FINAL VERSION

NHS South West Clinical Senate

Recommendations from the South West Clinical Senate Council on maximising resources for Children & Young People community and inpatient services for Eating Disorders to manage the increased demand and acuity

16 September 2021

1.0 Background

There is wide recognition of the need to improve mental health services and outcomes for all population cohorts and certainly for children and young people and the Government has made clear its commitment to mental health services and its improvement[1]. *Future in Mind*[2], the Children and Young People's Mental Health and Wellbeing Taskforce report sets out the priority for improving children and young people's mental health service provision across health, education, and social care.

Notably, since the COVID 19 pandemic there has been a sharp increase in demand and complexity of child mental referrals to Services that were already facing the challenge of dealing with increasing pre-pandemic demand.

Mental health services as with other aspects of healthcare are facing the challenge of recovering services within the constraints of limited resources, and realising the ambitions set out in key national policies: *The NHS Long Term Plan*[3], *The Five Year Forward View for Mental Health*[4], *Transforming Children and Young People's Mental Health Provision: a Green Paper*[5], and *Future in Mind: promoting, protecting, and improving our children and young people's mental health and wellbeing*[6].

2.0 The National Context

Nationally, a stark picture is painted of the demand and capacity for mental health services for children and young people which is reflected in the facts and figures below:

[1] Department of Health (2013). Improving Children and Young People's Health Outcomes: a system-wide response. London: Department of Health.
[2] Future in mind - Promoting, protecting, and improving our children and young people's mental health and wellbeing (publishing.service.gov.uk)
[3] NHS Long Term Plan
[4] The Five Year Forward View for Mental Health (england.nhs.uk)
[5] Transforming_children_and_young_people_s_mental_health_provision.pdf (publishing.service.gov.uk)
[6] Future in mind - Promoting, protecting, and improving our children and young people's mental health and wellbeing (publishing.service.gov.uk)

File path:

- The Mental Health of Children and Young People in England 2020 Survey highlights that there is an increased prevalence of mental health conditions amongst 5 -16 year olds: rising from 10% (in 2017) - to 16% (in 2021)[7].
- The Children's Commissioner's 4th Annual Report[8] shows the referrals to children and young people's mental health services and the impact of the COVID 19 pandemic, is reflected in the sharply increased and rising level of demand. (See Figure 1)

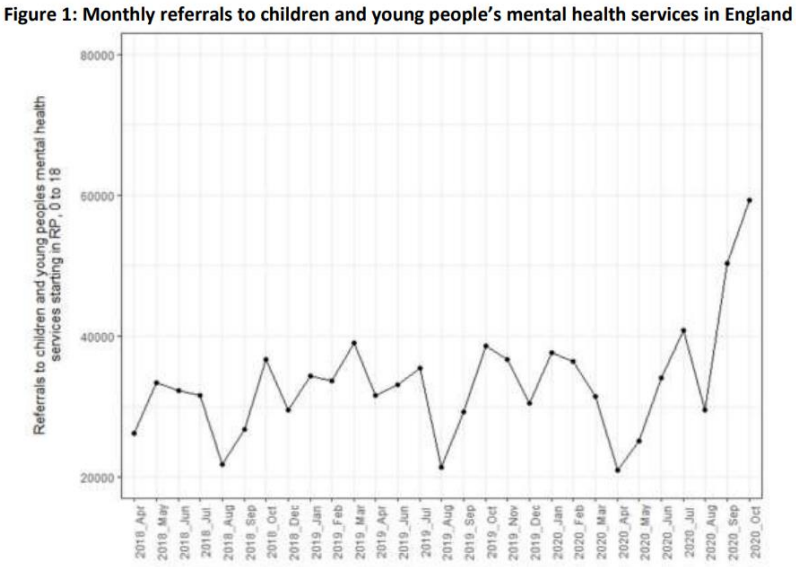


Figure 1: Monthly referrals to children and young people's mental health services in England (ref. Children's Commissioner: The state of children's mental health services 2019/20[9]).

- Child and Adolescent Mental Health Services (CAMHS) have increased the numbers they are seeing, without an increase in their resource. At approximately 39%, this already exceeds the NHS Long Term Plan 2023 target of 35%. (See Figure 2)

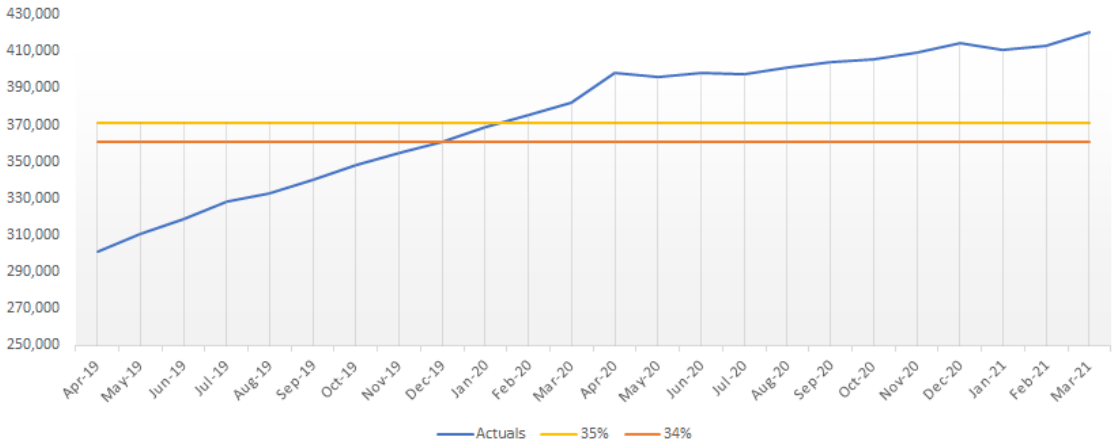


Figure 2: No. of Children & Young People with a diagnosable mental health condition receiving support from CAMHS Services between 2019 – 2021 (ref. Woodin, G. 2021. *Provider Collaboratives: National and Regional Update.* South West Clinical Senate Council Meeting, 16 September, Online.)

[7] Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey - NHS Digital
[8] occ-the-state-of-childrens-mental-health-services-2019-20.pdf (childrenscommissioner.gov.uk)
[9] occ-the-state-of-childrens-mental-health-services-2019-20.pdf (childrenscommissioner.gov.uk)

- There is a decrease in the number of CAMHS beds available nationally and regionally. Nationally, 174 of the 1334 beds were reported as temporarily closed on 30/06/21. It is important to note that 23 of these beds are in the South East and South West regions. No data has been released regarding permanent bed closures.
- NHS Eating Disorder Services last received significant funding investment in 2015 and since then, has been dealing with year-on-year increasing demand with constrained resources. The surge in demand during the pandemic has added pressure to already stretched Services.
- Eating disorders and urgent/crisis care have seen the largest increase with an increase in attendance at Emergency Departments.
- There is increased complexity & acuity in part due to late presentations
- The Royal College of Psychiatrists (RCPSYCH)'s recent analysis of the NHS published data shows that there are a significant number of children and young people waiting for urgent and routine treatment with some waiting times extending beyond the Government's Access and Waiting Time Standard for Children and Young People with Eating Disorders[10]. This is despite more children and young people being treated than ever before (See statistics below):

    - **Quarter 1 (2021/2022):** only 61% of patients started **urgent** treatment within a week as compared with the same Quarter (2020/2021) where 88% of patients started treatment.
    - **Quarter 1 (2021/2022):** 73% of patients started **routine** treatment within the 4-week timescale as compared with 87% in Quarter 1 (2020/2021) which highlights a drop in numbers and confirms more patients waiting to commence treatment. (ref. Govender, T. 2021. *Eating Disorders: A clinical perspective.* South West Clinical Senate Council Meeting, 16 September, Online.)

- The Get It Right First Time [GIRFT] Programme is unlikely to support the provision of additional specialist beds for eating disorders[11] as the focus is to meet patient needs in local Systems. This will be detailed in a report on Children & Young Peoples Mental Health Services – publication delayed from November 2021.
- The largest demand is for Tier 4 acute general adolescent units (GAU) and Eating Disorder (ED) units– both bed types offer treatment for eating disorders and for disordered eating. There is also a demand for Paediatric Intensive Care Units (PICU) for the most severe presentations requiring system support. The mismatch between capacity and demand for the most complex cases is impacting on acute trusts with children and young people with severe eating disorders being supported in acute inpatient beds.
- Finally, the constraints on society imposed to control the spread of Covid 19 have had a huge impact on the mental wellbeing of young people. Various contributing factors included loss of routine, social isolation, increased exposure to triggering messages,

[10] NICE Guideline Template (england.nhs.uk)
[11] Getting It Right First Time - GIRFT

pressure to exercise, and a decrease in the protective factors. This has manifested in an increased demand for all Children & Young People (CYP) Mental Health services.

3.0 The Provider Collaboratives

NHS England and Improvement (NHSEI) remains the accountable Commissioner for the NHS services. It has delegated the commissioning responsibility to the Provider Collaboratives (PCs). The PCs will be responsible for commissioning the following inpatient services for Children and Young People: GAUs including learning disability (LD), PICU, specialist ED Units, and low secure including LD. They will also commission in some community services. The PCs went live in October 2021 however NHSEI remains responsible for CAMHS Medium Secure Inpatient and under 13 years for mental health. 2021.

The guidance document *"Working together at scale: guidance on provider collaboratives"*[12] outlines expectations for how providers should work together in provider collaboratives. It offers principles to support local decision-making and suggests models that systems and providers may wish to consider. The key points set out in the guidance:

- The Provider Collaboratives will be a way in which providers work together to plan, deliver, and transform services. These should include acute trusts, community trusts, ambulance trusts, and non-NHS providers where this would be beneficial for patients.
- The Provider Collaboratives will provide opportunities to tackle unwarranted variation, make improvements and deliver the best care and outcomes for patients and communities. There is scope to deliver these benefits as exists within current legislation and it is expected that the Health and Care Bill will provide new options for trusts to make joint decisions, working with ICS leaders and system partners to identify shared goals, appropriate membership, and governance, and ensure activities are well aligned with ICS priorities.

In the South West region, there are three Provider Collaboratives for mental health services. The table below shows the areas that are covered by the Provider Collaborative, the CAMHS Tier 4 Units, and the types of beds provided (See Figure 3).

Provider Collaborative	Lead	Areas covered	CAMHS Tier 4 Units in PC Footprint (GAU, ED, LSU)	Types of CAMHS beds
South West CYPMHS Tier 4 (South West)	Devon Partnership NHS Trust	**Cornwall, Devon, Somerset, North Somerset, Bristol, South Gloucestershire**	• Riverside Unit (Bristol) • Plymbridge House (Plymouth) • Wessex House (Bridgewater) • Sowenna (Cornwall)	Generic/ GAU
Wessex and Dorset	Sussex Partnership NHS FT	Hampshire, Isle of Wight, Portsmouth, Southampton, **Dorset**	• Leigh House (Winchester) • Priory (Southampton) • Pebble Lodge (Dorset) • Austen House • Bluebird (Southampton)	Generic/ GAU Low secure Medium secure Dorset PICU (in development)
Thames Valley	Oxford Health NHS FT	Buckinghamshire, Oxfordshire, Berkshire, **Swindon, Wiltshire. Gloucestershire, Bath, and North East Somerset**	• Highfield (Oxford) • Huntercombe, Maidenhead • Willow House (Berkshire) • Marlborough House (Swindon)	Generic/ GAU Specialist ED PICU Day Care LDA (in development)

Figure 3: The Provider Collaboratives for Mental Health Services in the South West Region

[12] B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf (england.nhs.uk)

4.0 The South West Region

In the South West region, the Clinical Commissioning Group's CAMHS investment is an average of £66 per capita (the national average is £72 per capita) which constitutes an average of 7% of the whole mental health budget. Within the region, there are also significant workforce issues with challenges around recruitment and retention, and skills mix across community and inpatient settings.

The national picture, of upward demand for children and young people mental health services, is replicated in the South West region. NHS Benchmarking track an upward trend of 90% increase in urgent referrals, and a 60% increase in routine referrals to Community Eating Disorder teams in the region (comparing 2020 and 2021 referral data)[13]. There is also increased demand within the inpatient pathways.

5.0 Reflections from Services across the South West region

This section includes the reflections of three clinicians from the South West region on the impact of the COVID 19 pandemic in terms of demand (numbers and acuity), service delivery, and learning for their teams and organisations:

- A Specialist Service treating eating disorders in the under 18s: Gloucestershire Health & Care NHS FT
- A Children's hospital treating CYP with anorexia nervosa: Bristol Royal Hospital for Children.
- CAMHS Community Eating Disorder Services in the Bristol, North Somerset, and South Gloucestershire (BNSSG) geographical area

5.1 A Specialist Service treating eating disorders in the under 18s: Gloucestershire Health & Care NHS FT

Background and context

The Eating Disorders Service in Gloucestershire is an all-age, nurse-led service with medical input by psychiatrists and a GP. The Service receives direct referrals from professionals (with patient consent or parental consent for under 16s), and self-referrals. The Community Team, which is split into several sub-teams, assesses and treats children, adolescents and adults.
In addition, the Service delivers "The Body Project[14]", which is a group-based intervention for girls in Year 10 from four local Grammar Schools. The Project helps children and young people deal with unrealistic body image, body dissatisfaction, unhealthy eating and provides that preventative intervention. The ambition is to extend this project, to other schools and universities over time.

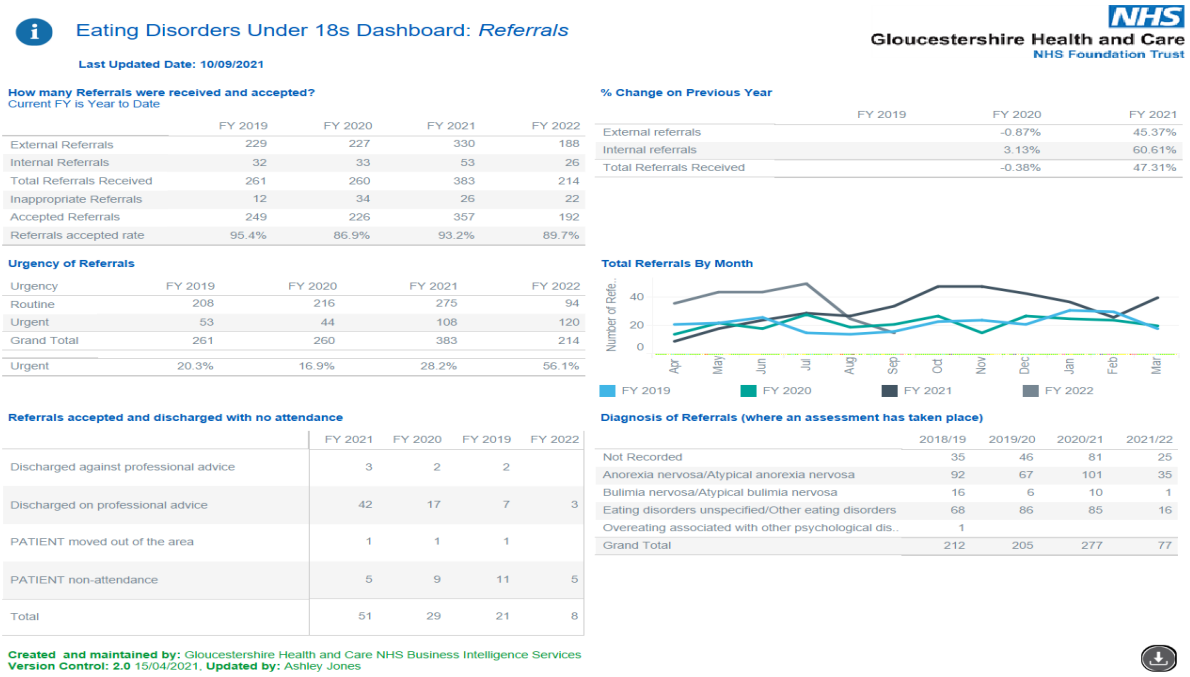
The Impact of the Pandemic

The COVID 19 pandemic has a significant detrimental impact on the mental health of

[13] this data is unpublished at the time of writing this report (February 2022)
[14] The Body Project: A Dissonance-Based Eating Disorder Prevention Intervention (Programs That Work): A Dissonance-Based Eating Disorder Prevention Intervention (Updated): Amazon.co.uk: Stice PhD, Eric, Rohde PhD, Paul, Shaw PhD, Heather: 9780199859245: Books

CYP – particularly those with eating disorders and disordered eating which was evidenced by the increased demand. Children and young people were presenting with lower weight, needing urgent medical assessment or with deranged vitals, needing medical stabilisation despite a healthy weight. Some CYP were going straight into Paediatric Assessment Unit (PAU) because of their acuity.

In response to the surge in demand, the Service stopped processing 'routine' referrals and moved to provide a ‘virtual’ offer (to reduce the risk of spread of COVID infection). However, the virtual offer was problematic for some CYP who didn’t want to ‘see themselves on camera’. Both staff and the CYP had to adapt and find workarounds that would be agreeable i.e. switching off the camera for some of the sessions, and the CYP that most needed physical monitoring were booked face-to-face appointments.



Eating Disorders Under 18s Dashboard: *Referrals*

Last Updated Date: 10/09/2021

NHS Gloucestershire Health and Care NHS Foundation Trust

How many Referrals were received and accepted?
Current FY is Year to Date

	FY 2019	FY 2020	FY 2021	FY 2022
External Referrals	229	227	330	188
Internal Referrals	32	33	53	26
Total Referrals Received	261	260	383	214
Inappropriate Referrals	12	34	26	22
Accepted Referrals	249	226	357	192
Referrals accepted rate	95.4%	86.9%	93.2%	89.7%

% Change on Previous Year

	FY 2019	FY 2020	FY 2021
External referrals		-0.87%	45.37%
Internal referrals		3.13%	60.61%
Total Referrals Received		-0.38%	47.31%

Urgency of Referrals

Urgency	FY 2019	FY 2020	FY 2021	FY 2022
Routine	208	216	275	94
Urgent	53	44	108	120
Grand Total	261	260	383	214
Urgent	20.3%	16.9%	28.2%	56.1%

Total Referrals By Month

Referrals accepted and discharged with no attendance

	FY 2021	FY 2020	FY 2019	FY 2022
Discharged against professional advice	3	2	2	
Discharged on professional advice	42	17	7	3
PATIENT moved out of the area	1	1	1	
PATIENT non-attendance	5	9	11	5
Total	51	29	21	8

Diagnosis of Referrals (where an assessment has taken place)

	2018/19	2019/20	2020/21	2021/22
Not Recorded	35	46	81	25
Anorexia nervosa/Atypical anorexia nervosa	92	67	101	35
Bulimia nervosa/Atypical bulimia nervosa	16	6	10	1
Eating disorders unspecified/Other eating disorders	68	86	85	16
Overeating associated with other psychological dis..	1			
Grand Total	212	205	277	77

Created and maintained by: Gloucestershire Health and Care NHS Business Intelligence Services
Version Control: 2.0 15/04/2021, **Updated by:** Ashley Jones

Figure 4: Gloucestershire Health and Care NHS Foundation Trust Eating Disorders Under 18s Dashboard: Referrals (Financial years 2019 -2022)

Challenges

- The increased need for medical re-feeding created pressure on acute medical beds and there is a long wait for specialist eating disorder beds. Consequently, children and young people are being managed on paediatric/ gastroenterology wards, with some patients detained under the Mental Health Act (MHA) and some detained informally.
- The focus on urgent referrals meant that CYP that are not deemed to be urgent may not receive treatment promptly. The risk is that if support is not received early enough, this could impact case severity and prognosis.
- The risk of getting into adversarial positions when faced with a crisis and acute demands for medical beds. It is important to negotiate the length of inpatient stay and community support, recognising that staffing issues will have an impact.

What worked

- The Service operated within a multi-disciplinary team (MDT) and liaised with physical and mental health services. Weekly meetings were held with open invitations to staff to attend, to discuss patients on the ward. There were also twice-weekly reviews for patients on the ward, and daily reviews of patients detained under MHA. These activities improved communication and collaboration.
- The Service developed guidelines for medical management of feeding and eating disorders broken down into the different roles and responsibilities, and a clear plan for each admission.
- The Service scheduled regular Eating Disorder Support Meetings to look at the practicalities (non-clinical aspects) so that children and young people are offered the best care possible.

Looking to the future

The Service identified innovations that should be developed, as these will help to deal with the current and any future periods of a surge in demand.

- Early intervention is crucial to addressing disordered eating and eating disorders in CYP. Funding should be identified to support early intervention and prevention programmes such as The Body Project and the University of West England's Centre for Appearance Research Unit[15].
- There should be increased training for healthcare professionals to better understand eating disorders and how to manage children and young people and, provide the support that the children and young people need in a Medical Unit. In addition, training needs to be provided to teachers and other professionals, that work with CYP, so that they are better equipped to identify these issues in CYP.
- There needs to be support developed specifically for parents – as family-based treatments can be difficult for parents to deal with.
- It is important to work with policymakers (particularly those working in related areas) to ensure that there is no harmful messaging which perpetuates disordered thinking in high-risk children and young people.
- It is important to work closely with schools to provide balanced information and guidance on weight, food, and body image, to be used with CYP.

[15] Centre for Appearance Research (CAR) - Research centres and groups | UWE Bristol

5.2 A Children's hospital treating CYP with anorexia nervosa: Bristol Royal Hospital for Children

Background and context

The Bristol Royal Hospital for Children (BRHC) accepts new referrals for the under 16-year olds with anorexia nervosa. Patients who are aged between 16- 18 years are expected to go to Bristol Royal Infirmary (BRI) to be treated by the adult gastroenterology teams. However, during the COVID 19 pandemic, the BRHC accepted referrals for 16 - 18-year olds.

The BRHC also provides secondary care for paediatrics for Bristol, North Somerset, and South Gloucestershire (BNSSG) geographical footprint, and tertiary specialist care for children across the South West region with fierce competition for acute beds.

Patients with a forward projection of continued weight loss are admitted and by the time of their admission, typically, they are at least 10kg underweight, with compromised physical observations, and considered to be at risk of refeeding.

The hospital has an Inpatient Protocol (IP) which means that Refeeding plans can be initiated without the need to wait for instructions from a Gastroenterologist which is helpful as the gastroenterologists do not currently provide on-call after 17:00hrs or at the weekend. Where patients are unable to comply with the regime within the Refeeding plan, the in-out NG feeding tube may be introduced however this requires negotiation and discussion between the hospital and CAMHS to understand the trajectory of the patient and how to get the patient on track.

The Impact of the Pandemic

Unsurprisingly, demand at BRHC has been at similar levels as with the rest of the South West region. During the pandemic, most of the admissions are "emergency" due to severe weight loss, and the patients were placed on specialist medical wards that had not previously had to nurse patients with eating disorders which presented some challenges however, the Inpatient Protocol (IP) helped support the staff on these wards.

Patients are discharged when they are gaining weight and are medically fit for discharge. Discharges are managed jointly with the CAMHS team, and the patient is either sent home or to a Tier 4 bed. If the patient requires a Tier 4 bed, they will be placed out-of-region, as there is no Eating Disorder Tier 4 Unit in the region. This is significant and difficult for their families to accept. [It is noted that whilst the Riverside Adolescent Unit provides mental health inpatient care for CYP in the region, it is not specifically for Eating Disorders and does not support NG feeding.]

The BRHC undertook an audit to review the demographics of inpatients for anorexia between 01 June 2018 – 31 May 2021 and to assess the impact of COVID 19 on admissions. Patients were identified using the BRHC diagnostic code F50 or F50.1 and then filtered for patients admitted for management of their anorexia.

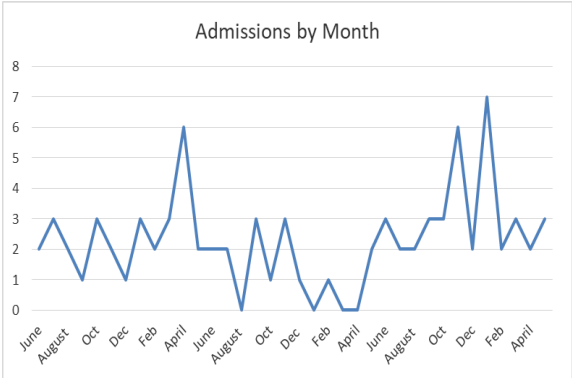


Figure 5: Bristol Royal Hospital for Children: new anorexia patient admissions (June 2018 – May 2021)
(ref: Bristow, J. Spray, C. 2021. *Patients admitted to BRHC with anorexia nervosa.* South West Clinical Senate Council Meeting, 16 September, Online.)

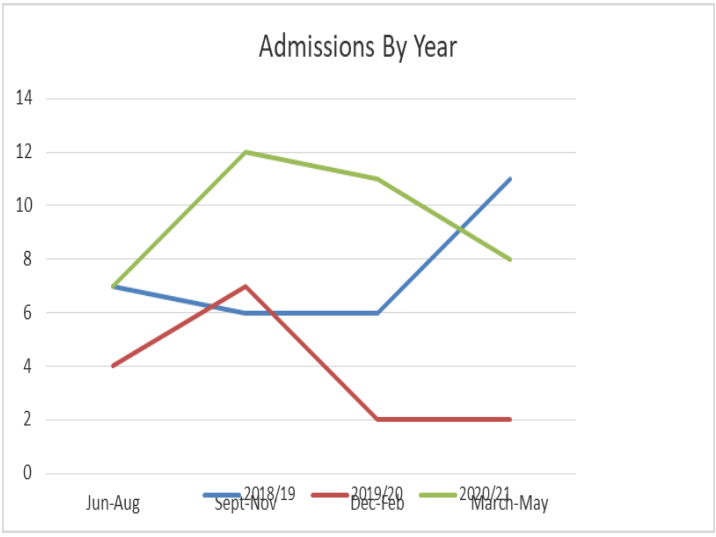


Figure 6: Bristol Royal Hospital for Children Annual admissions for anorexia patients by year
(ref: Bristow, J. Spray, C. 2021. *Patients admitted to BRHC with anorexia nervosa.* South West Clinical Senate Council Meeting, 16 September, Online.)

Summary findings from the audit show that in the early stages of the pandemic there were decreased numbers, but numbers increased to significant levels with patients admitted with increased complexity and severity and thereby requiring an increased length of stay. This was exacerbated by the lack of available Tier 4 beds in 2020/21 and so patients could not be discharged to a Tier 4 bed.

The audit also showed that patients required active management as opposed to pre-pandemic patients who were admitted semi-electively for refeeding. The latter cohort was no longer admitted due to a lack of available beds.

Finally, there was an increased requirement for CAMHS support for parents who were concerned about the apparent lack of therapy.

5.3 CAMHS Community Eating Disorder Services in the Bristol, North Somerset, and South Gloucester (BNSSG) geographical area

The Impact of the Pandemic

Local Community Eating Disordered Services in the BNSSG geographical footprint has experienced a spike in eating disorder referrals from new and existing patients – particularly those with 'urgent need'. The average number of referrals per month has doubled year on year between 2018 and 2020, and in 2021 this increased by a further 25%. In addition, the severity of eating disorder presentations has increased with patients requiring medical stabilisation in hospitals which increases pressure on acute medical beds. (See Figure 7 below).

Data from North Bristol Eating Disorders Service	2018	2019	2020	2021
Average number of Eating Disorder referrals per month	2	4	8	10
Highest number of Eating Disorder referrals per month	4	7	16	13
Lowest number of Eating Disorder referrals per month	1	1	1	7

Figure 7: Average number of Eating Disorder referrals in North Bristol (ref. Potter, M. 2021. *Working collaboratively with community provision.* South West Clinical Senate Council Meeting, 16 September, Online.)

What worked

- Services prioritised urgent referrals and developed waiting lists for routine referrals. They established physical health monitoring clinics within the CAMHS clinics to assess those on the waiting list to ensure that they are 'medically safe'

- Services developed agreements with primary care regarding the monitoring of these CYP

- Services delivered family treatment remotely although it was recognized quite early on that "virtual" appointments had limitations in terms of reflecting an accurate picture of risks and so this quickly reverted to face-to-face appointments.

- Several groups were established such as psychoeducation, parent, early intervention) which played a key role in prevention, support, and crisis response.
- Services were proactive in supporting staff by scheduling daily multi-disciplinary team meetings and by prioritising staff health and wellbeing given the risk of 'burn out' due to high workloads.
- The interfaces with acute hospitals are effectively managed with clear pathways in-and-out of hospitals, communication and liaison with the gastroenterology teams, and bridging the gap between the community and acute hospitals. The Community CAMHS teams provided daily input and support to the acute hospitals to manage high-risk complex eating disorder cases. Unfortunately, BNSSG Community Eating

Disorder Service (CEDS) is not co-located in acute hospitals and this creates challenges offering immediate support in difficult and demanding situations.

- Managing the transition for the 16 -18-year olds is particularly challenging and is being developed to ensure that the Junior Marispan guidelines[16] are within the protocols for the different acute adult hospitals and that there is a consistency of approach across the different trusts.

Looking to the future

The Service identified innovations that should be developed as these will help deal with the current and any future periods of a surge in demand:

- There needs to be an investment in workforce development.
- There should be the development of home treatment teams and step-down approaches, and step up to Tier 4, if required

6.0 The Questions

The SW Senate sought to explore the following questions regarding Children & Young People community and inpatient services for Eating Disorders across the region:

- Given that community and inpatients services for Eating Disorders are at capacity, how can we maximise existing resources whilst ensuring quality of outcomes and national standards?
- How can community and inpatients services for Eating Disorders support each other to manage the increased demand and acuity?

7.0 The Advice

The SW Clinical Senate Council met on 16 September 2021 to discuss Children & Young Peoples (CYP) community and inpatient Eating Disorders services across the region and explore how existing resources can be maximized to manage the increased demand and acuity.

The Council is supportive of several strategies to help CYP Mental Services better manage the demand and acuity, namely:

- Increased focus on early intervention and prevention, as well as services for those with long-term needs.
- An integrated, collaborative approach for service delivery which includes health, social care, education, and the voluntary sector utilising evidence-based operating models such as "iThrive[17]".
- A focus on locally determined models that deliver to principles such as co-production, evidence-based, ease of access rather than top-down determination

[16] MARSIPAN-risk-assessment.pdf (paediatricpearls.co.uk)

[17] National i-THRIVE Programme | i-THRIVE (implementingthrive.org)

8.0 Observations

The Council made several observations:

i. The Clinical Senate noted that early identification and intervention is key to addressing the rising demand and schools have a key role in this. The Senate noted that since the pandemic, this role has been compromised making the identification of high-risk children and young people more challenging.

ii. The Clinical Senate recognised that the current mismatch between capacity and demand for specialist eating disorder services for children and young people was impacting on acute trusts, with a number of young people being cared for and supported on in patient wards. Whilst the recommendations in this report are unlikely to resolve this issue, they should improve the level of support available to both patients and staff

iii. The Senate recognised both the negative impact of social media on individuals with this condition and the potential for national positive messaging to utilise these platforms, given their reach and influence.

iv. The Senate discussed the potential benefits of a screening tool but recognised that this would need more research to ensure its sensitivity and specificity.

v. The Senate observed that current plans for investment in training are encouraging The Foundation doctor curriculum for 2021, has prioritised mental health with an increased emphasis on eating disorders and the care of patients in hospitals and online training available.

9.0 The Recommendations

The South West Clinical Senate makes the following recommendations:

1. The Clinical Senate observed that the current national policy position is that there should be no further investment in specialist eating disorder services. This is supported by a Get It Right First Time (GIRFT) report which states that outcomes of young people in these units are no better than those in generic Children & Young People (CYP) inpatient units. This report has not been peer-reviewed and is based on limited analysis thus, the Clinical Senate recommends that the GIRFT report be peer-reviewed before publication.

2. The Clinical Senate heard that disordered eating in children and young people is often a symptom of underlying distress for which there are two main drivers:

    a. Appearance

    b. Suboptimal care or neglect

    These appear to have a different demographic profile and more should be invested in understanding these preconditions and the opportunities for targeted early intervention.

3. Ahead of additional resources for these services, the balance of investment in these services, between prevention and early intervention services and specialist services is reviewed.

4. The key to moving the dial on demand (in terms of numbers and acuity), lies in the early identification of the high-risk children and young people so that they are signposted early to engage with Early Intervention and Prevention programmes. The school team (nurses, counsellors, teachers, lecturers) plays an important role in this and should be supported through investment and training so that they know what to do if they are concerned that a young person has developed an eating disorder. For example, Healthy London Partnership[18] has developed guidelines for educational professionals about how to help children and young people, in their geographical footprint, with eating disorders to seek treatment. These guidelines are to increase knowledge, understanding, and put a stop to myths.

5. There should be programmes in schools that normalise conversations about health and wellness in school children and de-medicalise conversations about eating disorders. Strong links between Primary Care Networks and the schools in their area could support these programmes and early recognition and referral.

6. Learning from lived experience is crucial to service design and opportunities for prevention. Patients, ex-patients, carers, and other stakeholder groups should be proactively engaged and involved in the design of future services.

7. At present, the majority of staff with specialist skills and knowledge in responding to the needs of children and young people with eating disorders are employed in community settings but the most severely unwell children and young people are cared for in an acute setting (hospital). The Senate recommends that the South West services look at models of care that allow for greater integration of community and hospital teams, to foster the transfer of skills and knowledge, and support better-integrated care

8. The Clinical Senate recommends that there be effective liaison and communication between the Community CAMHS team and the Inpatient Unit so that all options for an earlier patient discharge are considered.

9. The Clinical Senate acknowledges the importance of the multi-disciplinary team (MDT) and its role in identifying and considering other enhanced offers that may be available around intensive home treatments. For example, the approaches used in the frailty pathway i.e. 'Hospital at Home[19]' which provides hospital-level care, in the patient's home, should be examined for learning to treat more Eating Disorder patients in their homes and free up capacity on acute wards.

10. The Clinical Senate observed that numerous agencies can play a part in the prevention and early intervention of eating disorders. The newly formed Integrated Care Systems (ICSs) should be encouraged to use their new directions to enhance

[18] New eating disorders guidelines launched for educational professionals - Healthy London Partnership

[19] Hospital at Home

collaboration and coordination for these services. To this end, a multi-disciplinary team/pathway approach linked to a specialist team could be effective. The Senate recommends that in tandem with this, it would be useful to develop a 'coordinator role' across the region to have oversight on pathways, given the numerous services/ units to navigate. This will improve coordination across the region however, the funding for this role would need to be negotiated and agreed upon.

11. The Clinical Senate recommends that the criteria-based admissions process for national beds be standardised to deliver a consistent national and regional service.
12. Given that the children and young people's Eating Disorder services can demonstrate the significant impact of COVID, in terms of demand, these services should be able to access COVID recovery monies.

A key consideration is the target audience for these recommendations to ensure that the work is promoted and externalized. The SW Clinical Senate will share the recommendations with the Senior Leadership in the South West region, NHSEI – South West Region Mental Health Team, and the regional Provider Collaboratives.

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Prepared: Ajike Alli-Ameh, Head of South West Clinical Senate
Signed off: Dr. Sally Pearson, Chair of South West Clinical Senate