SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	05/MHLD/0034
Service	Community Eating Disorders Service
Commissioner Lead	Clinical Commissioning Programme for Mental Health and Learning Disabilities
Provider Lead	Dorset HealthCare University NHS Foundation Trust
Period	April 2014 to March 2015
Date of Review	In year

1. Population Needs

1.1 National/local context and evidence base

This specification provides the framework for Dorset's Community Eating Disorders Service. The service will work within the requirements of the NHS Contract:

Local policies and strategies

- Local Joint Strategic needs Assessment
- Safeguarding - children and adults
- Mental Health and well-being agenda

In 2013 the responsibility for Commissioning inpatient eating disorders services was transferred to NHS England and for 2014 the responsibility is being broadened to include day patient services. The Community ED (CED) service in Dorset remains the responsibility of the clinical commissioning group and the purpose of this specification is to define the community service.

Evidence Base

NICE undertook the most thorough review and analysis of evidence for treatments for eating disorders so far and published their guidance in 2004 (National Collaborating Centre for Mental Health). There were 103 recommendations in total and they referred to all aspects of the delivery of treatment and care for individuals and carers with eating disorders. Key interventions were:

- There is good evidence to support the use of family based treatment for adolescents with anorexia nervosa for example the Maudsley model which has a very high success rate for those completing the programme
- There is strong evidence to support the use of Cognitive Behaviour Therapy (CBT) for adults with bulimia nervosa
- There is evidence to support the use of CBT for adults with atypical eating disorders including binge eating disorder

- There is evidence to support the use of Intrapersonal Psychotherapy (IPT) for adults with binge eating disorder or bulimia nervosa

More recently work was completed by the Royal College of Psychiatrists on guidelines for the care and treatment of those who are very ill with Anorexia Nervosa. The Guidance is: Management of Really Sick People with Anorexia Nervosa (MARSIPAN). Most recent evidence about the treatment of eating disorders suggests that if people are treated within the first three years of having an eating disorder with the appropriate ED interventions they have a 60-70% recovery rate which means that they do not need to progress to more intensive ED treatments or become long term patients of ED services. The later the treatment and support the less chance of full recovery and life away from ED services.

Incidence and Prevalence

Eating disorders occur mostly in young women and usually start in the mid-teens. Most eating disorders occur in young women; however, younger children and older people are also at risk of developing an eating disorder. All Eating Disorders are associated with physical and psychiatric complications. Anorexia has the highest mortality of any psychiatric disorder (Nielesn 2001). They often last several years and have a major impact on emotional, sexual and social development as well as causing co morbid psychiatric illness, chronic physical problems plus marked family distress and dysfunction. In particular, AN can become life threatening with children and adolescents becoming severely emaciated more rapidly and with muscle tissue breaking down at a much earlier stage in the disorder than in adults (Bryant-Waugh 1993). There are also the long-term consequences of disrupted growth, osteoporosis, the effect on fertility and other medical complications. EDs can have an enduring or relapsing course and create a significant burden for individuals with the disorder, their families and the wider health community. (The economic burden of EDs is described as substantial Simon et al. 2005).

As stated eating disorders mainly affect young women, although up to 1 in 10 of those affected by eating disorders is male. It is difficult to give an exact figure for the numbers of people affected especially since these conditions are often concealed and may go unnoticed and untreated. As many as 4 in 100 young women under 35 may have an eating disorder (Royal College of Psychiatrists).

The total prevalence of anorexia nervosa is estimated to be approximately 0.3% in young women (Hoek and Hoeken 2003) (under age 35).The average rate of prevalence for Bulimia Nervosa in young women and men has been estimated to be respectively 1% and 0.1% (Hoek and Hoeken 2003).

Table 1 Estimated projections of prevalence of Eating Disorders in Dorset

	2009	**2014**	**2019**
	Number	Number	Number
Young People under 35 years	123,000	125,200	126,100
Anorexia	369(37)	375(37)	378(37)
Bulimia	1230(123)	1252(125)	1261(126)

Source: ONS Sub-national population projections. The figures in brackets represent the likely prevalence in males.

The incidence of Bulimia Nervosa in a population of 100,000 has been estimated to be 12 new cases per year (Hoek and Hoeken 2003). The incidence of Anorexia Nervosa in a population of 100,000 has been estimated to be 8 new cases per year Hoek and Hoeken 2003).

Table 2 Estimated projections of incidence of Eating Disorders in Dorset

	2009	**2014**	**2019**
	Number	Number	Number
Population of Dorset	708,400	722,400	739,800
Anorexia	49	50	51
Bulimia	84	86	90

Source: ONS Sub-national population projections

Atypical Eating Disorders

Atypical Disorders are also known as Eating Disorders Not Otherwise Specified (EDNOS) (American Psychiatric Association 1994). About half of referrals to eating disorders services are for an atypical eating disorder either atypical anorexia or bulimia where the individual does not meet the full diagnostic criteria. (Fairburn and Harrison 2003). Few studies have identified the numbers of people with EDNOS. A major type of atypical eating disorder is Binge Eating Disorder. The lifetime prevalence of binge eating disorder (BED) is 3.5% in women and 2% in men (Hudson et al. 2006).

In terms of the patient experience it is anticipated that patients will still move from one part of the ED service to another dependent on their progress and treatment needs.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**x**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

2.2 Local defined outcomes

Activity and Performance

Patients who are accepted in to the service should report improvement in the following four areas: concern with shape and weight, eating disorder behaviours such as dietary restriction, binge and purging, depression and self-esteem

These are measured through completion of valid questionnaires on admission to and discharge from all parts of the service. Examples of these are included below and are included in Schedule 6 part F;

- Questionnaire EDE – Q
- Becks Depression inventory BDI 2
- Rosenberg self-esteem scale

The following are recorded in Schedule 4 Part C local quality requirements:

100% patients seen within 4 weeks from referral to assessments
100% patients in treatment within 8 weeks from assessment
80% of all patients completing treatment who show progress to achieving their identified goals
100% of patients accepted for treatment have Patient Identified Goals in place treatment
Baseline percentage of patients whose accommodation, employment/education status is recorded on PAS
85% of patient who complete EDE-Q, Becks or Rosenburg questionnaires showing improvement in their scores

In addition the service will record employment, accommodation and education status of their patients and report on RIO.

Activity (all by GP locality)

The following are reported in the scorecard in Schedule 6 Part B.

The service has an active caseload of 120 community patients. The active case load describes those who are engaging in the treatment programme and are PBR clustered. The service receives approximately 250 new referrals per year. The following activity data will demonstrate the effectiveness of the service.

Number of patients referred by GP locality
Number of patients re referred within 12 months of discharge
Number of referrals accepted
Number of patients in treatment
Number of patients who leave the service before completing treatment
Number of patients completing treatment and discharged from service
Number of patients discharged from the service
Number of patients who complete EDE-Q, Becks or Rosenburg

The Community ED (CED) Service will work within Dorset HealthCare's Transitions Policy. A key function of the CED service is to liaise closely with the Young Person's

ED (YPED) service. This will ensure that individuals' needs are met in line with their treatment and care plan and not solely determined by their age.

3. Scope

3.1 Aims and objectives of service

The aims of the Community ED service are to support and treat patients who have an eating disorder who do not require an admission to day or in patient services at the point of referral, and offer post discharge treatment and care from inpatient/day patient treatment.

The Community Service aims:

- Support people to manage and improve their condition in the community without the need for more intensive treatment or intervention
- To educate people about eating disorders
- Help prevent deterioration

3.2 Service description/care pathway

The community Adult ED service is the first step in the adult ED Care Pathway and it is the access point to other adult ED services. However the aim of the service is to minimise the need for more intensive interventions.

The referral process is open to patients registered with GP Surgeries in Bournemouth Dorset and Poole who have an eating disorder. They can refer themselves to the service for an assessment and then receive ongoing support as indicated by the assessment or they can be referred for example by a GP, family, social care or health care professional.

The Community Adult ED Service will be delivered from Kimmeridge Court 69 Haven Road, Canford Cliffs, POOLE, Dorset BH13 7LN 5days a week (on the St Ann's site) and from Maiden Castle in Dorchester, Dorchester Road DT1 2ER on Tuesday PM and Wednesday all day. It is also available from within CMHT bases in the west of Dorset.

The service will provide:

- Psychiatric assessment to include ED psychopathology and identify comorbid mental and physical health conditions
- Advice to referrers and others about eating disorders
- Motivational enhancement interventions to work with ambivalence
- Nutritional counselling and psychoeducation with the aim of restoring healthy balanced eating
- Intensive community treatment if a patient's condition is deteriorating or not progressing
- One to one support sessions utilising CBT and other forms of psychological interventions that are evidence based for the treatment of eating disorders
- Collaboration with family and carers with careful consideration of patient

confidentiality

- Carers needs assessment and appropriate advice and support
- Family intervention
- Group sessions for anyone accessing the ED services
- Occupational Therapy home assessments
- GP Clinic at Bournemouth University GP Practice
- Additional treatment and support options (in addition to day and inpatient treatments)

3.3 Population covered

The service will be available to people living in registered with a GP in Dorset, Bournemouth or Poole who have an eating disorder or are concerned that they might have an eating disorder.

3.4 Any acceptance and exclusion criteria and thresholds

The service will assess all referrals and agree an appropriate response which might be to accept the person into the service or it might be to recommend day or inpatient services dependent on the patients' needs. The exclusion criteria is:

- Obesity without an eating disorder
- Prader Willi Syndrome

3.5 Interdependence with other services/providers

The Community Adult Eating Disorders service could be a stand-alone service and it is funded separately in the sense that there is an identified value for the community service. However the community service will continue to be complementary to and an integral part of the ED Service Care pathway which includes Day and Inpatient services and close liaison with the YPED Service.

The Community Service will deliver evidence based treatment and support for people who have an eating disorder (or concerned that they may have). The community service will link to day and inpatient service and refer to and accept referrals from these two parts of the service ED service.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

CG9 Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders

CG9 Eating Disorders: algorithms

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Applicable local standards

The service will be subject to the local standards as detailed in schedule 4 part C.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

The main base for the service is: Kimmeridge Court, St Ann's Hospital but the service is also delivered from: Maiden Castle in Dorchester, Dorchester Road DT1 2ER on Tuesday PM and Wednesday all day and available from within CMHT bases in the west of Dorset.

The community service is available during the hours of 9am – 5pm on the days and from the locations it is provided.

7. Individual Service User Placement