HQIP Healthcare Quality Improvement Partnership

#CAAW26

Data-Informed Improvement: From Insight to Impact

Friday 26 June 2026, 1pm-3pm

THIS EVENT STARTS AT 1PM

Discover all the #CAAW26 events:
Scan the QR code or visit
www.hqip.org.uk/caaw26

CLINICAL AUDIT AWARENESS WEEK 2026

Improving lives with healthcare data

www.hqip.org.uk/caaw26

Data-Informed Improvement: From Insight to Impact

Welcome to Clinical Audit Awareness Week, 22-26 June 2026: www.hqip.org.uk/caaw26

Today's agenda:

- **Evidence into Practice category winner(s) presentation, Excellence in Clinical Audit Awards 2026**

Announced by Vicky Patel, *Clinical Effectiveness Manager, The Rotherham Foundation Trust*

- **From Data to Practice: How Audit Insights Shape Local CAMHS Care**

Tom Hunter, *Mental Health Nurse and Plymouth CAMHS* and Dr Salbu Krishnan, *Clinical Lead for South-West CAMHS Eating Disorders, Consultant Eating Disorders and CAMHS Psychiatrist*

- **Building the National Audit of Eating Disorders: Barriers, Data Quality, and Impact on Services**

Dr Karina Allan and Philippa Nunn, *National Audit of Eating Disorders (NAED)*

- **Resident Doctor Abstract Submission Winner: Turning Audit into Improved Patient Care**

Dr Alex Tebbett, *Anaesthetic Registrar – ST5, South Warwickshire University Foundation Trust*

Before we start…

Being seen and heard

- Event recorded
- Mics off for background noise
- Cameras on, if you are happy to

Asking questions

- Use the Q&A to post your questions
- Contact us via HQIP website if Q&A unavailable for you

Recommendations

- Laptop/PC, not phone
- Try browser version, not app
- If needed, rejoin using rejoin button on screen or original Teams link

Don't forget to share on social media: #CAAW26

#CAAW26

EXCELLENCE IN CLINICAL AUDIT AWARDS

Shining a Light on Data-Driven Healthcare Improvement

Evidence into Practice Award 2026

CLINICAL AUDIT AWARENESS WEEK 2026

Improving lives with healthcare data

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EXCELLENCE IN CLINICAL AUDIT AWARDS

Shining a Light on Data-Driven Healthcare Improvement

AND THE RUNNER UP IS...

CLINICAL AUDIT AWARENESS WEEK 2026

Improving lives with healthcare data

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Evidence into Practice Award Runner-Up 2026

Ty Llewelyn Medium Secure Services, Betsi Cadwaladr University Health Board (BCUHB)

Clozapine Monitoring in Medium Secure Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

EXCELLENCE IN CLINICAL AUDIT AWARDS

Shining a Light on Data-Driven Healthcare Improvement

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EXCELLENCE IN CLINICAL AUDIT AWARDS

Shining a Light on Data-Driven Healthcare Improvement

AND THE JOINT WINNERS ARE…

CLINICAL AUDIT AWARENESS WEEK 2026

Improving lives with healthcare data

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Evidence into Practice Award Joint Winner 2026

Dr Inderpal Singh OBE

Aneurin Bevan Fracture Liaison Service,
Aneurin Bevan University Health Board

Also a Joint Commendation Winner!
Using National Clinical Audit Commendation

EXCELLENCE IN CLINICAL AUDIT AWARDS

Shining a Light on Data-Driven Healthcare Improvement

#CAAW26

Evidence into Practice Award Joint Winner 2026

Urology Prostate Cancer Pathway team,

Ashford and St. Peter's Hospital NHS Foundation Trust

Service Redesign and Capacity Improvement Through Nurse Practitioner Role Expansion in the Prostate Biopsy Pathway

EXCELLENCE IN CLINICAL AUDIT AWARDS

Shining a Light on Data-Driven Healthcare Improvement

HQIP Healthcare Quality Improvement Partnership

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Evidence into Practice Award Joint Winner

Dr Inderpal Singh OBE

Aneurin Bevan Fracture Liaison Service,
Aneurin Bevan University Health Board

In association with

Commissioned by

Royal Osteoporosis Society
Better bone health for everybody

GIG CYMRU NHS WALES

Ariennir yn Rhannol gan **Lywodraeth Cymru**
Part Funded by **Welsh Government**

Royal College of Physicians | FFFAP

BONE HEALTH IN WALES
RESPECT YOUR BONES

Delivering Excellence in Secondary Fracture Prevention: Implementation, Adoption, Sustainability, and Spread of Fracture Liaison Service

Inderpal Singh
Consultant Geriatrician, ABUHB
National Clinical Lead, Bone Health, Wales

Excellence in Clinical Audit Awards 2026
(part of Clinical Audit Awareness Week): **Evidence into Practice award category**
26th June 2026

GIG CYMRU NHS WALES | Perfformiad a Gwella Performance and Improvement

closure: Presentation is based on my wider discussions and partnership working with WG colleagues, stakehola FFFAP Clinical Leads, ROS, and Welsh Health Board colleagues. Partly funded by WG.

Sponsored by Theramex/UCB to attend educational events/meetings/conference

Canolfan Gwerth mewn Iechyd Cymru
Welsh Value in Health Centre

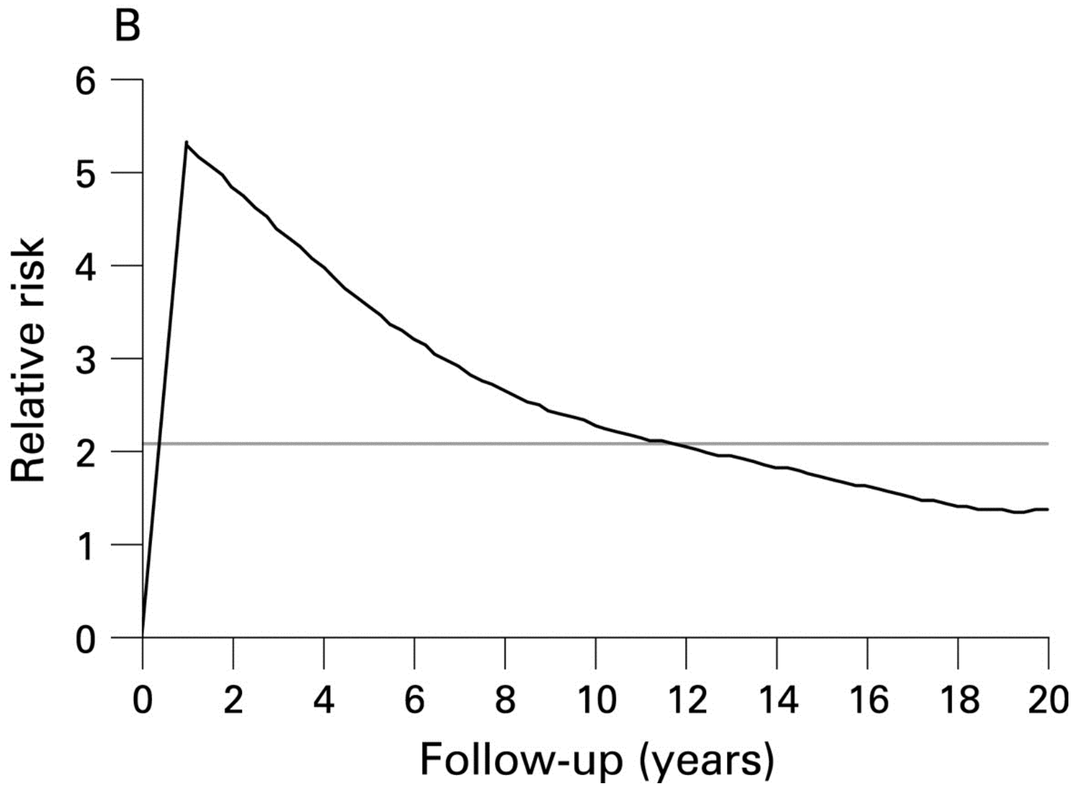
Acknowledgments

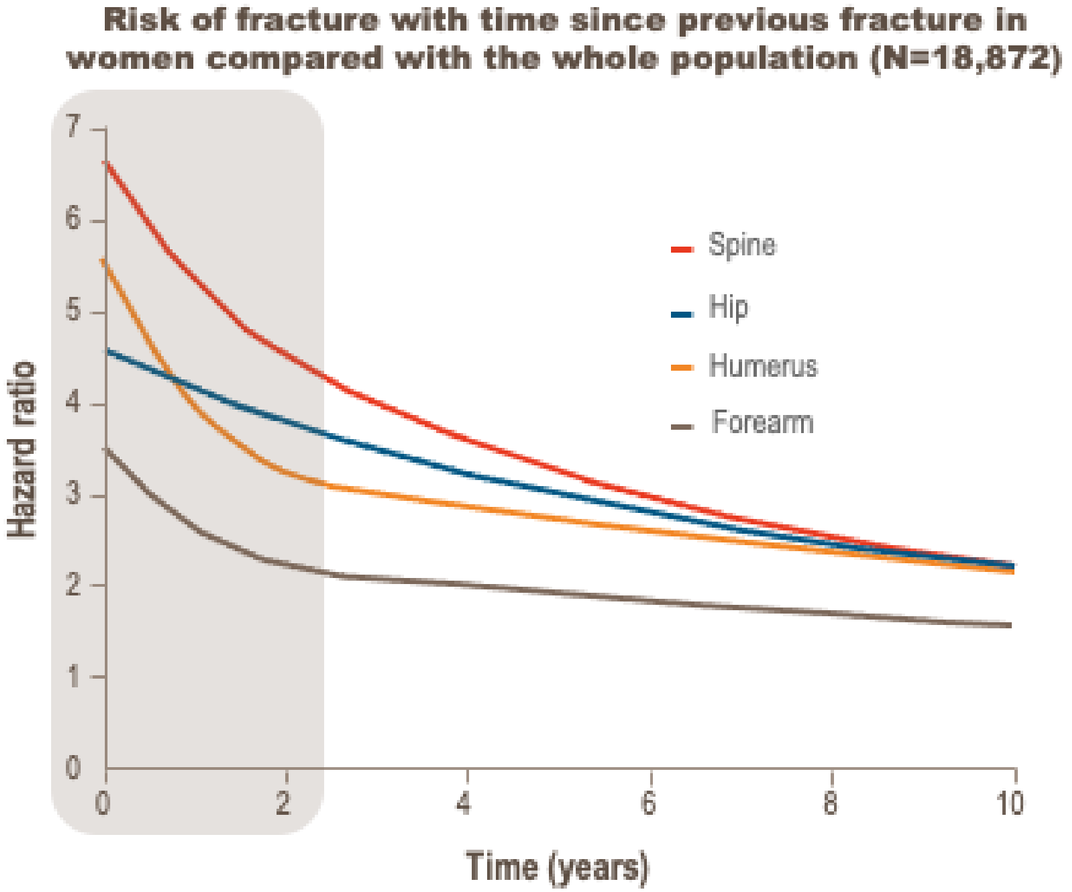
Patients
First Minister/Cabinet Secretary/Judith Paget/Chris Jones
WG colleagues – Gareth Hewitt/Laura Jones/Kevin Francis/Caroline Sparks/Lisa Dineen
Rheumatology/Radiology Directorate/FLS Teams/OG
Nursing Team – Gillian Knight and all Wales team
Six Goals team – Richard Bowen and team
Welsh Value in Wales – Sally Lewis and team
ROS team
BBC Wales
BGS/RCP/FFFAP team
EPP Cymru for promoting patient education and osteoporosis awareness
Bevan Commission
FLS D&QA network
Pharmacy – Gavin Rose and wider team
My own HB for supporting me to be here
NHS staff

Thanks

Inder.Singh@wales.nhs.uk

Why do we need to act fast?





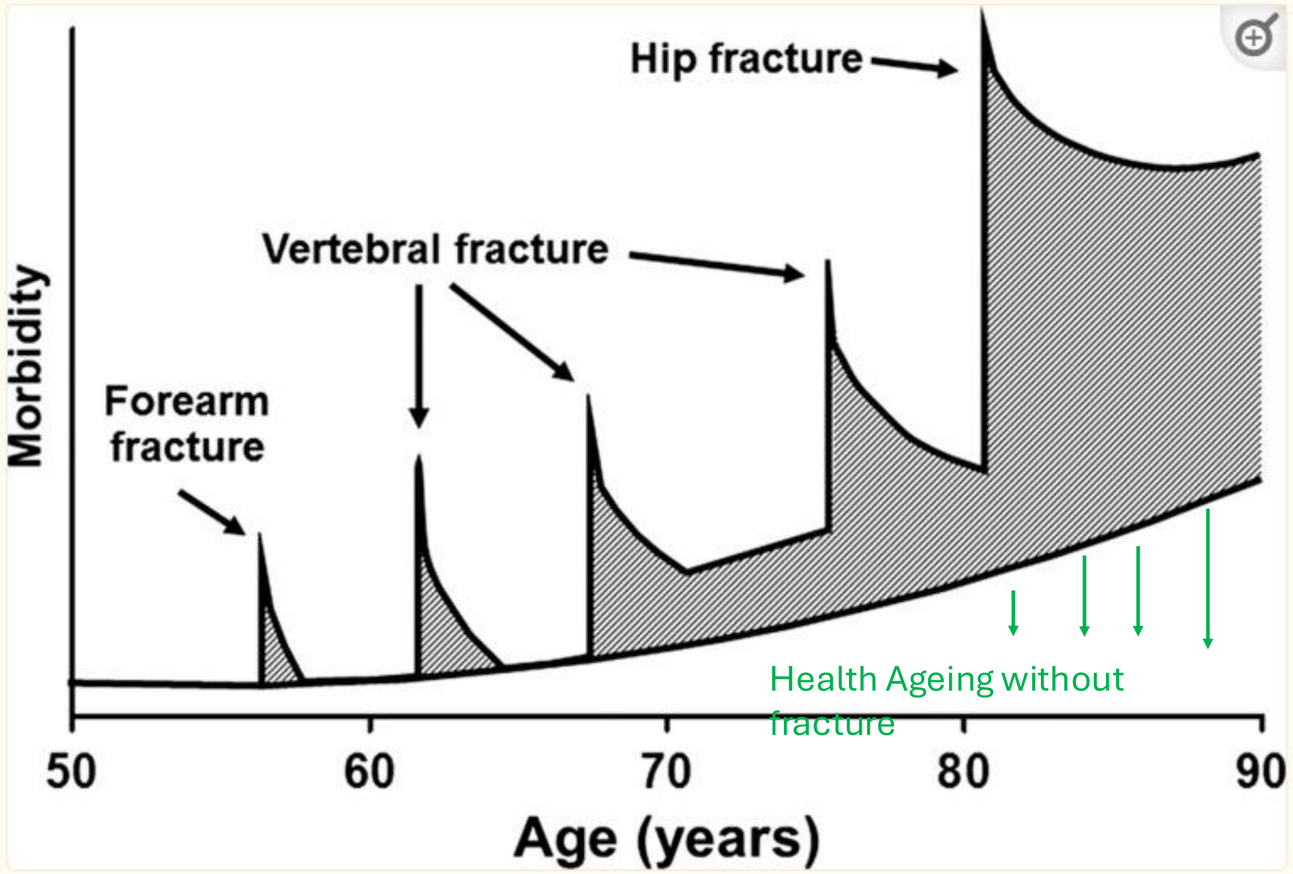
Clinical subsequent fractures cluster in time after first fractures

T A C M van Geel,[1] S van Helden,[2] P P Geusens,[3,4] B Winkens,[5] G-J Dinant[1]

Capture the Fracture Partnership: Guidance for Policy Shaping
https://www.capturethefracture.org/resource-center/advocating-for-pfc/policy-toolkits

Kanis OI 2022

More than a silent condition: The fracture cascade



Accumulation of fracture-specific morbidity over life

Traditional Reactive
to
Proactive-Reactive
Integrated Approach

Kanis JA, Johnell O. The burden of osteoporosis. *J Endocrinol Invest* 1999

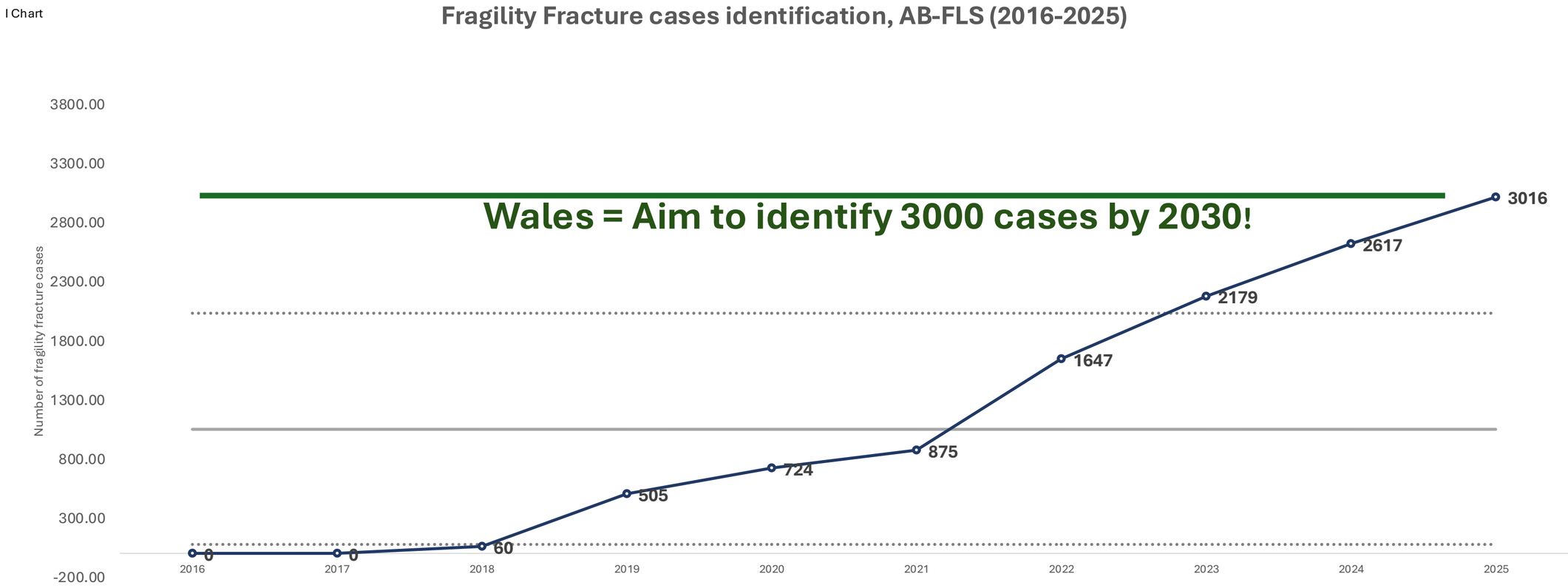
Clinical collaboration – Automated Digital Fracture Identification: Weekly radiology reports

Aneurin Bevan Health Board
Radiology Department
Radiology Information System
provided by RadIS 2
STRICTLY CONFIDENTIAL RADIOLOGY RESULTS

Radiology Results
age 65 and over
16/09/2024

Record Selection Criteria:
SELECTION CRITERIA:
Date Range: and
Procedure Group: Plain film, CT & MRI
Keywords Searched for: "Fracture"
Records Selected using : Age range 65+

No. of Records Selected: **189**

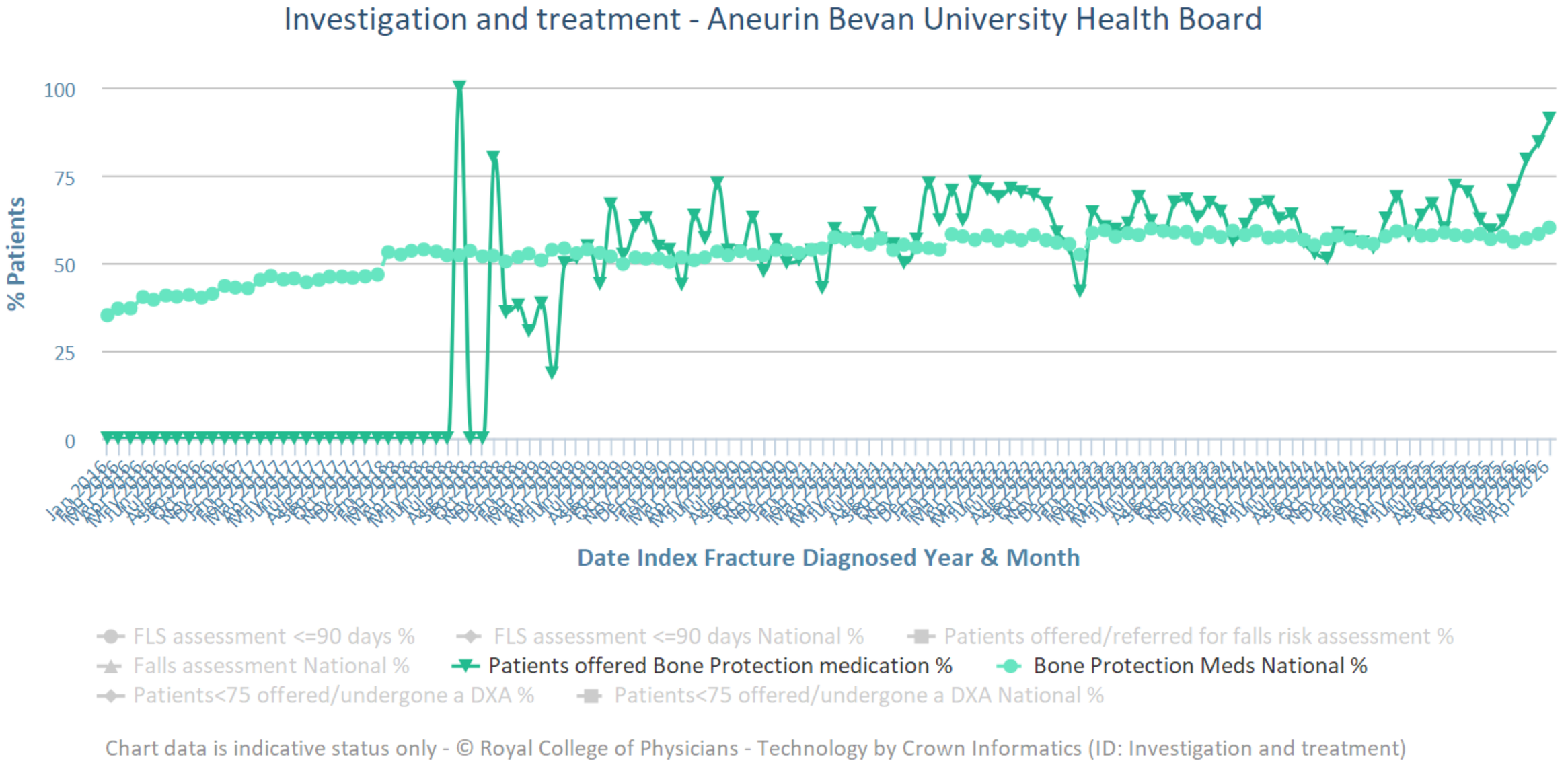


Target achieved 5 years earlier!

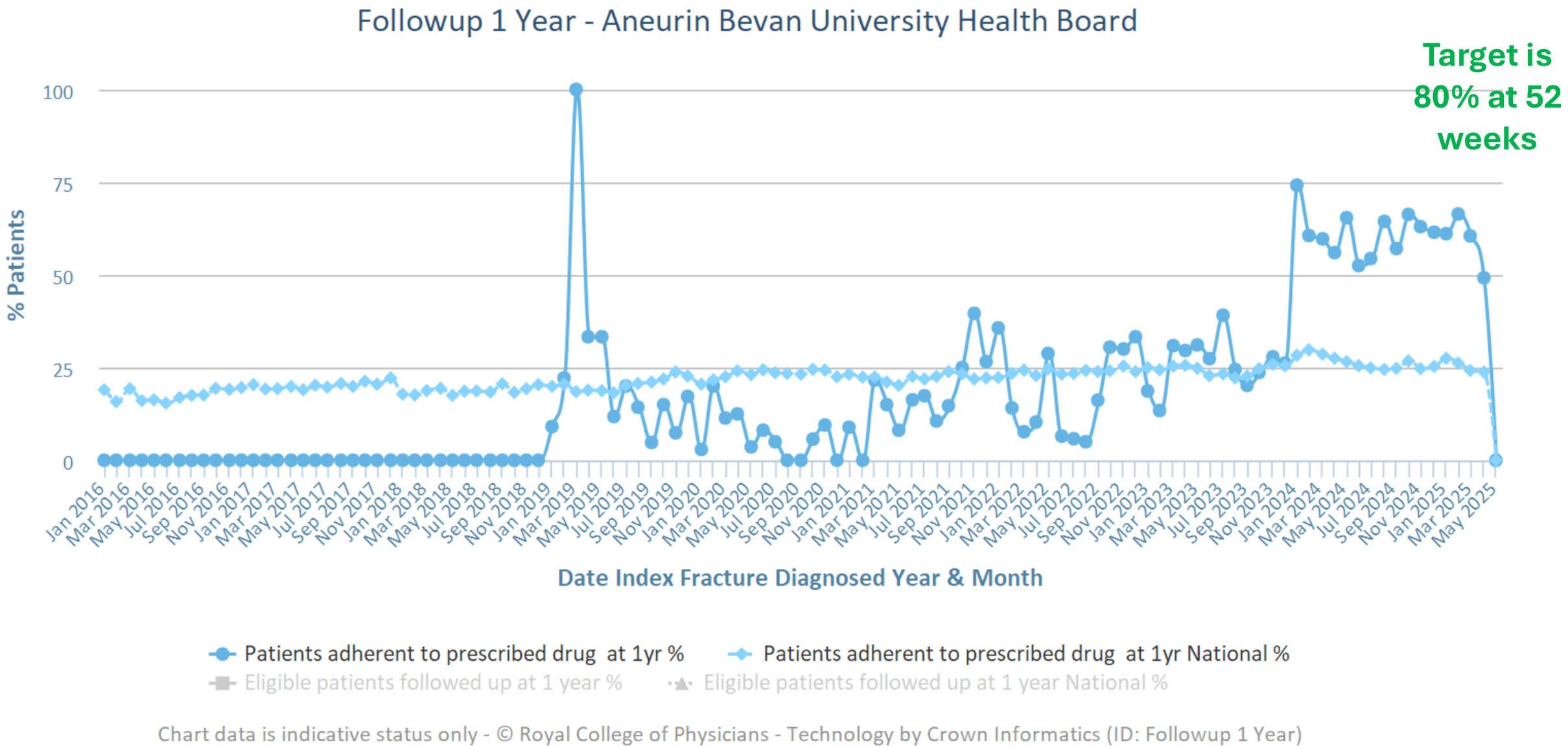
Source: FLS Web - FLS-DB FLS-Reporting Benchmarks 2026

Acknowledgment: I Singh FLS/Bone Health Clinical Lead, AB-FLS Team/Rheumatology/Radiology directorate/Primary Care

Sustainability – KPI-7



Sustainability – KPI-11



Sustainability – 80-50-80

Wales - 2025

2025 | Wales | Compare benchmarks | FLS services | Regions | Integrated care systems | KPI7 Tables

Copy | CSV | Print

Show entri

FLS Service/Unit	Unit Code	Total FLS submitted records	Rx5 Value*	KPI 2 Non-Spine Case identification	KPI 3 Spine fractures	KPI 4 Assessment within 90 days	KPI 5 DXA within 12 Weeks	KPI 6 Falls risk assessment	KPI 7 Bone treatment	KPI 8 Strength & Balance by 16 weeks	KPI 9 16 week follow up	KPI 10 Treatment by 1st followup	KPI 11 1 year drug adherence*
1. National averages	National	92369	225422	43	32.8	65.8	41.3	66.2	57.8	7.7	30.9	31.8	25.4
2. Wales		10277	21535	42.3	69.5	70.2	16.2	54.9	58.5	8.2	26.5	21.1	22.5
Aneurin Bevan University Health Board	NEV	3020	3950	58.2	149.4	67.3	43.1	83.4	63.3	28.3	57.4	49.7	59.6

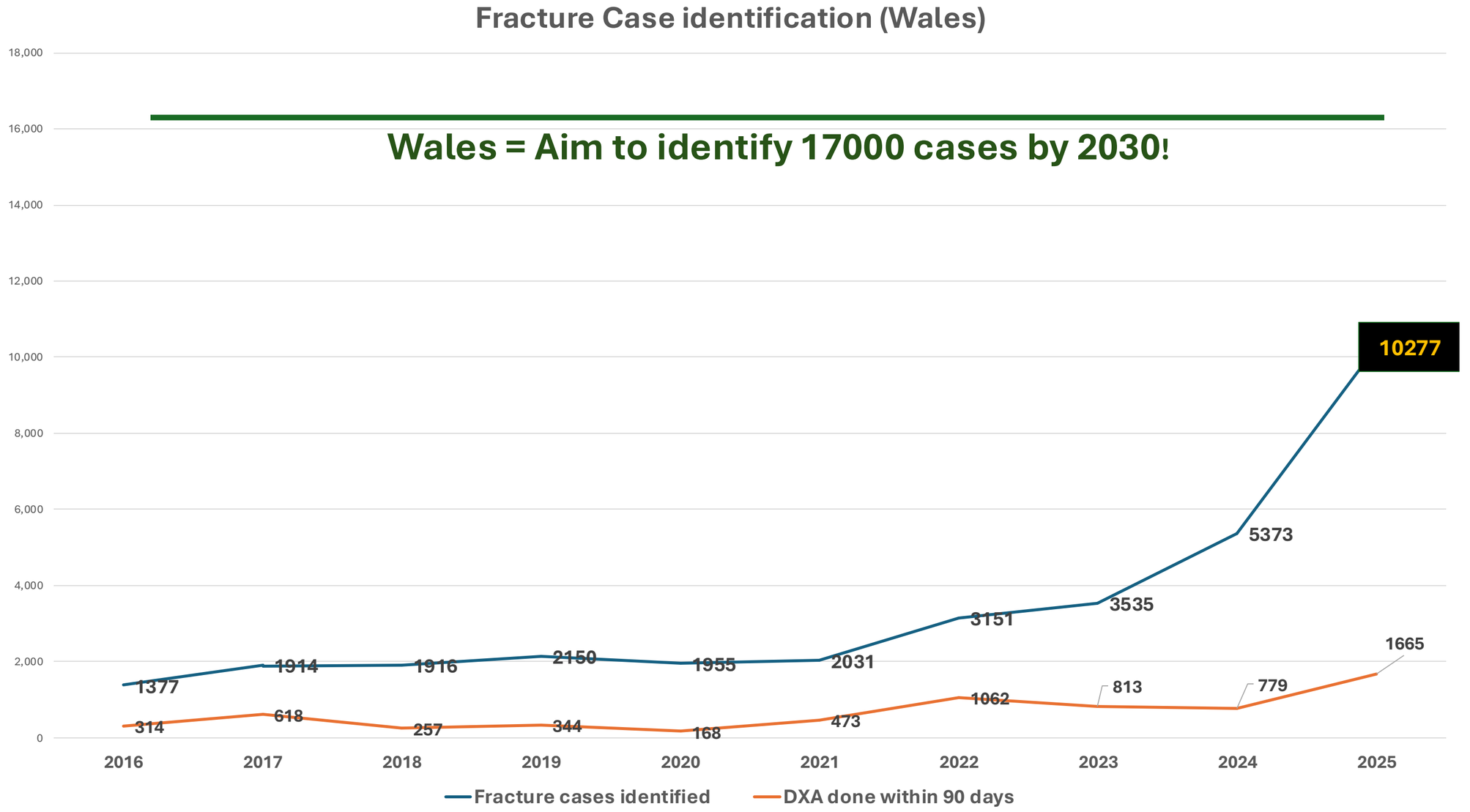
Comisiwn Bevan Commission

Adopt, Spread and Embed

Royal College of Physicians | FFFAP

Royal Osteoporosis Society
Better bone health for everybody

Spreading and Scaling the Welsh FLS Model



Year 2025
47.7%

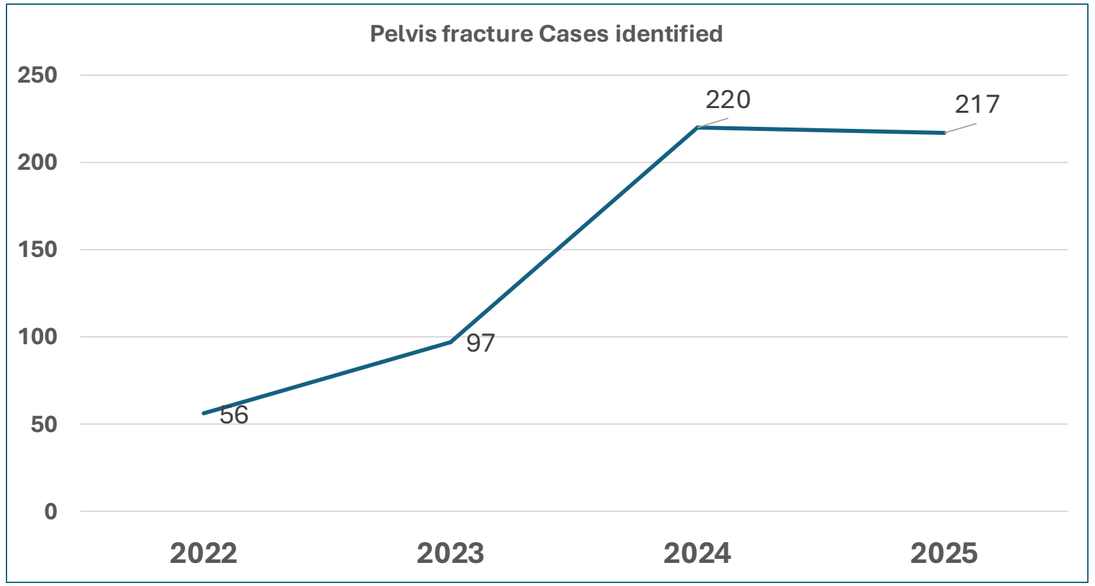
On target for 2030!

So What?

We need to measure health outcomes

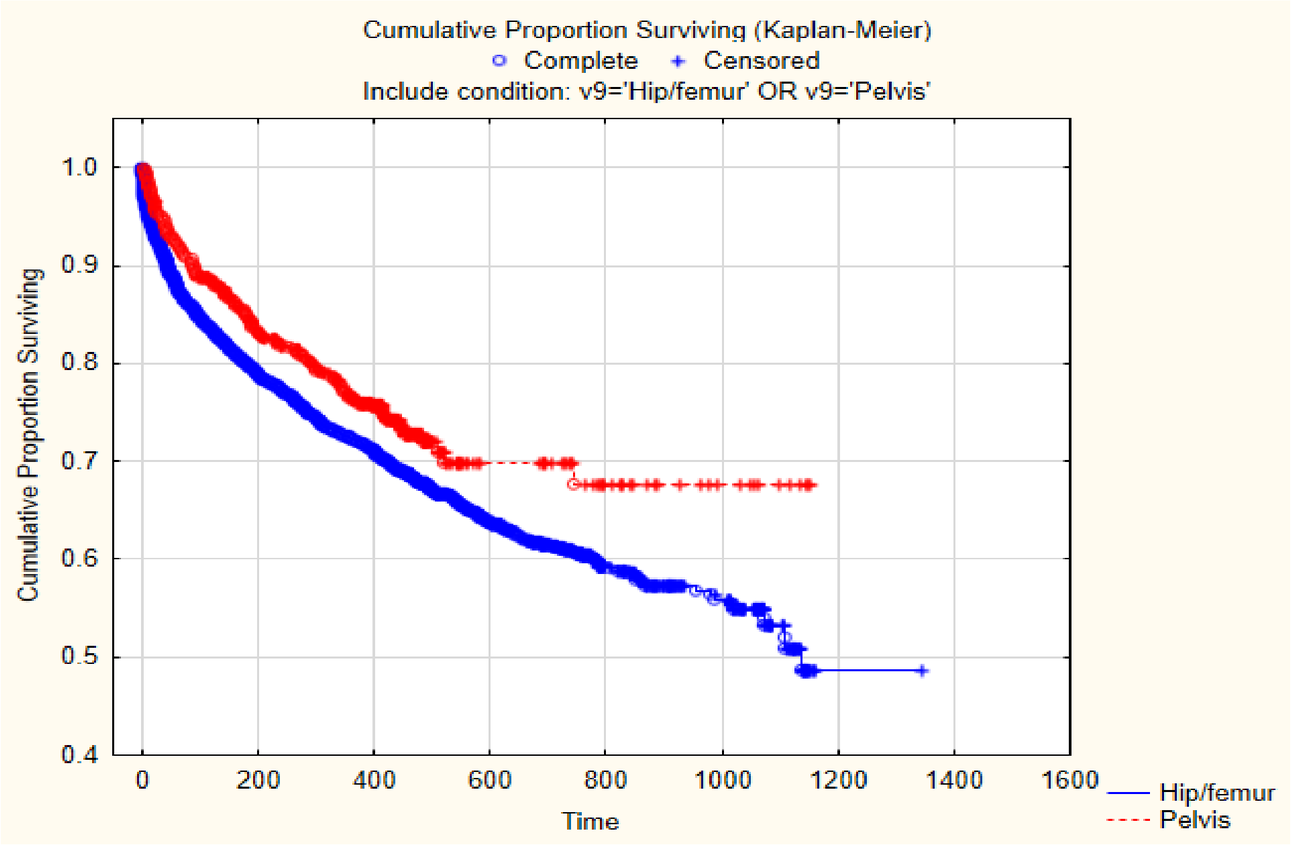
We have used data from the HQIP-commissioned NCAPOP to support improvements in healthcare

Impact: Pelvic Fractures



- **590 pelvic fractures (2022 to 2025)**
  - Mean age = 83.7±8.3, 78.6% females
  - Inpatients = 62.3%
  - Previous Fracture Hx = 58%

- **Mean length of stay**
  - Pelvis # = 32 ± 37 days
  - Hip # = 31 ± 48 days (p = 0.64)



JOURNAL ARTICLE

Fragility fractures of the pelvis—time to address the needs of people with these 'orphan injuries' FREE

Antony Johansen ✉, Megan James, Inder Singh

Age and Ageing, Volume 55, Issue 2, February 2026, afag047,

Areas to focus for the year 2026-27…..

- KPI 5 – Improving access to DXA within 90 days
- KPI 11 - Monitoring and adherence rates at 52 weeks
- Post 52 weeks care – Longitudinal and integrated care (Welsh Virtual KPI-12)

Inderpal Singh, Avtar Singh, Rashpinder Kaur; Amara Williams; Sophie Shah; Reetika Singh June 2026
Managing rising demand in fracture liaison services while achieving a net carbon-negative model | RCP

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#CAAW26

Evidence into Practice Award Joint Winner

Kathlene Rose Gumahad

Prostate Cancer Diagnostic Pathway Team,

Urology Department, Ashford and St. Peter's Hospital NHS Foundation Trust

Ashford and St. Peter's Hospitals
NHS Foundation Trust

Service Redesign and Capacity Improvement Through Nurse Practitioner Role Expansion: Transforming the Prostate Cancer Diagnostic Pathway

Kathlene Rose Gumahad
Prostate Cancer Diagnostic Pathway Team
Urology Department
Ashford and St. Peter's Hospitals NHS Foundation Trust

Patients first | Personal responsibility | Passion for excellence | Pride in our team

Ashford and St. Peter's Hospitals
NHS Foundation Trust

The Challenge: Demand vs Capacity

Challenges	Impact
Rising referrals	Increased demand on diagnostic services
Limited consultant capacity	Reduced biopsy availability
Theatre dependency	Scheduling delays

FDS performance: 57.6% (below target)

Clinical audit identified the need for a pathway redesign to improve capacity and reduce diagnostic delays.

Understanding the Problem

Ashford and St. Peter's Hospitals
NHS Foundation Trust

WORKFORCE

- Bottleneck due to limited clinician availability for biopsy procedures
- Heavy reliance on limited medical capacity

PATHWAY DESIGN

- Inefficient end-to-end pathway flow
- Avoidable delays between steps

CAPACITY

- Insufficient biopsy slots to meet demand
- Demand exceeding service supply

ACCESS

- Variability in scheduling and prioritisation
- Inequity in patient access to appointments

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Redesigning the Pathway

Ashford and St. Peter's Hospitals NHS Foundation Trust

BEFORE

- Consultant-led clinic decision-making
- Consultant-dependent biopsy pathway
- Limited procedural capacity

AFTER

- Streamlined triage with early diagnostics
- Shared clinic review model
- **NP-delivered** LATP biopsy service
- Increased capacity and improved flow

KEY CHANGES

- Expansion of **Nurse Practitioner** role into **LATP biopsy**
- Reduced consultant bottleneck
- Improved flow: Referral → Diagnosis

IMPACT

- **Increased** pathway capacity and efficiency
- **Reduced** reliance on consultants
- **Better utilisation** of advanced practice roles

Patients first **Personal responsibility** **Passion for excellence** **Pride in our team**

Impact: What Changed

Ashford and St. Peter's Hospitals
NHS Foundation Trust

PATIENT OUTCOMES
Faster diagnosis and improved performance

Average clinic to biopsy interval	Faster Diagnosis Standard (FDS)	62-day treatment performance
7 days BEFORE → 5 days AFTER	57.6% BEFORE → 71.6% AFTER	82.7% BEFORE → 86.7% AFTER

SERVICE CAPACITY
Increased capacity without additional resources

Clinic slots increased	LATP biopsy slots increased
24 per week BEFORE → 32 per week AFTER	8 per week BEFORE → 11 per week AFTER

Managed rising referrals without additional consultants or theatre resources.
Consultant time reallocated to complex diagnostics, MDTs and theatre work.

SAFETY & DIAGNOSTIC QUALITY
Safe, effective and appropriately escalated

- **169** NP-performed LATP biopsies
- Benign and malignant outcomes managed appropriately
- **7** Escalations to GA TP
- **2** Upgraded to treatment following re-assessment

Structured competency requirements and clear escalation pathways maintain diagnostic quality and patient safety.

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Beyond the Numbers

Ashford and St. Peter's Hospitals
NHS Foundation Trust

PATIENT IMPACT
Improved experience and continuity

- **Single point of contact** throughout the diagnostic pathway
- **Consistent nurse-led** communication and follow-up
- **Faster progression** from investigation to treatment planning
- **Reduced anxiety** through clearer guidance and support

WORKFORCE IMPACT
Developing advanced practice

- **Nurse Practitioner** role expansion and scope of practice
- **Increased autonomy** and specialist skills for NPs
- **Competency-based** training and governance model established
- **Sustainable workforce** development and succession planning

SERVICE IMPACT
Making better use of resources

- **Consultants released for**
  - complex diagnostics
  - MDT discussion
  - theatre capacity
- **Improved pathway** capacity, flow and resilience
- **Stronger multidisciplinary** collaboration across the prostate pathway

The redesign created a patient-centred, sustainable model that maximises specialist skills across the multidisciplinary team.

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Sustaining the Change

Ashford and St. Peter's Hospitals
NHS Foundation Trust

SUSTAINABLE MODEL
Embedded NP-led service

NP-led LATP lists
embedded into routine practice

Structured competency framework
≥50 supervised LATP biopsies

Clear governance and escalation
pathways

CONTINUOUS QUALITY IMPROVEMENT
Maintaining safety and performance

Ongoing audit of:
- diagnostic outcomes
- cancer targets
- biopsy performance

Data-driven
pathway improvements

FUTURE DEVELOPMENT
Scalable and adaptable

Development towards
one-stop MRI and biopsy pathway

Reduced reliance on
single staff groups and supports workforce resilience

Model transferable to
other diagnostic services facing capacity pressures

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From Audit to Action

Ashford and St. Peter's Hospitals
NHS Foundation Trust

1 AUDIT IDENTIFIED OPPORTUNITY

- Recognised pathway constraints
- Highlighted need for increased capacity

2 SERVICE REDESIGN DELIVERED CHANGE

- NP-led LATP pathway embedded
- Advanced practice roles expanded

3 IMPROVED PATIENT CARE

- Faster access to diagnosis
- Sustainable, safe and scalable model

Empowering advanced practice through clinical audit to improve outcomes, capacity and patient experience.

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From Data to Practice: How Audit Insights Shape Local CAMHS Care

Tom Hunter Mental Health Nurse and Plymouth CAMHS

Dr Salbu Krishnan Clinical Lead for South-West CAMHS Eating Disorders, Consultant Eating Disorders and CAMHS Psychiatrist

From Data to Practice:

How Audit Insights Shape Local CAMHS Eating Disorders Care

Presented by

Dr Salbu Krishnan
Clinical Lead for South-West CAMHS Eating Disorders (SWPC), Consultant Eating Disorders and CAMHS Psychiatrist, Livewell Southwest

Tom Hunter
Clinical Pathway Manager, Plymouth CAMHS Eating Disorders, Livewell Southwest

NHS HQIP: CLINICAL AUDIT AWARENESS WEEK 26 JUNE 2026

Data ····· Insight ····· Action ····· Improvement

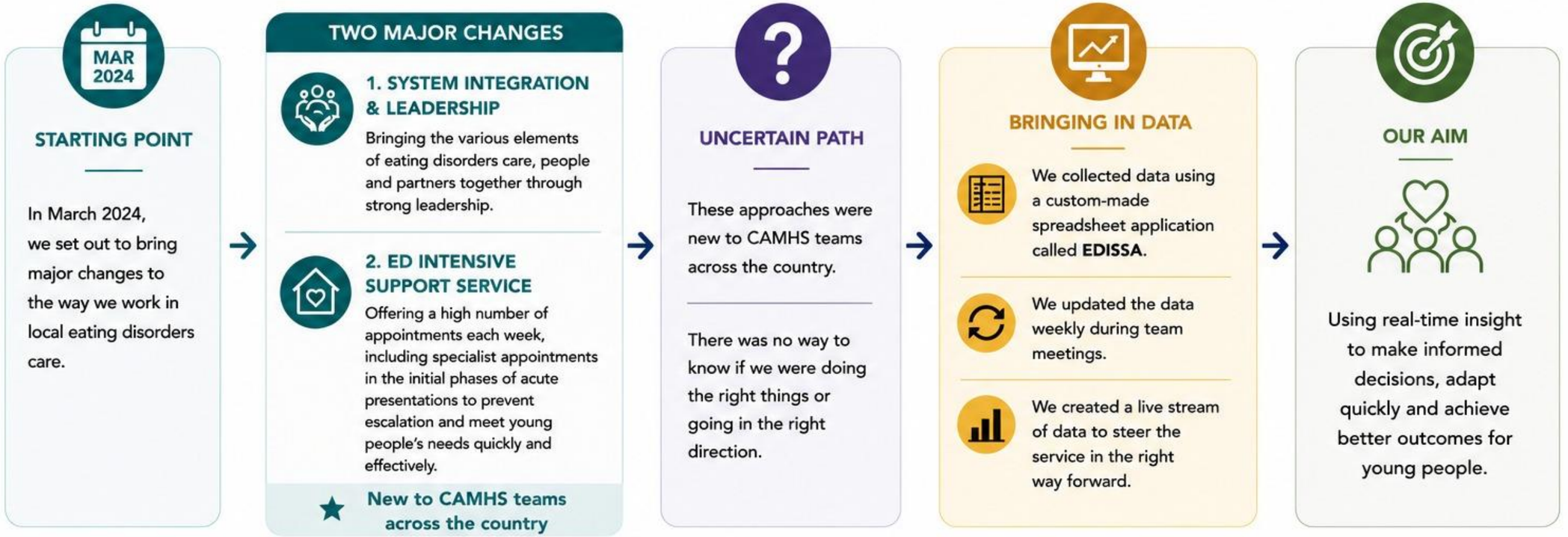
Better insights.
Better decisions.
Better outcomes.

Our Journey:

Plymouth CAMHS

Integrated Eating Disorder Team

In March 2024, we set out to bring major changes to the way we work in local eating disorders care.



THE TRANSFORMATION

How we changed the model of care

Plymouth CAMHS Integrated eating disorder pathway

Whole-System Integration & Leadership Model

Livewell Southwest

NHS

EARLY IDENTIFICATION & TRANSITION

Early Intervention
Identify early, prevent delay, reduce risk

Primary Care
Assessment, advice & initial management

CAMHS ED Team
Specialist assessment & treatment

Transition to Adult ED Services
Planned, supported transition

UNIVERSITY HOSPITALS PLYMOUTH

- **Psychiatry** (Outpatient)
- **Paediatric OP** (Outpatient)
- **CAU** Children's Assessment Unit
- **Paediatric Ward** (Inpatient)

Eating Disorders Liaison Nurse & ED Dietitian

PLYMOUTH CAMHS INTEGRATED EATING DISORDER SERVICE

Clinical leadership, coordination & specialist care

- Family Therapy
- Individual Therapies
- Dietetics
- Medical Monitoring
- ED Practitioners
- Occupational Therapy

Risk management • Care planning • Outreach • System leadership

INTENSIVE SUPPORT SERVICE – Home, School & Hospital

Integral part of the pathway

- Home-based support
- School-based support
- Meal support & therapeutic support
- Family & carer involvement
- Weekly MDT meetings & care planning
- Lead/co-lead multiagency meetings

Enhanced Care Programme Approach (CPA) meetings for all intensive support patients

SPECIALIST ESCALATION

(Increasing Intensity)

INTENSIVE COMMUNITY TREATMENT
- Liaison & discharge planning
- Dietetic interventions
- Communication

GAU (Inpatient)
If admission required, the intensive team works closely with GAU for:
- Shared care planning
- Regular liaison & reviews
- Prepare & support discharge
- Joint formulation meetings

SEDU (Inpatient)
For urgent/high risk needs, the intensive team:
- Early discharge
- Regular MDT reviews
- Joint formulation meetings
- Discharge planning & step-down support

COMMUNITY & SYSTEM PARTNERSHIPS

HOME
- Meal support
- Activity planning
- Parent & family support
- Home treatment

SCHOOL
- Education support
- Meal support at school
- School meetings
- Reintegration support

CAMHS PATHWAYS
- Neurodiversity assessments
- Co-morbidity treatment
- Joint working with CAMHS team
- DBT, art therapies, and psychotherapies

SOCIAL CARE
- Safeguarding
- Child in Need (Section 17)
- Child Protection Plan
- Carer support & training

Integrated • Person-Centred • Proactive • Collaborative • Consistent

ED = Eating Disorder CYP = Children & Young People MDT = Multi-Disciplinary Team
OSFED = Other Specified Feeding or Eating Disorder CPA = Care Programme Approach

VERSION 3.2

INTENSIVE SUPPORT SERVICE

Fast Response | Coordinated Care | System Leadership

HOME | SCHOOL | HOSPITAL

MEDICAL PATHWAY

ED SPECIALIST DOCTOR → ED SPECIALIST NURSE → ED LIAISON NURSE → ED PEDS DIETITIAN → ED PAEDIATRICIAN → CAU (Children's Assessment Unit)

Within 24 hours
Early connection and assessment

24/7 planned

TWO-WAY REFERRAL AND COMMUNICATION

ENHANCE RELATIONAL SECURITY
Building trust, connection and safety.

MAINTAIN CONTINUITY
Seamless support across settings.

6 APPOINTMENTS OR MORE PER WEEK
Flexible and responsive.

NO TIME LIMITS
Support for as long as needed.

INCREASE OR DECREASE SUPPORT BASED ON NEEDS
Tailored to each child and family.

KEY PEOPLE STAY INVOLVED AFTER STEP-DOWN TO REGULAR SUPPORT
Continuity of relationships.

WITHIN 24 HOURS

ED LIAISON NURSE
Eating Disorders Mental Health Liaison Nurse

Early connection and assessment

WITHIN 48 HOURS

INTENSIVE SUPPORT TEAM (HCA)
Two practitioners working in partnership

Coordinated intensive support to stabilise and support.

WITHIN 7 DAYS

ED PSYCHIATRIST
Psychiatric assessment and management

FAMILY INTERVENTIONS
Assessment of systemic needs and offering specific interventions

INDIVIDUAL THERAPIES
Personalized interventions to support progress

NEED-BASED SUPPORT

OCCUPATIONAL THERAPIST
Targeted support based on need.

DIETITIAN
Nutritional support tailored to need.

LEGEND

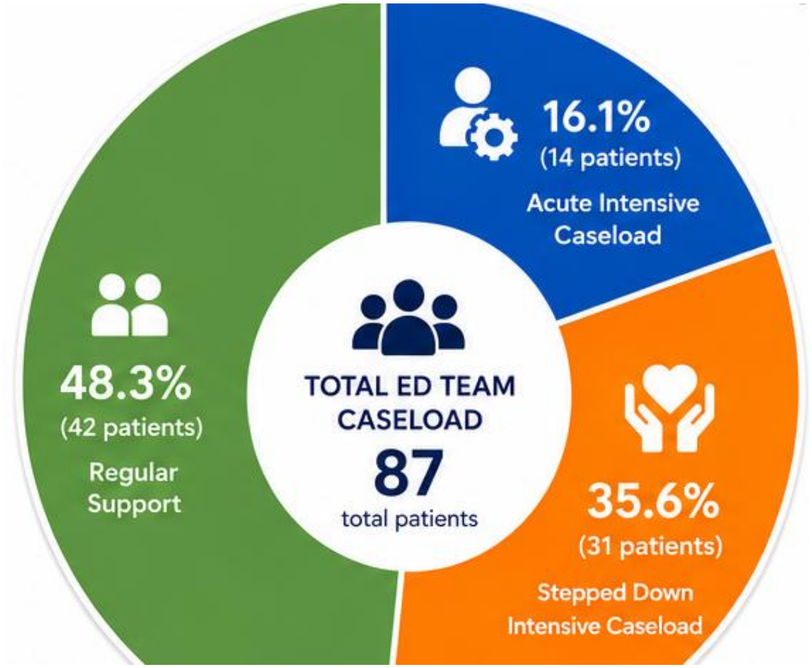
- Two-way medical pathway
- Care coordination connection
- Rapid access timeframe
- Intensive support team
- Need-based support

WRAPPED AROUND CARE | FAST RESPONSE, MULTIPLE APPOINTMENTS BY THE RIGHT PEOPLE.

THE EVIDENCE

INTENSIVE SUPPORT OVERVIEW

Understanding patient support levels across the ED Team



Total Patients: 87

SUPPORT LEVEL BREAKDOWN

ACUTE INTENSIVE CASELOAD

16.1% (14 patients)

Patients who are currently receiving intensive support.

WHAT THIS MEANS

These patients require the highest level of support at this time.

STEPPED DOWN INTENSIVE CASELOAD

35.6% (31 patients)

Patients who have stepped down from intensive support to regular care.

WHAT THIS MEANS

These patients no longer require the intense level of support and are progressing in their recovery.

REGULAR SUPPORT

48.3% (42 patients)

Patients who are receiving regular support and managing well.

WHAT THIS MEANS

These patients are stable and continue to receive the right level of support to maintain their progress.

51.7% OF PATIENTS HAVE RECEIVED INTENSIVE SUPPORT AT SOME POINT

This includes both patients who are currently receiving intensive support and those who have stepped down after receiving it.

Our goal is to provide the right level of support at every stage of the patient journey and help as many patients as possible reach stability and recovery.

ACUTE INTENSIVE CASELOAD	STEPPED DOWN INTENSIVE CASELOAD	REGULAR SUPPORT	TOTAL ED TEAM CASELOAD
14	31	42	87
16.1% of total	35.6% of total	48.3% of total	100% of total

DATA START DATE
01/03/2024

CURRENT DATE
15/05/2026

PERIOD (YEARS, MONTHS AND DAYS)
2 years, 2 months, and 14 days

01 Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

CLEAR STEPPED-CARE STRUCTURE ESTABLISHED

Acute intensive support, stepped-down intensive support and regular support.

51% OF PATIENTS RECEIVED INTENSIVE SUPPORT AT SOME POINT

This includes patients currently receiving intensive support and those who have stepped down.

51%

70%+ OF INTENSIVE CASES TRANSITIONED SUCCESSFULLY TO LOWER-INTENSITY CARE

Demonstrates strong recovery progression through our step-down model.

70%+

INTENSIVE SUPPORT INTEGRATED INTO THE WIDER ED PATHWAY

Intensive support is embedded within the full eating disorder pathway, not operating in isolation.

NEXT PRIORITIES

INTRODUCE ACUITY-WEIGHTED CASELOAD MANAGEMENT

Move beyond simple headcount to reflect complexity, acuity and intensity of need.

IMPLEMENT DYNAMIC CASELOAD-WIDE REVIEWS

Regular reviews during high demand periods to ensure safe, timely step-down and escalation.

45
Have received intensive support

31
Stepped down to regular support

8
Discharged from intensive support

87
Total ED team caseload

INTENSITY OF SUPPORT OVERVIEW

Understanding both peak support needs and current clinical intensity across the ED Team

HIGHEST INTENSITY OF SUPPORT

The highest level of support patients required at any point

HIGHEST INTENSITY CATEGORY	PROPORTION OF IS CASELOAD	TOTAL PATIENTS
1 or less appointment per week	15.1%	8
2–3 appointments per week	37.7%	20
3–5 appointments per week	28.3%	15
6 appointments or more per week	15.1%	8
Admission support – Paediatric ward	3.8%	2
Admission support – GAU	0.0%	0
Admission support – SEDU	0.0%	0
Stepped down to regular care	0.0%	0

66% of patients who received intensive support required 2–5 appointments per week at their highest level of need.

TOTAL PATIENTS (HIGHEST INTENSITY EVER REQUIRED) **53**

CURRENT INTENSITY OF SUPPORT

The level of support patients are currently receiving (excludes step down)

	ACUITY PATHWAY – FROM HIGHER INTENSITY TO RECOVERY	PROPORTION OF IS CASELOAD	TOTAL PATIENTS
ACTØE APPOINTMENT SPPOØPT	1 or less appointment per week	11.1%	6
	2–3 appointments per week	11.1%	6
	3–5 appointments per week	1.9%	1
	6 appointments or more per week	0.0%	0
SPECIALIST / ADMISSSS SPPOØPT	Admission support – Paediatric ward	1.9%	1
	Admission support – GAU	1.9%	1
	Community Treatment Order (CTO)	1.9%	1
	Admission support – SEDU	0.0%	0

70.4% of patients are now stepped down to regular care, reflecting positive progress and recovery.

TOTAL PATIENTS (CURRENT INTENSITY – EXCLUDES STEP DOWN) **16**

Note: Step down to regular care (38 patients) are excluded from the current intensity total.

1. CLINICAL COMPLEXITY AT PEAK

66% of patients who received intensive support required 2–5 appointments per week at their highest intensity, showing the significant acuity managed by the team.

2. POSITIVE RECOVERY PROGRESSION

70.4% of patients are now stepped down to regular care, highlighting strong recovery outcomes and successful transition to lower intensity support.

3. ONGOING CLINICAL NEED

16 patients (29.6% of the total caseload) continue to require active support, including frequent appointments and specialist/admission-related intervention.

DATA START DATE	CURRENT DATE	PERIOD (YEARS, MONTHS & DAYS)
01/03/2024	15/05/2026	2 years, 2 months, and 14 days

02 Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

MAJORITY OF PATIENTS REDUCED FROM HIGH INTENSITY

70.4%

70.4% of patients are now stepped down to regular care.

66% REQUIRED 2–5 APPOINTMENTS WEEKLY AT PEAK INTENSITY

66%

Reflecting complex presentations requiring significant support.

SAFELY MANAGED VERY HIGH INTENSITY CASES IN THE COMMUNITY

Evidence that intensive community support can reduce escalation to SEDU care.

STRONG STEP-DOWN RECOVERY STRATEGY

Demonstrated ability to support recovery and transition to lower levels of care.

INTENSIVE SUPPORT INTEGRATED INTO CAMHS ED PATHWAY

Working as part of a stepped-care model, not as a standalone service.

NEXT PRIORITIES

USE INTENSITY DATA FOR REAL-TIME CAPACITY PLANNING

Align staffing, appointment intensity and acuity to ensure sustainable capacity.

IMPLEMENT “SURGE PRESSURE” REVIEWS

Proactively identify and respond to periods of high demand or escalating acuity.

DYNAMICALLY STEP DOWN STABLE PATIENTS

To preserve intensive capacity for those with the highest clinical need.

ACUITY-TRIGGER SYSTEMS FOR MDT REVIEW

Automated alerts for MDT review when risk, intensity or deterioration indicators rise.

53

Total patients

received intensive support at some point

STEPPED DOWN TO REGULAR CARE

Patients showing positive progress and recovery.

2–5

APPOINTMENTS PER WEEK (PEAK)

The most common level of intensity required.

0.0%

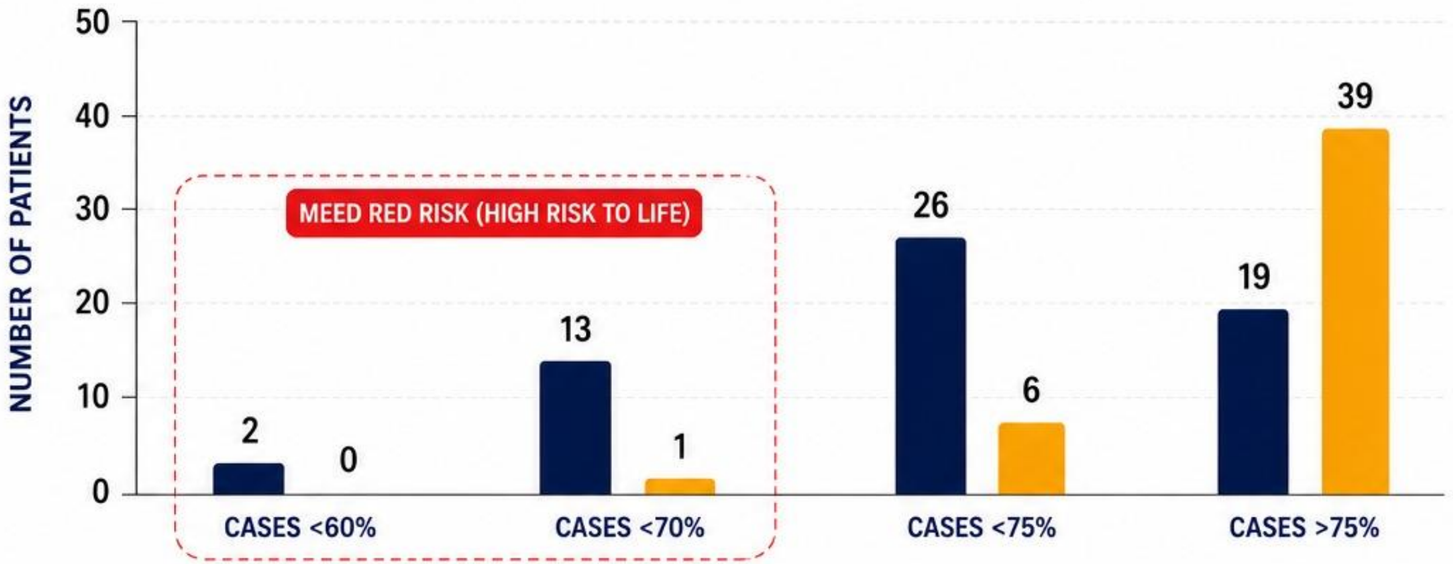
PATIENTS ESCALATED TO SEDU CARE

Demonstrating effective community management.

WEIGHT MANAGEMENT PROGRESS IN THE COMMUNITY

Patients supported with intensive intervention across care settings

PATIENTS BY LOWEST WEIGHT PERCENTAGE GROUP



INTENSIVE COMMUNITY SUPPORT IS MAKING A MEASURABLE DIFFERENCE

More patients are progressing to healthier weight ranges, with 39 currently above 75%, and continued reductions in the number at lower weight thresholds.

KEY TAKEAWAYS

13
PATIENTS HAVE BEEN MANAGED AT WEIGHT <70%

26
PATIENTS HAVE BEEN MANAGED AT WEIGHT <75%

39
PATIENTS ARE CURRENTLY ABOVE 75% WEIGHT, SHOWING POSITIVE PROGRESS

INTENSIVE SUPPORT IS HELPING MORE YOUNG PEOPLE MOVE TOWARDS HEALTHIER WEIGHT RANGRES.

PROGRESS HIGHLIGHTS

INTENSIVE SUPPORT MAKES AN IMPACT
26 patients have had intensive support at weights below 75%, with fewer patients at the lowest weight ranges.

POSITIVE MOVEMENT
39 patients are now above 75% weight, reflecting meaningful progress through intensive community support.

EARLY, TARGETED SUPPORT MATTERS
Identifying and supporting patients at lower weights early helps reduce risk and improves outcomes.

CONTINUED FOCUS
We remain committed to supporting those at <70% to reduce risk and promote recovery.

DATA START DATE	CURRENT DATE	PERIOD (YEARS, MONTHS AND DAYS)
01/03/2024	15/05/2026	2 years, 2 months, and 14 days

03 Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

SIGNIFICANT REDUCTION IN VERY LOW WEIGHT PRESENTATIONS

Fewer patients are presenting below 60%, showing earlier intervention impact.

COMMUNITY INTENSIVE INTEGRATION DRIVING WEIGHT RESTORATION

High-quality community support leads to improved physical health outcomes.

HIGH-RISK (MEED) PRESENTATIONS MANAGED IN THE COMMUNITY

Complex cases supported safely without immediate escalation to inpatient care.

POSITIVE WEIGHT TRAJECTORY ACROSS THE CASELOAD

Overall improvement in weight outcomes across the intensive support population.

39 PATIENTS ABOVE 75% WEIGHT-FOR-HEIGHT

Demonstrates meaningful progress in weight restoration through intensive community support.

NEXT PRIORITIES

PROACTIVE ESCALATION BEFORE WEIGHT DECLINE

Intervene earlier using risk indicators and trajectory monitoring, not just single-point BMI.

TARGETED SUPPORT FOR AT-RISK PATIENTS

Focus resources on those most likely to deteriorate to maximise outcomes and reduce escalation.

TREND-BASED MONITORING & EARLY WARNING SIGNALS

Monitor weight trends alongside engagement, behaviours and clinical factors to identify risk sooner.

39
Patients now above 75% weight-for-height

0
Current patients below 60% weight-for-height

6
Current patients below 75% weight-for-height

Positive direction
Fewer very low-weight presentations

CLINICAL COMPLEXITY OF INTENSIVE SUPPORT CASELOAD

Understanding the primary diagnoses and the comorbid complexity of the children and young people we support

HIGHEST PROPORTION STATE

30.2%

of the caseload have a primary diagnosis of Anorexia Nervosa.

PRIMARY DIAGNOSIS (TOP DIAGNOSES IN INTENSIVE SUPPORT CASELOAD)

	PROPORTION OF IS CASELOAD	CURRENT CASELOAD	DISCHARGED CASELOAD	TOTAL
Anorexia Nervosa	30.2%	13	3	16
ARFID	24.5%	10	3	13
OSFED	26.4%	13	1	14
Emotional Dysregulation	5.7%	2	1	3
Type 1 Diabetes + Anorexia	1.9%	1	0	1
PAWS / Severe Refusal	3.8%	2	0	2
Bulimia Nervosa	0.0%	0	0	0

KEY TAKEAWAYS

ANOREXIA NERVOSA IS THE HIGHEST PROPORTION STATE

30.2% of the caseload have a primary diagnosis of Anorexia Nervosa.

EMOTIONAL DYSREGULATION IS THE HIGHEST COMORBIDITY

30.2% of the caseload have emotional dysregulation.

COMPLEX PRESENTATIONS ARE COMMON

We support young people with pervasive arousal withdrawal (PAWS), severe refusal, and in some cases, primary emotional dysregulation.

HIGHEST COMORBIDITY

30.2%

of the caseload have Emotional Dysregulation.

COMORBID DIAGNOSIS (TOP COMORBIDITIES IN INTENSIVE SUPPORT CASELOAD)

	PROPORTION OF IS CASELOAD	CURRENT CASELOAD	DISCHARGED CASELOAD	TOTAL
Emotional Dysregulation	30.2%	13	3	16
Depression	26.4%	11	3	14
Anxiety Disorder	17.0%	9	0	9
Complex PTSD/PTSD	5.7%	3	0	3
Obsessive Compulsive Disorder (OCD)	3.8%	2	0	2
Oppositional Defiant Disorder	0.0%	0	0	0

A THREE-LAYER DIAGNOSIS SYSTEM

1	PRIMARY DIAGNOSIS	The main eating disorder or clinical presentation.
2	COMORBID DIAGNOSIS	Co-occurring mental health difficulties that impact recovery and complexity.
3	NEURODIVERGENCE & TRAUMA	Neurodivergence and trauma histories that add further complexity to care.

COMPLEX NEEDS. PERSONALISED CARE. BETTER OUTCOMES.

Our caseload reflects high levels of clinical complexity across multiple domains. Intensive support is tailored to address the interplay of eating disorders, comorbid mental health needs, neurodivergence, and trauma to support safe recovery in the community.

DATA START DATE
01/03/2024

CURRENT DATE
15/05/2026

PERIOD (YEARS, MONTHS AND DAYS)
2 years, 2 months, and 14 days

04 Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

DETAILED COMPLEXITY PROFILING ESTABLISHED
Comprehensive understanding of our intensive support caseload across key complexity domains.

RECOGNISED COMPLEXITY BEYOND ANOREXIA NERVOSA
Atypical presentations and ARFID presentations now together dominate the picture.

THREE-LAYER DIAGNOSTIC FRAMEWORK ESTABLISHED
Primary diagnosis, comorbid diagnosis and neurodiversity / trauma profiles inform our clinical understanding.

DATA-INFORMED CLINICAL LEADERSHIP
We now acknowledge the complexity of each case, often involving layers of comorbidity and co-occurring conditions.

INFORMED MULTI-DISCIPLINARY COLLABORATION
Shared understanding of complexity enables better team collaboration and integrated care.

TARGETED INTERVENTIONS LIKE CREATING HANDOUTS AND LEAFLETS
Development of clear, accessible resources to support patients, families and referrers with complex needs.

NEXT PRIORITIES

CONDUCT FULL SKILLS MAPPING ACROSS THE MDT
Map current skills and identify gaps to match the complexity of the caseload.

ALIGN TEAM COMPETENCIES TO COMPLEXITY
Ensure the right competencies are available across the CAMHS ED team.

EXPAND EXPERTISE IN KEY AREAS AND ACCESS EXPERTISE FROM OTHER PARTS OF CAMHS
Grow specialist capacity in trauma, neurodivergence, family work, ARFID and emotional dysregulation.

USE COMPLEXITY DATA TO GUIDE RECRUITMENT & TRAINING
Data-led workforce planning to prioritise recruitment, development and supervision needs.

DEVELOP COMPETENCY-BASED WORKFORCE PLANNING
Build a sustainable workforce model that reflects the true clinical complexity of our population.

73.6% NEURODIVERGENT (39 patients)

50.9% TRAUMA AFFECTED (27 patients)

26.4% COMORBID DEPRESSION (14 patients)

30.2% EMOTIONAL DYSREGULATION (16 patients)

THREE LAYERS OF COMPLEXITY
Primary diagnosis, comorbid diagnosis, neurodiversity / trauma

LAYER 3 OF CLINICAL COMPLEXITY: NEURODIVERGENCE & TRAUMA

The third layer of diagnosis that significantly shapes need, risk and treatment intensity

NEURODIVERGENCE STATUS

	Proportion of IS CASELOAD	Current Caseload	Discharged Caseload	Total
Autism Spectrum	26.4%	10	4	14
Autism Suspected	32.1%	15	2	17
Autism & ADHD	3.8%	1	1	2
ADHD	7.5%	3	1	4
NEURODIVERGENCE (OVERALL)	**73.6%**	**39**	—	**39**
Neurotypical	30.2%	14	2	16

THREE-LAYER DIAGNOSIS SYSTEM

1. **PRIMARY DIAGNOSIS**
   e.g. Anorexia Nervosa, ARFID, OSFED
2. **COMORBID DIAGNOSIS**
   e.g. Depression, Anxiety, Emotional Dysregulation
3. **NEURODIVERGENCE & TRAUMA**
   Neurodivergence and/or trauma are critical third-layer considerations.

TRAUMA STATUS

	Proportion of IS CASELOAD	Current Caseload	Discharged Caseload	Total
Trauma Affected	50.9%	22	5	27
No Known Trauma	41.5%	19	3	22
TRAUMA AFFECTED (OVERALL)	**50.9%**	**27**	—	**27**

NEURODIVERGENCE & TRAUMA COEXIST IN MANY CASES

These conditions frequently overlap, increasing complexity, emotional vulnerability, and treatment intensity.

KEY MESSAGES

- Nearly **three-quarters (73.6%)** of the intensive support caseload present with **neurodivergence.**
- Around half (50.9%) of the caseload report **significant trauma.**
- These factors are critical **third-layer** considerations that shape presentation and response to treatment.
- A **trauma-informed** and **neuro-affirming** approach is essential for safe, effective and sustainable support.

DATA START DATE	CURRENT DATE	PERIOD (YEARS, MONTHS AND DAYS)
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05 Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

OT-LED SENSORY ASSESSMENTS AND ADAPTATIONS.
Personalised sensory assessments inform environmental and therapeutic adaptations.

SCHOOL-BASED OT ASSESSMENTS AND RECOMMENDATIONS.
Targeted assessments and recommendations delivered in school to support young people.

TRAUMA-INFORMED AND NEURO-AFFIRMING APPROACH EMBEDDED.
Embedding understanding, acceptance and collaboration across our practice and services.

DIGITAL NEURODIVERGENCE SCREENING TOOL DEVELOPED.
Efficient, standardised screening to identify neurodivergent early in the pathway developed using existing tools such as AQ, CAT-Q, and SNAP.

ASSESSMENTS FOR PREFERENCES, ADJUSTMENTS AND ADAPTATIONS DURING INPATIENT ADMISSION IN PLACE.
Systematic profiling to understand preferences and needs during inpatient admission.

NEXT PRIORITIES

STRENGTHEN TARGETED PREVENTION.
High-risk groups, such as neurodiversity and trauma, should be targeted specifically to reduce eating disorder pathology.

IMPROVE IDENTIFICATION BEFORE SIGNIFICANT WEIGHT LOSS.
Recognise neurodivergence and trauma earlier through screening and assessments to enable early support before crises develop.

USE SCREENING DATA TO IDENTIFY HIGH-RISK GROUPS EARLIER.
Leverage data insights to proactively identify those most at risk and monitor trends.

STRENGTHEN TRAUMA-INFORMED PRACTICES TRAINING IN THE TEAM.
Build team knowledge and confidence to deliver trauma-informed, neuro-affirming care consistently.

BUILDING UNDERSTANDING.
DELIVERING EARLIER SUPPORT.
PREVENTING CRISIS.
IMPROVING OUTCOMES.

Better understanding of individual needs

More personalised, neuro-affirming support

Stronger support in schools and communities

Earlier identification and prevention of deterioration

Better outcomes and experiences for young people

SETTINGS OF SUPPORT

Delivering integrated support across multiple settings to meet patients where they are

Our team delivers support in a range of settings, ensuring care is accessible, flexible and integrated across the system.

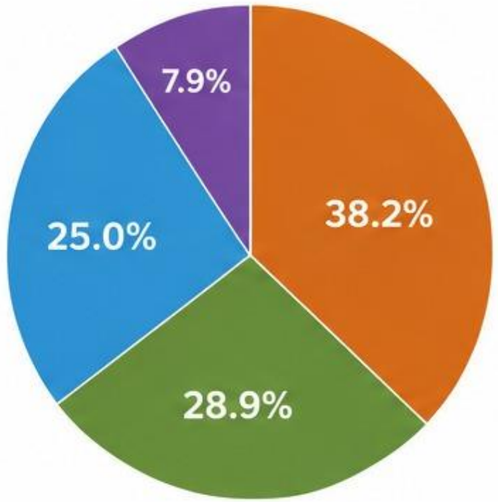
Support delivered in **4 key settings**

Care provided **where it's needed**

Strong system **integration**

PROPORTION OF SUPPORT BY SETTING

% of all support delivered (All Time)



- **Home** (29 patients) — 38.2%
- **Hospital** (22 patients) — 28.9%
- **Outpatient Only** (19 patients) — 25.0%
- **School** (6 patients) — 7.9%

Patients may receive support in more than one setting. Percentages reflect the proportion of all support delivered.

CURRENT PATIENTS BY SETTING

Active caseload at the time of reporting

Home	Support provided in the patient's home environment	27 patients
Hospital	Support delivered within inpatient hospital settings	22 patients
Outpatient Only	Support delivered in community outpatient clinics	13 patients
School	Support delivered in school or education settings	6 patients

Why multiple settings matter

Many patients access support in more than one setting based on their individual needs, ensuring coordinated, flexible and holistic care.

KEY HIGHLIGHTS

Most support is delivered at home

Over one third (38.2%) of all support is delivered in the home, ensuring care is accessible and family-centred.

Strong hospital presence

Nearly 3 in 10 (28.9%) of all support is delivered in hospital settings, reflecting close system integration.

Outpatient care remains vital

A quarter (25.0%) of all support is delivered through outpatient clinics, providing ongoing community care.

We support young people where they learn

7.9% of all support is delivered in schools, strengthening partnerships with education settings.

We are committed to delivering person-centred care across the full spectrum of settings – meeting patients where they are, working in partnership across the system, and ensuring no one is left behind.

06

Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

INTEGRATED SUPPORT ACROSS MULTIPLE SETTINGS.
Young people receive coordinated care across home, hospital, outpatient and school.

STRONG HOME-TREATMENT MODEL ESTABLISHED.
Home remains the primary setting of care, supporting recovery in a familiar environment.

EFFECTIVE HOSPITAL–COMMUNITY INTEGRATION.
Effective transitions between hospital and community support when needed.

FLEXIBLE SUPPORT BASED ON PATIENT NEED.
Support is tailored and delivered in the setting that best meets each young person's needs.

YOUNG PEOPLE RECEIVE COORDINATED CARE ACROSS HOME, HOSPITAL, OUTPATIENT AND SCHOOL.

NEXT PRIORITIES

EXPAND SCHOOL-BASED INTERVENTIONS AND SUPPORT.
Increase the reach and intensity of support available within educational settings.

STRENGTHEN PARTNERSHIPS WITH EDUCATION SETTINGS.
Build stronger collaboration and shared planning with schools and colleges.

DEVELOP STRUCTURED SCHOOL REINTEGRATION PATHWAY.
Create clear, supported pathways for return to education following illness or admission.

IMPROVE CONTINUITY BETWEEN EDUCATION AND HEALTH SERVICES.
Ensure joined-up care and communication across systems for consistent support.

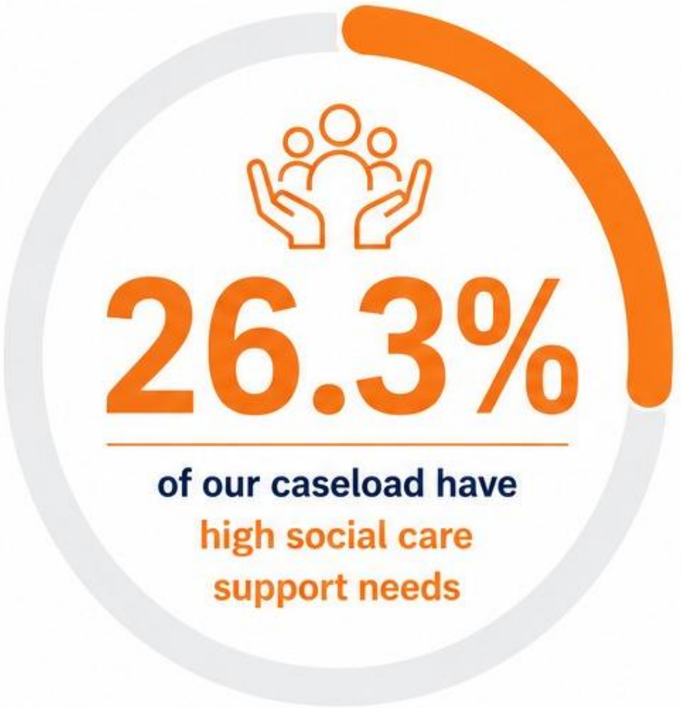
INCREASE EARLY INTERVENTION WITHIN SCHOOLS.
Identify and support young people earlier to prevent deterioration and reduce escalation.

Our multi-setting approach ensures young people receive the right support, in the right place, at the right time.

Coordinated care. Better outcomes. Stronger futures.

SYSTEM LEADERSHIP: WORKING WITH SOCIAL CARE

Strong leadership and collaboration with social care enables safe, effective treatment at home



More than one quarter of the young people we support present with high social care support needs.

Where **direct social care involvement** is available, we work closely with services to coordinate care.

Where this is not immediately available, risk is managed through **multi-agency support networks** around the family.

For some families, direct social care involvement is essential. For others, safe home-based care is supported through **coordinated multi-agency planning** with schools, health, community services and family networks.

BREAKDOWN OF SOCIAL CARE SUPPORT NEEDS
(within the 26.3% with high social care support needs)

Social Care Complexity	Proportion of Caseload (within the 26.3%)
Safeguarding concerns	11.3%
Child in Need (CIN)	7.5%
MASH referrals	3.8%
Child Protection Plan	1.9%
Child in Care	1.9%
CIC & DOL Order (Court Order)	1.9%

These categories reflect the complexity within the 26.3% of young people with high social care support needs. Some have active social care involvement; others are supported through wider **multi-agency networks.**

THE IMPACT OF STRONG SOCIAL CARE PARTNERSHIPS

Enables safe care at home
Reducing unnecessary hospital admissions and out-of-area placements.

Improves outcomes for young people
Stability, continuity of care and better engagement in treatment.

Stronger families and communities
Timely support reduces crisis, risk and the need for statutory intervention.

True system leadership
Building trusted relationships and creating integrated solutions together.

Better use of resources
Prevents escalation and supports sustainable, cost-effective care.

Without social care support, many of these young people would be at risk of hospital admissions or out of area placement.

Partnerships make home-based care possible.

07 Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

STRONG MULTI-AGENCY COLLABORATION ESTABLISHED.

Effective partnership working across health, social care, education and safeguarding services.

HOME-BASED CARE SUPPORTED THROUGH COORDINATED PLANNING.

Young people supported safely at home through robust multi-agency care planning.

EFFECTIVE SAFEGUARDING INTEGRATION.

Safeguarding needs identified early and managed through close collaboration with social care.

SYSTEM LEADERSHIP DEMONSTRATED THROUGH PARTNERSHIP WORKING.

Active leadership to improve coordination, reduce risk and prevent hospital admissions.

FLEXIBLE SUPPORT BASED ON PATIENT NEED.

Support is tailored and delivered in the setting that best meets each young person's needs.

NEXT PRIORITIES

JOINT EDUCATION AND TRAINING WITH SOCIAL SERVICES.

Build shared knowledge and confidence in understanding eating disorder complexity.

SHARED UNDERSTANDING OF EATING DISORDER COMPLEXITY.

Develop a common language and approach to support young people and families.

INTEGRATED CARE–PLANNING FRAMEWORKS.

Co-create holistic, coordinated plans that address clinical, emotional and social needs.

SHARED OUTCOME METRICS ACROSS AGENCIES.

Measure what matters together to drive improvement and accountability.

EARLIER IDENTIFICATION AND INTERVENTION THROUGH COLLABORATIVE SYSTEMS.

Work together to identify risk earlier and provide the right support, at the right time.

TOGETHER, WE CAN SUPPORT YOUNG PEOPLE EARLIER, KEEP THEM SAFE AT HOME AND IMPROVE OUTCOMES.

- Safer care at home
- Reduced crisis and admissions
- Better outcomes for young people and families
- Stronger, more connected systems
- Prevention and early intervention

RISK MANAGEMENT THROUGH COLLABORATIVE WORKING

Managing high levels of risk in the community with minimal use of inpatient beds

We support young people with high and complex risks every day.

Through strong multi-agency collaboration, structured risk management and intensive community support, we are able to provide safe care in the community and reduce reliance on inpatient beds.

28.3% of our caseload present with **Restrictive Intake Self-Harm (RISH)**

This is the highest single risk within our cohort, highlighting the complexity of needs and the need for trauma-informed practices to avoid nasogastric feeding in this group.

Risks	Proportion of Support Setting	Current	Discharged	Total
Restrictive Intake Self-Harm (RISH)	28.3%	13	2	15
Overexercising	24.5%	12	1	13
Self-harm thoughts / behaviours	17.0%	8	1	9
Self-harm & Suicidal Behaviours	11.3%	4	2	6
Absconding	5.7%	2	1	3
Laxative abuse	3.8%	2	0	2
Suicidal thoughts / behaviours	1.9%	1	0	1
Purging	1.9%	1	0	1
Overexercise and Purging	1.9%	1	0	1
Assaulting parents	1.9%	1	0	1
Insulin abuse	1.9%	1	0	1
Assaulting staff	0.0%	0	0	0

COMPLEX NEEDS. COMMUNITY FOCUS.

We manage a wide range of high-risk presentations within the community.

MANAGED THROUGH COLLABORATIVE WORKING

Close working with social care, schools, mental health, safeguarding teams and wider partners.

ENABLING SAFE CARE AT HOME

Proactive risk management helps prevent escalation, hospital admission and out of area placements.

HIGH RISK. HIGH SUPPORT. BETTER OUTCOMES.

Our model demonstrates that with the right partnership, young people can recover safely in the least restrictive setting.

Through collaborative risk management and intensive community support, young people can be cared for safely in the least restrictive setting.

Partnership working makes community care possible.

08 Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

COMPLEX RISK SAFELY MANAGED WITHIN COMMUNITY SETTINGS.

High-risk young people supported therapeutically in the least restrictive environment.

STRONG COLLABORATIVE MULTI-AGENCY RISK MANAGEMENT.

Integrated working across CAMHS ED, social care, paediatrics, schools and families.

REDUCED RELIANCE ON INPATIENT / SEDU ESCALATION.

Effective community management reduces the need for hospital admission.

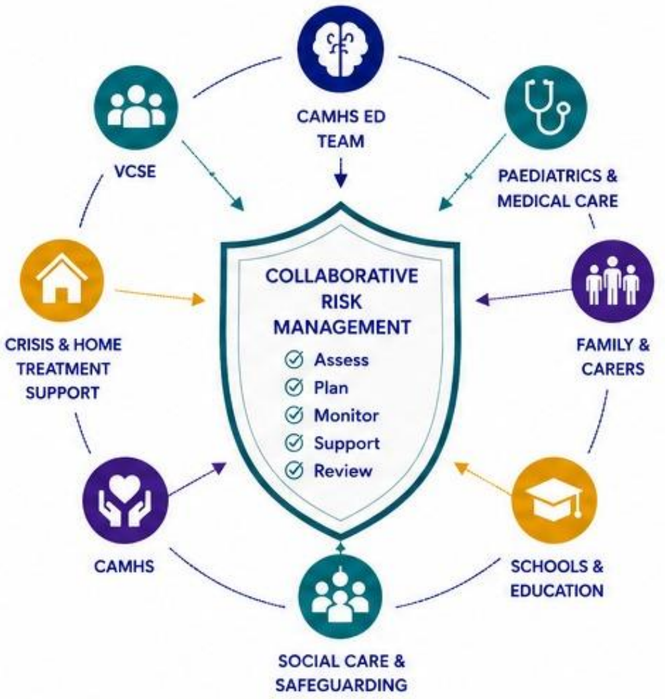
HIGH-RISK RESTRICTIVE INTAKE SELF-HARM MANAGED THERAPEUTICALLY.

Specialist expertise and intensive support help young people stay safe at home.

NO USE OF NG FEEDING UNDER RESTRAINTS.

We do not resort to restrictive practices. Care is delivered with dignity and respect.

HIGH-RISK YOUNG PEOPLE CAN BE SAFELY MANAGED IN THE LEAST RESTRICTIVE ENVIRONMENT THROUGH INTENSIVE COLLABORATIVE COMMUNITY SUPPORT.



Working together to keep young people safe, stable and supported at home.

RIGHT SUPPORT. RIGHT TIME. RIGHT PLACE.

NEXT PRIORITIES

PREDICTIVE RISK ASSESSMENT SYSTEMS.

Use data and clinical insight to identify young people at risk of escalation earlier.

EARLIER IDENTIFICATION OF ESCALATING RISK.

Strengthen early warning signs and rapid response pathways.

STANDARDISED MANAGEMENT STRATEGIES FOR COMMON RISK PROFILES.

Develop consistent, evidence-informed approaches across the system.

FAMILY GUIDANCE PACKS AND PSYCHOEDUCATION RESOURCES.

Empower families with practical tools and clear information.

SAFE. SUPPORTED. AT HOME.

Our collaborative approach reduces risk, prevents escalation and supports recovery in the least restrictive environment.

PREVENT CRISIS

PROMOTE SAFETY

IMPROVE OUTCOMES

PAEDIATRIC ADMISSIONS DATA – PART 1

Short-stay admissions and intensive home treatment reduce reliance on prolonged inpatient care.

44.6%

of admissions were 1-day CAU admissions (25)

Rapid assessment in CAU enables timely decisions and prevents escalation to prolonged inpatient stays.

AVERAGE ADMISSION LENGTH COMPARISON

OVERALL AVERAGE ADMISSION LENGTH

8 DAYS

Includes all admissions, including first-onset presentations unknown to the service.

COMPARISON EXCLUDING FIRST-ONSET ADMISSIONS

KNOWN-TO-SERVICE ADMISSIONS ONLY

6.3 DAYS

Excludes first-onset admissions (new to service). Reflects effectiveness of intensive home treatment and ongoing community management.

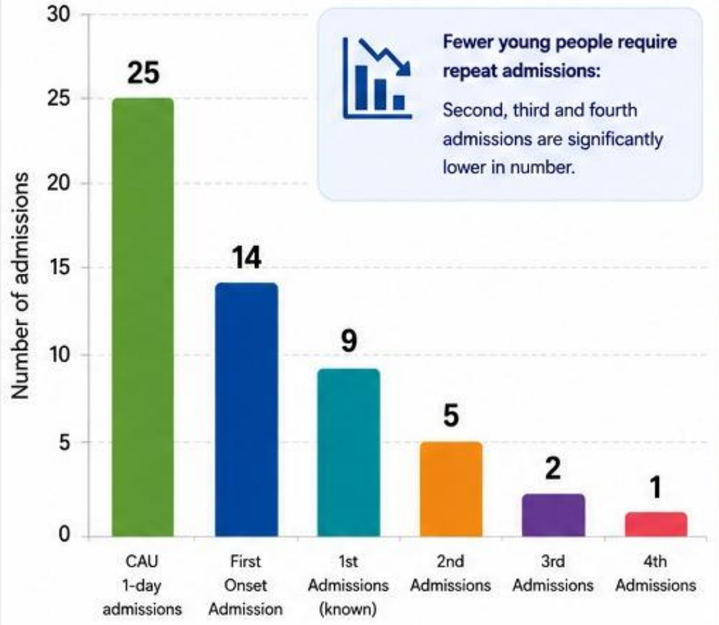
Longer admissions are disproportionately driven by first-onset presentations unknown to the service. **Admissions for young people already receiving community support are typically shorter.**

Total bed days	450
First-onset bed days	187
Known-to-service bed days	263

Calculations based on 56 total admissions.

NUMBER OF ADMISSIONS BY EPISODE

(number of admissions)



Fewer young people require repeat admissions:

Second, third and fourth admissions are significantly lower in number.

First-onset admissions create the greatest demand on inpatient resources, demonstrating the cost of late presentation.

WHY PAEDIATRIC ADMISSIONS MATTER

Medical safety
Assessment for very low weight or medical instability

ECG & blood tests
Timely investigations & monitoring

24-hour access to care
Overnight observation when needed

Space for assessment & planning
Supports rapid return to community treatment

Integrated with community pathway
Ensures safe, coordinated care

Paediatric admission is a vital part of the community eating disorder pathway, providing safe medical assessment (ECG, blood tests, stabilisation) for young people with very low weight.

Keeping the majority of admissions short reduces the overall number of admissions and strengthens community management & safety.

DATA START DATE	CURRENT DATE	PERIOD (YEARS, MONTHS & DAYS)
01/03/2024	15/05/2026	2 years, 2 months, and 14 days

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Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

SHORT-STAY ADMISSION MODEL DELIVERS BETTER OUTCOMES.

Average admission length is 8 days, well below national comparator.

RAPID ASSESSMENT AND CAU PATHWAYS WORKING WELL.

44.6% of admissions are 1-day CAU admissions, preventing escalation and longer stays.

KNOWN-TO-SERVICE ADMISSIONS ARE SHORTER.

Known-to-service young people stay an average of 6.3 days.

EFFECTIVE BED MANAGEMENT AND UTILISATION.

High demand is managed effectively through efficient use of capacity.

COMMUNITY TREATMENT REDUCES INPATIENT RELIANCE.

Strong community support and early intervention keeps young people safe at home wherever possible.

PAEDIATRIC ADMISSIONS DATA – PART 1

SHORTER STAYS. FASTER SUPPORT. BETTER OUTCOMES.

Our admission data shows effective use of inpatient care for short-term stabilisation, with strong community pathways helping young people recover at home.

KNOWN-TO-SERVICE ADMISSIONS

6.3 DAYS

Average length of stay for known-to-service young people.

CAU ADMISSIONS

44.6%

are 1-day CAU admissions.

Rapid assessment and discharge prevents escalation.

COMMUNITY TREATMENT REDUCES THE NEED FOR INPATIENT CARE

Through intensive community support, family involvement and timely intervention, we help more young people recover safely at home.

NEXT PRIORITIES

EARLIER INTERVENTION TO PREVENT ESCALATION.

Strengthen early identification and rapid access to stop crises before inpatient care is needed.

EXPAND RAPID ASSESSMENT AND CAU CAPACITY.

Increase Same Day/CAU capacity to further reduce avoidable admissions.

ENHANCE COMMUNITY STABILISATION AND STEP-UP SERVICES.

Provide intensive home-based support to maintain safety and avoid admission.

No dependence on CAU for ECGs and blood tests – provision in the community for easy and timely access.

INTEGRATED DISCHARGE AND FOLLOW-UP PATHWAYS.

Ensure seamless step-down to community teams and reduce readmission risk.

OUR APPROACH DELIVERS BETTER OUTCOMES

- Shorter stays, better outcomes.
- Right care, right time, right place.
- Safe, effective and proportionate care.
- Support recovery in the community.

PAEDIATRIC ADMISSIONS DATA – PART 2

First-onset admissions drive the highest bed occupancy, highlighting gaps in early intervention and targeted prevention.

First-onset admissions are young people presenting for the first time as a paediatric inpatient, unknown to CAMHS Eating Disorder Service or Paediatrics beforehand.

FIRST-ONSET ADMISSIONS DRIVE THE HIGHEST BED DAYS

Young people presenting for the first time as paediatric inpatients account for a disproportionate share of bed occupancy.

FIRST-ONSET ADMISSIONS

25.0%
of all admissions

187
bed days

VS

ALL OTHER ADMISSIONS
(known to service)

75.0%
of all admissions

263
bed days

First-onset admissions generate **41.6%** of total bed days, despite accounting for only **25%** of all admissions.

ADMISSIONS & BED DAYS BY ADMISSION TYPE

Admission type	No. of admissions	% of total admissions	Bed occupancy days	% of total bed days
CAU 1-day admissions	25	44.6%	25	5.6%
First-onset admission	14	25.0%	187	41.6%
1st admissions (known)	9	16.1%	92	20.4%
2nd admissions	5	8.9%	82	18.2%
3rd admissions	2	3.6%	62	13.8%
4th admissions	1	1.8%	2	0.4%
TOTAL	56	100%	450	100%

First-onset admissions create the greatest demand on inpatient resources, demonstrating the cost of late presentation.

KEY INSIGHTS

Late presentation drives demand
First-onset admissions account for the highest bed days, highlighting delayed access to targeted prevention.

Repeated admissions are uncommon
Only 14.3% of admissions are second or more episodes, showing that most young people do not require repeated inpatient admissions.

Early intervention can reduce inpatient need
Strengthening targeted prevention may prevent crisis presentations and long inpatient stays.

Focus on first contact
Improving early identification, rapid access and outreach is critical to reduce the impact of first-onset admissions.

STRATEGIC IMPLICATIONS

Close gaps in early intervention
Strengthen access to targeted prevention and early support services.

Expand outreach & partnerships
Work closely with schools, GPs and community services to identify need earlier.

Reduce crisis presentations
Earlier support can prevent medical deterioration and reduce demand on paediatric inpatient beds.

Investing in early support reduces the need for inpatient care and improves outcomes.
Timely community intervention ensures young people get the right support sooner, protecting physical health and supporting recovery in the least restrictive environment.

DATA START DATE
01/03/2024

CURRENT DATE
15/05/2026

PERIOD (YEARS, MONTHS & DAYS)
2 years, 2 months, and 14 days

Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

STRONG MANAGEMENT OF KNOWN-TO-SERVICE YOUNG PEOPLE.
Effective pathways and continuity of care support earlier stabilisation.

REDUCED REPEAT ADMISSIONS.
Fewer known-to-service young people require readmission.

EFFECTIVE COMMUNITY STABILISATION PATHWAYS.
Timely support at home helps prevent escalation and crisis.

EXISTING INTENSIVE SUPPORT REDUCES ESCALATION.
Targeted input for known patients prevents deterioration.

BETTER CONTINUITY BETWEEN INPATIENT AND COMMUNITY CARE.
Smooth transitions reduce risk and support recovery.

PAEDIATRIC ADMISSIONS DATA – PART 2

FIRST-ONSET ADMISSIONS DRIVE BED OCCUPANCY

Late identification leads to more severe illness, longer admissions and higher use of inpatient capacity.

EARLY IDENTIFICATION (FUTURE REALITY)

EARLIER SUPPORT REDUCES CRISIS AND INPATIENT BURDEN

Early recognition	Early intervention	Stabilisation in the community	Fewer admissions & bed days
Awareness, screening & early help	Timely community support	Prevent escalation and crisis	Reduced pressure on inpatient capacity

Investing in early identification and intervention will **reduce crisis-driven admissions**, improve outcomes and use inpatient capacity more effectively.

NEXT PRIORITIES

DEVELOP EARLY INTERVENTION EATING DISORDER SERVICE.
Build proactive, accessible services focused on prevention and early support.

EXPAND GP AND SCHOOL OUTREACH.
Increase awareness, training and links to identify concerns earlier.

RAPID FIRST-PRESENTATION PATHWAYS.
Ensure quick access to assessment and intensive support at first signs of illness.

REDUCE CRISIS-DRIVEN ADMISSIONS.
Shift from reactive inpatient care to proactive early intervention.

OUR APPROACH DELIVERS BETTER OUTCOMES

- Shorter stays, better outcomes.
- Right care, right time, right place.
- Safe, effective and proportionate care.
- Support recovery in the community.

SPECIALIST & INPATIENT ADMISSIONS:
REDUCING LENGTH OF STAY, AVOIDING OUT-OF-AREA CARE

Significantly shorter admissions, fewer escalations and minimal reliance on out-of-area specialist care through intensive community integration.

0 SEDU ADMISSIONS in the last 1.5 years

Last scheduled admission: December 2024. Sustained inpatient–community engagement and intensive home treatment support earlier discharge and reduce reliance on out-of-area specialist eating disorder admissions.

PLYMOUTH vs SOUTH WEST AVERAGE (2023 SWPC AUDIT)

Average Length of Stay (Days)

GAU
General Adolescent Unit Admissions

58% SHORTER than SWPC average

Very low number of GAU admissions reflects effective engagement and support, helping young people remain safely in the community.

NUMBER OF ADMISSIONS	
Plymouth	SWPC Avg.
4	–

SEDU
Specialist Eating Disorder Unit Admissions

44% SHORTER than SWPC average

Specialist eating disorder admissions remain rare and are for significantly shorter periods.

NUMBER OF ADMISSIONS	
Plymouth	SWPC Avg.
1	–

0 scheduled SEDU admissions in the last 1.5 years.
Last scheduled admission: December 2024.

WHY OUR OUTCOMES ARE STRONG

INTENSIVE COMMUNITY INTEGRATION MAKES THE DIFFERENCE

Regular inpatient engagement
Our community team maintains weekly involvement with young people in hospital.

Seamless continuity of care
Ongoing relationships ensure consistent support from ward to community.

Earlier, safer discharge
Active planning and support enable young people to return home sooner.

Reduced need for specialist beds
Avoids escalation to long-stay or out-of-area specialist placements.

Better outcomes, lower disruption
Supports recovery, education and family stability within the community.

REAL IMPACT. REAL DIFFERENCE.

Cost effective
Fewer admissions and shorter stays reduce system costs.

Less disruption
More time at home means better education and life continuity.

Family centred
Keeps young people connected with their families and support networks.

Local care, better outcomes
Avoids out-of-area admissions and supports regional resilience.

> "Integrated care. Better outcomes. Stronger futures."

DATA START DATE
01/03/2024

CURRENT DATE
15/05/2026

PERIOD (YEARS, MONTHS AND DAYS)
2 years, 2 months and 14 days

Our Progress & Priorities

Plymouth CAMHS Integrated Eating Disorder Service

ACHIEVED

SIGNIFICANT REDUCTIONS IN GAU AND SEDU LENGTH OF STAY.

Much shorter stays compared to SWPC average, reducing bed utilisation and system pressure.

MINIMAL RELIANCE ON OUT-OF-AREA SPECIALIST CARE.

Zero SEDU admissions in 1 year and 5 months.

STRONG INPATIENT–COMMUNITY INTEGRATION.

Regular community team presence on GAU/SEDU supports continuity and earlier discharge.

EARLIER AND SAFER DISCHARGE PLANNING.

Timely, intensive support at home reduces length of stay.

ENHANCED POST-DISCHARGE INTENSIVE SUPPORT.

Boost support in the critical weeks after discharge to sustain recovery and prevent readmission.

BETTER CONTINUITY OF CARE.

Smooth transitions between inpatient and community services support recovery and reduce readmission risk.

NEXT PRIORITIES

FORMALISED DATA-INFORMED STEP-DOWN PATHWAYS.

Standardised pathways and criteria for safe, consistent progression from inpatient to community care.

STRUCTURED DISCHARGE READINESS FRAMEWORK.

Clear readiness criteria to support earlier, confident and safer discharge.

EXPAND GP AND SCHOOL OUTREACH.

Increase awareness, training and links to identify concerns earlier.

REDUCE CRISIS-DRIVEN ADMISSIONS.

Shift from reactive inpatient care to proactive early intervention.

Our integrated approach reduces reliance on specialist care, shortens stays and improves outcomes.
Better outcomes for young people. Better use of system capacity.

No Nasogastric Feeding

for Plymouth Eating Disorder Patients in any settings over the last two years

Voluntary or Restraints Nasogastric Feeds Have Not Been Used

NASOGASTRIC FEEDING	Paediatric ward	GAU	SEDU	Current	Discharged
Voluntary nasogastric feeding	0	0	0	0	0
NG feeding under restraints	0	0	0	0	0

KEY MESSAGE

Over the last two years, **no nasogastric feeding** has been used for Plymouth Eating Disorder patients **in any settings**: Paediatric, GAU or SEDU.

Why This Has Been Achieved

- Intensive support that meets needs early and effectively
- System integration through leadership and collaborative working

Culture Shift Towards Therapeutic Approaches

- Trust building
- Collaborative problem solving
- Motivational therapies
- Trauma-informed approaches
- Neurodiversity affirmative care
- Working on social isolation, connectedness and relational security

DATA START DATE
01/03/2024

CURRENT DATE
15/05/2026

PERIOD (YEARS, MONTHS AND DAYS)
2 years, 2 months, and 14 days

12 NO NASOGASTRIC FEEDING

LEAST RESTRICTIVE CARE. THERAPEUTIC ENGAGEMENT. BETTER OUTCOMES.

ACHIEVED

NO NG FEEDING UNDER RESTRAINT.
Zero use of NG feeding under restraint across all settings and caseloads.

REDUCED RESTRICTIVE PRACTICES.
Therapeutic engagement prevents escalation and reduces the need for restrictive interventions.

INTENSIVE THERAPEUTIC ENGAGEMENT.
High levels of individual and family support prevent the need for NG feeding.

TRAUMA-INFORMED AND NEURO-AFFIRMING CARE.
Our care is tailored, compassionate and responsive to individual needs.

COLLABORATIVE LEADERSHIP ACROSS SYSTEMS.
Strong partnerships with inpatient teams, paediatrics and community services.

RELATIONAL, SECURITY-BASED MODEL THAT WORKS.
Building trust, choice and safety supports recovery and prevents the need for coercion.

FUTURE PRIORITIES

FORMAL MOU WITH PAEDIATRICS ON NG FEEDING THRESHOLDS.
Agree clear, evidence-based criteria for life-threatening medical risk only.

CLEAR ESCALATION CRITERIA FOR MEDICAL RISK.
Ensure shared understanding and decision-making where escalation is required.

ENHANCE THERAPEUTIC DE-ESCALATION MODELS.
Invest in advanced training and therapeutic environments.

BALANCE SAFETY AND LEAST RESTRICTIVE PRACTICE.
Strengthen governance, review processes and learning.

RESEARCH, EVIDENCE AND SHARING OUR LEARNING.
Publish outcomes to inform best practice nationally.

NO NG FEEDING.
NO NG FEEDING UNDER RESTRAINT.
ACROSS ALL SETTINGS AND CASELOADS.

THERAPEUTIC ENGAGEMENT PREVENTS ESCALATION AND PROMOTES RECOVERY.

OUR YOUNG PEOPLE ARE AT THE CENTRE OF EVERY DECISION.

FAMILIES AND PARTNERS WORK TOGETHER TO CREATE LASTING CHANGE.

COMPASSIONATE CARE TODAY.
HEALTHIER, STRONGER FUTURES TOMORROW.

DATA START DATE
01/03/2024

CURRENT DATE
15/05/2026

PERIOD (YEARS, MONTHS AND DAYS)
2 years, 2 months, and 14 days

What We Thought → What Data Showed → What We Changed → What Happened

Plymouth CAMHS Integrated Eating Disorder Service

WHAT WE THOUGHT

- Capacity problem
- Too many referrals
- Need more staff
- Rising demand was the main issue

WHAT DATA SHOWED

- **Complexity** problem
- **Neurodiversity** and **trauma** were highly prevalent
- **Escalation often** occurred before intervention
- **Caseload numbers** alone did not reflect workload

WHAT WE CHANGED

- **Data-informed** capacity planning
- **Acuity and intensity** monitoring
- **Intensive community** support
- **Dynamic step-down** pathways
- **Integrated multi-**agency working

WHAT HAPPENED

- **Reduced inpatient** reliance
- **Shorter admissions**
- **Earlier intervention**
- **Improved recovery** pathways
- **Better outcomes** closer to home

Data changed how we understand demand, plan capacity and deliver care.

Better data → Better decisions → Better outcomes

Thank You

What We Learned

Better data revealed what matters most

Better understanding led to better decisions

Better decisions improved outcomes closer to home

Any Questions?

HQIP Healthcare Quality Improvement Partnership

#CAAW26

Building the National Audit of Eating Disorders: Barriers, Data Quality, and Impact on Services

Dr Karina Allan and Philippa Nunn

National Audit of Eating Disorders (NAED)

Building the National Audit of Eating Disorders (NAED)

Barriers, Data Quality, and Impact on Services

Dr Karina Allen and Philippa Nunn

26 June 2026

What we will cover

- An overview of the National Audit of Eating Disorders (NAED)
- Key NAED milestones to date
  - Service mapping, staffing and core audit metrics
- Data quality & barriers
- Impacts

What is the NAED?

- The National Audit of Eating Disorders (NAED) aims to improve identification and management of eating disorders.
- Focuses on quality and consistency of services for:
  - Children and young people (CYP)
  - Adults of working age
  - Older adults

Runs from **August 2024 to July 2027**

Healthcare Improvement Goals

1. Reduce barriers to early intervention
2. Improve offer and uptake of NICE concordant treatment
3. Improve recording of patient outcomes
4. Reduce health inequalities

Audit Timeline

2024-25

Year 1

- Audit registration
- Service mapping report
- Build data dashboard

2025-26

Year 2

- Staffing report
- Launch of quality improvement network
- Core audit: first drop of data available on dashboard

2026-27

Year 3

- Quarterly reports available on dashboard
- Quality improvement network continues
- State of the nation report

Who We Work With

NAED Advisors

Prof Ulrike Schmidt OBE (Clinical Advisor)
Dr Karina Allen (Clinical Advisor)
Rebecca Regler (Lived Experience Patient Advisor)
Vicky James (Lived Experience Carer Advisor)

Our patient and carer advisors act as a conduit between each part of the audit to ensure that lived experience perspectives are promoted throughout.

NAED Service User and Carer Advisory Group (SUCAG)

The SUCAG is made up of people who have lived experience of eating disorders services. The group is coordinated and facilitated by our partnering eating disorders charity, Beat.

NAED Steering Group

Provides expertise from multiple backgrounds to provide advice on the audit. Includes clinicians, commissioners, charities, and Royal Colleges.

The SUCAG works in parallel to the Steering Group to provide feedback on key decisions in the audit to ensure these reflect issues of importance to patients with eating disorders and their families/carers.

Implementation Group

Lived Experience advisors

Lived Experience advisors

SUCAG

Beat Eating disorders

Lived Experience Advisors

Steering group

SUCAG Co-Production

Service Mapping Report

Access and Waiting Times

Number of People on Waiting Lists

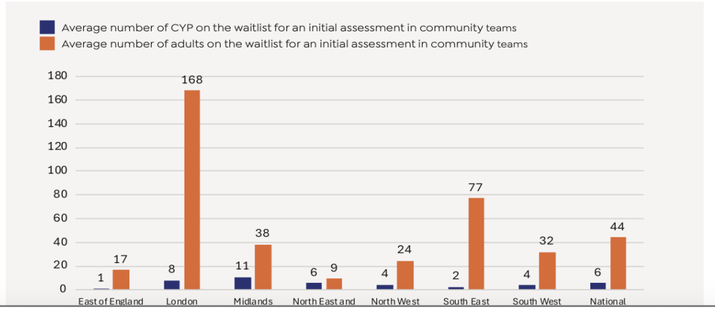
At the time of data collection, **3,855** people were waiting for an initial assessment and **4,537** for treatment in community teams.

National mean averages per community team:

- **Assessment (Figure 8):**
  - Adult: 44 people (range: 0–500)
  - CYP: 6 people (range: 0–77)
- **Treatment:**
  - Adults: 55 people (range: 0–436)
  - CYP: 6 people (range: 0–150)

Why this matters

"Waiting lists can be difficult in terms of where you are at with your recovery. Being referred and feeling ready but if there is a long wait, struggling physically with anorexia, being too unwell to access the therapy and ending up in inpatient care." Service user

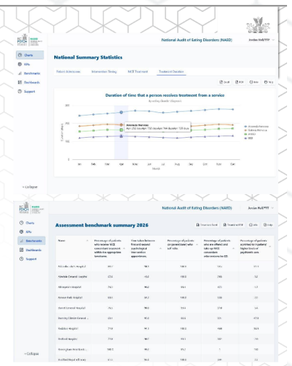


Data Dashboard

You said, we did

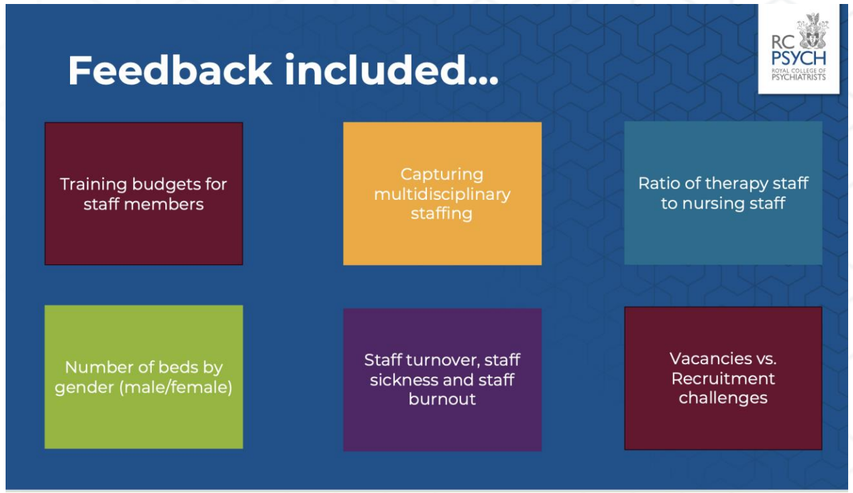
Data Dashboard

- In May, we asked for your feedback on the online data dashboard prototypes
- We fed this back to our dashboard developers
- They were very appreciative of the feedback
- They are continuing to develop the dashboard and have let us know they have already made some changes to the dashboard based on your feedback



Service Mapping Video

Staffing Report



Service Mapping Report

Service Mapping – Year 1

- Despite increasing prevalence and awareness of eating disorders, service provision in England remains highly variable
- Previous reports have highlighted a stark mismatch between rising demand and service capacity, but a comprehensive national overview of service provision has been lacking
- The service mapping exercise aimed to understand the breadth and depth of service provision in England for the first time
- Aimed to identify strengths and gaps to provide a foundation for targeted improvements

Participation

97%

(288/297) of eligible teams registered for the audit

Teams were asked to complete **two surveys** about their **service provision**

96% (277/288)
of registered teams completed at least **one** survey

91% (262/288)
of registered teams completed **both** surveys

Key findings

Participation of Teams

- **209 eligible services** in England were identified, comprised of **297 teams**
- **97% of teams registered** to take part in the audit

NHS England and Private Provision

- **78%** of all eating disorders teams are **NHS-delivered**
- **42% of adult** and **27% of CYP inpatient** services are delivered by **private providers**

Provision across ICBs

- **100%** of ICBs have at least one team delivering **CYP** and **adult community care**
- **Inpatient services** are specially commissioned and typically delivered across multiple ICBs

Children and Young People (CYP) and Adult Team Provision

- **93 CYP community** teams and **69 adult community** teams identified in England
- **54 inpatient CYP teams** – mostly based in general adolescent units – and **33 inpatient adult teams** located in dedicated eating disorder inpatient units, identified in England
- Nationally, **adult community** teams have **1.89** people on their caseload for every **1** patient open to **CYP** teams. This means **adult community** teams face an **89% higher demand***

Access and Waiting Times

- The national median wait for **CYP community care** is **14 days for assessment** and **4 days for treatment**, with **waiting times of up to 450 days**
- The national median wait for **adult community care** is **28 days for assessment** and **42 days for treatment**, with **waiting times of up to 700 days**
- **15%** of community adult teams **accept self-referrals** compared to **62%** of CYP teams

Provision for Eating Disorder Diagnoses

- **Binge eating disorder (BED)** is treated by **63%** of CYP teams, **55%** of adult teams, and **94%** of all age teams
- **Avoidant restrictive food intake disorder (ARFID)** is treated by **48%** of CYP teams, **29%** of adult teams, and **25%** of all age teams

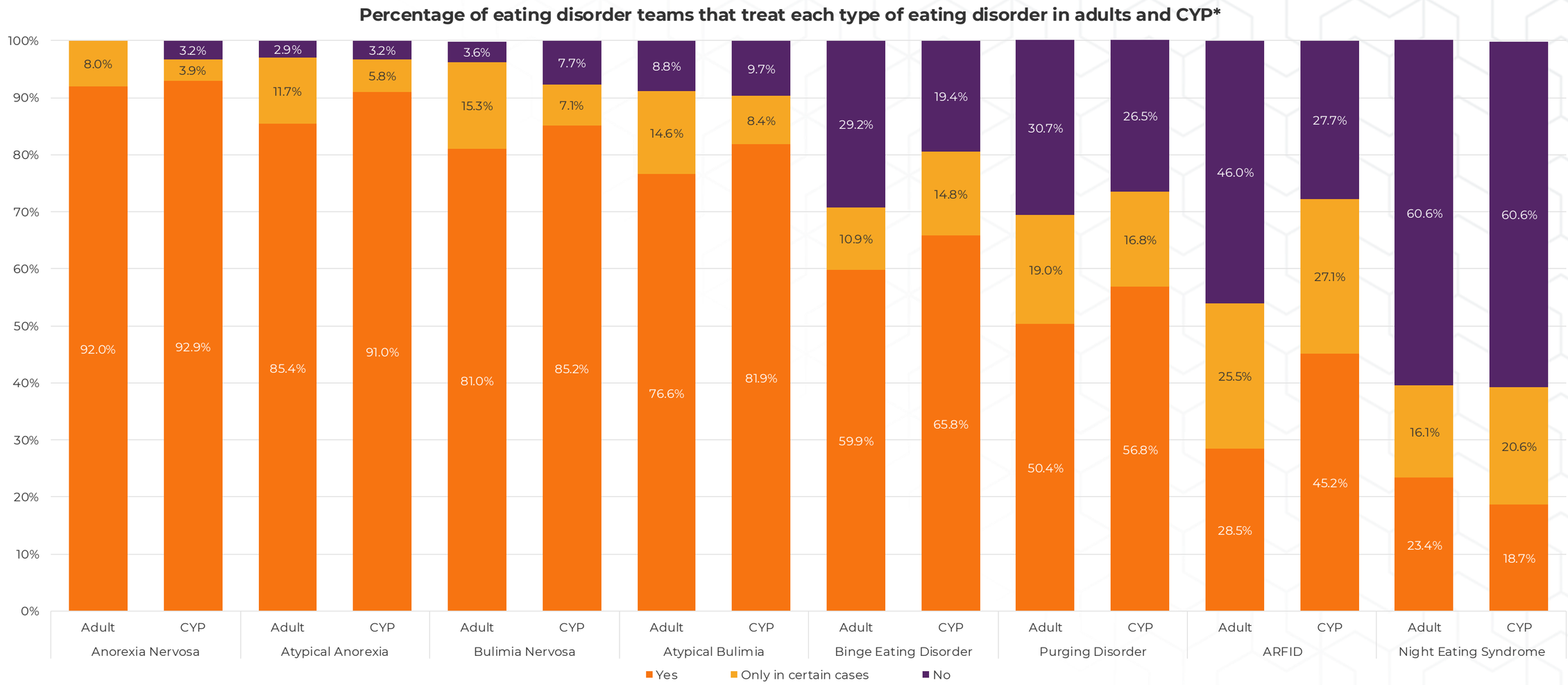
Shared Care Protocols

- **36%** of teams have **shared care protocols** for **psychiatric comorbidities** and **35%** for **physical comorbidities**

NICE-Recommended Psychological Therapies in Community Teams

- **85%** of CYP and **90%** of adult teams offer cognitive behavioural therapy for eating disorders (CBT-ED)
- **86%** of **CYP teams** offer **family therapy** for eating disorders (FT-ED)
- **62%** of **adult teams** offer **guided self-help**

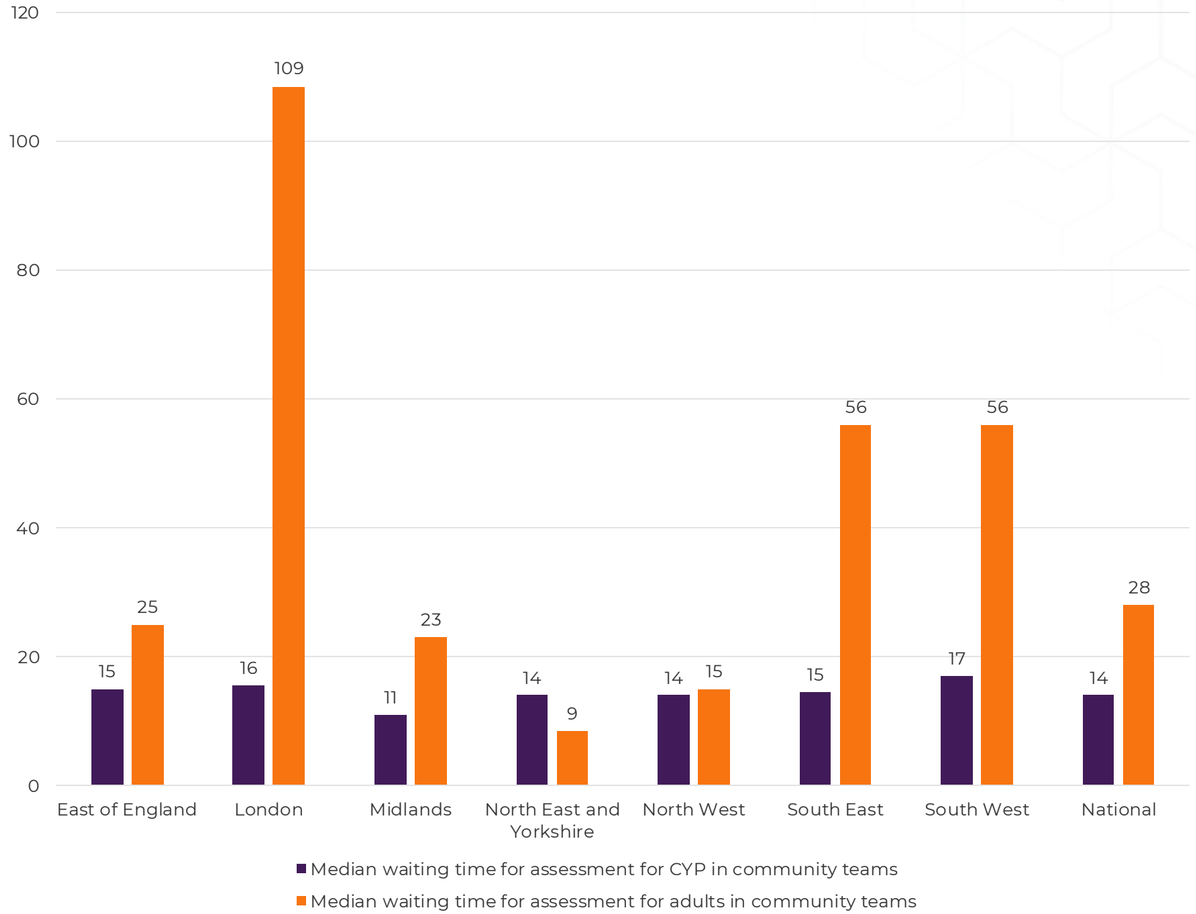
Key findings: Eating disorders treated across teams



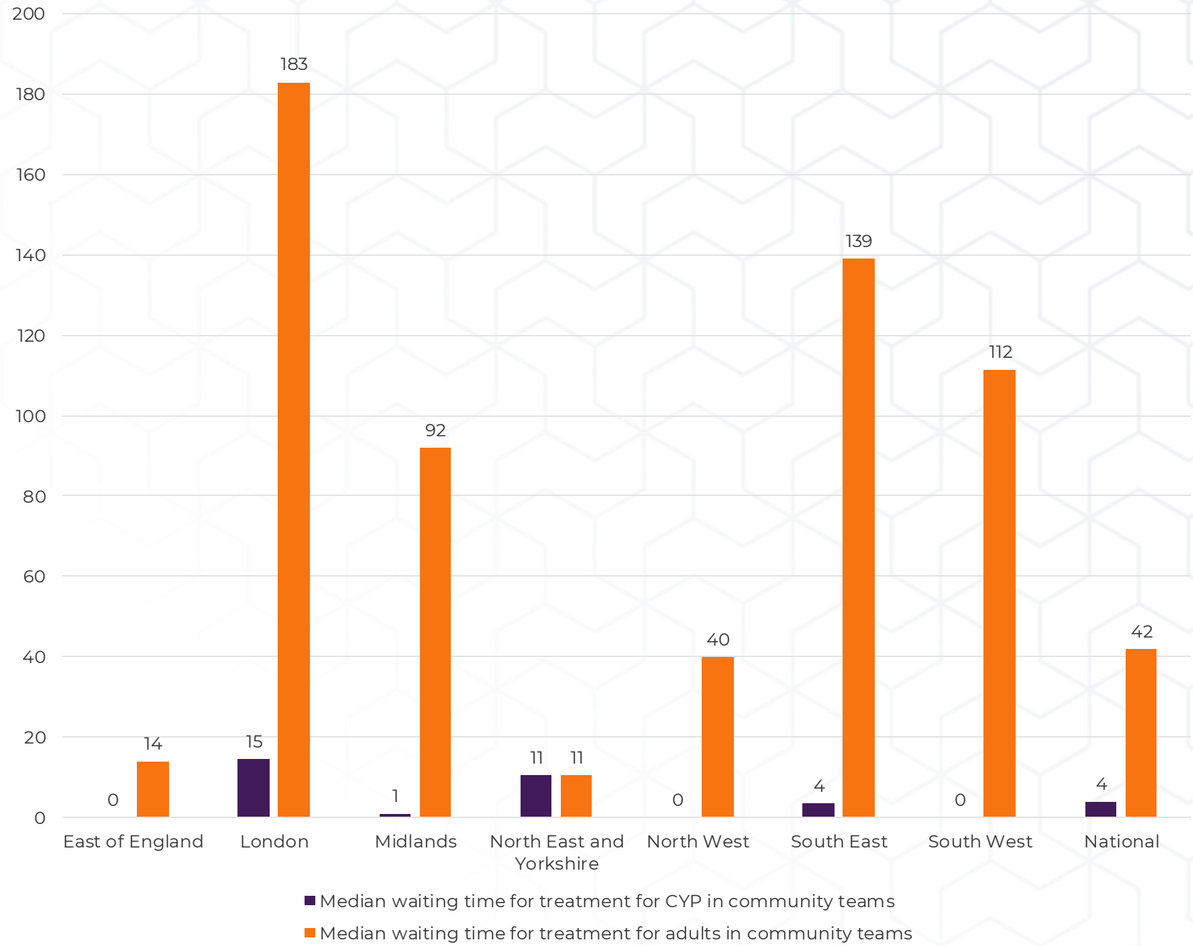
* All age teams are included in both the adult and CYP categories

Key findings: Waiting times in community services

Median waiting time (in days), reported by services, for initial assessment for an eating disorder in community teams, nationally and by region



Median waiting time (in days), reported by services, for treatment for an eating disorder in community teams, nationally and by region



Staffing Report

Staffing Report – Year 2

In 2026, we are taking more of an in-depth look at staffing within teams. Each team was asked to complete one survey about their staffing.

95% (273/289) of eligible teams are taking part.

The report will be published at the end of 2026.

Staffing Report – Year 2

Referrals

Workforce

Multidisciplinary team composition

Inpatient beds

Budget

Contacts

Caseloads

Core Audit

Audit Metrics

There are **12** audit metrics, divided into **three** categories:

Access and Waiting Times

Interventions

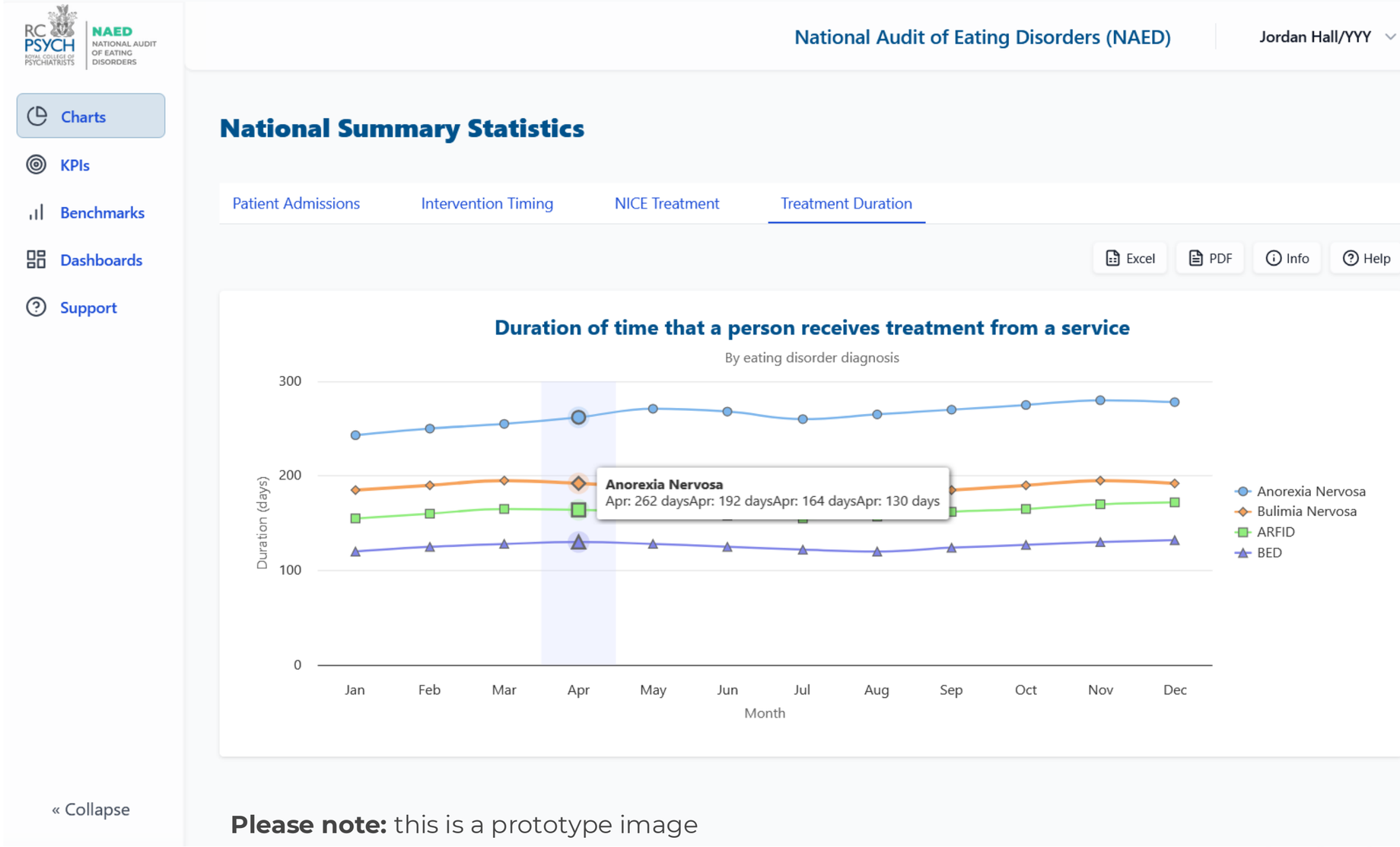
Outcomes

The metrics were developed in consultation with the Steering Group and Service User and Carer Advisory Group (SUCAG)

Audit standards

Access & waiting times	1	Percentage of patients who receive NICE concordant treatment within the appropriate timeframe.
	2	Time taken between first and second psychological intervention appointment.
	3	Percentage of patients (or parent/carer) who self refer
Interventions	4	Percentage of patients who are offered and take-up NICE concordant interventions for ED
	5	Percentage of patients admitted to inpatient/higher levels of psychiatric care
	6	Hospitalisations for acute medical/paediatric care
	7	Percentage of patients treated under the Mental Health Act
	8	Percentage of people with eating disorders who are open to more than one mental health service.
Outcomes	9	Percentage of patients with clinical outcome measures recorded at two time points
	10	Percentage of patients who transition from CYP to adult services
	11	Number of evidence based psychological intervention sessions received
	12	Percentage of deaths of people in ED services and up to a year after discharge.

NAED data dashboard



Please note: this is a prototype image

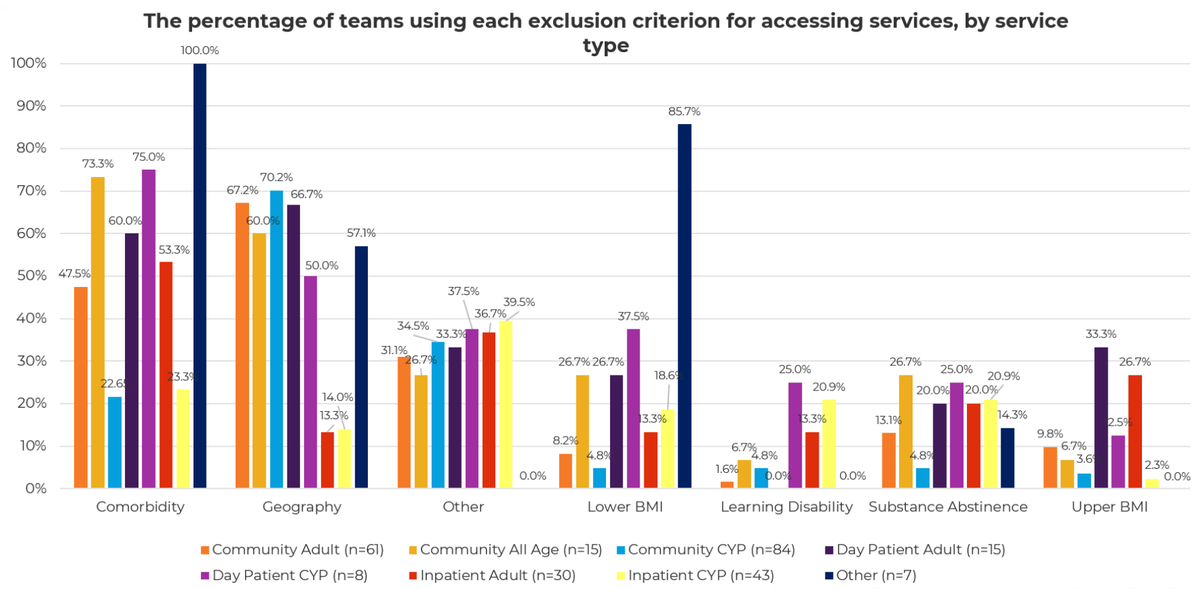
Data Quality & Barriers

Data quality

- Good participation and buy-in from services
- Data quality strong for our service level datasets as a result
- Routine data (e.g. MHSDS) has known data quality issues and gaps
- Working with NHSE to produce guidance for teams to help improve data quality
- Contacting data teams to promote joined up working
- QI Network will help teams to improve data quality

Barriers: Service level data

- Clarity around participation of General Adolescent Units
- Diversity in team set-up means a ‘one-size-fits-all’ data collection tool is difficult to develop
- Different teams have different data systems – data are stored in different places, in different formats



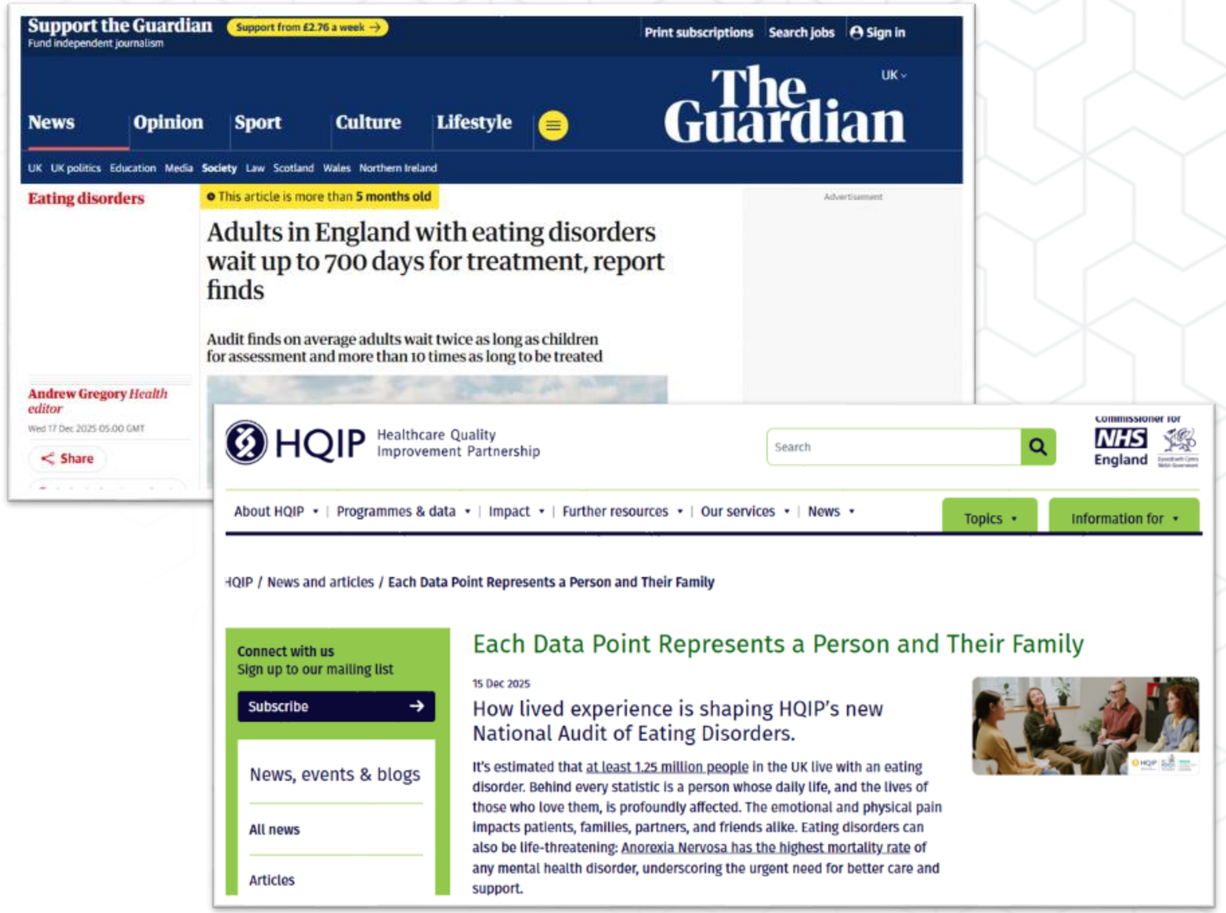
Barriers: Routine data

- Delays in accessing data
- Relevant data is held in disparate locations
- Multiple SNOMED codes available for the same data item
- Work arounds required to build data dashboard in absence of data
- We’re working with other national audits held at the RCPsych to formulate combined solutions

Impact

Impact so far

- Strong national buy-in from Eating Disorder services
- High-quality stakeholder engagement and coproduction
- Establishment of a robust national benchmarking framework
- Delivery of the first national overview of ED service provision
- High impact, accessible reporting formats



Stakeholder feedback loops

NAED has invested in professional awareness and engagement, creating a cycle between understanding, participation and feedback

- RCPsych Eating Disorders Faculty Conference (Nov 2025)
- National whole-team training for adult services (Jan 2026)
- Medical Research Foundation Eating Disorders Conference (Mar 2026)
- Quality improvement meetings, eliciting strong professional support for embedding the data collection and QI processes.

Impact on Eating Disorder Teams

- Recognition of the challenges, gaps and disparities
- Hope from areas of positive practice and the potential for improvements
- Feeling heard as a field – that there is an interest in the landscape of eating disorder treatment provision and what is/isn't working well

Service User and Carer Advisory Group (SUCAG) feedback

Q: What do you feel has been the most impactful aspect of the NAED so far?

Raising awareness of regional and other disparities in service provision.

Being able to reflect on and share my experiences and seeing this meaningfully presented in the current work. It has also been really impactful hearing others' experiences and seeing this be represented in the audit so far.

Feeling like voices are being heard and change can be made - especially where things can seem so different depending on where you live - and data to compare services and see the gaps is not readily available.

Thank you!

Any Questions?

HQIP Healthcare Quality Improvement Partnership

#CAAW26

Congratulations to Resident Doctor Abstract Winner: Turning Audit into Improved Care

Dr Alex Tebbett

Anaesthetic Registrar – ST5,

South Warwickshire University Foundation Trust

Creating

Tabtracker

A Digital Shift in Post-Caesarean Medication Self-Administration

Dr Alex Tebbett
Anaesthetic Registrar – ST5
South Warwickshire University Foundation Trust (SWFT)

With special thanks to:
Dr Smita Gohil Clinical Director, Anaesthetics, SWFT
Ms Kirsty Hartwell QIP Midwife, SWFT

Self-Administration

- Independence
- Empowerment
- Patient satisfaction
- Improved knowledge
- Streamlines discharges(1)

- But it needs accurate record keeping

(1) Richardson, S.J., Brooks, H.L., Bramley, G. and Coleman, J.J., 2014. Evaluating the effectiveness of self-administration of medication (SAM) schemes in the hospital setting: a systematic review of the literature. *PLoS One*, *9*(12), p.e113912.

An audit showed

- Only 63% kept records
  - Logistical reasons
  - Human factors
- New baby
- Sleep deprivation

- Mistakes were made…

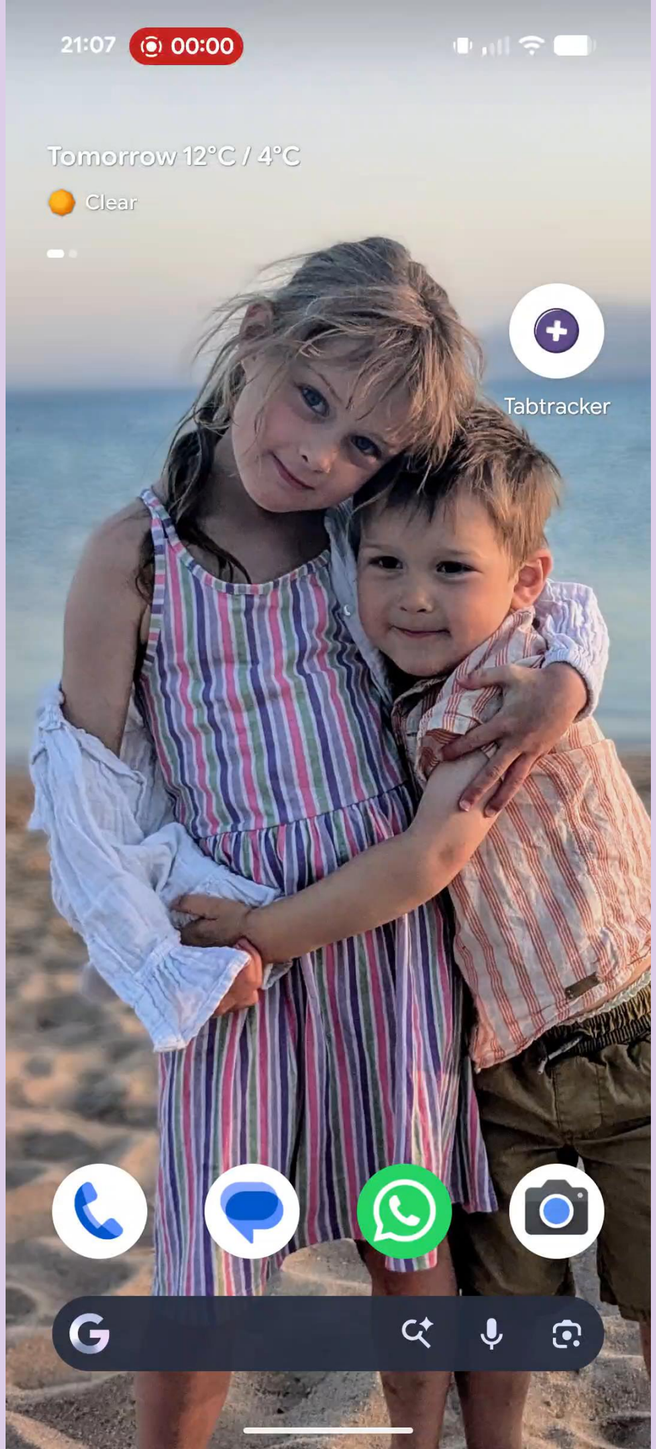
Tabtracker was born

Bespoke App
Digital transformation
Personalised record keeping

WITH

- Records
- Notifications
- Warnings
- Advice


Tabtracker


21:07
00:00
Tomorrow 12°C / 4°C
Clear
Tabtracker

Closing the loop

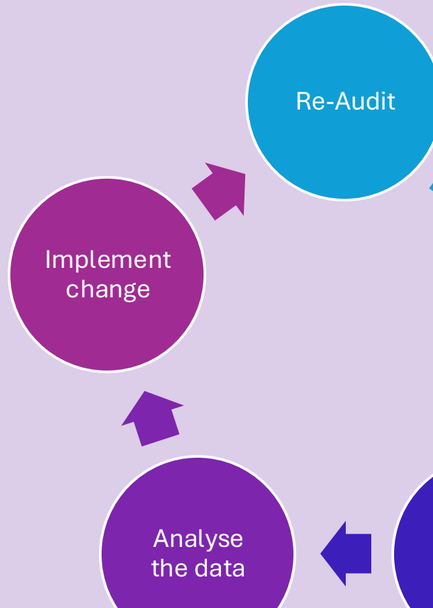
Pre **vs** **Post**

- Nov 2024 and April 2025

- App data
- Surveying patients
- Surveying midwives

- Satisfaction
- Ease of medication management
- Staff workload

Participation was based on informed consent, with individual self-administration records viewed only with patient permission.



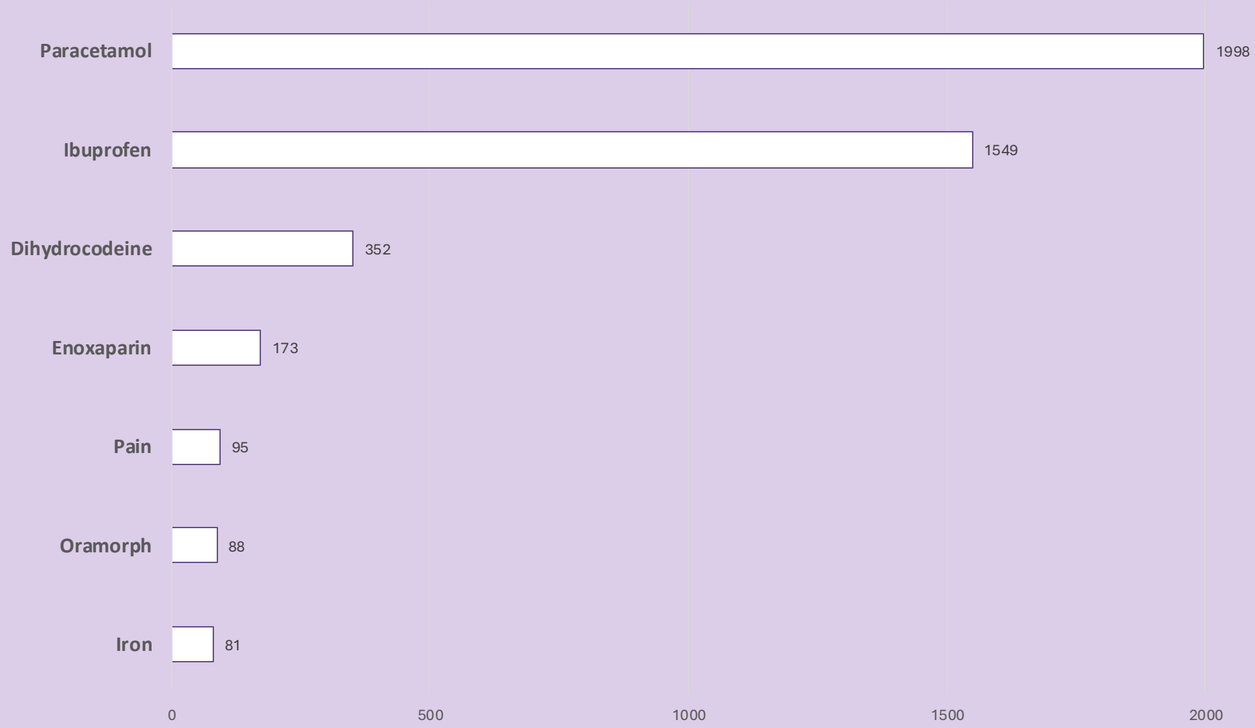
Results – App Data

228 unique users

19 Entries per user

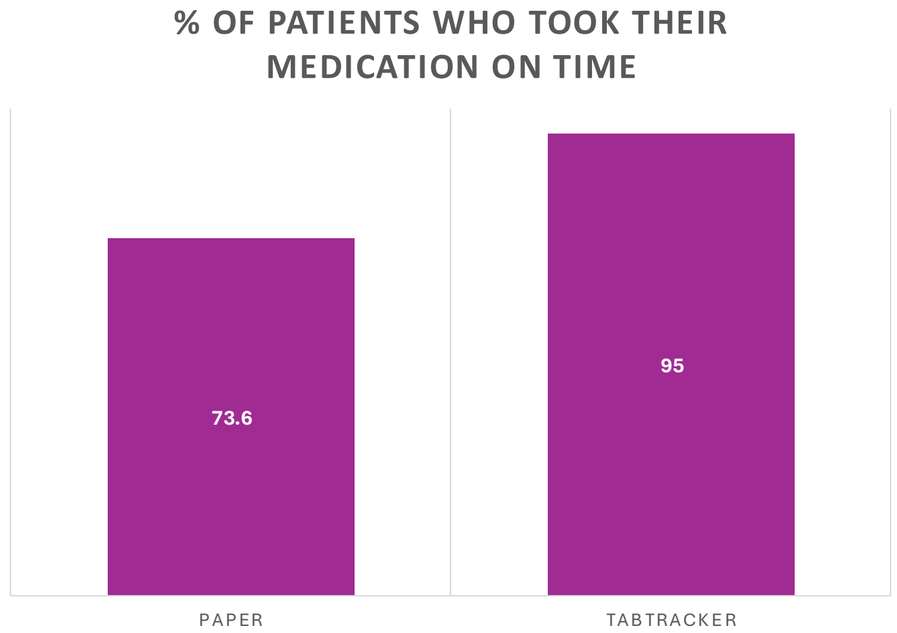
4329 doses recorded

5.3 days used



Results – Patient Survey

	PAPER (% Satisfied)	TABTRACKER (% Satisfied)
Information Received	73.5	95
Care Provided	73.5	95
Type of Medication	79.4	85
Frequency of Medication	82.4	90
Amount of Medication	88.2	95



Results – Midwife Survey

75%

Reported work reduction

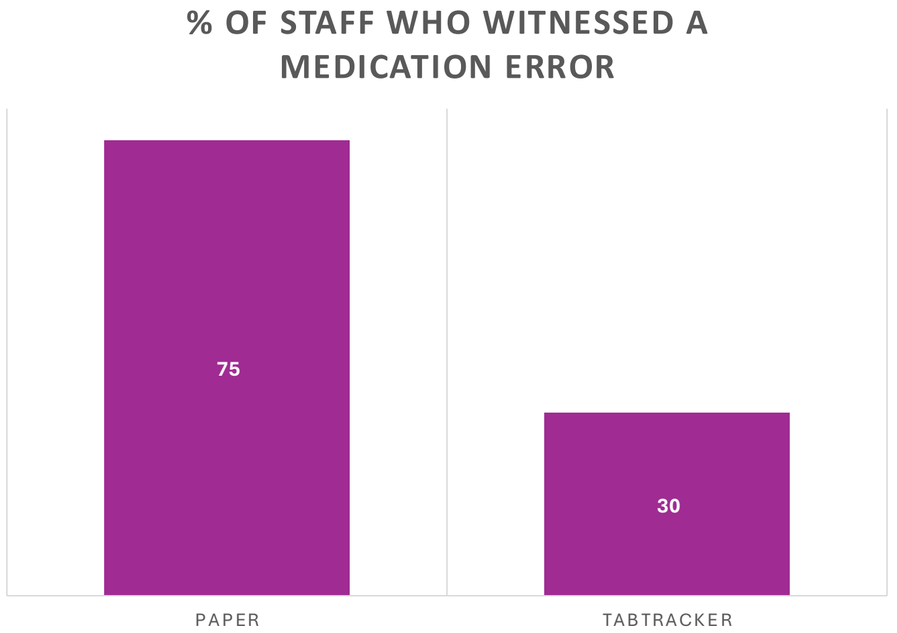
With 77% saying they spent less than 5 minutes explaining the process to the patient (46% prior)

92%

Reported improved accuracy

77%

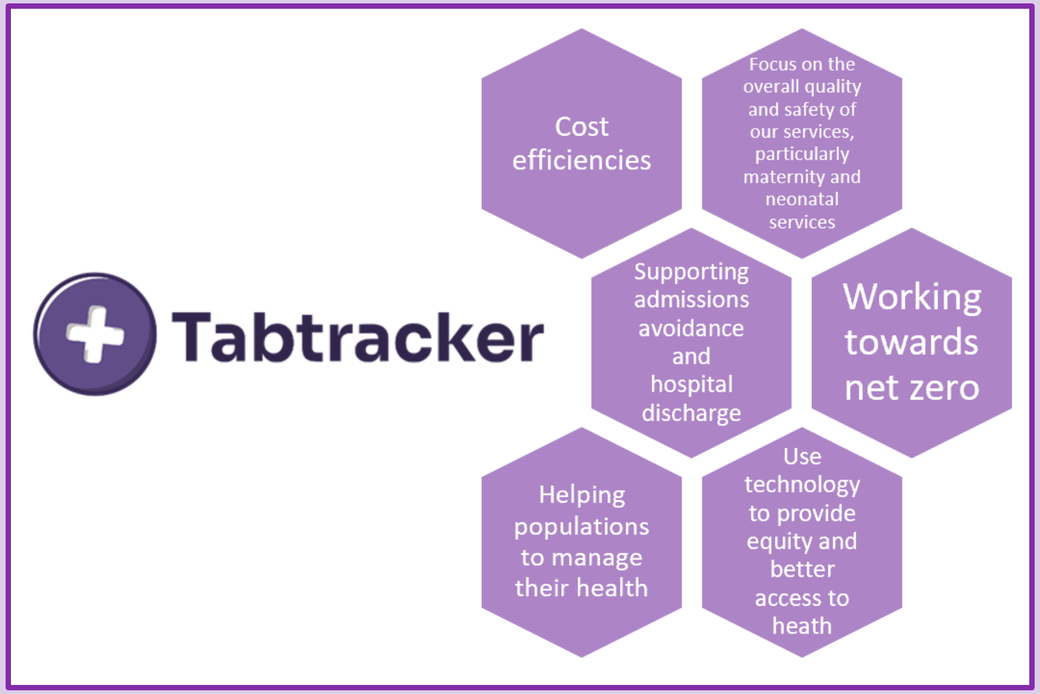
Reported more positive patient interactions



Tabtracker

- Successfully addressed logistical barriers
- Lead to near-universal understanding of medications
- Improved patient safety and satisfaction
- Reduced observed medication errors
- Reduced staff workload
- Bridged the gap between clinical standards and practice
- Aligns with NHS priorities for digital health access and safety.

But…



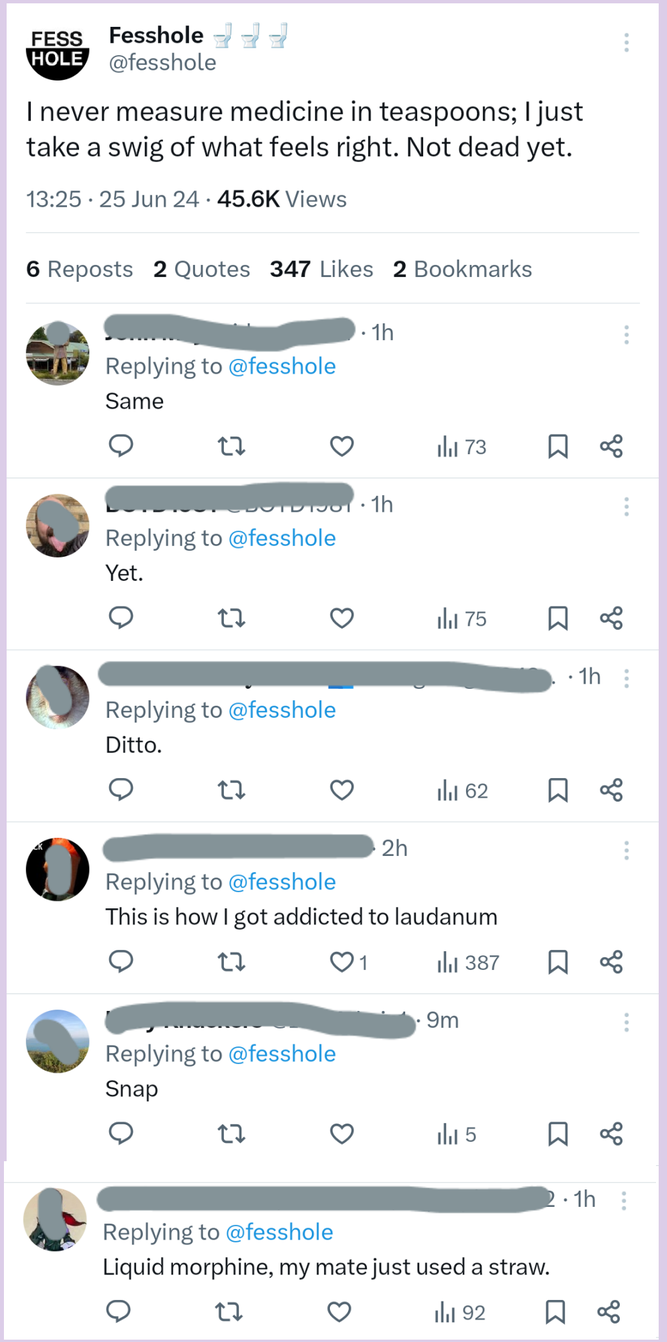

DEVELOPMENT TIME & RESOURCES
• Coding, design iterations, QA testing
• features development
STORE FEES & COMPLIANCE
• Apple App Store & Google Play fees, yearly subscriptions, guidelines review
LOCALIZATION & TRANSLATIONS
• Professional translation services, multi-language support, cultural adaptation
TABTRACKER
HOSTING & BACKEND INFRASTRUCTURE
• Cloud servers, databases, APIs, scalable architecture, storage
SECURITY & INSURANCES
• Data protection, legal compliance (e.g., GDPR), security audits, liability insurance
ONGOING MAINTENANCE & UPDATES
• Bug fixes, security patches, compatibility updates for new OS versions

Tabtracker

Download

tabtracker.app

Thank-you for listening
Questions?



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