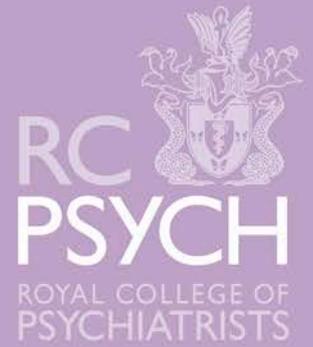


QED
QUALITY NETWORK FOR
EATING DISORDERS



Quality Standards for Adult Community Eating Disorder Services

Pilot Edition

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Number	Type	Standard
ACCESS AND ASSESSMENT		
Access, referral and waiting times		
1.1	1	The service has a local strategy in place to promote and monitor equality and diversity, prevent discrimination and to address any barriers to access.
1.2	2	The service has a strategy in place to ensure reasonable access for all in the catchment area.
1.3	1	<p>Clear information is made available, in paper and/or electronic format, to patients, carers and healthcare practitioners on:</p> <ul style="list-style-type: none"> - A simple description of the service and its purpose; Clear referral criteria; - How to make a referral, including self-referral if the service allows; - Clear clinical pathways describing access and discharge (and how to navigate them); - Main interventions and treatments available; - Contact details for the service, including emergency and out of hours details. - Written criteria for acceptance of referrals. <p>Guidance: <i>The information is co-produced with patients and carers.</i></p>
1.4	1	A clinical member of staff is available to discuss urgent referrals during working hours.
1.5	2	Where referrals are made through a single point of access, these are passed on to the community team within one working day unless it is an urgent referral. Urgent referrals are passed on within four hours.
1.6	1	<p>The team assess patients, who are referred to the service, within a timeframe which complies with national standards as set by commissioners.</p> <p>Guidance: <i>The service has a local protocol that sets appropriate timeframes for screening and responding to referrals.</i></p>
1.7	1	Outcomes of referrals are fed back to the referrer, patient and carer (where appropriate with the patient's consent) in writing. If a referral is not accepted, the team advises the referrer, patient and carer on alternative options.
1.8	1	The team sends a letter detailing the outcomes of the assessment to the referrer, the GP and other relevant services within 14 days of the assessment.
1.9	1	<p>The team provides patients and carers with information about expected waiting times for assessment and treatment.</p> <p>Guidance: <i>Support and signposting is offered while on the waiting</i></p>

		<i>list.</i>
E1.10	1	Referrals for people with diabetes or pregnant women are accepted into the service with a lower threshold of eating disorder severity.
E1.11	1	When outpatient treatment is not effective, the service has a protocol for deciding: <ul style="list-style-type: none"> - When to discharge; - When to intensify; - When to provide support of clinical management or supportive monitoring; - Alternative intervention from the MDT.
E1.12	1	When a decision is made to intensify treatment, Intensive Community options should be considered before the inpatients admission (where available).
E1.13	1	Inpatient treatment or day patient treatment is considered according to NICE Guidance.
1.14	1	The service has a protocol for prioritising patients on the waiting list according to clinical need. Factors to consider include but not limited to: <ul style="list-style-type: none"> - Severity and risk (including psychosocial risk); - Recent onset/good prognosis; - Transfer from inpatient or day patient or other specialist community services (CAMHS or Adult); - Pregnancy or impact on young children.
1.15	1	The outpatient service provides a named worker to inpatient services throughout admission and they are involved in care planning, admission and discharge planning meetings and CPAs.
1.16	1	When on the waiting list for treatment, there is a care plan in place to ensure risk is monitored, that there is a crisis plan and a named professional within the eating disorder service for the patient, carer (if appropriate) and the GP to contact if they have concerns or questions.
E1.17	2	There is a protocol to follow for patients who are on the waiting list, including support for carers, frequency of follow ups with a defined time scale and medical monitoring.
Preparing for the assessment		
2.1	1	For planned assessments the team makes written communication in advance to patients that include: <ul style="list-style-type: none"> - The name and designation of the professional they will see; - An explanation of the assessment process; - Information on who can accompany them; - How to contact the team if they have any queries, require support (e.g. an interpreter), need to change the appointment or have difficulty in getting there.

2.2	1	Patients (and carers where applicable) are given verbal and written information on their rights under the Mental Health Act if under a community treatment order (or equivalent) and this is documented in their notes.
2.3	1	Patients have access to written information. Where appropriate staff members talk through with them as soon as is practically possible: <ul style="list-style-type: none"> - Their rights regarding consent to care and treatment; - How to access advocacy services (including independent mental capacity advocate and independent mental health advocate); - How information on how to request a second opinion; - How to access interpreting services; - How to raise concerns, complaints and compliments; - How information on how to request access to their own health records.
Initial assessment		
3.1	1	Staff members wear their Trust ID at work and this is easily visible.
3.2	1	Patients and carers feel welcomed by staff members when attending the team base for their appointments. <i>Guidance: Staff members introduce themselves to patients and address patients using the name and title they prefer.</i>
E3.3	1	The initial assessment is conducted by a staff member who is trained in a specialist ED assessment and formulation.
3.4	1	The initial assessment should include: <ul style="list-style-type: none"> - Assessment of ED compliant with NICE guidance; - A full psychiatric history including co-morbidity; - A review of their physical health, including co-morbidity (e.g. pregnancy, diabetes); - Nutritional assessment; - Social care needs; - Mental state; - Physical exam.
3.5	1	When indicated, an appropriately trained psychiatrist is available to undertake a psychiatric assessment. <i>Guidance: e.g. Where there is a history of co-existing or co-morbid psychiatric conditions e.g. bi-polar disorders, severe depression, or significant self-harm or suicidal thoughts or intent.</i>
3.6	1	A physical health review is undertaken by a specialist with ED knowledge and takes place as part of the initial assessment. The review includes but is not limited to: <ul style="list-style-type: none"> - Medical complications of an eating disorder; - Details of past medical history; - Current physical health medication, including side effects and compliance with medication regime;

		- Lifestyle factors
3.7	1	The service should have the capacity to provide the following as part of the physical health assessment and ongoing review: <ul style="list-style-type: none"> - Height and weight; - Blood pressure and pulse; - Skin and mouth condition; - Squat (SUSS) test; - ECG; - Blood test.
3.8	1	If initial assessment identifies co-existing physical conditions that increase risk (e.g. diabetes, pregnancy), the assessing practitioner liaises with, or refers to, a doctor and this is recorded.
3.9	1	Patients have a documented risk assessment and management plan which is co-produced and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers: <ul style="list-style-type: none"> - Risk to self; - Risk to others; - Risk from others.
3.10	1	All patients have a documented diagnosis and a clinical formulation. <i>Guidance: The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.</i>
Following up patients who do not attend appointments		
4.1	1	The service has a DNA and cancellation policy that is accessible to patients and carers.
4.2	1	The team follows up patients who have not attended an appointment/assessment or who do not want to engage as per local policy. <i>Guidance: This could include making a phone call, sending a letter, visiting patients at home or another suitable venue, using text alerts, or engaging with their carers to make it more proactive. If patients continue to not engage, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient.</i>
4.3	1	If a patient does not attend for an assessment, the assessor contacts the referrer. <i>Guidance: If the patient is likely to be considered a risk to themselves or others, the team contacts the referrer immediately to discuss a risk action plan.</i>
Reviews and care planning		

5.1	1	Patients know who is co-ordinating their care and how to contact them if they have any questions.
5.2	2	The service has an agreed set of care pathways that define frequency of clinical review and define treatment interventions. This ensures that all patients accessing the service get an equal service.
5.3	1	Risk assessments and risk management plans are updated according to clinical need or in line with local policy.
5.4	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. Guidance: <i>Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.</i>
5.5	1	Every patient has a written care plan, reflecting their individual needs. Staff members actively seek to collaborate with patients and their carers (with patient consent) when developing the care plan. Guidance: <i>The care plan clearly outlines:</i> - <i>Agreed intervention strategies for physical and mental health</i> - <i>Measurable goals and outcomes;</i> - <i>Strategies for self-management;</i> - <i>Any advance directives or statements that the patient has made;</i> - <i>Crisis and contingency plans;</i> - <i>Review dates and discharge framework.</i>
5.6	1	The patient (and carer, with the patient's consent) are offered a copy of the care plan and the opportunity to review this.
CARE AND TREATMENT		
Therapies and activities		
6.1.1	1	Patients begin evidence-based interventions, of intensity and duration consistent with NICE guidance which are appropriate for their bio-psychosocial needs and motivation. Any exceptions to the above are documented in the case notes.
6.1.2	2	The service is able to provide a social and occupational assessment for those patients who require it to ensure the safe and effective provision of social and occupational interventions. Guidance: <i>This might include support for patients to undertake structured activities such as work, education and volunteering</i>
E6.1.3	1	Services demonstrate that they are able to provide nutritional assessment and provision of nutritional interventions.
6.1.4	1	Patients and their family/carers are offered written and verbal information about the patient's mental illness. Guidance: <i>Verbal information could be provided in a 1:1 meeting with a staff member or in a psycho-education group.</i>

6.1.5	2	<p>The team provides information and encouragement to patients to access local organisations for peer support and social engagement, when appropriate. This is documented in the patient's care plan and includes access to:</p> <ul style="list-style-type: none"> - Voluntary organisations; - Community centres; - Local religious/cultural groups; - Peer support networks; - Recovery colleges.
E6.1.6	2	For patients with severe and enduring eating disorders, e.g. those who are functionally impaired, clinicians are encouraged to attempt creative and innovative practice that takes account of the views of patients and the formulation, which is overseen via supervision and evaluation.
6.1.7	1	All staff members who deliver therapies and activities are appropriately trained and supervised.
6.1.8	1	The patient and the team can request a second opinion if there is doubt, uncertainty or disagreement about the diagnosis, formulation or treatment.
E6.1.9	1	The use of a micronutrient supplements is recommended in both inpatients and outpatient weight restoration.
E6.1.10	2	The service has a clearly defined strategy for ensuring optimal and efficient use of resources to balance the need for evidence-based therapies for less severe cases and care for those with severe and enduring illness.
6.1.11	1	The service provides one or more of the NICE recommended treatments for each of the disorders for which they are commissioned.
6.1.12	2	The service provides two or more of the NICE recommended treatments for each of the disorders for which they are commissioned.
E.6.1.13	1	Patients are supported to make an informed choice of psychological therapy from those recommended within the NICE guidance and that are available within the service.
E6.1.14	1	Patients with binge eating disorder are informed that all psychological treatments have a limited effect on body weight and this is recorded.
E6.1.15	1	When providing psychological treatments for patients with binge eating disorder, consideration is given to the provision of consecutive interventions focusing on the management of comorbid obesity.
E6.1.16	1	Psychological therapies offered to out-patients with anorexia nervosa include an explicit focus on reducing risk, encouraging weight gain, healthy eating and reducing other symptoms related to an ED and to facilitate psychological and physical recovery as appropriate.

E6.1.17	1	Patients with severe and high-risk illness whose condition has not improved with treatment or who have declined treatment should be offered ongoing support and care with a specialist eating disorder clinician, with a focus on a personal recovery model.
Medication		
6.2.1	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions), QTC prolongation and benefits are reviewed, a timescale for response is set and patient consent is recorded.
6.2.2	1	Patients (and their carers, with patient consent) are helped to understand the purpose, expected outcomes, interactions, limitations, side effects and how to safely reduce or come off their medications and to enable them to make informed choices and to self-manage as far as possible.
6.2.3	1	Medication reviews take place at a frequency according to the evidence base and individual need. <i>Guidance: This includes an assessment of:</i> <ul style="list-style-type: none"> - Therapeutic response; - Safety; - Side effects monitoring using a standardised tool and adherence to medication regime. <i>Long-term medication is reviewed by the prescribing clinician at least once a year as a minimum.</i>
6.2.4	3	Patients, carers and prescribers are able to contact a specialised pharmacist and/or pharmacy technician to discuss medications.
E6.2.5	1	Where patients with bulimia nervosa or binge eating disorder are offered a trial of high dose anti-depressant medication, this is done alongside other treatments.
Physical healthcare		
7.1	1	Staff members arrange for patients to access screening, monitoring and treatment for physical health problems in conjunction with primary care. This physical risk monitoring plan is well integrated with psychological therapy and is documented in the patient's care plan.
E7.2	2	There is a care pathway in place to assess and manage physical co-morbid conditions and risk integrated with other physical health teams e.g. diabetes and/or pregnancy.
7.3	1	Patients are offered personalised healthy lifestyle interventions appropriate to an eating disorder setting, such as advice on appropriate physical activity and access to smoking cessation services. This is documented in the patient's care plan.
7.4	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency.

E7.5	1	The service has a protocol for screening, monitoring, psychoeducation and management of bone health.
E7.6	1	The service has the capacity to provide at least weekly blood tests and physical health reviews from an eating disorder specialist for patients at high risk, as defined by MaRSiPAN.
E7.7	1	The service has a protocol for an integrated approach to psychoeducation, monitoring of frequency and physical health risks associated with common compensatory behaviours such as vomiting and laxative misuse, and exercise.
Risk and safeguarding		
8.1	1	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults, and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.
Discharge planning and transfer of care		
9.1	1	A discharge letter is sent to the patient and all relevant parties within 14 days of discharge or transition between service. The letter includes the plan for: <ul style="list-style-type: none"> - On-going care in the community/aftercare arrangements; - Crisis and contingency arrangements including details of who to contact; - Medication, including monitoring arrangements; - Details of when, where and who will follow up with the patient as appropriate.
9.2	1	Patients who are discharged from hospital to the care of the community team are followed up within one week of discharge, or within 48 hours of discharge if they are at risk.
9.3	1	When patients are transferred between community services there is a handover which ensures that the new team have an up to date care plan and risk assessment.
9.4	2	When high-risk patients are transferred from inpatient/day patient to community, evidence based psychological outpatient treatment starts immediately (within 2 weeks), even when this involves being taken onto a new community team.
9.5	1	There is active collaboration between Children and Young People's Eating Disorder and Adult Eating Disorder Services for patients who are approaching the age for transfer between services. This starts at least 6 months before the date of transfer and actively involves patients and carers.
9.6	1	The team follows a protocol to manage high risk patients who drop out against medical advice. This includes: <ul style="list-style-type: none"> - Recording the patient's capacity to understand the risks of self-discharge; - Putting a crisis plan in place;

		- Contacting relevant agencies to notify them of the discharge.
E9.8	1	Patients who are at moderate to high risk should not have a service withheld because of failure to register with a GP.
E9.9	1	Services make an assertive effort to support patients to register with a GP.
E9.10	1	Patients that are university students can access treatment in both their home and university towns.
E9.11	1	When working with university students, the local and home service should work together to ensure seamless continuity of care both in and outside of term time.
E9.12	1	The service should have a clear protocol for liaison and collaborative work with the patient's university service.
E9.13	2	The service offers continued support to families of patients who have moved away to university.
E9.14	2	The service is proactive and assertive in following up with university students who DNA or evade treatment. <i>Guidance: For example, this might be during the Christmas holidays or other potentially triggering periods.</i>
E9.15	1	Care plans for patients going to university should be developed in collaboration with the university service and families (where appropriate) which include arrangements for the following: - Physical health monitoring - Who to contact in case of emergency - Contingency plans in the event of DNAs - Plans for follow-up meetings
Interface with other services		
10.1	1	Patients can access help from mental health services 24 hours a day, 7 days a week. <i>Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams and telephone helplines.</i>
10.2	1	The service liaises with primary care teams to ensure that patients with severe chronic eating disorders are on their registers of people with severe and enduring mental illness.
10.3	1	The team supports patients to access organisations which offer: - Housing support; - Support with finances, benefits and debt management; - Social services; - Employment and education.
10.4	1	Patients with drug and alcohol problems have access to specialist help e.g. drug and alcohol services.

10.5	1	The service/organisation has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: - Assessment; - Care and treatment (particularly relating to prescribing psychotropic medication); - Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.
10.6	2	The service has a formal link with an advocacy service for use by patients and carers.
E10.7	1	Teams have invited their local district general hospital to collaborate in a MaRSiPAN group, and the team provides specialist ED input into any agreed MaRSiPAN pathway.
E10.8	2	The service provides risk assessment tools, consultation and advice to all local referrers.
Capacity and consent		
11.1	1	Assessments of patients' capacity to consent to care and treatment are performed in accordance with current legislation and documented in the patients' notes. When patients don't have capacity, best interests processes involving professionals and carers (where appropriate) are followed. These assessments should be undertaken: - At the initial assessment; - At regular intervals as required by the relevant legal requirement; - If the patient's capacity changes; - If the treatment plan changes; - If the patient, family or professionals request it.
11.2	1	There is a protocol in place to deliver Mental Health Act assessment when required.
11.3	1	There are systems in place to ensure that the service takes account of any advance directives or statements that the patient has made. Guidance: <i>These are accessible and staff know where to find them.</i>
Patient involvement		
12.1	1	Patients and their carers are encouraged to feed back confidentially about their experiences of using the service, and their feedback is used to improve the service. Guidance: <i>Feedback is independently sought (i.e. not by the clinical team). Their feedback is triangulated with other feedback to make it as accurate as possible. Staff members are informed of feedback from patients.</i>

12.2	2	<p>Services are developed in partnership with patient and carer representatives.</p> <p>Guidance: <i>This might involve patient and carer representatives attending and contributing to local and service level meetings and committees, or attending commissioner meeting.</i></p>
12.3	1	<p>Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.</p>
Carer engagement and support		
13.1	1	<p>Carers (where appropriate and with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.</p>
13.2	1	<p>Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency.</p> <p>Guidance: <i>This advice is offered at the time of the patient's initial assessment, or at the first opportunity.</i></p>
13.3	2	<p>Carers are offered individual time with staff members to discuss concerns, family history and their own needs.</p>
13.4	2	<p>The team provides each carer with carer's information.</p> <p>Guidance: <i>Information is provided verbally and in writing (e.g. carer's pack). This includes the names and contact details of key staff members in the team and who to contact in an emergency. It also includes information about confidentiality, and the parameters professionals have to work within, as well as local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.</i></p>
13.5	1	<p>Staff understand carers have a right to access them for information and support even if the patient does not consent to confidential information to be shared.</p>
13.6	2	<p>Carers feel supported by staff members.</p> <p>Guidance: <i>This could be through the provision/sign-posting to carer support networks or groups. It could be through the provision of a designated staff member dedicated to carer support.</i></p>
Treating patients with compassion, dignity and respect		
14.1	1	<p>Staff members treat patients and carers with compassion, dignity and respect.</p> <p>Guidance: <i>This includes respect of a person's age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.</i></p>

14.2	1	Patients do not feel stigmatised by staff members and the service can evidence efforts to reduce weight and ED based stigma within the service.
14.3	1	Patients feel listened to and understood by staff members.
14.4	1	Staff members are knowledgeable about, and sensitive to, the mental health needs of patients from minority or hard-to-reach groups in relation to eating disorders. This may include: - Men, black, Asian and minority ethnic groups; - Asylum seekers or refugees; - Lesbian, gay, bisexual or transgender people; - Travellers.
14.5	2	The service has a strategy for improving access for male patients to the eating disorder service. This may include but is not limited to: - Ensuring there are male staff - Male targeted literature - A gender neutral clinical environment.
Providing information to patients and carers		
15.1	1	Patients are offered copies of letters about their health and treatment, dependent on clinical risk.
15.2	1	Information for patients and carers is written simply and clearly.
15.3	2	Information can be provided in languages other than English (ensuring cultural relevance if necessary). It is available in easy-to-use formats for people with sight/hearing/cognitive difficulties or learning disabilities. Audio, video, symbolic and pictorial materials, communication passports and signers are used as necessary.
15.4	1	The service uses translators who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. <i>Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.</i>
15.5	1	When talking to patients and carers, health professionals communicate clearly, avoiding the use of jargon.
Patient confidentiality		
16.1	1	Confidentiality and its limits are explained to the patient and carer at the initial assessment, both verbally and in writing. <i>Guidance: This includes transfer of patient identifiable information by electronic means. This includes sharing information outside of the clinical team and confidentiality in relation to third party information (for carers).</i>

16.2	1	Patients' preferences for sharing information with their carer are established, respected and reviewed throughout their care.
16.3	1	All patient information is kept in accordance with current legislation. <i>Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.</i>
16.4	1	Patients are informed of any breach of confidentiality, and the reason why it is important to their continuing care is explained.
Service environment		
17.1	1	Clinical rooms are private and conversations cannot be over-heard.
17.2	1	The environment complies with current legislation on disabled access (Equality Act 2010). <i>Guidance: Relevant assistive technology equipment, such as handrails, are provided to meet individual needs and to maximise independence.</i>
17.3	1	Staff members follow a lone working policy and feel safe when conducting home visits.
17.4	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed.
17.5	1	Furniture is arranged so that doors, in rooms where consultations take place, are not obstructed.
17.6	1	There is an alarm system in place (e.g. panic buttons) that is easily accessible to staff at all times.
17.7	1	Staff members follow an agreed response to alarm calls.
17.8	1	All staff take ownership of maintaining a clean, comfortable and welcoming environment.
17.9	1	Emergency medical resuscitation equipment, as required by Trust/organisation guidelines, is available immediately (available for use within the first minutes of a cardiorespiratory arrest) and is maintained and checked weekly, and after each use.
17.10	2	Staff members have access to a dedicated staff room.
STAFFING		
Leadership, team-working and culture		
18.1	2	Staff members can access leadership and management training appropriate to their role and speciality.

18.2	1	The team has designated time at least once a month to meet as a group to reflect upon the process and the impact of the clinical work. Guidance: <i>Arrangements are in place for small teams.</i>
18.3	3	The team has received training in reflective practice and maintaining a psychologically informed environment.
18.4	2	Team managers and senior managers promote positive risk-taking to encourage patient recovery and personal development. They ensure staff members have appropriate supervision and MDT support to enable this.
18.5	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns.
Staffing levels		
19.1	1	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: - A method for the team to report concerns about staffing levels; - Access to additional staff members; - An agreed contingency plan.
19.2	1	When a staff member is on annual leave or off sick, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member.
19.3	1	The service has a MDT team, which will usually include psychiatry nursing, psychology/psychotherapy, dietetics, and also ideally includes OT and Social work. Where not all these disciplines are within the team, the team can demonstrate a rationale for that, and that patient care is not compromised.
Staff recruitment, induction and supervision		
20.1	2	Patient or carer representatives are involved in the interview process for recruiting staff members. Guidance: <i>This could include co-producing interview questions or sitting on the interview panel.</i>
20.2	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. Guidance: <i>This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.</i>
20.3	1	The service has a clear supervision structure so that each individual receives, professional, clinical and line management supervision and understand who is responsible for each of these elements.

20.4	1	All clinical staff members have access to monthly group or individual clinical/therapy supervision, using a psychological supervision model delivered with someone with appropriate experience.
20.5	1	For staff delivering specific psychological therapy models, supervision is provided by a supervisor who is adequately trained to deliver supervision in that specific therapy model in eating disorders. Frequency of supervision is commensurate to the size of caseload with this specific therapy and level of experience of the therapist.
20.6	1	All staff members receive professional supervision at a frequency consistent with profession guidelines.
20.7	1	All staff members receive line management supervision at least monthly.
20.8	2	Patients and carers who volunteer with the service receive monthly supervision.
Staff well-being		
21.1	1	The service actively supports staff health and well-being. <i>Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.</i>
21.2	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. <i>Guidance: They have the right to one uninterrupted 20-minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks.</i>
21.3	1	Staff members, patients and carers who are affected by a serious incident are offered post incident support.
Staff training and development		
22.1		Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:
22.1a	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).
22.1b	1	Physical health assessment. <i>Guidance: This could include training in understanding physical health problems, understanding physical observations and when to refer the patient for specialist input.</i>

22.1c	1	Risk assessment and risk management. Guidance: <i>This could include:</i> - Safeguarding vulnerable adults and children; - Assessing and managing suicide risk and self-harm; - Prevention and management of aggression and violence; - Prevent training; - Recognising and responding to the signs of abuse, exploitation or neglect.
22.1d	1	Recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities.
22.1e	1	Statutory and mandatory training. Guidance: <i>Includes equality and diversity, information governance, basic life support.</i>
22.1f	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.
22.2	2	Patients and carers are involved in delivering staff training face-to-face.
SERVICE MANAGEMENT		
Clinical outcome measurement		
23.1	1	Clinical outcome measurement data is collected at beginning of treatment, after 6 months, 12 months and then annually until discharge.
23.2	2	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.
23.3	2	The service's clinical outcome data are reviewed at least 6-monthly. The data is shared with commissioners, the team, patients and carers, and used to make improvements to the service.
The service learns from feedback, complaints and incidents		
24.1	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.
24.2	1	Staff members share information about any serious incidents involving a patient with the patient themselves and their carer, in line with the Duty of Candour agreement.
24.3	1	Lessons learned from incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.