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NHS
East of England

Transition Standards for Eating Disorder Services in the East of England

Produced on behalf of the East of England Regional Mental Health Team, NHS England & NHS Improvement

Who Contributed?

Standards Development Group:

Tim Clarke, Children and Young People's Mental Health Clinical Advisor, NHSE/I East of England (Chair)

"Improving and optimising transitions between Services who support those with Eating Disorders is essential. It has been a privilege to lead this work alongside a wonderful group whose expertise, knowledge and experience has been key in developing these standards"

Jo Wallace, Eating Disorders Clinical Advisor, NHSE/I East of England

"Careful management and guidance around transitions and times of change for people with eating disorders is absolutely fundamental in terms of both risk and supporting their recovery"

Marissa Hodson, Clinical Team Lead, Adult Community Eating Disorders

"Over the time I have worked within Eating Disorders Services I have been acutely aware of the difficulties experienced by service users and their carers at time of transition. At times of heightened risk of emotional stress and relapse, I have been keen to work to improve some of these transition processes within my own team. Working within a regional group has been really beneficial to share ideas and good practice"

Fiona Lain, Advanced Nurse Practitioner, All Age Eating Disorder Service, Norfolk & Suffolk NHS Foundation Trust

"Transition standards for Eating Disorders Services are vital for ensuring all young people receiving treatment for an eating disorder have the best transition from CAMHS-ED to adult Services, providing continuity of care and essentially promoting recovery"

Tanya Lovett, Professional Lead Community Eating Disorders and OCD Services, Hertfordshire Partnership University NHS Foundation Trust

"I was particularly driven to bring more quality into the numerous transitions university students experience which results in them being so vulnerable when they also have an eating disorder. I hope this document helps clinicians and teams bring strength into these points of vulnerability"

Patrick Santry, Case Manager for Adult Eating Disorder, NHSE/I East of England Provider Collaborative

"It is important that we make the transitions process as smooth and easy as possible for patients and their families."

Nathan Samuels, Regional Nurse Advisor for Young People's Healthcare and Transition, Burdett National Transition Nursing Network

"These standards demonstrate both a need to and commitment to improving Transition for young people in Mental Health Services across the East of England and being involved in helping to move this forward is a huge honour"

Connor Sutton, CBT Therapist & Clinical Lead, Caraline

"This has been such an important process to be a part of, as it ensures that there are recognised standards in place to give safe and professional care to individuals, that would be recognised across a variety of different Services"

Matt Young, Assistant Psychologist, Caraline

"With the desktop review I worked on, these standards will help provide clear, evidenced-based strategies to prioritise patients and improve communications between Services"

Shiona Whitmore, Assistant Psychologist, West Norfolk CAMHS ED Team, Norfolk & Suffolk NHS Foundation Trust

"I'm passionate about recovery for individuals with eating disorders and have seen first-hand how transitions can negatively impact this recovery. I hope this guidance can help highlight the importance of getting transitions right, and to increase support for individual with eating disorders around these transitions"

Mike Bell, Senior Programme Manager, NHSE/I East of England

Maja Gaborovic, Assistant Psychologist, Norfolk & Suffolk NHS Foundation Trust

Francesca Hankins, Adult Eating Disorders, Senior Programme Manager, NHSE/I East of England

Julian Puttergill, Parent/ Carer Representative

Patrick Santry, Case Manager for Adult Eating Disorder, NHSE/I East of England Provider Collaborative

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Naomi Wilcox, Service User Representative, Clinical Design and Delivery Group for Adult Eating Disorder, East of England

Review Group:

Keith Grimwade, Parent/Carer Representative, Co-chair of NHS England and NHS Improvement's East of England Eating Disorder Network

Laura Edwards, Consultant Clinical Psychologist, Norfolk Community Eating Disorder Service, Cambridge & Peterborough Foundation Trust

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Emma Sinclair, CAMHS Commissioning Manager, Integrated Health and Care Commissioning Team, Hertfordshire County Council

Andrea Ramsden, Newmarket House Healthcare Ltd

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Forewords

Naomi Wilcox, Service User Representative

"Hello, I am Naomi and I have lived experience of an eating disorder. I sit on a Clinical Design and Delivery Group in the East of England for Adult Eating Disorders as a Service User Representative. It is important to me that the voice of service users informs the planning, implementation, and evaluation of Services to bring about meaningful change to ensure that Services have high satisfaction for those that use them. I was particularly interested to be part of a group focussing on transitions as the move from home to university was personally difficult for me and I developed anorexia during my first year of studies. Furthermore, throughout my eating disorder treatment, I went between two locations hundreds of miles apart which presented many challenges. The difficulties of transitions are not unique to me; from speaking with other individuals with lived experience, transitions of a diverse range are often a time of uncertainty, anxiety, vulnerability, and risk. The devastating consequences of which are evident in the Ombudsman report into the death of Averil Hart, which stated that "inadequate coordination and planning... when (Averil) was leaving home to go to university" was one avoidable failing that contributed to her death. This highlights the importance of managing transitions to ensure patients are well supported throughout the vulnerable period, and potentially devastating consequences are avoided.

Many helpful things can be drawn out from shared learning from professionals and service users to highlight what works well to reduce adverse impacts and risks associated with transitions, including early identification, good communication, close links between Services, clear protocols, and overlap periods. Co-producing a toolkit with a set of transition standards for the East of England is important as it has the potential to make a difference to the experience of many patients and their families, to not hinder a patient's recovery but support them to progress towards their treatment goals."

Keith Grimwade, Co-chair of NHS England and NHS Improvement's East of England Eating Disorder Network

"As a parent/carer representative I am delighted that these standards have been developed in conjunction with the East of England Eating Disorders Network. Parent/carers experience at first-hand how hard transitions invariably are for our loved ones. Sadly, the evidence is that sometimes the baton is dropped, and transitions fail with catastrophic consequences. Agreed protocols that are fully implemented and adhered to, combined with an inclusive approach that involves service users, parents and carers at all stages, is the best way of improving outcomes. These standards build on best practice and provide that framework. Some require additional resource, which must be forthcoming, but most can be incorporated into how Services currently work. They are all the stronger for involving parents and carers as part of the solution to the challenge of transitions: giving parent/carers the opportunity, where appropriate, to inform decisions, to have their own needs assessed and to be given the knowledge and skills we need to play our part in supporting our loved ones' recovery.

I am proud that the East of England is leading the way with these standards and urge their rapid and wide implementation."

Helen Hardy, Regional Head of Mental Health, Clinical Networks and Transformation, NHS England and NHS Improvement, East of England

"As the NHSE/I East of England Head of Mental Health and Chair of the East of England Eating Disorder Strategic Board I really welcome the development of these transition standards. This work is an example of the importance of cross-system and cross-organisational working within the East of England region including providers, commissioners, and Integrated Care Board representatives.

We have unfortunately seen where poor transition experiences for those accessing support for eating disorders has contributed to negative outcomes, but through our regional Board and collaborative development of these standards, have committed to implementing these at a local level to better meet the needs and improve the outcomes of all those transitioning with mental health needs.

This is a great example where we have come together across different systems, providers, roles and experts by experience in the East of England and I truly hope these will be adopted and make a real difference"

What was our aim?

To produce a set of Eating Disorder (ED) transition standards and resources to support systems to optimise transitions for all those accessing Services with an eating disorder and ensure transition guidance and protocols across the East of England (EoE) are consistently based on best practice, guidance, and evidence.

What were our objectives?

To develop a set of ED transition standards that all ED teams in the EoE should adopt and that have been co-produced alongside experts by experience, clinicians, specialists, and commissioners

To summarise the best practice, guidance, and evidence in relation to ED transitions through a scoping review

To support the adoption of these standards which we hope will mean service users, and those that support them, will feel psychologically and physcially safe during service transitions

To ensure that carer / family needs are also considered in the transition process

To ensure that these standards are clearly communicated to teams and that they are supported to implement them to optimise effective, efficient, and safe transitions between services

Why develop Eating Disorder Transitions Standards?

Transition refers to the purposeful and planned process of supporting service users from one service to another. It is critical for those accessing support for eating disorders to experience effective and high-quality transitions between Services. The NICE eating disorder quality statement 6 highlights the importance of transitions and the failure to ensure high quality transitions can lead to inconsistent messages and management of treatment as well as risks to the service user. The Ignoring the alarms: How NHS eating disorder Services are failing patients (2017) report emphasises that moving between Services can be a challenging time for people with eating disorders and that poor transitions and coordination can often, sadly, be catastrophic. Clear communication and coordination when transitioning across or between Services is essential to avoid negative outcomes, worsening of symptoms and in some cases, contributing to death.

We need to ensure that all those receiving support from eating disorder Services have confidence that, if they transition to other Services, they will experience after, they will experience the best quality care possible.

What did we do and how did we do it?

1.

We brought representatives from teams across the East of England including clinicians, service managers, commissioners, regional advisors, Provider Collaborative & experts by experience together to develop these standards

2.

We used current guidance, user experience, clinical / commissioning experience, reports, and published literature to inform the development of our standards

3.

As a group we then achieved consensus as to which standards to include and whether we propose they are 'Expected' or 'Advised'

4.

We then asked other system-wide representatives to review and comment before finalising

How would we like these standards to be used

As agreed by system representatives at the East of England Eating Disorders Oversight Board, we would like all commissioners and providers of Eating Disorder Services to review their compliance with these standards and adopt those that are relevant and feasible to do so as part of routine clinical care.

We advise that commissioners and providers work together to benchmark themselves against these standards and put plans in place to ensure they are met, and if it is felt to be of benefit to service users. We also suggest that any transition protocols and joint working arrangements across Services are reviewed and updated considering these standards. There is also a helpful self-audit checklist included to support audit / benchmarking.

The standards are split into Core and Specific standards. Core standards are those that we would expect to be implemented across all transitions. Specific standards refer to specific transitions e.g. Children's Eating Disorder teams to Adult Eating Disorder teams. Each set of standards are displayed graphically followed by further details relating to that standard. These standards are then recommended as either 'Expected' or 'Advised'.

East of England ED Transitions

Core Standards ('Expected' across all transitions)

- Clear transition protocols
- Medical & physical monitoring clinical protocols & processes agreed and adhered to during transitions
- Sharing of records & information during transitions
- Transitions should be seamless, with no gaps in support or quality of provision
- Service user actively involved in transition planning
- Sensitive to presenting needs at the time of transition and considered in advance
- Transitions form part of care planning
- Transition planning must involve close liaison and clear communication with wider support network
- Parent / carer / family needs assessed & support offered during transitions
- Assessment of any additional needs and reasonable adjustments required to support transitions
- Transition role or coordinator should be identified
- Learning from Serious Incidents (SIs) involving transitions and feedback from service users related to transitions
- Collaborative care agreements during transitions
- Pre-agreed (through team guidance & individual case basis) period of co-working during transitions across teams

Core ('Advised') Standards

- Transition packs
- Peer support integrated into optimising transitions
- Transitions clinical and/or operational leads roles identified
- Routine outcome measures and other relevant clinical outcomes are shared with the receiving team/s at transition

Specific ED Transitions

- CYP to adult ED Services
- Community to inpatient & acutes (vice versa)
- Specialist community to Higher Education Institutes (HEIs) and out of area moves / geographical moves
- Specialist ED community to general community MH
- Return to specialist ED Services after relapse
- Voluntary, Community and Social Enterprise (VCSE) ED teams to specialist ED community (and vice versa)
- Specialist ED *return* to specialist ED after relapse
- Return to education / employment
- Community to Day Patient Unit / Day Patient Unit to Community

Core Standards ('Expected' across all transitions)

Clear transition protocols

Recommendations	Expected or Advised	Self-Audit / implementation Status
These protocols take into account all types of transitions, not just CYP to Adult. Transition protocols, including risk assessment and monitoring, will ensure treatment and support is not compromised and health care professionals all know about patient's care needs and plans for ongoing management (NICE, 2018). Evidence of joint transition protocols between ED Services and other Services, using formal processes of care planning, such as the CPA, should be in place (NICE, 2018). Evidence of joint working arrangements, including regular liaison and meetings, to discuss risk assessment and monitoring at transition between ED Services and other Services providing care for ED patients (NICE, 2018).	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Medical & physical monitoring clinical protocols & processes agreed and adhered to during transitions

Recommendations	Expected or Advised	Self-Audit / implementation Status
All Services to ensure that they are adhering to clear medical and physical monitoring standards / procedures with clarity around roles and expectations in the system. Shared care protocols should be developed across Services. Medical and physical monitoring plans / agreements should be clearly documented and planned in all care. These protocols and processes should be informed by evidence and recommendations from e.g., the Royal College of Psychiatrists Guidance on Recognising and Managing Medical Emergencies in Eating Disorders (MEED; replacing the MARSIPAN and Junior MARSIPAN guidance).	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Sharing of records & information during transitions

Recommendations	Expected or Advised	Self-Audit / implementation Status
Clear and pre-agreed plans of information / record sharing across teams. Ideally this should be digital / electronic sharing of records, but if not then a plan and safe process for the manual sharing of records needs to be agreed involving the service user and in line with data protection.	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Transitions should be seamless, with no gaps in support or quality of provision

Recommendations	Expected or Advised	Self-Audit / implementation Status
Always ensure that the patient stays under the active care of a specialist ED service throughout the transition process (BEAT, 2020).	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Service user actively involved in transition planning

Recommendations	Expected or Advised	Self-Audit / implementation Status
Service users and carers (where appropriate) should be involved in transition plans and where possible this should be a collaborative process taking into account service user preferences, which should be clearly documented. Likely or possible transitions should be discussed through the course of treatment and expectations clearly managed. Transition support should sensitively involve family & carers (RCPsych, 2017).	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Sensitive to presenting needs at the time of transition and considered in advance

Recommendations	Expected or Advised	Self-Audit / implementation Status
Transitions should be delayed if the service user is in crisis. Transition timings must factor in the needs of service users and carers (where appropriate), not just the service (e.g. degree of maturity, separation from family, education/employment issues, etc; RCPsych, 2017). Transitions should be flexible to allow for continuity of care but must take into account local governance processes and resource availability.	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Transitions form part of care planning

Recommendations	Expected or Advised	Self-Audit / implementation Status
Potential and upcoming transitions are regularly asked about, discussed, and reviewed as part of care / treatment planning. Agreed and well-structured transition care plans that are patient-centred can be the single most important element in whole transition experience (RCPsych, 2017). Transition protocols (preferably joint protocols agreed across Services), including risk assessments and monitoring should be comprehensive, updated and shared.	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Transition planning must involve close liaison and clear communication with wider support network

Recommendations	Expected or Advised	Self-Audit / implementation Status
Evidence of this communication and liaison should be clearly documented in treatment / care plans and as part of any transition documentation. Wider support network includes (but not limited to) GP, University, Children's Services, VCSE, Local Authority Housing Support, Education, Employment.	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Parent / carer / family needs assessed & support offered during transitions

Recommendations	Expected or Advised	Self-Audit / implementation Status
An Eating Disorder can impact negatively on those that are supporting the service user. If not already considered, a carer's assessment of need should be considered / conducted at transition points to allow for support for parent / carers / family to be identified and actioned.	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Assessment of any additional needs and reasonable adjustments required to support transitions

Recommendations	Expected or Advised	Self-Audit / implementation Status
If additional needs (e.g. related to learning disability and / or autism) are assessed and present then these must be considered within transition planning to make any reasonable adjustments that might be required. These reasonable adjustments and additional needs should be clearly documented, collaboratively planned and shared across support systems.	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Transition role or coordinator should be identified

Recommendations	Expected or Advised	Self-Audit / implementation Status
A transitions co-ordinator should be appointed, with a role to support service users and carers (where appropriate) through transition and function as a point of contact (RCPsych, 2017). If this is not a separate position / appointment a transitions coordinator/s or lead should be part of existing workforce roles. This role could be administrative. Although considered 'Expected', we are aware that this is budget / resource dependent and perhaps could be considered for future team expansion, transformation and business proposals.	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Learning from Serious Incidents (SIs) involving transitions and feedback from service users related to transitions

Recommendations	Expected or Advised	Self-Audit / implementation Status
There should be evidence that teams review and actively learn / action recommendations from SIs where 'transitions' have been identified as a contributing factor. Services must demonstrate how they are eliciting service user and carer feedback around transition experience (positive and negative) for optimal transitions to be experienced by others, and acting upon this to make improvements.	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Collaborative care agreements during transitions

Recommendations	Expected or Advised	Self-Audit / implementation Status
Information Sharing Agreements (ISAs) and clear processes across organisations should be in place to support seamless transitions, proactively.	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Pre-agreed (through team guidance & individual case basis) period of co-working during transitions across teams

Recommendations	Expected or Advised	Self-Audit / implementation Status
The receiving service and the current service work jointly for an agreed amount of time based on treatment planning / clinical need and service user preference. Period of monitoring agreed and documented with clear expectations around roles and contacts for the service user and carer (where appropriate).	Expected	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Advised

Transition Packs

Recommendations	Expected or Advised	Self-Audit / implementation Status
Transition packs (ideally co-produced) are developed, regularly reviewed, and tailored to service user needs as transitions are planned. This would include recommendations, resources, clear expectations, contact details, escalation guidance etc. These are then copied and shared with receiving teams, if applicable and with carers (where appropriate).	Advised	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Peer Support integrated in to optimising transitions

Recommendations	Expected or Advised	Self-Audit / implementation Status
Where possible transitions should be optimised by the involvement of peer support and / or support that has been co-produced by experts by experience. This could range from the employment of transitional peer support workers or the development of, for example, videos, top tips, FAQs informed by past service users for those currently experiencing transitions.	Advised	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Transitions clinical and/or operational leads roles identified

Recommendations	Expected or Advised	Self-Audit / implementation Status
Transition lead with a senior clinical / operational position is in post and accountable for ensuring optimal and safe transitions but may be supported by other staff / roles.	Advised	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Routine Outcome Measures and other relevant clinical outcomes are shared with the receiving team/s team/s and oranisations during transitions

Recommendations	Expected or Advised	Self-Audit / implementation Status
This will support transitions and future treatment by facilitating ongoing monitoring of needs / goals. Facilitative roles may be required e.g. Assistant Psychologists and Admin.	Advised	☐ Yes – Fully implemented ☐ Partial – Implementation planned or in development ☐ No – Will consider how / if we can implement

Specific ED Transitions: Standards

CYP to adult ED Services

Standard	Recommendations	Expected or Advised	Self-Audit / implementation Status
Continuity of Care and Completion of treatment	If a young person is engaging and benefiting from their current treatment plan / intervention this should not be ceased automatically when transitioning to adult Services. A period should be agreed where this can continue until safe to transition and handover of care occurs or intervention is complete. Transitions timings must factor in needs of patient e.g. they should be delayed if the patient is in a period of crisis (RCPsych, 2017). Attention must be paid to the likely differences in how teams operate and their cultures. Collaborative relationships / underpinned by inter-team trust must be present and established across teams where transitions are present / common.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Active engagement and follow up during and after transitions	Within an agreed period of overlap, both Services should liaise together with the service user and carer (where appropriate) around initial engagement and collaboratively problem solve any issues / concerns arising from transition.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Pre-planned and regular Transition Planning Meetings based on need (sensitively involving parents / carer / family) in good time prior to any expected transitions	The parents or carers should be provided with information and advice around the young person's transition, given the change in their rights and role when a young person enters adult Services NCCMH Commissioning Guidance, 2019). Parents / carers / families (where appropriate) should collaboratively be involved in transition planning early on to support the process and for their insights to be used.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Period of co-working between services (ideally 3-6 months)	Discussions should take place between services, users, carers and families (where appropriate) at least 6 months prior to transition. As soon as a transition is identified, clinicians should make contact with appropriate future service and transition meetings should be held and ongoing (RCPsych, 2017). Ensure transition planning is developmentally appropriate (NICE, 2016) and based on individual needs. Consider the need for period of co-working to be part of contracts / service specifications.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Transition based on 'NEED' not 'AGE'	Consider developmental needs and adjust transition planning accordingly. Considerations should be made to a flexible / longer transition period based on this. Service Level Agreements in place to review those that may benefit from continued treatment in CYP team based on their clinical needs and preferences. Ensure there is a clear clinical governance process to adhere to for this and clear limits set. Ensure that a young person reaching 18 as an inpatient has an individualised person centered care plan with clinical need prioritised over age.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Collaborative joint assessment (between teams) and treatment plan to support transition planning	There should be at least one MDT discharge planning meeting for a formal handover (RCPsych, 2017). Offer children/young people help to become involved in own transition planning (NICE, 2016). Parents / Carers and Families (where appropriate) are offered needs assessments when moving between teams to assess any ongoing needs and support. Before transition / transfer a practitioner from each service should meet the child / young person together prior to transition and a named worker allocated. A contingency plan should be put in place if the named worker leaves position.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

	CYP clinicians / team consider working with service user and carer (where appropriate) to create a personal folder to share with AMHS (NICE, 2016). Named worker should help patient become familiar with AMHS, support visits to AMHS, provide information on relevant Services, including social care and statutory adult care (NICE, 2016).		
Clear communication and expectation management with service users and parent / carer / family (where appropriate) including all pertinent information to aid transition planning & that this is recorded	Ask service user how they would like carers to be involved throughout transition & discuss transitions with carers to understand their expectations (NICE, 2016). Improved information, enhanced training for professionals, greater involvement of families and policy changes are required for better transitions (Cribben et al., 2021). There is evidence of team training, team operating procedures and clear expectations around involvement and communication with service users and carers / families (where appropriate).	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Consent and Information Sharing Processes made very clear with written guidance and decisions clearly recorded	Consent and confidentiality is very important. Service user preferences should be respected. A common sense approach should be taken and these preferences should be regularly revisited if it is considered to be in the service user's best interests to do so. Parent / carer preferences should also be recorded and respected.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Clinician (CYP service & Adult Service) named and allocated to support transition during the transition process	Help patient identify single practitioner (and contingency) to coordinate transition care & support (NICE, 2016). Transitions coordinator should be appointed, with a role to support service user and carers through transition and function as a point of contact (RCPsych, 2017).	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

Community to inpatient and acutes (vice versa)

	Recommendations	Expected or Advised	Self-Audit / implementation Status
Continuity of Care and Completion of Treatment	Once a person is transferred to an inpatient setting, the treating community team should be centrally involved on an ongoing basis in their care planning. Based on clinical need, formulation, service user preference and care planning, interventions that were being received in the community should be continued if indicated. Allocated community care coordinator remains actively involved in admission, treatment planning and contact with service user, ward and parent / carer / family. This care-coordinator has set and regular contact and is involved in care planning meetings and maintains good information sharing. Joint interventions between teams and the ongoing support of community Services should be explored and considered. Where temporary transitions are needed to inpatient / acute settings, local systems must ensure that this is an integrated part of the care pathway, where clinically indicated.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Overlap of teams and clear communication during leave and at discharge	A period of overlap should take place with inpatient and community teams during times of home leave, as discharge is said to be one of the most challenging and most crucial transitions. Close communication should take place between both teams, and the service user should be provided with a high level of support for an appropriate period of time after discharge (RCPsych, 2017).	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

Clear Preparation Plans	Service users and family / carers (where appropriate) should be allowed to prepare for admission (Specialised Eating Disorder Units [SEDU] or general) through such measures as: allowing an opportunity to visit the unit, an explanation of the rules about visiting, practicalities, discussion with in-patient dietician, a discussion of aims of treatment (RCPsych, 2017).	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Locally agreed and shared Medical Monitoring and MEED protocols	Ensure safe, effective, collaborative care. Consider identifying a transitions and medical monitoring or MEED lead in community teams as well as from in-patient settings and Acute Trusts e.g. Gastro Nurse or Paediatric Nurse. Within Specialist Eating Disorder Unit (SEDU) Services, a continuing expansion of medical monitoring or MEED guidelines is encouraged, in order to protect against tragedies, by consistently adhering to life-saving medical protocols across different units (N.B the RCPsych, 2017 refer to previous MARSIPAN guidelines). Ensure regular learning sessions between Community and inpatient / acute provision occurs to maximise learning and problem serving. Nasogastric tube (NGT) feeding should be a short-term measure & the least restrictive option always considered. Oral / supplements should be considered first. Bolus feeding can be considered to support transition. Decisions should be collaborative & agreed with MDT. Clear records and information is expected. Service users should be monitored and guidance e.g. MEED adhered to.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Parent / Carer / Family support and inclusion in transition / discharge planning / relapse prevention where required and appropriate	Parents/carers should be given a clear understanding of their role, and how to carry it out. They should be provided with a key contact should they have any concerns or problems.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Clear and recorded conversations with service users and carers (where appropriate) relating to differences in clinical models	Written information should be provided to service users and carers.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Clear and Pre-Planned review points	Clear and pre-planned review points involving the service-user and carers (where appropriate) relating to transitions back to community should occur and be evidenced and clearly communicated to all (including service user, inpatient care team, community care team, GP, carers). Assertive, early discharge planning should be used with the construction of a relapse prevention plan or advance statement (RCPsych, 2017).	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Provider Collaborative Case Manager should be included in transition discussions	Provider Collaborative Case Manager should be included and / or aware of transition discussions / process and decisions before admission, during and prior to discharge back to community. Case Manager ensures that care received by service users in their journeys through SEDUs is safe and of a high quality.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Assessment of Neurodevelopmental needs and learning disabilities to be considered in transition planning with Care and Treatment Reviews evidenced where required	If additional needs are assessed then these must be considered within transition planning to make any reasonable adjustments that might be required. Where indicated and appropriate, Care and Treatment Reviews should be carried out to support the individual and family / carers (where appropriate) needs.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Use of psychological interventions to support transitions	Bryan et al., (2021) found that psychological interventions to support transitions from intensive treatment / inpatient to community for adults with an ED have good adherence and fewer drop-out rates than mediation and stepped care approaches.	Advised	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

Specialist community to Higher Education Institutes (HEIs) and out of area moves / geographical moves

	Recommendations	Expected or Advised	Self-Audit / implementation Status
Ongoing Liaison, Training and Consultation to HEIs	Where appropriate teams provide local HEI's with information necessary to support the student during HEI transitions and while studying at HEI e.g. regarding fitness to study, university agreement for the student to be studying, managing risk etc. Urgent need to increase collaboration between ED Services and internal HEI / University mental health support (RCPsych, 2017). Improved training of professionals without specialist ED knowledge to ensure prompt detection, signposting and management of students with EDs. This should include general awareness raising amongst their students and staff.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Early identification of HEI, GP and local ED support once a service user is aware of their new location	Healthcare practitioners and prospective / current students should discuss potential changes to geographical areas, identifying alternative support arrangements where necessary (e.g. remote contacts) and ensure students are aware of implications of change of addresses such as GP and plan for access to support.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Transitions Contact / Professional identified to support HEI transition	Discussion should be had with the service-user about who is best to take on this role. This may not be a specific transition role / lead but could be the care-coordinator or therapist working with that person who is likely to know them best. This role is responsible for supporting the service user before, during and after transition to an HEI and will ensure excellent communication across geographies and Services. The role should include regular and a pre-agreed contact schedule with service users while away to check in and support. This is in line with the suggestion that specific professionals should be appointed to hold the responsibility of providing liaison across transitions, perhaps using the CPA as an appropriate structure (RCPsych, 2017).	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Evidence of clear communication and established treatment / care plans	Responsibilities for aspects of care should be clear, agreed and documented. All those involved in care across geographies should be included e.g. GPs / Primary Care.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Ongoing parent / carer / family support offered	While service-users are still open to Community ED teams there is an offer of ongoing support to parent / carers / family (if appropriate and indicated) while their loved one is away at a HEI. Carers should be given advice and support with regards to 'long distance caring'.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

ED Services to provide information to HEIs	Where indicated and based on individual need there should be evidence that ED Services are providing information to HEIs, this should include local contact details and other information required (conforming with information sharing agreements, consent and GDPR).	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Pre-agreed period of simultaneous care and / or co-working	Ideally an overlap period should be planned of simultaneous contact/ support or co-working with outgoing and receiving teams / support. Time period to be agreed based on individual needs and as detailed in agreed care plan.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Consultation & advice from originating team	Service user, receiving service, HEI and GP at HEI geographical area are able to liaise and receive advice from originating team. This is made clear as transition is planned with clear contact details and expectations of timeframes for communication established.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Specific Care Planning for service users transitioning to HEIs	Care plans need to take in to account the variety of needs that require support well in advance of transition. Clear acknowledgement of risks and mitigations should be included. These care plans are collaborative with all professionals, service-users, carers (where appropriate) and reviewed / updated regularly with receiving teams / support. Early contact with new 'receiving' teams / support, including HEI Wellbeing, to aid transition and agree information sharing process. The referrers (initial provider) should not assume that referrals are successful, and Services open / meet their needs - this needs to be actively confirmed and planned.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Flexible care agreements discussed and agreed in advance of HEI transitions	The support available when service user returns during holiday / non-term time periods must be agreed in advance and regularly reviewed with both outgoing and receiving teams / support. This could involve temporary GP registrations and ensuring that patient records are shared in advance and throughout.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Information and contact details for ED teams serving HEIs	All teams to have access to information and contact details about ED support in HEI areas, preferably including GPs affiliated with HEIs. Team must establish contact well in advance of transition.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Clear information sharing to aid HEI transitions & use of digital solutions / agreements / protocols	Where possible care should continue (where clinically indicated) using video or remote technology where required e.g. to complete a course of psychological therapy when transitioning. Where it is possible to digitally share records (following local procedures and information sharing guideline) this should be encouraged. Where it is not possible then the teams should agree a process for that sharing of relevant records / information. Encouragement of the transfer of work between geographical regions that improves electronic access to records and to make use of video-link technology to provide continued therapy across geographical divides (RCPsych, 2017).	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

Evidence of collaboration locally between ED provision and HEI Wellbeing Teams	Collaboration would be the establishment, in each area, of close links between specialist ED Services & student health, involving training and joint working (RCPsych, 2017). Evidence that the ED teams / provision are offering local HEI wellbeing provision support / training / consultation if accepted by HEI. If requested, Services should support local HEIs to maximise their wellbeing support offers specifically for those with Eating Disorders. This could include general awareness raising, education and specific tailored support / advice around things such as food shopping, meal planning, living in catered accommodation, choosing meal options, sports society involvement etc.	Advised / Optional	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
HEI/Uni Preparation Group	Consider the development of HEI / Uni preparation groups for prospective service users planning to transition to HEI and undertake studies.	Advised / Optional	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

Specialist ED community to general community MH

	Recommendations	Expected or Advised	Self-Audit / implementation Status
Ongoing advice, consultation and guidance offer	Specialist ED Community Teams to provide ongoing advice, guidance and consultation on management of ED if required during and following transition.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Clear information for Service Users	Clear information provided to Service Users (and carers / family - where appropriate) relating to new service with contact information / details. General MH / ED signposting and resources made available to aid transition and beyond. Expectations managed around reason for onward referral / support and how new team operates and clear care plan for ongoing treatment with handover.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Collaborative assessment of need and treatment planning	Agreed processes with local community MH teams around how MH needs are assessed with collaborative conceptualisation and treatment planning across teams to address any co-morbid or residual MH difficulties / eating difficulties. Clear referral guidance and agreements with community MH teams to aid optimal transitions and continuity of care with minimal disruption to service user.	Advised / Optional	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

Specialist ED community to primary care

	Recommendations	Expected or Advised	Self-Audit / implementation Status
Clear discharge summary shared with GP / Primary Care	Discharge summary to include relapse prevention plan and any ongoing care / treatment plans clearly articulated to GP / Primary Care including Voluntary, Community, Social Enterprise) (VCSE) support.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Clear information for Service Users & GP / Primary Care	Clear information provided to Service Users (and carers / family - where appropriate) relating to other Services / support available. Patient and carers / family (where appropriate) aware of post-discharge support with contact details made available e.g. if they can call community teams, local support groups, peer-support etc. General MH and ED support signposting and resources made available to aid transition and beyond. Information made available relating to any VCSE support that might be available and any referrals made in advance and should be clearly communicated to all.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Local pathways and expectations agreed between GPs / Primary Care and Specialist ED Teams	Local, robust pathways and expectations explicitly agreed between GPs / Primary Care and specialist ED teams relating to ED discharges back to primary care and including ongoing medical monitoring arrangements and support are agreed, documented and regularly reviewed.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Joint GP / Primary Care transition planning	As part of transition / discharge planning there should be an agreed period of transitional care appropriate to the individual. Pre-arranged appointment/s between service user (carers or family - if appropriate) ED team and GP / Primary Care planned to allow for a clear transition plan and assessment / treatment plan of ongoing needs. If this is not possible then all discharge summary and treatment plans should be sent in advance of discharge / transition and at least one appointment between the service user and GP / Primary Care arranged prior to transition, and follow up appointment scheduled post-transition. Review period with discharging team agreed in advance and any relevant re-referral routes / processes discussed in advance. Any onward referrals or signposting that is required should be done in advance of discharge to GP / Primary Care and this should be clearly communicated to all.	Advised / Optional	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
GP / Primary Care Mental Health and/or Eating Disorder leads with specific interest in ED to be identified and championed	GP / Primary Care Mental Health and /or ED leads within local areas with a specific interest / expertise in ED to be identified and to support improvement and implementation of: transition planning, ED and MH referrals, medical monitoring agreements, local training / awareness raising and inter-organisational collaborations / agreements.	Advised / Optional	☐ **Yes – Fully Implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

VCSE ED teams to specialist ED community (and vice versa)

	Recommendations	Expected or Advised	Self-Audit / implementation Status
Step Up & Step Down agreements	Clear escalation processes are agreed if service users stepped down but some additional support is later required or needs escalate. Clear service level agreements in place to ensure continuity of care and documented in care plans.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
VCSE Integrated in to ED Care Pathways	Where available and appropriate VCSE ED Services should be commissioned as part of ED pathways to support statutory Services. They should be valued partners and be part of clinical pathway planning.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

Return to specialist ED Services after relapse

	Recommendations	Expected or Advised	Self-Audit / implementation Status
Escalated assessment and treatment commencement	Consider escalation of and/or immediate assessment & treatment if known relapse factors are indicated (e.g., particularly if previously admitted). Assessment and treatment ideally with practitioner familiar to service user from prior episode (if possible, clinically indicated and appropriate). Thorough assessment needed with history taken into account so that risks are managed appropriately and immediately, with appropriate treatment offered ASAP.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Community ED Teams to consider 'Follow up support'	Based on individual need, care plan and discharge planning, consider the need to offer follow-up support / contact and / or Top-Up sessions for those at higher risk of relapse. If limited capacity to offer this then ensure that those at higher risk of relapse have onward referrals and ongoing support from other provision e.g. VCSE providers where appropriate. Community ED teams to consider this additional resource / capacity / offer in future improvement plans and business case proposals.	Advised / Optional	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

Return to education / employment

	Recommendations	Expected or Advised	Self-Audit / implementation Status
Clear and collaboratively developed relapse prevention plan	If suitable and applicable, the relapse prevention plan should be shared with education setting / employer. Relapse prevention plans and ongoing support should take in to account social, educational and occupational needs.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Specific planning, liaison & review relating to return to Education / Employment	In collaboration with the service user (with consent) and their parents/carers (where appropriate) Services should work with education providers and employers to plan for supportive returns to education and employment. This could include: - Employing specific roles e.g. employment and education advisors within ED (and/or mental health) Services. - Evidence of working closely with VCSE, Local Authority, DWP/Job Centres or Council provision that support return to education and employment. - Evidence that Services are supporting service users to return to education / employment (if applicable) at a pace that suits their needs and with realistic agreements/plans. - Services support service users (where required) to engage with their education provider / employer and agree what reasonable adjustments and pastoral / occupational health support might be required as part of return (e.g. a quiet place to eat, regular breaks, time to attend clinical sessions).	Advised / Optional	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**
Specific planning, liaison & review relating to return to Education / Employment	- Planned reviews with care team, service user, parents/carers (if appropriate) and education / employment representatives (where applicable) to include plan for return according to their individual care needs and care plan. - Liaison with local IAPT provision and their social recovery support offers, where appropriate.	Advised / Optional	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

Community to day patient unit / day patient unit to community

	Recommendations	Expected or Advised	Self-Audit / implementation Status
Social /Occupational / Education Support Offered	During transition planning, identify support relating to social, occupational or educational needs / requirements in addition to information relating to activities of daily living. During day-care 'admission' work with service user, parents / carers / family (if appropriate), community care team and other Services to plan for engagement in meaningful activities as day-care support reduces and identify / signpost to further support.	Expected	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

Care / Treatment & Discharge	Service user, parents/carers/family (if appropriate), day-care team and community team to work collaboratively together to develop care/treatment plan and discharge plan. Community team to remain involved in day-care treatment planning to enhance continuity of care. This could involve: - Clear service criteria / indicators for stepping up/down day-care and anticipated duration of treatment / support based on individual needs and clear treatment goals. - Phased approach to discharge back to community / primary care team where indicated. - Clear relapse prevention planning and medical / physical health monitoring plans, acknowledging increased risk of relapse. - Clear communication with service user, primary care and community teams relating to discharge planning. - Clear identification of residual support / skill acquisition required with plans and clarity of roles and responsibilities e.g. meal preparation. - Regular reviews with care team (across Services), service user, parents/carers/family (if appropriate) throughout and for a pre-arranged duration following discharge.	Advised / Optional	☐ **Yes – Fully implemented** ☐ **Partial – Implementation planned or in development** ☐ **No – Will consider how / if we can implement**

How should we implement these standards?

We hope that as you have reviewed these standards you have been able to consider whether your service is implementing them and if not, what might be required to embed them in practice. There are a range of implementation frameworks and theories that you can use to inform the application and sustainment of these standards into practice. These include the Exploration, Preparation, Implementation and Sustainment (EPIS) framework and the Consolidated Framework for Implementation Research (CFIR).

To ensure a greater chance of implementing and sustaining changes please consider the following implementation factors (as an example) when planning how you adopt these standards:

Your service's / organisation's readiness for change or implementation

Any additional resources that might be required

Any required 'influencers' including the involvement and co-work of experts by experience

Is any additional funding / change in how funding is used required (also consider contracting)?

What impact it will have on staff members and partners in your inner and outer contexts?

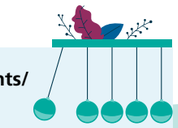
Any incentives require to promote the adoption of standards?

The degree to which these standards might need adapting to service needs / processes

Any training needs?

Mitigation of risks associated with process changes

Impact on the patients/ service users



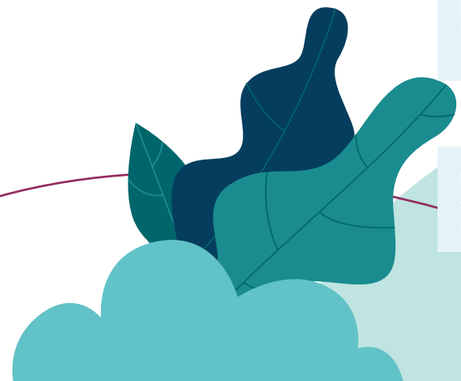
Internal or external policy or strategy adaptations required

Evaluation of the implementation and impact

Identify and ensure that there is good clinical and operational engagement, commitment and leadership

Your style of communication and engaging staff in change

Please review the standards that you feel that your service/s are not fully implementing and if helpful complete the plan on the following page (please use as a template).



ED Standards Self-Assessment Checklist

Transition Standard	Implementation factors?	Action Plan / Next Steps / How?	Who	By When?
EXAMPLE **Parent / Carer / Family Needs assessed & support offered**	Is there a family / carer lead that can be involved and steer change? Can we engage with parents/carer representatives to assess how best to implement this locally? What examples of good practice do we have where this occurred? We don't have training for staff on assessing parent /carer/family needs.	Identify family/carer lead and work with them and staff to identify best practice.	Service manager	2 weeks
		Ask current service users/ patients if we can liaise with family members to ask for their advice / input	Patient participation lead	4 weeks
		Develop a clear / simple process and training for staff on assessing parent/ carer needs	Business support alongside clinical staff	6 weeks
		Link in with local VCSE providers and parent/ carer forums to support and link as part of the outer context	Service manager and patient participation lead	4 weeks
		Implement / start adopting new process to adhere to standard and measure impact		7/8 weeks +

Transition Standard	Implementation factors?	Action Plan / Next Steps / How?	Who	By When?

NHS
East of England

Resources and References

Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers (england.nhs.uk)

BEAT (2020). Best practice in managing service transitions for patients affected by eating disorders.

Bryan, D. C., Cardi, V., Willmott, D., Teehan, E. E., Rowlands, K., & Treasure, J. (2021). A systematic review of interventions to support transitions from intensive treatment for adults with anorexia nervosa and/or their carers. European Eating Disorders Review, 29(3), 355-370.

Cribben, H., Macdonald, P., Treasure, J., Cini, E., Nicholls, D., Batchelor, R., & Kan, C. (2021). The experiential perspectives of parents caring for a loved one with a restrictive eating disorder in the UK. BJPsych Open, 7(6).

Ignoring the alarms: How NHS eating disorder Services are failing patients (ombudsman.org.uk) (2017).

National Collaborating Centre for Mental Health (NCCMH; 2019). Adult Eating Disorders: Community, Inpatient and Intensive Day Patient Care: Guidance for commissioners and providers.

Overview | Eating disorders | Quality standards | NICE (2018).

Overview | Transition from children's to adults' Services for young people using health or social care Services | Guidance | NICE & Transition from children's to adults' Services for young people using health or social care Services (nice.org.uk) (2016).

RcPsych (2017). Managing Transitions.

Royal College of Psychiatrists, 2022. Medical emergencies in eating disorders (MEED) Guidance on recognition and management. London.

Student Minds (2021). Supporting Students With Eating Disorders.

Student Minds (2014). University Challenge: Integrating Care for Eating Disorders at Home and at University.