CDI Clinical Designs - Cover Sheet*

Document Type	Model of Care
Document Title	National Clinical Programme for Eating Disorders HSE Model of Care for Ireland - Executive Summary
Document Owner (e.g. NCP)	National Clinical Programme for Eating Disorders
NCAGL	NCAGL Mental Health
Approved by	CCO Clinical Forum
Unique Identifier Number (UID)	CDI/0240/1.0/2025
Version Number	V1.0
Publication Date	January 2018
Recommended Revision Date **	December 2026
Electronic Location	

National Clinical Guidelines must use NCR cover sheet if being uploaded onto NCR. Otherwise this cover sheet applies

***** Refer to HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs)***

Version	Revision Date	List Section Numbers Changed	Author
1.0	Reviewed May 2025	No change-Recommended Revision 2026	NCP Eating Disorders

National Clinical Programme
for Eating Disorders

EXECUTIVE SUMMARY

Eating Disorder Services

HSE MODEL OF CARE FOR IRELAND

Clinical Strategy and Programmes Division

HSE Mental Health Services

READER INFORMATION

Division: National Clinical Strategy and Programmes Division and National Mental Health Division

Title: Model of Care for Ireland Eating Disorder Services Executive Summary

Document Number: CSPD020/2017

Version Number: V.1

Author: Based on the work of the National Working Group and Clinical Advisory Group of College of Psychiatrists of Ireland

Approved Date: December 2017

Published Date: January 2018

Revision Date: The HSE National Clinical Programme will be reviewed in 2021, unless the need for revision is identified by: Findings from the audit and evaluation process, or significant changes in evidence etc.

Web: To access National Clinical Programme for Eating Disorders please click: http://www.hse.ie/eng/about/Who/cspd/ncps/mental-health/eating-disorders/mac/

Designed by: Studio 10 Design

ISBN: 978-1-78602-069-7

Executive Summary

The National Clinical Programme for Eating Disorders has been prioritised within the HSE's National Clinical Programme for Mental Health in order to develop and improve its eating-disorder service provision in Ireland. The aims of the HSE Clinical Strategy and Programmes Division are to improve health services in terms of:

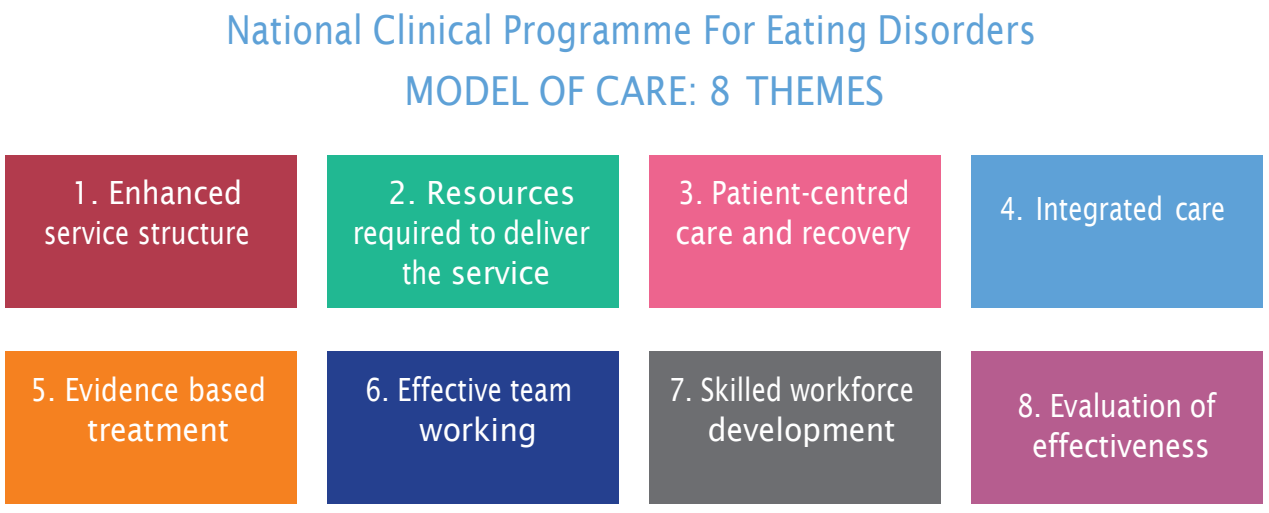
- quality and safety
- access to services and treatment
- cost effectiveness

Background

Eating disorders affect up to 5% of the population at some point in their lives, and anorexia nervosa has the highest mortality rate of all of the mental health conditions.[1] Because eating disorders tend to develop at a relatively young age, they result in very high psychosocial, healthcare and socio-economic cost over the lifespan.[2] Quality of life for people with eating disorders can be poor with significant impact on education and occupation. However, early intervention and specialised treatment programmes have been shown to be effective in improving clinical outcomes, promoting recovery and shortening the duration of illness.

A challenge is that the clinical needs of this group cross the traditional divide between mental and physical health services. They therefore require an integrated approach to service provision. Barriers to recovery and access to services also include societal misunderstanding as to the causes of eating disorders, which have both genetic and environmental influences.[3] This can lead to stigma and delay in seeking help.[3] A relative lack of access to specialised training in eating disorders for clinicians can also lead to delay in access to services and appropriate evidence-based treatment.[4]

This Model of Care outlines the HSE's vision for its eating disorder services in Ireland into the future. This includes services for children and adults with eating disorders, at all clinical stages, levels of severity and settings. It has been developed by an interprofessional national working group of HSE clinicians, in collaboration with Bodywhys and the Eating Disorder Clinical Advisory Group from the College of Psychiatrists of Ireland. Recommendations are based on analysis of the evidence based international literature in relation to best practice and clinical care for eating disorders service delivery, discussions with clinicians and service users on the ground, and consultation with Clinical Leads from key related HSE clinical programmes. Its recommendations can be summarised under eight themes:



Summary of Recommendations

Theme 1: Enhanced Service Structure

1.1 A **stepped care** approach to service delivery is recommended so that eating-disorder services can be effectively delivered to people according to their level of clinical need. This includes four levels: primary and community care, outpatient services, day and intensive programmes, and inpatient care. (Figure 1).

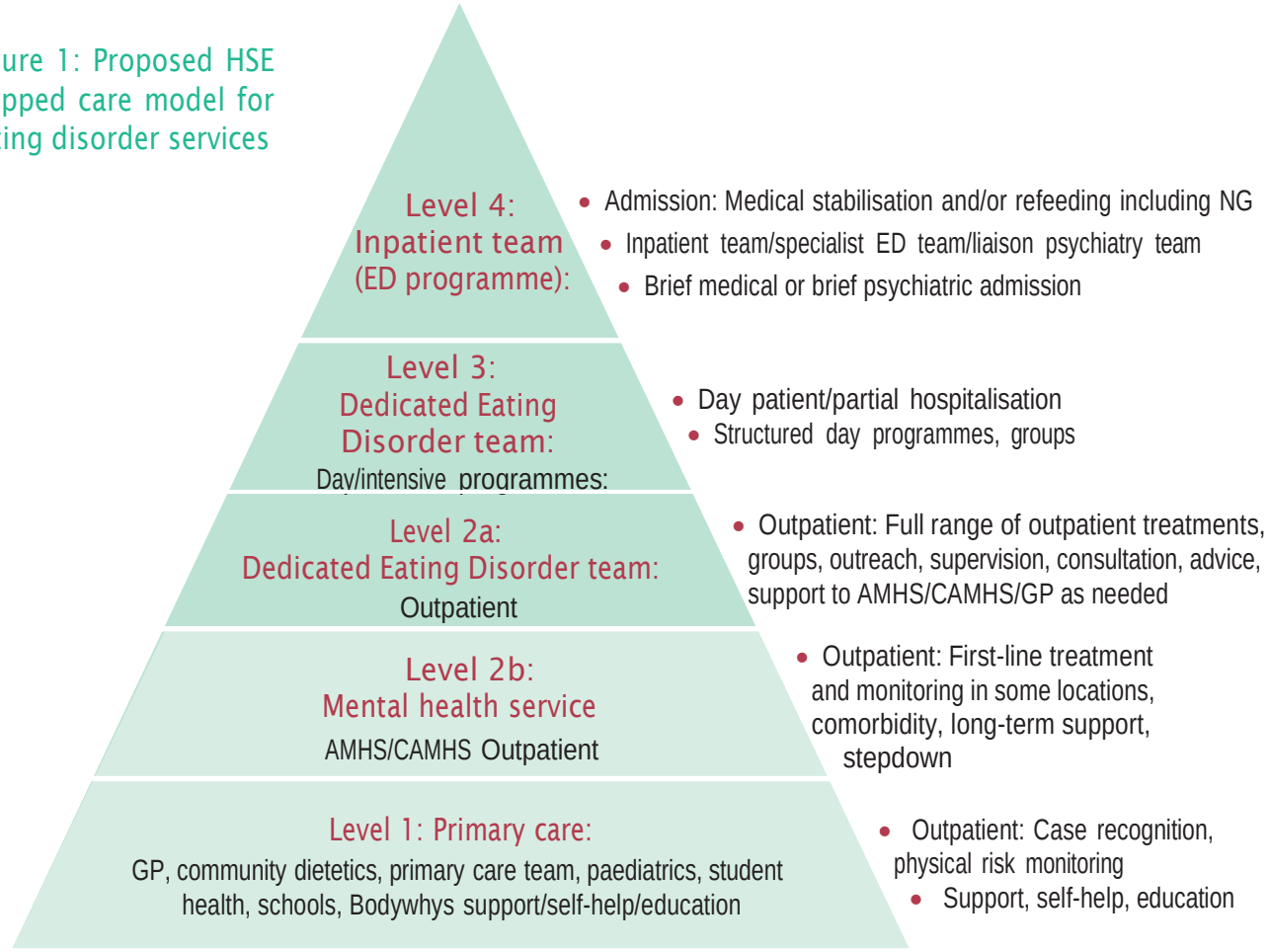
1.2 For most people with eating disorders, treatment can be safely and effectively provided outside of an inpatient setting. It is therefore a **priority to develop specific outpatient and day service provision**.

1.3 To deliver this stepped care model, it is recommended that a **national network of dedicated eating-disorder teams** be established to support existing adult and child mental health teams in the delivery of eating-disorder care. These teams will predominantly provide outpatient and intensive/day programmes, as well as consultation and support to people admitted to acute hospitals, in collaboration with liaison psychiatry services, medical, paediatric and inpatient teams. In the case of admissions of adults to psychiatric units, the eating disorder team will provide ongoing clinical care. In the case of admissions of under 18's to psychiatric units, the eating disorder team will provide consultation and support to the inpatient team as required.

1.4 Eating Disorder teams will be located at key locations nationally in proximity to existing mental health services, dedicated inpatient beds, and population centres (see Table A and B). They will provide support to local AMHS/CAMHS including to teams in more geographically remote regions within their sector.

1.5 Whilst clinically distinct , it is recommended that the adult and child eating disorder teams form ED **'Hubs' and 'Minihubs'** within each sector with the aim of collaboration on ED service improvement in each CHO on issues such as clinical access pathways, local clinical guidelines (e.g. transition pathways), training, resources and strategic planning.

Figure 1: Proposed HSE stepped care model for eating disorder services



1.6 Each ED 'hub' will have provision for out-patient, day-patient, and inpatient mental health services. Each 'minihub' will serve a smaller catchment area and have provision for outpatient and day-patient mental health services. ED teams will refer people who need inpatient psychiatric admission to their a linked inpatient eating disorder programme/ unit (Table A and B).

1.7 Eating disorder teams will be **embedded within their local mental health service** and under the clinical governance of their local Executive Clinical Director, Head of Mental Health Services, and CHO area management structures.

1.8 It is recommended that the teams operate as a national network in developing and implementing the quality standards and recommendations of the National Clinical Programme for Eating Disorders and international best practice.

1.9 It is recommended that access to **inpatient psychiatric beds for eating disorders be reconfigured to align with a Vision for Change recommendation of 4 adult inpatient centres nationally**. This will allow for the development of expertise and an adequate volume of cases for specialised inpatient eating disorder programmes to run. These beds should be collocated close to acute hospitals with ICU facilities and liaison psychiatry services, where possible.

Table A: Proposed base locations for Adult Eating Disorder Teams

ED hub or minihub team	Total pop. AMHT 18-65 yrs (2016 census)	Psychiatry beds (acute hospital)
CHO 1: Sligo/Leitrim/Donegal/Cavan-Monaghan • Sligo ED minihub • Cavan minihub with outreach to CHO 9	394,333	GUH (5 beds) * Connolly Hospital
CHO 2: Galway/Roscommon/Mayo • Galway ED hub	453,109	GUH (5 beds) (Acute hospital link: GUH)
CHO 3: Limerick/Clare/North Tipperary • Limerick ED minihub	384,99	1 short-term bed at LUH ** Long term >> GUH
CHO 4: Cork and Kerry • Cork ED hub	690,575	5 beds at SLMHU (Acute hospital link: CUMH)
CHO 5: South Tipp/Carlow/Kilkenny/Wexford/Waterford • Kilkenny ED minihub	510,333	1 short-term bed ** Long-term >>(SVUH or SLMHU)
CHO 6: Dublin South-East and Wicklow (SVUH) • ED hub –extended team also covers CHO 7 and part of 8	445,590	6 at SVUH (Acute hospital link: SVUH)
CHO 7: Dublin South-West and Kildare • Covered by the CHO 6-based extended ED hub team	645,293	SVUH
CHO 8: Laois, Offaly, Longford, Westmeath • Laois/Offaly to be covered by CHO 6 ED hub • Longford/Westmeath, Meath and Louth to be covered by CHO 9 ED hub	616,229	(SVUH) Connolly Hospital
CHO 9: North Dublin and Dublin North City MHS • North Dublin ED hub also covers part of CHO 8 North Dublin also covered by CHO 1	621,405	5 beds at Connolly Hospital (acute hospital link – Connolly Hosp.)

* All psychiatric beds are collocated with an acute hospital with AMU/ICU.** The beds in LUH and SLH are for local respite/short-term use. If longer-term admission is needed, transfer to a psychiatric unit with an inpatient ED programme is recommended. Attendance at local intensive day programme may also be an option. CHO 5: if Kilkenny, link with Dublin; if Waterford, link with Cork.

Theme 2: Resources Required to Deliver the Service

2.1 It is recommended that **8 additional dedicated child and adolescent and 8 adult eating disorder teams** be established in order to support and collaborate with existing mental health services in delivering this model of care.

2.2 The majority of these teams will be CHO-based in location (see Tables A and B) and will thus cover sector populations of approx. 384,908–694,575, with some geographical variance where populations are too low or dispersed to sustain a full team.

2.3 Team size will vary as they will require a staffing **level proportionate to their sector population size**. The recommended team composition for a sample sector of 500,000–600,000 is displayed in Tables C and D.

2.4 It is recommended that the HSE work towards the co-development of paediatric, physician and hospital dietetic **special-interest posts** in eating disorders in each hub location.

2.5 Currently, HSE eating-disorder services are provided through community AMHS and CAMHS teams with a small number of ED specialist clinicians in some areas. Redeployment of existing ED posts alone is insufficient, and additional funding and staffing resources will be required to implement this model of care.

Table B: Proposed base locations for Child and Adolescent Eating Disorder Teams

Hub/Minihub Sector	Total pop. CAMHS (2016 census)	Psychiatry beds (acute hospital)
National: Psychiatric unit in NCH (Linn Dara**) • ED hub team- service to Dublin sectors 8 national beds	National CHO 7/all	National ED beds Up to 18 years 8 ED-dedicated beds (Acute link: onsite NCH)
CHO 1: Sligo/Leitrim/Donegal/Cavan-Monaghan • Outreach to Donegal from Galway minihub • Cavan/Monaghan ED minihub	394,333	CAMHS Inpatient Unit Merlin Park (GUH link)
CHO 2: Galway/Roscommon/Mayo • Galway ED hub	453,109	CAMHS Inpatient Unit Merlin Park (Acute link with GUH)
CHO 3: Limerick/Clare/North Tipperary • Limerick ED minihub	384,998	CAMHS Inpatient Unit Merlin Park
CHO 4: Cork & Kerry • Cork ED hub	690,575	Eist Linn adolescent unit (Acute hospital link: CUH)
CHO 5: South Tipp/Carlow/Kilkenny/Waterford/Wexford • Waterford ED minihub	510,333	Eist Linn adolescent unit
CHO 6: Dublin South-East and Wicklow* • Covered by the CHO 7 Linn Dara ED hub (below)	549,531	Linn Dara adolescent unit
CHO 7: Dublin South-West and Kildare* • Linn Dara ED hub team- extended** Also covers CHO 6 and part of 8	541,352	Linn Dara adolescent unit (Acute hospital link NCH, Connolly)
CHO 8: Laois, Offaly, Longford, Westmeath • Laois/Offaly to be covered by Linn Dara hub • Longford/Westmeath, Meath and Louth to be covered by CHO 9 hub	616,229	Linn Dara / St Joseph's (Tallaght/NCH)
CHO 9: North Dublin and Dublin North City MHS • North Dublin ED hub (also covers part of CHO 8) North Dublin also covered by CHO 1 minihub	621,405	St Joseph's (NCH, Beaumont)

* The variance in the total populations CHO 6 & CHO 7, reflects the current coterminous anomaly between specialities.
** Linn Dara ED team will also be supported by NCH-based HSE hub. NCH unit is an approved centre linked with Linn Dara Services.

2.6 It is recommended that, when planning to implement the National Clinical Programme For Eating Disorders in their area, ECDs and local management teams conduct a needs-based analysis of current ED capacity and resources within their CHO.

2.7 Because experience in both mental health and in eating disorders is essential for clinicians working with this clinical group, it is recommended that redeployment and backfilling of existing senior clinical staff with ED expertise, as well as the creation of ED specific national recruitment panels be considered, in order to recruit appropriately trained staff to the eating disorder teams whilst also not depleting existing CAMHS and AMHS.

2.8 **Inpatient psychiatric treatment for adults**

As detailed in Table A, **23 dedicated inpatient adult psychiatric eating disorder beds** are required in order to deliver inpatient care to the smaller number of people who require inpatient psychiatric treatment. This approximates the 24 recommended in A Vision for Change (2006). These dedicated beds should be **collocated with an acute hospital site**, so that patients can be safely and efficiently transferred between services and wards should deterioration arise. Three beds are currently operational at St Vincent's Hospital in Dublin. All units with a dedicated ED capacity should have a specialist ED inpatient programme to include both refeeding and biopsychosocial components of care.

In order to achieve adequate inpatient numbers to run therapeutically meaningful inpatient ED programmes, it is recommended that adult patients who require longer periods of admission from Limerick or Kilkenny, be transferred to an inpatient ED programme in a larger adult unit with dedicated ED beds, or if physically able, attend an ED dedicated day service in their area.

2.9 **Inpatient psychiatric treatment for children and adolescents**

Inpatient psychiatric treatment for children and adolescents will continue to be provided through specialist ED inpatient programmes at each of the 4 regional inpatient adolescent units.

In addition, the planned **8 dedicated ED psychiatric beds in the new National Children's Hospital** will provide additional inpatient capacity, including for children up to 12 years who have eating disorders.

2.10 As the eating disorder programme is primarily focused on outpatient and day services, each eating disorder team will require dedicated outpatient and day facilities, as specified in the model of care document.

2.11 It is recommended that IT infrastructure be resourced in each hub so as to enable:

- Evaluation of the effectiveness of the clinical programme (data analysis, software, support)
- **Telemedicine** – video consultation and clinical support to those in more remote areas is a strong component of this Model of Care.
- Development of a dedicated national eating disorder website resource for both patients and professionals.

Theme 3: Patient-Centred Care and Recovery

3.1 The National Clinical Programme for Eating Disorders has worked closely with Bodywhys, the national eating disorder support group in Ireland, in the development of this Model of Care. This has ensured that the values of patient-centred care and recovery are embedded in the heart of the National Clinical Programme for Eating Disorders.

3.2 It is recommended that this partnership between HSE and the national support group continue into the future, at national level through the development of joint initiatives and reviews of the clinical programme, and at local level through collaboration between ED hubs and Bodywhys in planning local public education initiatives, support groups and in obtaining service-user perspectives.

3.3 Patient support is a key part of recovery and enablement. The National Clinical Programme recommends that all people with eating disorders and their families be encouraged by clinicians to access support services in addition to their treatment services. This is particularly important for people who are beginning to seek treatment, and for those who are isolated or lack social networks.

3.4 The HSE Clinical Programme will support Bodywhys in developing and evaluating its support programmes. Bodywhys is developing its services to complement each level of the HSE stepped model of care.

Table C: Sample Adult Eating Disorder Team composition (500,000–600,000 sector population)

Discipline*	Whole-time equivalence (WTE)	Minimum grade
Consultant psychiatrist	1	Consultant
Psychiatric nursing**	3	At least 1 CNS, 1 CMHN
NCHD	1.5	1 registrar (OP/DH)*** 0.5 senior registrar (SR supports eating disorder team liaison with inpatient service)
Clinical psychologist	1	Senior
Consultant physician	0.2 +0.1	Consultant
Dietitian	1	Senior
Dietitian – acute hospital	0.1	Senior
Occupational therapist	1	Senior
Social worker	1	Senior
Creative therapist	1	Senior
Clinical coordinator (clinician)	0.5	Senior
Admin	2	1 x grade 4; 1 x grade 3
Ancillary staff for day programme	Sessional	
Total	**13.4**	

* Includes a trained family therapist in the team from among these disciplines. ** Nurse numbers reflect their key role in supporting the day programmes, meals and hospital liaison. *** OP = Outpatient; DH = Day Hospital.

Table D: Sample Child Eating Disorder Team composition (500,000–600,000 sector population)

Discipline*	(WTE)	Minimum grade
Consultant child psychiatrist	1	Consultant
Senior registrar/registrar	1.5	1 registrar (OP/DH)*** and 0.5 senior registrar (SR supports liaison with inpatient service)
Clinical psychologist	1	Senior
Social worker	1	Senior
Dietitian with ED specialism	1	Senior
Dietitian – acute hospital	0.1	Senior
Psychiatric nursing**	3	CNS/CMHN
Occupational therapy	1	Senior
Paediatrician/adolescent health physician/acute physician	0.2 +0.1	Consultant
Co-coordinator	0.5	Senior
Admin	2	1 grade 4, 1 x grade 3
Ancillary (staff for day programme/ education/ creative)	2	Department of Education
Total	**14.4**	

* Includes a trained family therapist in the team from among these disciplines. ** Nurse numbers reflect their key role in supporting the day programmes, meals and hospital liaison. *** OP = Outpatient; DH = Day Hospital.

3.5 It is recommended that training initiatives on eating disorders include a service-user session, so that clinicians can develop deep understanding of the experience of living with, and caring for someone with, an eating disorder.

3.6 Evaluation of patient experience is recommended as part of the standard evaluation of the quality of this clinical programme (Table F).

3.7 At clinical level, it is recommended that eating disorder services adopt a recovery and evidence-based ethos in their day-to-day working.

Theme 4: Integrated Care

4.1 It is recommended that adult and child eating disorder teams in each area form '**eating disorder hubs**' in order to collaborate on developing ED services in their sector (e.g. care pathways, collaboration with other care/support services, training, evaluation, research, and development of local initiatives for public and professionals). This will enable other services to engage with them more seamlessly.

4.2 The referrals coordinator on the team will enhance the integration of the service locally by providing referrers with a **single initial point of referral** contact for advice, requests for consultation and referrals.

4.3 Given the high medical need of people with eating disorders, it is recommended that quarterly 'ED Hub' business meetings also include representatives from key acute hospital disciplines and primary care.

4.4 The NCPED will collaborate with the National Clinical Programme for Primary Care and aims to engage a General Practitioner to help it identify and develop resources for clinicians working in primary care.

4.5 The HSE National Clinical Programme for Eating Disorders endorses the **MARSIPAN and Junior MARSIPAN risk-management guidelines** (RCPsych 2014, 2016) for anorexia nervosa as a framework for shared and collaborative care between acute hospitals and ED services. This has also been supported at national level by the National Clinical Programmes for Paediatrics and Acute Medicine. A key task of local ED hubs will be to design, pilot, and develop integrated patient care pathways, standards and checklists for clinicians based on these guidelines, so that service transitions of people with eating disorders can be managed safely and efficiently on a 24/7 basis.

4.6 The National Clinical Programme for Eating Disorders plans to collaborate at a national level with the following programmes in the promotion of best practice, quality improvement and **integrated service pathways** for people with eating disorders, as well as in the development of joint training initiatives and resources:

- National Clinical Programme for Acute Medicine
- National Clinical Programme for Paediatrics
- National Clinical Programme for Primary Care
- National Clinical Programme for Emergency Medicine
- National Clinical Programme for Palliative Care

4.7 It is recommended that transitions of people with eating disorders between adult and child services are supported by:

- Regular scheduled transition meetings between adult/ child services
- Transition communication begins at six months before 18th birthday
- Information and statement of engagement between person and the new service.
- Joint written care plan at three months before 18th birthday.

Theme 5: Evidence-Based Practice

5.1 In order to deliver evidence based care, most individuals with a clinical diagnosis of an eating disorder require treatment by a core group of clinicians that includes a **Consultant Psychiatrist or Child Psychiatrist, a therapist with ED training, access to a dietitian/dietitian consultation on the case, as well as physical risk monitoring by a GP and/or hospital physician/ paediatrician**. These clinicians will be drawn from within the larger multi-disciplinary team (MDT).

5.2 All people with eating disorders should be given the opportunity of a trial of first-line evidence based psychosocial treatment, as recommended in the most up-to-date best practice guidelines available unless contraindicated. [5, 6, 7]

5.3 In line with international research on treatment fidelity,[8,9,10] it is recommended that clinicians have access to, and are supported by supervisors, to use, manuals and fidelity scales where available and to attend peer supervision groups and other supports in order to enhance their effectiveness in providing eating disorder treatment to people with eating disorders.

The National Clinical Programme will support this by developing training resources, a dedicated website and peer supervision groups.

5.4 Each case also provides its own clinical evidence and it is recommended that progress in clinical outcomes be mapped collaboratively during the patient journey, particularly in the early stages of engagement in treatment.

5.5 The National Clinical Programme supports the international view that **outpatient treatment by skilled specialist staff** is the most effective setting for treatment for the majority of people with eating disorders. Inpatient care should be reserved for those who have high clinical risk, require high structure, or where evidence based outpatient or day/intensive treatment has been unsuccessful. Prolonged inpatient care can risk disempowering patients and families in terms of recovery.

5.6 In the context of the evidence that early intervention and early weight-gain predicts better outcomes, the working group and Eating Disorder Clinical Advisory Group recommend the following standards in terms of access

Recommended timeframes

- Referral to assessment time: maximum 4 weeks
- Assessment to first treatment appointment: maximum 4 weeks

5.7 It is also recommended that people who are waiting for eating disorder care are provided both support and self-help materials in order to help them remain active in their own recovery (e.g. NCPED website when available), bibliography recommendations, Bodywhys support, leaflets, etc.

Theme 6: Effective Team Working

6.1 In line with recommendations in *A Vision for Change* (2006), each eating disorder team will include three key operational roles:

- A Consultant Psychiatrist/ Child and Adolescent psychiatrist (clinical lead)
- A referrals and team clinical coordinator
- A team administrator

6.2 Standards of **clinical governance** for the National Clinical Programme as a whole are outlined in the Model of Care document (Section 14) and will align with current HSE and MHC standards. At team level, governance structures will be the same as those currently in operation for HSE mental health teams in each CHO.

6.3 It is recommended that all clinicians on the ED team also have interdisciplinary training in order to deliver a range of evidence-based ED interventions and assessments within their competency (Table E). This will serve to minimise external and internal waiting lists.

6.4 It is recommended that all team members have core training in key areas of clinical risk management appropriate to their profession.

6.5 In order to enhance team communication, it is recommended that each patient has a designated clinical **keyworker** as an important point of contact for them for support, advice and updates. This can be any clinical member of the team, ideally, the one who is working most closely with the person with the eating disorder.

6.6 Given the complex nature of ED care, it is recommended that eating disorder teams have access to monthly **process/peer support groups**, which in ideal circumstances will be externally facilitated.

6.7 It is recommended that teams engage in **quarterly business meetings** in order to oversee their clinical governance at team level, and to promote service improvement, develop pathways, resources and systems, and evaluate their clinical outcomes.

6.8 It is recommended that each team include a grade 4 administrator with data skills and access to appropriate statistical resources, in order to facilitate clinical audit and evaluation of this clinical programme.

Table E: Current minimum psychological treatment competencies required within each ED team

Adults with eating disorders	Children and adolescents with eating disorders
CBT-ED – individual and group	FBT/ FT-AN/-individual and group
MANTRA	FT-BN
SSCM	CBT-ED
(FPT)? IPT-BN	AFT-AN
MARSIPAN	Junior MARSIPAN

Theme 7: Skilled Workforce Development

7.1 It is recommended that all clinicians working in the eating disorder teams be of a senior grade within their discipline, and have prior experience and training in working with eating disorders.

7.2 An interprofessional education and training group will be established by HSE to develop a **core interprofessional curriculum and competency framework** for HSE clinicians to use in their professional development planning. This will include representatives from clinicians in related clinical programmes.

7.3 The NCPED plans to develop a **core HSE training programme** on aspects of eating disorders that clinicians come across in their regular clinical work. This will be provided to all clinicians during their first year of working on the programme, as well as to other interested clinicians in AMHS/CAMHS and acute services who are working with people with eating disorders on a regular basis. It will include face-to-face, online, audit and case study components. The HSE will work with key interested national clinical programmes and professional training bodies in this regard.

7.4 It is recommended that each ED team has access to a team based training budget in order to access **team-specific training** to implement their work and enhance collaborative care and capacity.

7.5 It is recommended that each ED team also promotes an internal learning culture in their sector by developing regular internal ED-focused **CPD** events (case discussion, journal clubs, etc). Clinicians from AMHS/ CAMHS, acute services and primary care ED leads who are working regularly with eating disorders should be invited to attend these educational events if they so wish.

7.6 Each ED hub will promote ED awareness and expertise in their area by organising **local educational events** and resources.

7.7 At national level, the National Clinical Programme will continue to support a culture of evidence-based and best-practice treatments for people with eating disorders. The current state of play in terms of international recommendations for psychosocial treatments is summarised in Section 7 of the full Model of Care document. Table E summarises the implications that this has for the training of ED clinicians at the present time.

7.8 The National Clinical Programme for Eating Disorders will develop a **website resource** for professionals so that they can easily access educational and clinical content to support their daily work.

7.9 All educational programmes supported by the NCPED will be subject to **evaluation** of their educational effectiveness and direct benefit on patient care.

Theme 8: Evaluation of Effectiveness

8.1 This Model of Care recommends that the national network of eating disorder teams and individual clinicians from AMHS/CAMHS who are working regularly with people with eating disorders engage in a culture of ongoing cycles of service improvement, clinical outcome evaluation and audit as part of their standard practice (e.g. IHI's Plan-Do-Study-Act model[9].

8.2 In order to evaluate the eating disorder service, and in line with service audit in other parts of the HSE, key anonymised demographic data will be collated by teams as part of clinical audit and quality improvement (see Table G).

8.3 A **360° approach to clinical outcome evaluation** is recommended, so that progress toward recovery can be understood comprehensively in terms of the following domains:

- Patient-Reported Outcome Measures (psychological, quality of life) – PROMs
- Key **physical parameters** (e.g. BMI, blood results)
- Patient-Reported Experience Measures (e.g. goals, satisfaction) – PREMs
- Clinician-Reported Outcome Measures – CROMs.

The specific clinical measures recommended in the NCP-ED are displayed in Table F. Many clinicians already use these instruments regularly as part of good clinical practice.

8.4 Access and the cost-effectiveness goals of the clinical programme will be evaluated through the measurement of key activity parameters. The recommended provisional activity dataset for this programme is displayed in Table G.

8.5 It is recommended that the role of the team administrator (grade 4) and of the team coordinator will include collation of this data on behalf of their sector in advance of business meetings, and that both team mentors will work with the consultant psychiatrist/ child psychiatrist in the planning of service evaluation.

Table F: Recommended clinical outcome and quality evaluation metrics (for each case)

Purpose

- To enable the individual clinician and local ED team to clinically audit their work
- To enable 360° progress tracking and collaborative care planning for individual patients with their clinician and at team level
- To assist the clinical team in collaborative decision-making around service improvement, professional development and learning
- Broader recovery focus than just weight

Each Case **When?**	**What?** *Which clinical tool or instrument?*	**Why?** *Domain being considered*	**How often?** **How to gather?**
Baseline assessment 6 weeks 3 months 6 monthly At discharge	DSM 5/ ICD 11 Diagnosis	Diagnostic classification	Collected by individual clinicians to evaluate progress on case-by-case basis Anonymised team data is then collated by team coordinator monthly for local clinical evaluation, clinical audit, service improvement
	EDE-Q[1]	ED Psychopathology- (PROM)	
	CIA[3]	Quality of life measure (PROM)	
	HONOS/HONOSCA[2] (consider MFQ[7].)	Comorbidity	
	CGAS[5] (child) or GAF[4] (adult)	Clinician-rated outcome measure (CROM)	
	ESQ[8]	Patient experience (PREM)	
	BMI if over 18, %BMI if <18 years	Physical parameter (risk and safety)	
	Physical risk severity	Monitoring of risk (CROM)	
	DSH category (NCP-DSH metric)	Suicidality (PROM)	
	Psychotropic medication	Other treatments needed	
	PVAS[6] (if < 18)- consider SCORE 15	Measure of carer functioning	
	Main therapeutic approach (multiple)	Measure of evidence base	
	Bodywhys engagement (yes/no)	Receiving support services	
	Substance use	Comorbidity	
At baseline	Gender	Demographics	
At baseline	Age category – range	Demographics	
At baseline	Electoral area	Demographics	

1. Eating Disorder Ex mination Questionnaire (EDE-Q); 2. Health of the Nation Outcome Scales/Children and adolescents (HO OS/HONOSCA);
3. Clinical Impairment Assessment 3.0 (CIA); 4. Global Assessment of functioning scale (GAF) 5. Children's Global Assessment Scale (CGAS),
6. Parent Versus Anorexia Scale (PVAS), 7 Mood and Feelings Questionnaire; 8. Experience of Service questionnaire

8.6 Where clinically and operationally useful, de-identified national data will be fed back regularly to ED teams on the ground to help them evaluate and reflect on their own service delivery and make changes for service improvement.

8.7 A review of the proposed national dataset will take place after one year. Feedback on its utility will be obtained from clinicians and teams on the ground. Where change is needed, the dataset will be updated within this quality-improvement cycle.

Table G: Recommended Clinical Programme – access and cost metrics- by team/sector

Purpose

National evaluation of HSE ED programme to ensure its goals of: access, safety & quality, and value for money

Each Team When?	What? Which domain?	Why? How to gather?	How often?
Assessment	No. of cases referred and referrer	Access to assessment	Collated by team administrator and coordinator Submitted monthly by the coordinator to leadership/management for purpose of evaluation, service improvement and reflection
	Source of referral	Access to assessment	
	No. of consultations (i.e. FtF or by phone)	Access to advice	
	No. of assessments offered	Access to assessment	
	No. of assessments declined	Access and value	
	Time from referral to assessment	Access to assessment	
	No. of assessment DNAs	Access, value for money	
MH treatment	Total no. of clinical appointments offered and by type (individual or group)	Value for money	
	No. of first treatment appointments offered	Access to treatment	
	Time from assessment to 1st treatment session	Access to treatment	
	No. of treatment appointments declined	access, value for money	
	No. of clinical sessions provided	Access, value for money	
	No. of clinician sessions	Value, access,	
	No. of inpatient admissions	Safety, access, value for money	
	No. of day-patient admissions	Safety, access, value for money	
	No. of open cases, by how long open	Effectiveness; value	
	Type of psychosocial intervention	Quality	
	No of discharges	Effectiveness, value	
	Referrals to private treatment	Value for money, access	
	Referrals abroad for treatment	Value for money, access	
Acute Hospital	No. of admissions	Access, safety	
	Dietitian reviews	Access, safety	
	Length of stay	Access, safety, value	
	Special nursing	Safety, value	
	ICU	Safety, quality	
	NG feeding	Safety, quality	
	Deaths	Safety, quality	
Inpatient Psych	TBA		

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Eating Disorder Services:
HSE Model of Care for Ireland
ISBN: 978-1-78602-069-7