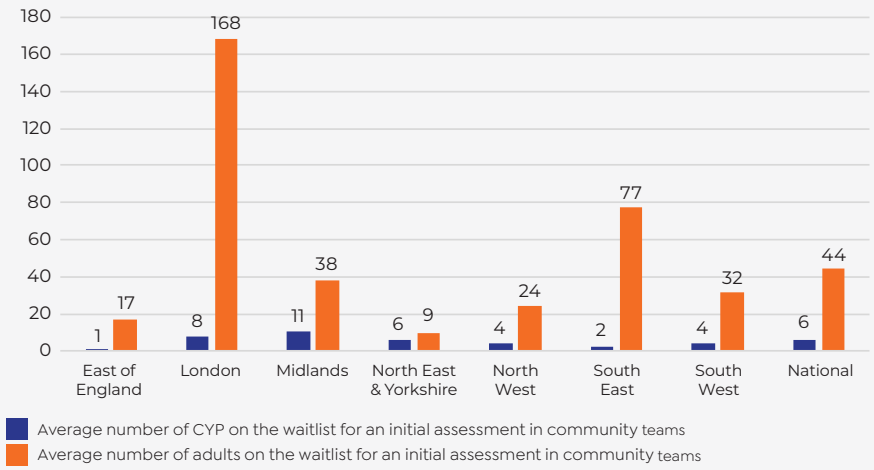
National mean averages per community team:

- **Assessment (Figure 8):**
  - Adult: **44** people (range: **0–500**)
  - CYP: **6** people (range: **0–77**)
- **Treatment:**
  - Adults: **55** people (range: **0–436**)
  - CYP: **6** people (range: **0–150**)

Why this matters

"Waiting lists can be difficult in terms of where you are at with your recovery. Being referred and feeling ready but if there is a long wait, struggling physically with anorexia, being too unwell to access the therapy and ending up in inpatient care." Service user

Figure 8: Figure 8: Average number of people on waiting lists for an initial assessment in community teams, nationally and by region*



Waiting Times

National median waiting time per community team:

- **Assessment (Figure 9):**
  - Adults: **28** days (range: **0–700**)
  - CYP: **14** days (range: **0–137**)
- **Treatment:**
  - Adults: **42** days (range: **0–700**)
  - CYP: **4** days (range: **0–450**)

Reasons for Waitlists

Out of those with waitlists in community teams, the most common reason was demand exceeding capacity (**71%**).

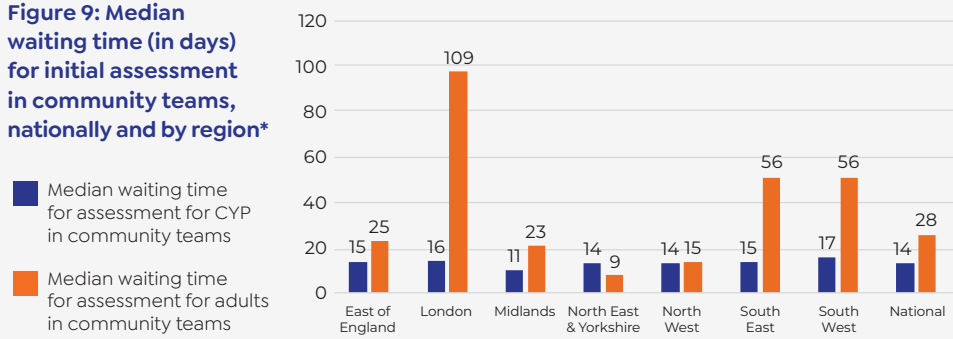
Variation by Service Type

Waiting times and lists vary by service type:

- **Average waiting times for CYP** meet the Access and Waiting Times (AWT) Standard for routine cases. According to the NHS Futures dashboard:
  - **72–82%** of routine referrals began treatment **within 4 weeks** (July 2024–July 2025).
  - **64–83%** of urgent referrals began treatment **within 1 week** during the same period.
- There is no national standard for **adult access** and **waiting times**.
- **Day patient and inpatient teams** typically report minimal or no waiting lists.
- **Services with strict criteria** may show shorter waits, likely due to smaller eligible populations.

See Appendix I for further breakdowns.

Figure 9: Median waiting time (in days) for initial assessment in community teams, nationally and by region*



Why this matters: "This huge pressure was created on us to work through the waiting list. We managed to do it, but at what cost … The moral injury and the burnout and everything to work on that waiting list." Clinician

* Note: All age services are excluded from Figure 8 and 9 due to low numbers of teams per region.

Staffing

Staff Roles / Types of Staff

Figure 10 shows the proportion of all teams with staff employed in each role.

- Most frequently reported: Dietitians (**88%**) and mental health nurses (**88%**)
- **21%** of teams lack psychotherapists, and **16%** lack consultant psychiatrists
- Other roles, like social workers (**30%**), are also underrepresented

Staff Vacancies

Nationally, **22%** of teams reported **no vacancies**, while **10%** had vacancy rates **over 20%** (Figure 11).

Regional variation:

- **Highest vacancy levels:** South East (**7%** fully staffed)
- **Lowest vacancy levels:** South West (**29%** fully staffed)

Among 200 teams reporting vacancies:

- **25%** had vacancies for General Nurses
- **24%** for Psychologists

Reasons for Vacancies

Recruitment difficulties were the most common reason nationally (**53%**) and in most regions. In the North East and Yorkshire, the top reason was categorised as "Other" (e.g. new roles, staff progression). Nationally recruitment freezes were less common (**6%**), ranging from **0%** in the North West and South West to **14%** in London.

Further breakdowns by service type can be found in Appendix J.

Figure 10: Percentage of all eating disorder teams that have staff members within each profession

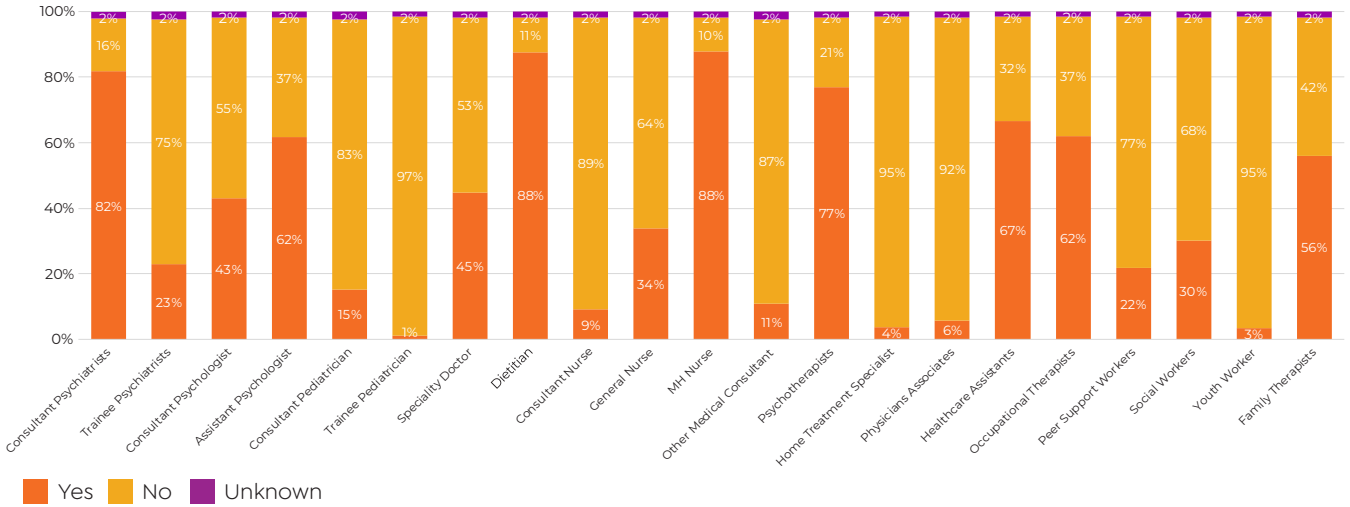
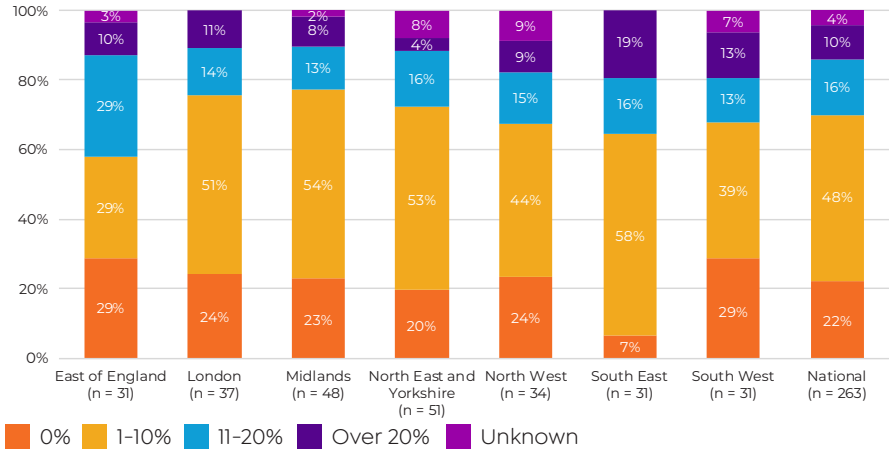


Figure 11: Percentage of all eating disorder teams reporting estimated staff vacancies, by region



Why this matters

"One thing I feel like my experience lacked was dietetic support. Rest of team were great, had psych for therapy, nurse as care-co (weekly visits) and support worker."
Service User

Why this matters

"...the morale of the team ... has gotten so much better, and we got a load of new staff... we had over a year's waiting time. And now I think it's more like 6 to 8 months, and that is because of the increase in staff." Clinician

Therapist Caseload

The average caseload for full-time Band 7 (or equivalent) therapists is **12**, ranging from **0 to 50**.

The average caseload in community teams is **15** (range: **0–50**), compared to **7** (range: **0–18**) in inpatient settings.

Team Caseload

The median number of people under treatment per team is **40**, with wide variation by region and service type.

For example, London teams report the lowest median (**15**), while the North West and South West report the highest (**60**).

Further breakdowns on staffing are in Appendix J.

Psychological Interventions for Eating Disorders

Figure 12 shows the percentage of community teams with staff trained in NICE-recommended psychological interventions.

- **85%** of CYP teams and **90%** of adult teams offer cognitive behavioural therapy for eating disorders (CBT-ED), which is recommended for all ages.
- **86%** of CYP teams and **67%** of all age teams offer family therapy for eating disorders (FT-ED),
- **62%** of adult teams and **67%** of all age teams offer guided self-help, indicating a gap in provision.

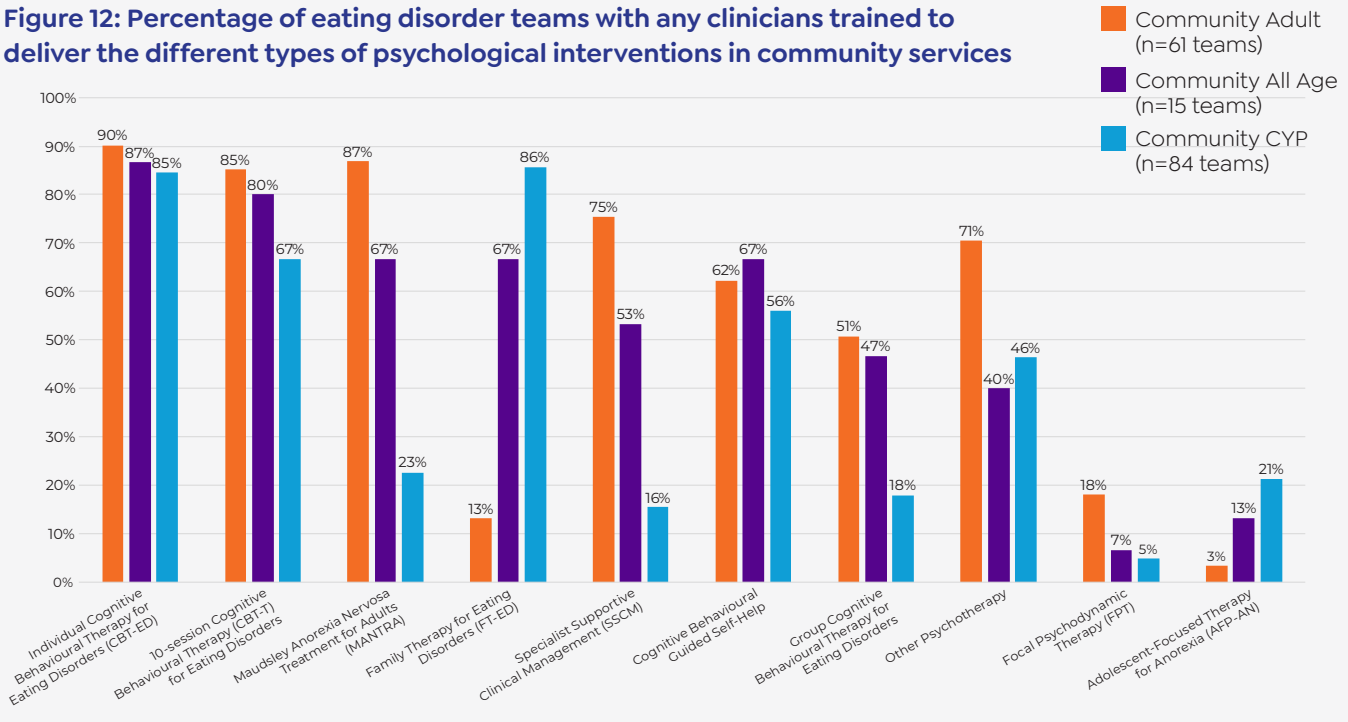
Please note, these data do not show the amount of trained therapy capacity in teams, only that there is some capacity. Therefore, the true size of the treatment gap remains unknown.

To view this data by region and service type, please see Appendix K.

Opportunity to Discuss Psychological Treatment Options

People with eating disorders should be offered the opportunity to discuss psychological treatment options with a healthcare professional (NICE QS2). **94%** of teams offer patients this opportunity, supporting personalised care. This is consistent across regions and service types (Appendix L).

Figure 12: Percentage of eating disorder teams with any clinicians trained to deliver the different types of psychological interventions in community services

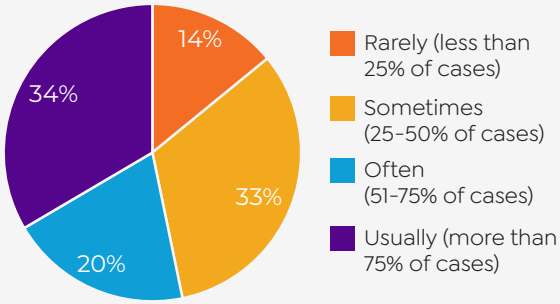


Joint Working Arrangements

Effective care relies on coordination across services (NHS England, 2019).

- **Multidisciplinary discussions** are held for **>75% patients** by **85%** of teams.
- **Collaboration with other mental health services** varies widely (Figure 13).

Figure 13: Percentage of eating disorder teams that collaborate with other mental health teams or services



Care Plans

Every person that presents to an eating disorder service should receive a care plan following assessment. This practice is high across teams:

- **96%** of teams create care plans for all accepted patients.
- **91%** coordinate plans with other services.
- **71%** produce joint care plans outlining how services will work together.

Shared Care Protocols

Shared care protocols set out how teams will work with other teams when a person is receiving care from more than **one** healthcare provider type (e.g. primary care). The proportion of teams with shared care protocols was broadly similar across categories:

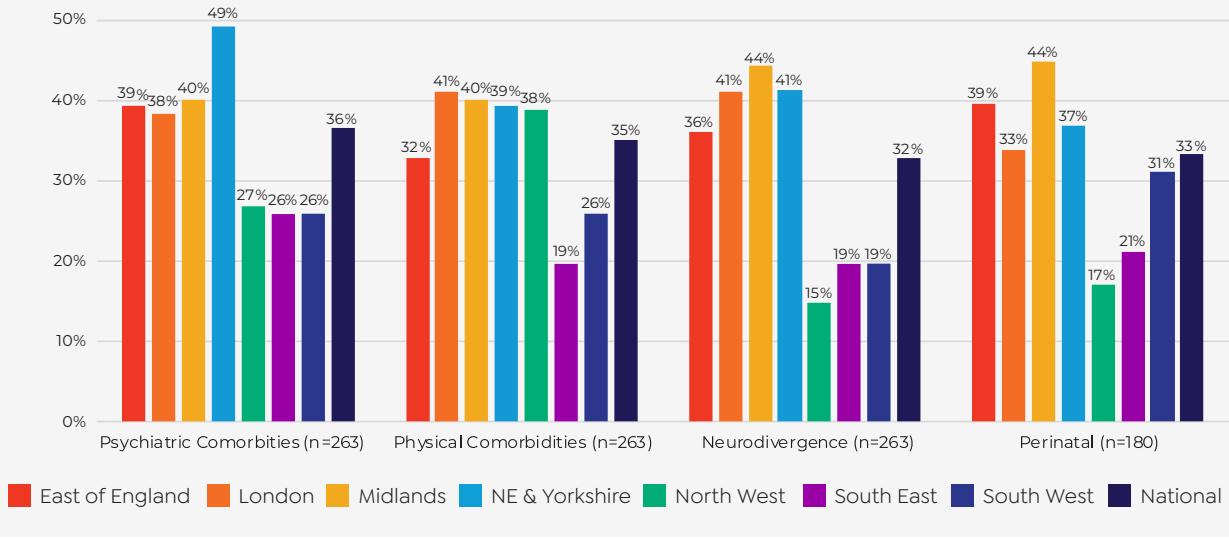
- Psychiatric comorbidities: **36%**
- Physical comorbidities: **35%**
- Neurodivergence: **32%**
- Perinatal women: **33%** (of applicable teams)

Regional variation is notable (Figure 14): e.g. only **15%** of North West teams have neurodivergence protocols compared to **44%** in the Midlands. Service-type differences are detailed in Appendix M.

Why this matters

"FBT was offered as the only intervention, and his autism and ADHD were looked at as adjuncts- however they are intensely important to viewing him holistically." Carer

Figure 14: Percentage of eating disorder teams that have a protocol for shared care of disordered eating behaviour, by region



Outcomes

As part of service mapping, teams were asked which outcomes they routinely collect to support the upcoming core audit. The most frequently collected outcomes were:

- Physical health outcomes (**89%**)
- Patient-reported outcomes focused on eating disorder symptoms (**85%**)
- Paired outcome measures – outcomes recorded at **two** time points or more during treatment time (**82%**)

Less common routinely collected outcomes included:

- Mortality (**8%**)
- Outcomes before and after transition to adult services (**14%**)
- Quality of life (**22%**)

Full results are in Appendix N.

Discharge Readiness

Most teams assess discharge readiness using **four** key criteria: progress towards goals (**92%**, including weight restoration), psychological readiness (**90%**), nutritional stability (**86%**), and medical stability (**85%**). **77%** of teams use all **four**. In contrast, **38%** consider completion of planned treatment as a discharge criterion, usually alongside other factors. Only **six** teams use treatment completion as the sole criterion.

Regional and service-type breakdowns are available in Appendix O.

Why this matters

"Then the actual therapy started which was 18 weeks... but because it was an 18-week therapy programme, on the last day, it was see you later." Service user

Artist: Sophia Coles

Description from artist: This piece portrays eating disorder recovery as a journey from dark chaos to discovering the renewed vibrance in life. The swirling colours represent the overwhelming, non-linear experience of an eating disorder, while also representing the hope and energy that recovery can bring.

A torn, prison-like wall represents the grip of the illness slowly breaking open, as helping hands reach through but remain held back by the walls of isolation the ED has built. This artwork aims to capture the painful yet hopeful path of rediscovering colour, freedom, and a sense of self through recovery.

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

NAED NATIONAL AUDIT OF EATING DISORDERS

NAED, Royal College of Psychiatrists
21 Prescot Street, London E1 8BB

Publication ref:
If citing this report, please reference it as: Royal College of Psychiatrists (2025) *National Audit of Eating Disorders: Service mapping report 2025*. London: Healthcare Quality Improvement Partnership.
Cover image by Sophia Coles. Designed and typeset by White Halo Design
December 2025