

QED COMMUNITY

ANNUAL REPORT

2022 - 2023

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FOREWORD

I am delighted to introduce the 2024 QED Community report. QED is part of the College Centre for Quality Improvement (CCQI) and has been running for more than 12 years.

I am a parent of a daughter who has required numerous admissions to specialist hospitals throughout the past decade. It has been wonderful to use this lived experience, both positive and negative, to help shape the services of the future through my work with the QED.

The number of those struggling with eating disorders in the UK is ever growing and this has of course led to increased demand on already over stretched services. This is inevitably a challenging time for many patients trying to access the lifesaving treatment needed, but also for the staff working within eating disorder care. We know that recruitment and retention of staff continues to be a challenge and teams across the country are working incredibly hard to manage this. This year's report highlights the difficulties many services are facing with regards to recruitment, in particular peer workers and social workers. I know from first-hand experience the contribution properly trained peer workers can add to a team. Being supported by someone who has also struggled with an eating disorder can offer deep understanding, empathy and most importantly hope for recovery.

Although the report highlights areas of very good practice within community services and compliance with many of the standards, it also demonstrates some areas where many services are not meeting the threshold requirements. One example that is reflected across many teams is the lack of support for families of patients who are away at university. Additionally, there are not always protocols in place to ensure that there is sufficient collaborative working between patients' home team and the university eating disorder service.

I very much hope that being a part of the QED network will enable services to make the improvements required and help ensure that there is better consistency in treatment throughout the whole of the UK.

I would like to thank everyone working within eating disorder community services who are part of the network for their hard work and dedication to improving the quality and consistency of care. Additionally, I would like to thank all those who have worked as peer reviewers, the patients, and carers and of course the fantastic QED team who do such an incredible job in keeping the network working so successfully.

Rachel Bannister
Carer Representative, QED

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INTRODUCTION

Who we are

The Quality Network for Eating Disorders (QED) works with inpatient and community services to ensure and enhance the quality of care provided to individuals with eating disorders and their carers. Established as an independent network in 2012, QED is part of a larger initiative by the Royal College of Psychiatrists Centre for Quality Improvement (CCQI), which includes approximately 30 quality networks, accreditation projects, and audit programmes.

What we do

Through a comprehensive process of review, we identify and acknowledge high standards of organisation and patient care and support other services to achieve these. We support and engage inpatient units and community services in a process of quality improvement through peer-led reviews against a set of specialist standards for eating disorders. The process is supportive and promotes sharing of best practice between units. Involving service users and carers in QED is a priority, and people with first-hand experience of using eating disorders services are encouraged to get involved in all stages of the review process.

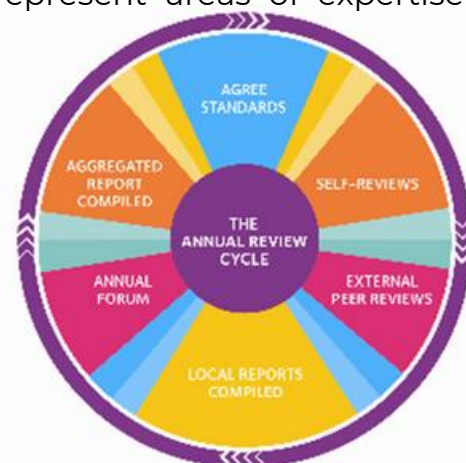
The network is supported by two crucial groups: the Advisory Group who is a dedicated team to provide guidance for the network's continued development and promotion. They actively contribute to shaping national recommendations for inpatient and community services. The Accreditation Committee also plays a pivotal role in informing key accreditation decisions and upholding consistency of the process. Comprising professionals and experts by experience, both groups represent areas of expertise within the field of eating disorder services.

Annual review cycle

The review process has 2 phases:

- Completion of a self-review questionnaire
- External peer-review

Each year, community members undergo their self-review, followed by an in-person developmental review. If the team chooses to pursue accreditation, their accreditation status remains valid for three years from the date of their initial presentation to the accreditation committee.



REPORT INFORMATION

The 2022-2023 QED Community report provides an overview of the adherence to the QED 3rd Edition Community Standards from six services across England (the six teams involved in this report were from England (see Appendix 1)).

The QED team collated the data from the five developmental peer reviews and one accreditation review and carried out quantitative analysis to ascertain the overall compliance to the QED 3rd Edition Community Standards.

What to expect in this report:

This national report contains the aggregated results of the reviews undertaken by six adult community eating disorder services during the 2022-2023 cycle (September 2022 to June 2023). It examines contextual data obtained from all services, including total caseload, referrals, number of cancelled appointments, did not attends, and discharges.

A QED Community member service's local report provides the team with a summary of the number of criteria met, partly met and not met, which then yields an average score for each individual standard. These averages enabled us to obtain a measure of the team's overall performance for each section of the service standards.

The overall compliance for standard domains can be found on page 7.

How to use this report:

The main body of the report highlights key achievements and areas for improvement across services from each standard domain of the QED standards. Average scores met across the standard domains by services are also shown in graphs. To ensure the report is as useful as possible to member services, recommendations for how to meet the standards that are highlighted as being most commonly unmet are listed, and best practice examples and feedback from patients and carers are also provided for each standard domain.

Finally, a full summary detailing the average scores for each criterion for all participating teams is included (see Appendix 1), helping to show the current aggregated compliance of member community eating disorder services for each standard. If a service is undergoing accreditation, for a standard to be marked as fully met, a service must provide up-to-date evidence deemed sufficient by the review team.

The QED network assesses eating disorder services according to a set of standards. The network undergoes a standards revision process every two years. These standards are drawn from a variety of authoritative sources and incorporate feedback from patient and carer representatives, as well as experts from relevant professions and external organisations.

The standards are used to generate a series of data collection tools for use in the self and peer review processes. Participating teams rate themselves against the standards during their self-review. This model aims to facilitate incremental improvements in service quality.

The standards are split into eight subsections:

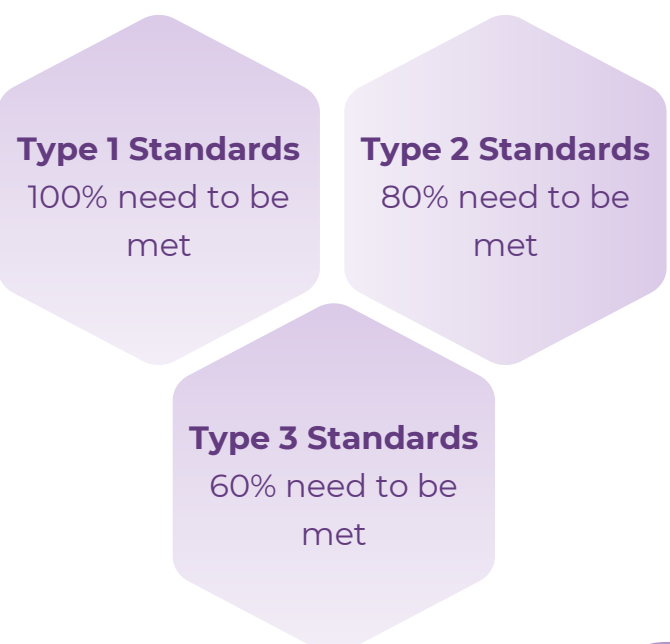
1. Access, Referral and Assessment
2. Staffing and Training
3. Care and Intervention
4. Information, Consent and Confidentiality
5. Rights and Safeguarding
6. Joint Working and Transfer of Care
7. Environment and Facilities
8. Service Management

Standards are categorised as a type 1, 2 or 3.

Type 1 standards relate to patient safety, rights or dignity. Failure to meet these standards would represent a significant threat to patients and/or would break the law. Accredited services need to meet 100% of these.

Type 2 standards are standards we expect services to meet. Accredited services need to meet at least 80% of these.

Type 3 standards are criteria that an exceptional service should meet or are standards that are not the direct responsibility of the team. Accredited services must meet at least 60% of these.



CONTEXTUAL DATA



SIX

Services took part in the 2022-2023 cycle

FIVE

Developmental Peer Reviews

ONE

Accreditation Review

100%

of services received a face-to-face review attended by peers from other specialist eating disorder services

17 Patients provided feedback



9 Carers provided feedback

24 staff members provided feedback



22 partner agencies provided feedback

All services were asked to provide up-to-date contextual data including total caseload, total number of referrals, total number of accepted referrals, average number of appointments that were not attended, number of people discharged and number of cancelled appointments.

CONTEXTUAL DATA CONTINUED

Data taken from the **six** services' self review workbooks. The numbers below are based on data collected within the last six months of the teams completing their workbook in the 2022-2023 cycle. The services range in size.



The average total case load for services was **292**, ranging from 101 and 653



232

The average total number of referrals into services was **232**, ranging from 88 and 598



152

The average total number of accepted referrals for services was **152**, ranging from 44 and 435

The total percentage of appointments that were not attended was **19.26%** ranging from 5% and 46.5%

19.26%



The average number of people discharged within the last six months was **121.66** ranging from 30 and 151



121.66

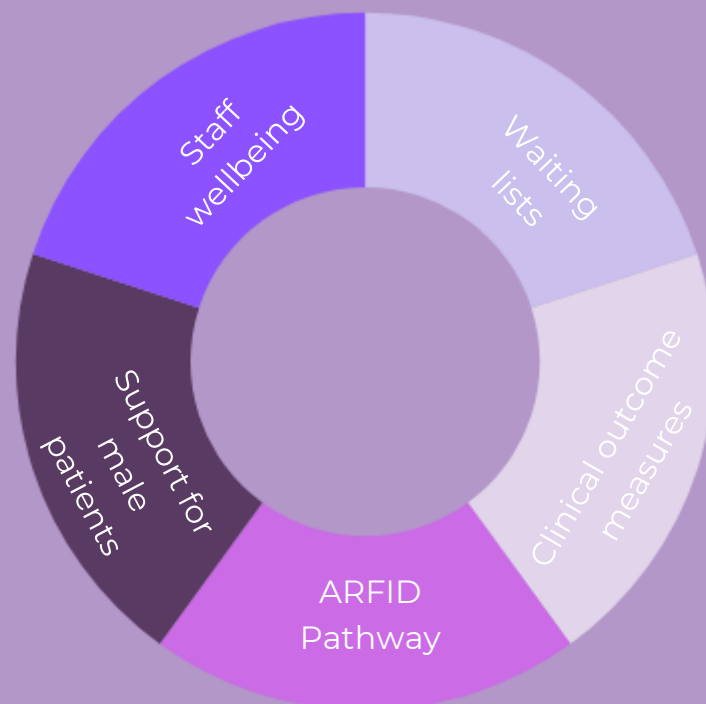
The total percentage of cancelled appointments was **27.63%**, ranging from 5% and 50.25%

27.63%

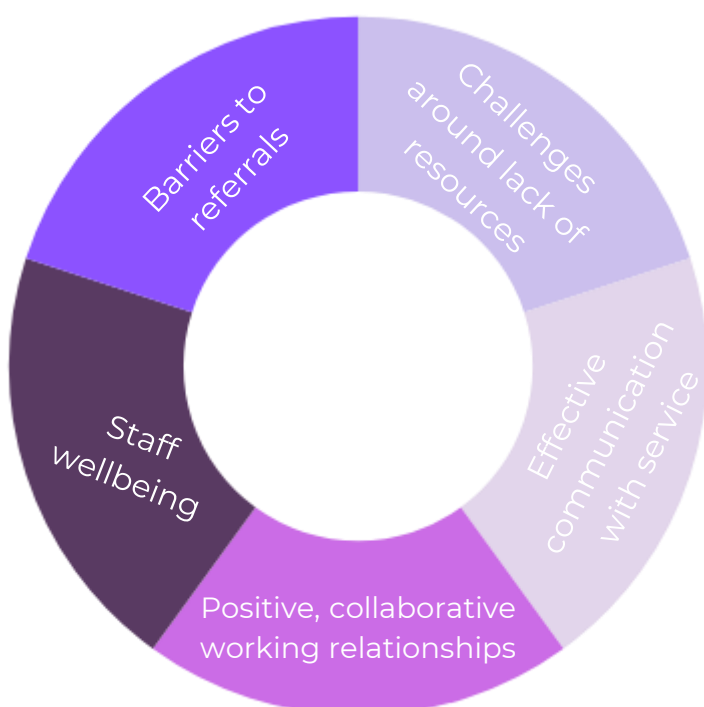


OPEN DISCUSSION THEMES

A key part of the peer review process is an open discussion session during which the team being reviewed can seek advice and guidance on a topic of their choice. The open discussion sessions foster diverse perspectives and promote collaborative learning where teams can share best practice on a specific topic. Displayed are the most commonly chosen topics.



PARTNER AGENCY FEEDBACK



Representatives from partner agencies are invited to give feedback as part of a service's developmental review. Partner agencies include GPs, CMHT staff and colleagues in local inpatient units. It helps to identify areas of success, acknowledge achievements and provides constructive criticism for continuous improvement. The following topics were identified most commonly.

OVERALL COMPLIANCE WITH STANDARDS

All services were assessed on their compliance with the Third Edition of the QED Community standards. Below is the average total adherence to each of the subsections of these standards (counting "Partly Met", and "Unmet" as not adherent, and "met" and "N/A" as adherent).

Section 1: Access, Referral, And Assessment



Section 2: Staffing And Training



Section 3: Care And Intervention



Section 4: Information, Consent and Confidentiality



Section 5: Rights and Safeguarding



Section 6: Joint Working and Transfer Of Care



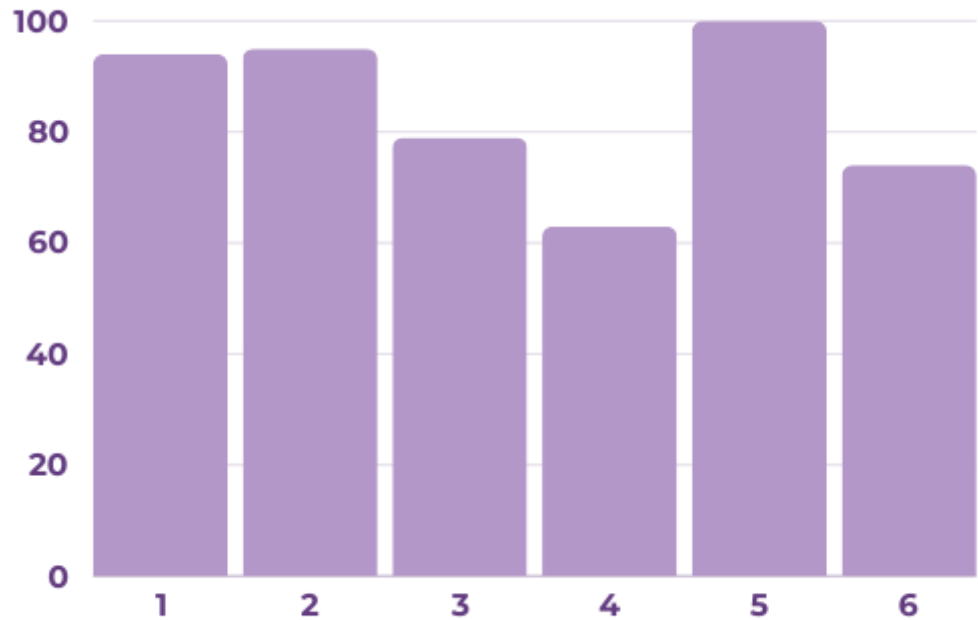
Section 7: Environment and Facilities



Section 8: Service Management



SECTION ONE: ACCESS, REFERRAL AND ASSESSMENT



*Each bar represents a community service

- **100%** of teams offer an appointment both in person and virtually and patient preference is taken into account (1.1.3).
- **100%** of services have a protocol to follow for patients who are on the waiting list, including support for carers and frequency of follow ups with a defined timescale and medical monitoring (1.2.8).
- **All** services reported having a risk assessment plan which is co-produced where possible, updated regularly and shared where necessary with relevant agencies (1.3.4).

- **33%** of services reported that they do not provide information about how to make a referral and waiting times for assessment and treatment (1.1.4), especially the latter part of the standard.
- **50%** of services reported sending out correspondence detailing the outcomes of assessments to referrers, the GP and other relevant services within one week (1.3.5). Services report that there can be administrative delays.

Total Met standards (%)



Key Achievements

Areas of Development

SECTION ONE: ACCESS, REFERRAL AND ASSESSMENT

Standard Criteria

Recommendations

Standard 1.1.4



The service provides information about how to make a referral and waiting times for assessment and treatment.

Teams have developed online referral forms which clearly outline the information required to make a referral. Teams also ought to explain to referrers, patients and carers what the expected time for treatment is.

Standard 1.3.3



A physical health review is conducted by a professional with specialist ED knowledge as part of the initial assessment or as soon as possible. The assessment includes consideration of: Physical health checks (including blood pressure, skin and mouth condition, and squat (SUSS) test); Medical complications of an eating disorder; Details of past medical history; Current physical health medication, including side effects and compliance with medication regime; Any mental and physical co-morbidities which may increase risk (e.g. pregnancy or diabetes); Lifestyle factors.

Consideration of all the factors listed as part of the assessment ought to be conducted as soon as possible, as it is important for physical health needs to be considered early within eating disorder treatment. The team could conduct an audit to determine how quickly they are taking place, and ensuring that it is recorded within the patient's notes.

Standard 1.3.5



The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within one week of the assessment. The patient receives a copy.

For teams to accelerate the process of sending assessment outcomes to the referrer, GP, and other relevant services within one week of the assessment, teams can implement the following strategies: electronic referral systems, immediate triage and decision-making, automated reminders to prompt timely correspondence, and to standardise templates and workflows to ensure efficient distribution of correspondence.

Example of Good Practice



- One service developed a useful resource with their dieticians. It outlines the dieticians' roles, provides guidance on initial advice, and specifies appropriate referral criteria. Additionally, the guide includes consultation slots, allowing dieticians to allocate time for specialised aspects such as refeeding and managing comorbidities. This resource has significantly enhanced the team's ability to identify suitable candidates for dietician referrals and has contributed to the growth of their knowledge base.

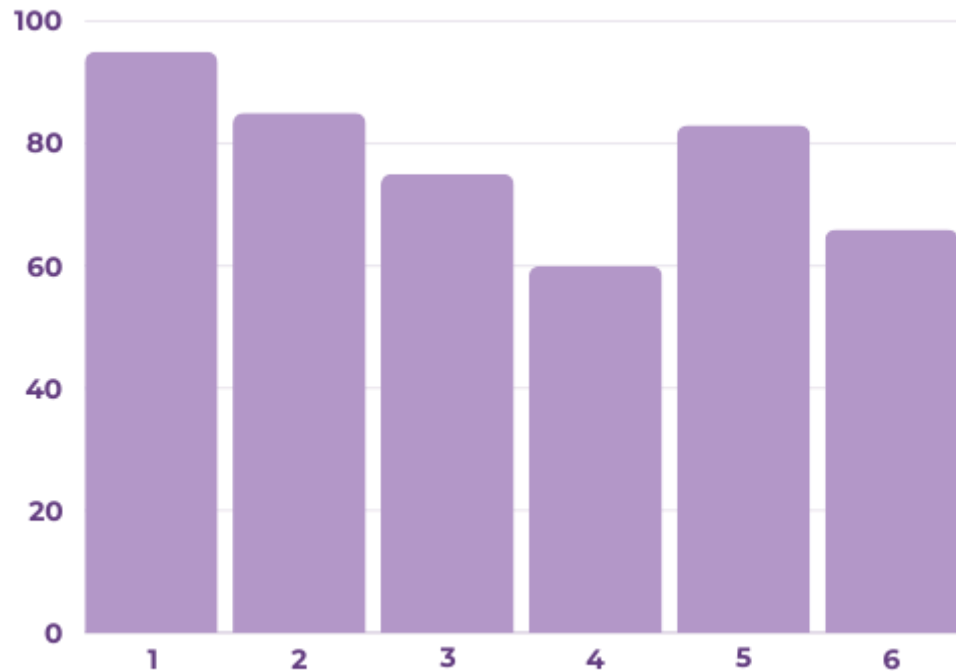
“

I have been lucky with being seen as quick as I have.

- Patient”

SECTION TWO: STAFFING AND TRAINING

Total Met standards (%)



*Each bar represents a community service

Key Achievements

- **100%** of services have dedicated sessional input from support workers to: provide interventions and support for individuals or groups (with appropriate supervision and training) and to work with clinicians to collect and analyse outcomes and feedback (2.1.12).
- **100%** reported having sessional input from administrative staff to provide administrative support to the service (2.1.13)
- **100%** reported they have dedicated sessional input from nursing staff to: conduct initial patient contact, facilitate engagement and assessments, deliver evidence-based individual and family psychological interventions and liaise with the wider network (2.1.8)

Areas of Development

- **17%** of services reported having dedicated sessional input from social workers to provide individual, couple and family support, facilitate support groups and facilitate links to other community resources (2.1.10).
- **17%** reported having input from input from peer support workers (2.1.11)
- **20%** of services reported reviewing the environmental and social value of its current practices against the organisation or NHS green plan (2.5.4).

SECTION TWO: STAFFING AND TRAINING

Standard Criteria

Recommendations

Standard 2.1.10



There is dedicated sessional input from social workers to: provide individual, couple and family support, facilitate support groups, facilitate links to other community resources.

Teams should contact provider collaboratives and local inpatient services consider the possibility of having input from social workers to consult on matters such as safeguarding or housing placements. It is important to have input from a social worker who would have valuable insight and support patients' social and emotional needs.

Standard 2.1.11



There is dedicated sessional input from peer support workers to: support the recovery model, act as a mentor, assist in the delivery of peer support groups, eating disorder training, education, and awareness (with appropriate training and clinical supervision).

Many services do not have commissioned dedicated sessional input from peer support workers. It is important for patients and their carers, where appropriate, to have dedicated time with peer support workers, who can draw from their lived experiences, and offer empathy and understanding to individuals facing similar challenges as stories of recovery are proven to support patients.

Standard 2.5.4



The service reviews the environmental and social value of its current practices against the organisation or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions).

Services could improve sustainability through focusing on operational efficiency, implementing cost-effective practices, adopting technology for streamlined processes and seeking feedback from patients, carers and staff to identify areas of improvement. (See guidance and documents developed by RCPsych: <https://www.rcpsych.ac.uk/improving-care/net-zero-mental-health-care-guidance-education>)

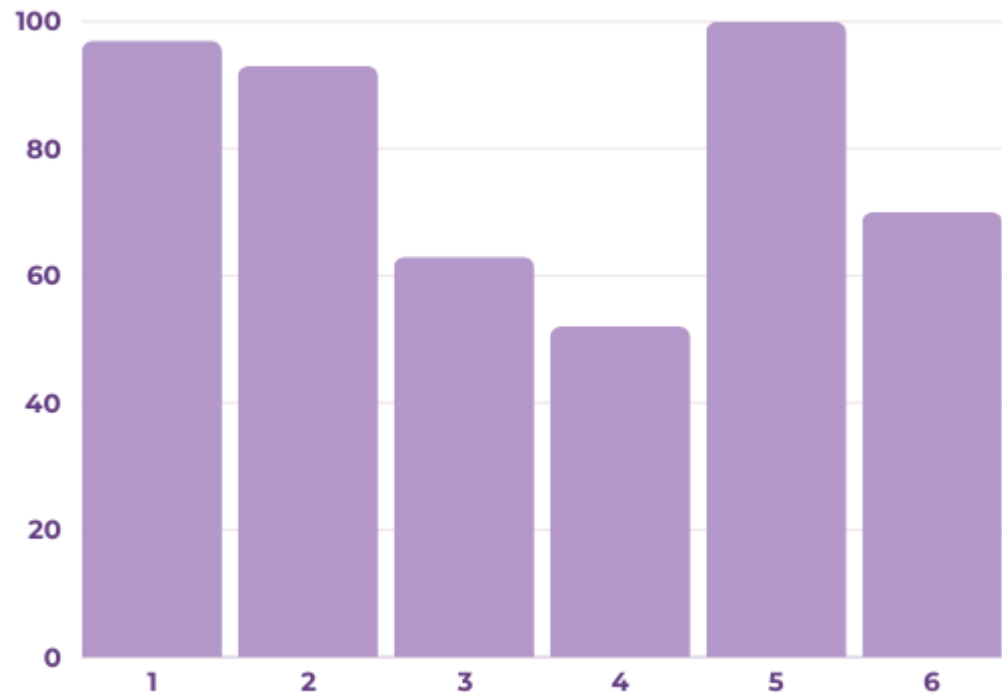
Example of Good Practice



- Many of the teams presented as integrated work collaboratively, providing the best care possible despite potential limitations around staffing.
- One Trust has a Recovery College providing free educational workshops and courses, designed to support people on their recovery journey. Eating disorder patients are referred to access these courses, which cover a variety of topics including personal recovery approaches, encouraging self-knowledge/acceptance, and applying new knowledge and skills.

“**The staff I was with were sincere, serious but also light-hearted and I genuinely think agreeing to treatment from the ED team was one of the best decisions I ever made.**”
- Patient

SECTION THREE: CARE AND INTERVENTION



*Each bar represents a community service

- **100%** of teams reported supporting patients to undertake structured activities such as work, education and volunteering (3.2.2).
- **100%** of teams reported that they support patients to develop a plan for appropriate levels of exercise or movement as part of their recovery pathway (3.4.4).
- **All** services reported involving carers (with patient consent) in discussions and decisions about patient's care, treatment and discharge planning, including attending review meetings where patients consent (3.5.1).

- **50%** of services reported that they support patients to access local green spaces on a regular basis (3.2.3).
- **50%** of services reported having 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 the Guidance on Recognising and Managing Medical Emergencies in Eating Disorders (MEED) (3.4.7).
- In **50%** of services, patients, carers and prescribers can contact a specialist pharmacist to discuss medications (3.3.3).

Total Met standards (%)



Key Achievements

Areas of Development

SECTION THREE: CARE AND INTERVENTION

Standard

Recommendations

Standard 3.2.3



The team supports patients to access local green space on a regular basis.

Services should encourage patients to access green spaces regularly by providing information about nearby parks, organising group activities, and discussing personalised strategies to incorporate nature into their routine. Teams could collaborate with local community programmes to organise nature-based events.

Standard 3.3.3



Patients, carers and prescribers can contact a specialist pharmacist to discuss medications.

Teams should ensure resources are allocated to employ or designate a pharmacist with expertise in eating disorders, for example through fostering collaboration between healthcare providers and pharmacists to integrate pharmacy services seamlessly into the care team. Teams could then offer video consultations with the specialist pharmacists to facilitate easy access for patients and carers.

Standard 3.4.7



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 the Guidance on Recognising and Managing Medical Emergencies in Eating Disorders (formally known as MaRSiPAN (Management of Really Sick Patients with Anorexia Nervosa)).

To ensure high-risk patients receive optimal care, teams should establish care plans with MDT collaboration following the most recent iteration of MEED guidance. They should establish protocols for regular blood tests and physical health reviews and educate patients on the importance of consistent monitoring.

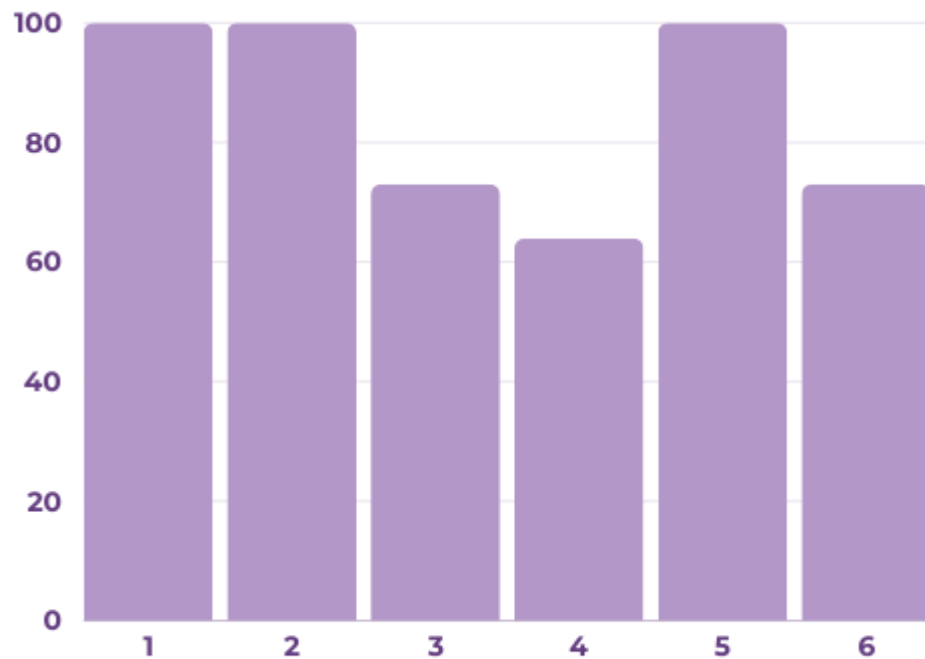
Example of Good Practice



- First Episode Rapid Early Intervention for Eating Disorders (FREED) has become well-implemented within many teams who also have a dedicated FREED champion within their service. The champions have had the role of tracking referrals and playing a crucial role in ensuring timely intervention and coordinated care is established.
- Teams offer a range of therapeutic treatments and programmes, with more groups being run more frequently, including Compassion Focussed Therapy.

“
Staff at the service are life savers – their care and treatment has been truly incredible
- Patient”

SECTION FOUR: INFORMATION, CONSENT AND CONFIDENTIALITY



*Each bar represents a community service

Total Met
standards (%)

Key
Achievements

- **100%** of services reported working with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation (4.1.6).
- **100%** reported that they ensure all patient information is kept in accordance with current legislation (4.2.3).
- **All** services reported that their team knows how to respond to carers when the patient does not consent to their involvement (4.2.4). Principles of Common Sense Confidentiality ought to be applied.

Areas of
Development

- **50%** of services do not always provide each carer with accessible carer information (4.1.3).
- **33%** reported that they have not consistently provided patients with accessible written information which includes information about their rights regarding consent to treatment, rights under the Mental Health Act, how to access advocacy services, how to access a second opinion, how to access interpreting services, how to view their health records and how to raise concerns, complaints and give compliments (4.1.1).

SECTION FOUR: INFORMATION, CONSENT AND CONFIDENTIALITY

Standard Criteria

Standard 4.1.1



Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes:

- Their rights regarding consent to treatment;
- Their rights under the Mental Health Act;
- How to access advocacy services;
- How to access a second opinion;
- How to access interpreting services;
- How to view their health records;
- How to raise concerns, complaints and give compliments.

The team provides each carer with accessible carers information.

Standard 4.1.3



Recommendations

This is a commonly unmet standard among teams. Services should ensure that patients and their carers/families, where appropriate, are provided with written information which staff members discuss with them as soon as possible. Teams could add this onto an admission checklist to ensure that each of the points are spoken through with the patient, or at least they know where to go if they would like further information on the matter. The information could be online, or through a QR code or website link for ease of access.

Sharing carers' information is vital for fostering collaboration and helps patient's loved ones foster a better understanding of their condition, which is very important once they are discharged from the community team. Teams ought to develop a carers' information pack, which could contain information on eating disorders, useful reading materials, FAQs, understanding meal plans etc. The team could also provide pre-admission materials via email.

Example of Good Practice

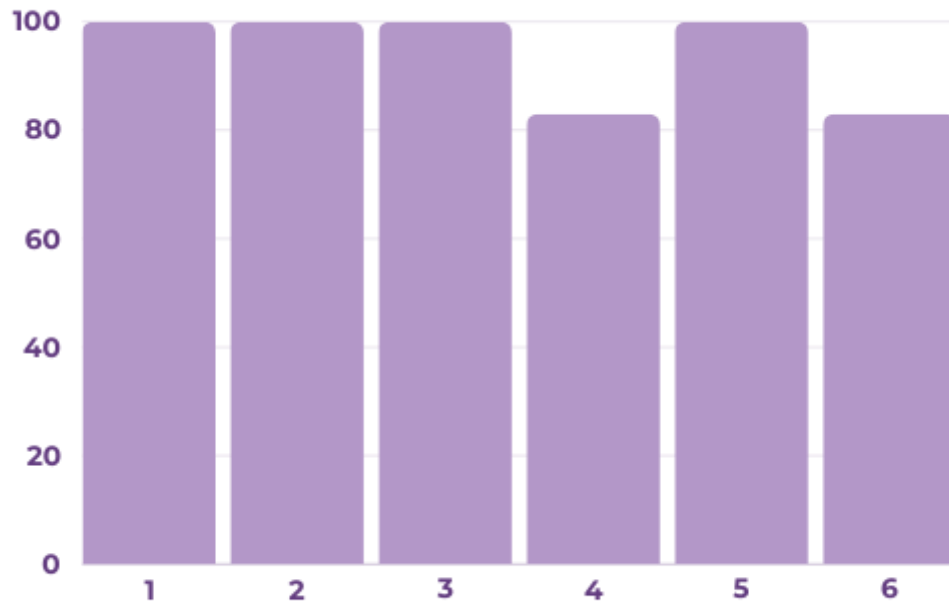


“ ***They were always offering information if something new came out. I liked that they tailored the information to you.***
- Carer

I received information about how to access resources on the internet, along with individually tailored/relevant information about my diagnosis.

- Patient

SECTION FIVE: RIGHTS AND SAFEGUARDING



*Each bar represents a community service

- **100%** of teams reported that staff members treat patients and carers with compassion, dignity and respect. (5.1.1)
- **100%** reported that patients feel listened to and understood by staff members (5.1.2)
- **100%** reported that staff members are knowledgeable about, and sensitive to, the social, cultural and mental health needs of patients from minority or hard-to-reach groups in relation to eating disorders (5.1.3)
- **100%** shared that patients feel welcomed by staff members when attending their appointments (5.2.1)
- **100%** shared that the team records which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary (5.2.1)

- **Not all** services reported having a strategy for improving access for male patients to the eating disorder service. this includes (but is not limited to): ensuring there is male staff, male targeted literature, a gender-neutral clinical environment (5.1.4)

Total Met standards (%)



Key Achievements

Areas of Development

SECTION FIVE: RIGHTS AND SAFEGUARDING

Standard Criteria

Recommendations

Standard 5.1.3



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. These groups may include:

- Men;
- Black, Asian and minority ethnic groups;
- Asylum seekers or refugees;
- LGBTQ+;
- Travellers.

Services should ensure that they engage in regular meetings to discuss equality, diversity and inclusion. This standard can be used as guidance of the different groups that can be discussed, to consider how the service can work to reach out to these groups. Teams who prioritise accessibility often appoint a named champion for EDI who can be can develop links with groups, liaise with patients around their individual needs, and disseminate learning amongst staff in the wider team via upcoming webinars and training relating to eating disorders (e.g. fasting during religious festivals. Dieticians also ought to consider meal plans with reference to patients' individual and cultural needs.

Standard 5.1.4



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.

The service should continuously be working to improve access for male patients. For example, the service could assign a lead from their staff team to work on how best to ensure appropriate male patients are referred into the service, and work to remove or reduce any barriers to them accessing treatment. Teams can ask a previous or current male patient to help review the service's environment and resources, to try and create more inclusivity for this group.

Interview Feedback Highlights



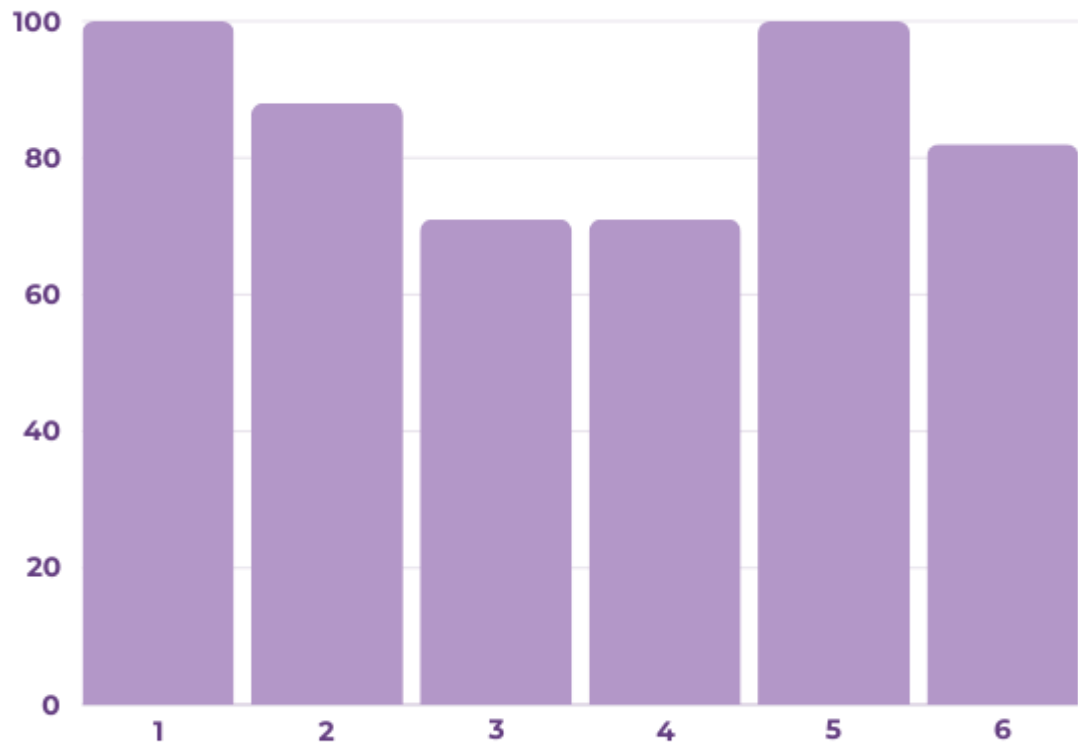
“ ***I have always been given the option of treatment – I feel like it has always been my decision.***

- Patient

In terms of being treated with dignity and respect that has always been the case and I have been treated as an individual. Staff always listen to what I have to say.

- Patient

SECTION SIX: JOINT WORKING AND TRANSFER OF CARE



*Each bar represents a community service

- **100%** of services reported that 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 (6.2.3).
- **100%** of services reported that the team supported patients to access housing support, support with finances, benefits and debt management and social services (6.3.2).
- **All** services reported that their service has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum; 6.3.2).

- **33%** of services reported that a discharge letter is not always sent to the patient and all relevant professionals involved within 10 days of discharge (6.2.1).
- **33%** shared that the service do not have a ratified protocol for liaison and collaborative working with patients who are attending university, and their university (6.2.7)
- **33%** shared that they are not able to offer continued support to families of patients who have moved away to university (6.2.8).

Total Met standards (%)



Key Achievements

Areas of Development

SECTION SIX: JOINT WORKING AND TRANSFER OF CARE

Standard Criteria

Recommendations

Standard 6.2.1



A discharge letter is sent to the patient and all relevant professionals involved (with the patients' consent) within 10 days of discharge. The letter includes the plan for:

- 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.

Teams should create template letters to make sure discharge letters/emails are going out to patients in a consistent manner and to ensure efficient distribution of correspondence. Template letters ought to include all of the relevant details listed in the standard. Teams could also generate automated reminders to prompt timely correspondence.

Standard 6.2.7



Where a patient is attending university, the service has a protocol for liaison and collaborative working with the patients' home/university service.

Services should make sure they have a written protocol for staff that clearly outlines how this process takes place. Teams could add this to their induction checklist to ensure staff are aware of this protocol as many patients experience this transition.

Standard 6.2.8



The service offers continued support to families of patients who have moved away to university.

Services should ensure continued support is offered for families of patients who have moved away to university through creating transition resources such as information packs with details about emergency contacts, available support services and coping strategies. Teams could appoint liaison officers within universities, and some teams have developed a university pathway as it is such a crucial point in a patient's journey and often patients will experience more stress.

Example of Good Practice

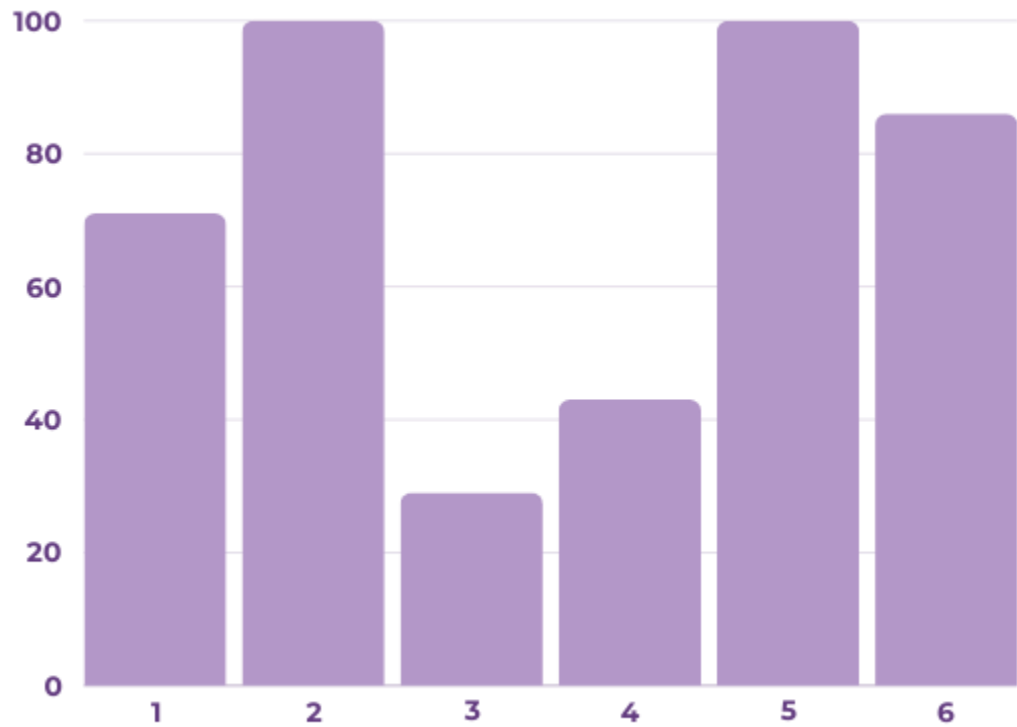


- One service runs a 'family and friends' group on a Saturday morning. It is run virtually which is fantastic as it helps to overcome geographical barriers.
- For community teams that are linked to inpatient wards, if there are staff working across the two settings, those staff will act as their key worker where appropriate to encourage familiarity when there is a transfer of care required.

“We have been involved in discussions around discharge and what support will be available to us when we leave the service. Having those conversations at the right time has really helped.”

- Patient

SECTION SEVEN: ENVIRONMENT AND FACILITIES



*Each bar represents a community service

Total Met standards (%)



Key Achievements

- **All** services shared that they have measures in place to ensure staff are as safe as possible when conducting home visits (7.1.4). Often teams have advanced systems in place to notify other staff members of their whereabouts.
- **All** services reported conducting an audit of environmental risk and a risk management strategy annually (7.1.5). Services ensure that they are aware of lines of sight and will mitigate environmental risks within community bases and centers that are used for appointments.

Areas of Development

- **50%** of services reported that their service is clean, comfortable and welcoming (7.1.1).
- **50%** felt that not all clinical rooms are entirely private, therefore conversations could potentially be overheard (7.1.2). Teams will try their best to report such issues to Estates teams.
- **67%** of teams reported that staff members have access to a dedicated staff room (7.1.7).

SECTION SEVEN: ENVIRONMENT AND FACILITIES

Standard Criteria

Recommendations

Standard 7.1.1



The service environment is clean, comfortable and welcoming.

Teams should ensure the environment is welcoming and inviting, ensuring there is enough space and furnishings for patients and carers/family members to join appointments. Often patients report that seeing scales left out in rooms can be triggering, so the team ought to ensure equipment is stored away.

Teams could decorate with plants, paintings, posters, etc, and could undertake QI projects to ask patients what they would like to see. Teams should also ensure spaces respect cultural diversity and foster a sense of belonging. Consideration ought to be given to ensure male patients also feel welcome.

Standard 7.1.2



Clinical rooms are private, and conversations cannot be overheard.

To ensure clinical rooms are soundproof for privacy and confidentiality, teams could consider the following measures: sealing doors or windows to prevent sound leakage, soundproof partitions to create flexible room layouts, install white noise machines, or install soundproof walls or paintings which reduce sound transmission.

Standard 7.1.7



Staff members have access to a dedicated staff room.

Evidence shows that it is important that ward/staff members have a designated staff room that is easily accessible and promotes relaxation and interaction. The team can look to optimise other existing spaces, such as converting often unused rooms into staff rooms where there is comfortable seating, tables, a table, kettle or microwave for staff convenience.

Example of Good Practice



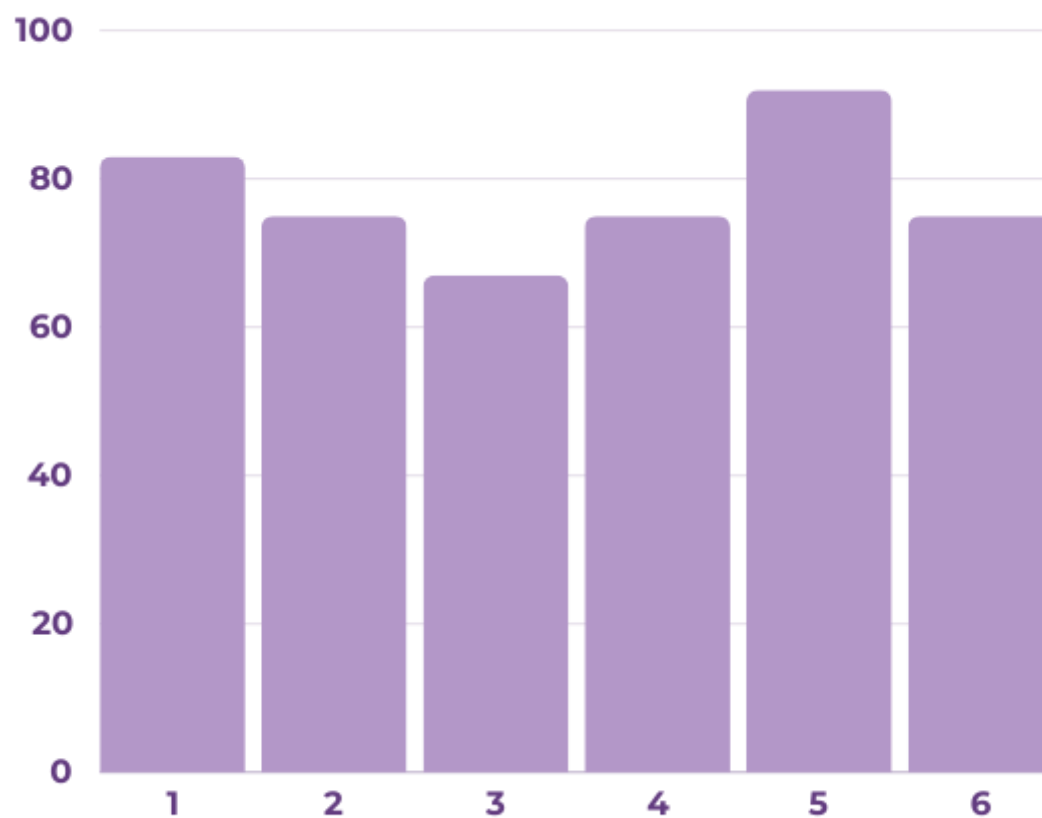
- Some services lack clinical space at their bases and may be shared with other services. One service had six well-signposted rooms, each adorned with tree signs indicating that they belong to the Eating Disorder Service. Patients were asked to design the artwork as part of a creative therapies project

“

Inclusivity is felt - you can tell from the environment that everyone is welcome.
- Patient

”

SECTION EIGHT: SERVICE MANAGEMENT



*Each bar represents a community service

Total Met standards (%)



Key Achievements

- **100%** of services ask patients and carers for their feedback about their experiences of using the service and this is used to improve the service (8.1.1).
- **All** services reported that patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management (8.1.4).
- **All** services reported that progress against patient-defined goals is reviewed collaboratively between the patient and staff members during clinical review meetings and at discharge (8.2.2).

Areas of Development

- **17%** of services shared that feedback from patients and carers is analysed and explored to identify any differences of experiences according to protected characteristics (8.1.2).
- **33%** reported that the service is developed in partnership with appropriately experienced patients and carers, who have an active role in decision making (8.1.3). Recommendations are made on the following page.

SECTION EIGHT: SERVICE MANAGEMENT

Standard Criteria

Recommendations

Standard 8.1.2



Feedback received from patients and carers is analysed and explored to identify any differences of experiences according to protected characteristics.

For teams to ensure that feedback from patients and carers is thoroughly analysed and explored, with attention to analysis based on protected characteristics, teams should first collect data through surveys and questionnaires, outreach and engagement activities, as well as qualitative research using interviews or focus groups. Teams can then conduct qualitative or quantitative analyses. Finally, teams can create actionable recommendations, report findings transparently and continuously improve their service to address disparities. Many services have identified a lead within their team to conduct such audits, and will link in with third sector organisations to establish links with communities.

Standard 8.1.3



The service is developed in partnership with appropriately experienced patients and carers, who have an active role in decision making.

Services should collaborate with patients and carers who have relevant experience and actively involve them in decision-making. For instance, an “expert by experience” could participate in meetings such as governance, steering, or advisory groups to ensure their perspectives are heard, and their ideas and feedback are acted upon.

Example of Good Practice



Services that are considering how to be more accessible have been analysing referral and caseload numbers with reference to protected characteristics. The teams have been able to identify specific groups that are often missed, and undertake outreach work (e.g. displaying posters in GP surgeries or within specific cultural or religious centres).

One community team uses a system called CheckWare that has a database of outcome measures, and it has a patient tracking system to automatically send out links to patients, who then fill in questionnaires. It then generates a report which clinicians can access instantly.



I feel like I am allowed to speak about what's been helpful and unhelpful when giving feedback which will genuinely shape the service
- Patient



Appendix 1: All standards data

1		Section 1: Access, Referral And Assessment	Percentage Met
1.1		Accessibility	
1.1.1	1	The team reviews data at least annually about the people who use it. Data are compared with local population statistics and actions taken to address any inequalities of access that are identified.	67%
1.1.2	3	Everyone can access the service using public transport or transport provided by the service.	83%
1.1.3	2	The team offers appointments both in person and virtually and patient preference is taken into account.	100%
1.1.4	1	The service provides information about how to make a referral and waiting times for assessment and treatment.	67%
1.2		Referral And Waiting Times	
1.2.1	1	A clinical member of staff is available to discuss emergency referrals during working hours.	100%
1.2.2	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 emergency referral which should be passed across immediately.	100%
1.2.3	1	The team assess patients, who are referred to the service, within an agreed timeframe.	67%
1.2.4	1	Outcomes of referrals are fed back to the referrer, patient and carer (where appropriate with the patient's consent) in writing.	83%
1.2.5	1	If a referral is not accepted, the team advises the referrer, patient and carer (where appropriate with the patient's consent) on alternative options.	83%
1.2.6	1	Referrals for people with diabetes or pregnant women are accepted into the service with a lower threshold of eating disorder severity.	100%
1.2.7	1	When on the waiting list for treatment, there is a care plan in place that demonstrates that:- risk is monitored,- there is a crisis plan - there is 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.	83%
1.2.8	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 timescale and medical monitoring.	100%
1.3		The Initial Assessment	
1.3.1	1	For non-emergency assessments, the team makes written communication in advance to patients that includes: - The name and title 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 or require support (e.g. access to an interpreter, how to change the appointment time or have difficulty in getting there).	100%
1.3.2	1	Patients have a comprehensive evidence-based assessment which includes their: - Mental health and medication; - Psychosocial and psychological needs; - Strengths and areas for development; - Eating disorder history (assessment performed in line with NICE guidelines).	100%

Appendix 1: All standards data

1.3.3	1	A physical health review is conducted by a professional with specialist ED knowledge as part of the initial assessment or as soon as possible. The assessment includes consideration of:- Physical health checks (including blood pressure, skin and mouth condition, and squat (SUSS) test);- Medical complications of an eating disorder;- Details of past medical history;- Current physical health medication, including side effects and compliance with medication regime;- Any mental and physical co-morbidities which may increase risk (e.g. pregnancy or diabetes);- Lifestyle factors.	67%
1.3.4	1	Patients have a risk assessment and management plan which is co-produced where possible (including carers, if the patient's consent is given), updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality).	100%
1.3.5	2	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within one week of the assessment. The patient receives a copy.	50%
1.4		Following Up Patients Who Do Not Attend Appointments	
1.4.1	1	The team follows up patients (including carers, if the patient's consent is given) who have not attended an appointment/assessment. If patients are unable to be engaged, 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.	100%
1.4.2	1	If a patient does not attend for an assessment / appointment, the assessor contacts the referrer.	83%
2		Section 2: Staffing And Training	Percentage Met
2.1		Staffing Levels	
2.1.1	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, such as the minor and temporary reduction of non-essential services.	50%
2.1.2	1	There is dedicated sessional input from psychiatrists to: - Provide biopsychosocial assessment; - Provide medical and psychological treatments - Coordinate care, including assessment, diagnosis and management of comorbidities; - Monitoring and managing of physical and psychological risks, especially for people with complex needs - Hold medico-legal responsibilities around using the Mental Health Act and Mental Capacity Act if needed	83%
2.1.3	1	There is dedicated sessional time from psychologists to: - Provide assessment and formulation of patients' psychological needs; - Ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway.	100%
2.1.4	2	There is dedicated sessional time from psychologists to support a whole team approach for psychological management.	67%
2.1.5	1	There is dedicated sessional input from occupational therapists to: - Provide an occupational assessment for those patients who require it; - Ensure the safe and effective provision of evidence based occupational interventions adapted to patients' needs.	50%
2.1.6	1	There is dedicated sessional input from dieticians to: - Provide dietetic assessment, advice and treatment to patients and to staff; - Support staff to devise meal plans, manage risk related to refeeding; - Oversee the nutritional care plan and psychoeducation regarding nutrition, weight and food	100%
2.1.7	1	There is dedicated sessional input from medical professionals (e.g. clinical nurse consultant, GP, physician) to: - Facilitate medical monitoring, blood tests, electrocardiograms (ECGs) - Liaise with other medical professionals (e.g. gastroenterologists and primary care)	83%

Appendix 1: All standards data

2.2		Staff Recruitment, Induction And Supervision	
2.2.1	2	Patients and carer representatives are involved in the interview process for recruiting potential staff members.	83%
2.2.2	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies.	83%
2.2.3	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body.	100%
2.2.4	2	All staff members receive line management supervision at least monthly.	83%
2.2.5	2	Patients and carers who collaborate the service receive monthly supervision.	25%
2.3		Staff Well-Being	
2.3.1	1	The service actively supports staff health and well-being.	83%
2.3.2	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive.	100%
2.3.3	1	Staff members, patients and carers who are affected by a serious incident are offered post-incident support.	83%
2.4		Staff Training And Development	
2.4.1a	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	100%
2.4.1b	1	Physical health assessment.	100%
2.4.1c	1	Safeguarding vulnerable adults and children.	100%
2.4.1d	1	Risk assessment and risk management.	100%
2.4.1e	1	Recognising and communicating with patients with cognitive impairment or learning disabilities.	100%
2.4.1f	1	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.	100%
2.4.1g	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	100%
2.4.1h	1	Managing distorted perceptions of food and body image, managing clients with co-morbidity and understanding the impact of trauma within eating disorders.	67%
2.4.1i	3	Atypical presentations including muscularity-oriented body image and disordered eating and people with a higher BMI	67%
2.4.2	1	Specialist ED assessment and formulation.	100%
2.4.3	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	83%
2.4.4	2	Patient and Carer representatives are involved in delivering and developing staff training.	50%
2.5		Leadership, Team-Working And Culture	
2.5.1	2	Staff members can access leadership and management training appropriate to their role and specialty.	100%
2.5.2	3	Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.	83%
2.5.3	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 or whistleblowing.	100%
2.5.4	3	The service reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions).	20%

Appendix 1: All standards data

3		Section 3: Care And Intervention	Percentage Met
3.1		Reviews And Care Planning	
3.1.1	1	Patients know who is co-ordinating their care and how to contact them if they have any questions.	100%
3.1.2	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.	50%
3.1.3	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews.	100%
3.1.4	1	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy.	83%
3.1.5	1	All patients have a documented diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	83%
3.2		Therapies And Activities	
3.2.1	1	Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to the bio-psychosocial needs	83%
3.2.2	2	The team supports patients to undertake structured activities such as work, education and volunteering.	100%
3.2.3	1	The team supports patients to access local green space on a regular basis.	50%
3.2.4	1	The service provides one of the NICE-recommended/evidence-based treatments for each of the disorders for which they are commissioned.	100%
3.2.5	2	The service provides two or more of the NICE-recommended/evidence-based treatments for each of the disorders for which they are commissioned.	83%
3.2.6	1	Patients with binge eating disorder are informed that all psychological treatments have a limited effect on body weight and this is recorded.	75%
3.2.7	1	Patients with severe and high risk illness whose condition has not improved with treatment are offered ongoing support and care with a specialist eating disorder clinician in order to support the risk assessment.	83%
3.3		Medication	
3.3.1	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.	83%
3.3.2	1	Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime.	83%
3.3.3	3	Patients, carers and prescribers can contact a specialist pharmacist to discuss medications.	50%
3.3.4	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.	83%
3.3.5	1	For patients who are taking antipsychotic medication, the team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	67%

Appendix 1: All standards data

3.4		Physical Healthcare	
3.4.1	1	Staff members arrange for patients to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the patient's care plan.	83%
3.4.2	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.	83%
3.4.3	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.	100%
3.4.4	3	Patients are supported to develop a plan for appropriate levels of exercise or movement as part of their recovery pathway	100%
3.4.5	1	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency.	100%
3.4.6	1	The service has a protocol for screening, monitoring, psychoeducation and management of bone health.	67%
3.4.7	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 the Guidance on Recognising and Managing Medical Emergencies in Eating Disorders (formally known as MaRSiPAN (Management of Really Sick Patients with Anorexia Nervosa)).	50%
3.4.8	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.	50%
3.4.9	1	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). If a physical health abnormality is identified, this is acted upon.	83%
3.5		Carer Engagement And Support	
3.5.1	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning. This includes attendance at review meetings where the patient consents.	100%
3.5.2	1	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency.	83%
3.5.3	2	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	83%
3.5.4	2	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to promote carer involvement.	83%
4		Section 4: Information, Consent And Confidentiality	Percentage Met
4.1		Providing Information To Patients And Carers	
4.1.1	1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: <ul style="list-style-type: none"> - Their rights regarding consent to treatment; - Their rights under the Mental Health Act; - How to access advocacy services; - How to access a second opinion; - How to access interpreting services; - How to view their health records; - How to raise concerns, complaints and give compliments. 	67%

Appendix 1: All standards data

4.1.2	1	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness and treatment.	83%
4.1.3	1	The team provides each carer with accessible carer's information.	50%
4.1.4	1	Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment.	83%
4.1.5	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.	83%
4.1.6	2	The team works with interpreters 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.	100%
4.1.7	1	When talking to patients and carers, health professionals communicate clearly, avoiding the use of jargon.	100%
4.2		Capacity, Consent And Confidentiality	
4.2.1	1	Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment are performed in accordance with current legislation.	100%
4.2.2	1	Confidentiality and its limits are explained to the patient and carer, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.	83%
4.2.3	1	All patient information is kept in accordance with current legislation.	100%
4.2.4	1	The team knows how to respond to carers when the patient does not consent to their involvement.	100%
5		Section 5: Rights And Safeguarding	Percentage Met
5.1		Treating Patients With Compassion, Dignity And Respect	
5.1.1	1	Staff members treat patients and carers with compassion, dignity and respect.	100%
5.1.2	1	Patients feel listened to and understood by staff members.	100%
5.1.3	1	Staff members are knowledgeable about, and sensitive to, the social, cultural and 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; - LGBTQ+ people; - Travellers.	100%
5.1.4	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.	83%
5.1.5	1	Patients feel welcomed by staff members when attending their appointments.	100%
5.2		Risk And Safeguarding	
5.2.1	1	The team records which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.	100%
6		Section 6: Joint Working And Transfer Of Care	Percentage

Appendix 1: All standards data

6.1		Intensifying Treatment	
6.1.1	1	When outpatient treatment is not effective, the service has a protocol for deciding: - When to discharge; - When to intensify; - When to provide support of clinical management or supportive monitoring; - Alternative intervention from the MDT.	100%
6.1.2	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: - Severity and risk (including physical and 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. - Diabetes	100%
6.1.3	1	A named worker is provided to inpatient services throughout admission and they are involved in care planning, admission and discharge planning meetings and CPAs.	100%
6.2		Discharge Planning And Transfer Of Care	
6.2.1	2	A discharge letter is sent to the patient and all relevant professionals involved (with the patient's consent) within 10 days of discharge. The letter includes the plan for: - 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.	67%
6.2.2	1	The team makes sure that patients who are discharged from hospital are followed up within 72 hours.	83%
6.2.3	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.	100%
6.2.4	2	When high-risk patients are transferred from inpatient/day patient to the community service, evidence-based psychological treatment starts within two weeks, even when new to the community team.	83%
6.2.5	1	There is active collaboration between Children and Young People's Eating Disorder Services and Adult Eating Disorder Services for patients who are approaching the age for transfer between services. This starts at least six months before the date of transfer.	83%
6.2.6	2	Teams provide specific transition support to patients when their care is being transferred to another community team, or back to the care of their GP.	83%
6.2.7	1	Where a patient is attending university, the service has a protocol for liaison and collaborative working with the patient's home/university service.	67%
6.2.8	2	The service offers continued support to families of patients who have moved away to university.	67%
6.2.9	1	Care plans for patients transitioning between university and home are developed in collaboration with both the university and home service, patients and their families (where appropriate). Plans 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.	83%

Appendix 1: All standards data

6.3		Interface With Other Services	
6.3.1	1	Patients can access help from mental health services 24 hours a day, seven days a week.	100%
6.3.2	1	The team supports patients to access: - Housing support; - Support with finances, benefits and debt management; - Social services.	100%
6.3.3	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.	100%
6.3.4	1	The service has invited their local district general hospital to collaborate in a group dedicated to working with the Guidance on Recognising and Managing Medical Emergencies in Eating Disorders (formally known as MaRSiPAN (Management of Really Sick Patients with Anorexia Nervosa)), and the team provides specialist ED input into an agreed pathway that is consistent with the pathway.	67%
6.3.5	2	The service provides risk assessment tools, consultation and advice to all local referrers.	100%
7		Section 7: Environment And Facilities	Percentage Met
7.1		Service Environment	
7.1.1	2	The service environment is clean, comfortable and welcoming.	50%
7.1.2	1	Clinical rooms are private and conversations cannot be overheard.	50%
7.1.3	1	The environment complies with current legislation on accessible environments.	67%
7.1.4	1	There are measures in place to ensure staff are as safe as possible when conducting home visits. These include: □ Having a lone working policy in place; □ Conducting a risk assessment; □ Identifying control measures that prevent or reduce any risks identified.	100%
7.1.5	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed.	100%
7.1.6	1	There is a system by which staff are able to raise an alarm if needed.	67%
7.1.7	2	Staff members have access to a dedicated staff room.	67%
8		Section 8: Service Management	Percentage Met
8.1		Patient And Carer Involvement	
8.1.1	1	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service.	100%
8.1.2	2	Feedback received from patients and carers is analysed and explored to identify any differences of experiences according to protected characteristics.	17%
8.1.3	2	The service is developed in partnership with appropriately experienced patients and carers, who have an active role in decision making.	33%

Appendix 1: All standards data

8.1.4	1	Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.	100%
8.2		Clinical Outcome Measurement	
8.2.1	1	Clinical outcome measurement is collected at two time points (at assessment and discharge).	100%
8.2.2	2	Progress against patient-defined goals is reviewed collaboratively between the patient and staff members during clinical review meetings and at discharge.	100%
8.2.3	2	The service's clinical outcome data are reviewed at least six-monthly. The data are shared with commissioners, the team, patients and carers, and used to make improvements to the service.	83%
8.3		The Service Learns From Feedback, Complaints And Incidents	
8.3.1	1	Systems are in place to enable staff members to report incidents quickly and effectively, and managers encourage staff members to do this.	100%
8.3.2	1	When serious mistakes are made in care, this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement.	100%
8.3.3	1	Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	100%
8.3.4	2	The team is actively involved in QI activity.	83%
8.3.5	2	The team actively encourages patients and carers to be involved in QI initiatives.	33%

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QED Community Member services:

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Get Involved!

Join the network!

Specialist community services across the UK are encouraged to join the QED network to be able to take part in peer reviews and share best practice. In order to register, you must provide a purchase order for the relevant membership fee and send a completed joining form. For all QED membership enquiries, please contact qed@rcpsych.ac.uk.

Benefits of Membership

Quality Improvement

Sharing of good practice, challenges and recommendations

Events

Members have discounted access (free if online!) to in person Annual Forums, Special Interest Days, and webinars

Networking

Members can access Knowledge Hub, an interactive online discussion platform and post questions, and can meet peers on reviews across the UK

Lived Experiences

Involving our patient and carer representatives in QED is our priority, including peer reviews. All resources are co-produced

Resources & Publications

Published annual reports and resources are shared to member services, allowing national recommendations and benchmarking.