

Hull and East Riding CAMHS Eating Disorders Team Operational Guidance

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1. INTRODUCTION AND LOCAL CONTEXT

Hull and East Riding CCGs have commissioned Humber Teaching NHS Foundation Trust to provide a specialist community eating disorder service for children and young people residing in the region that covers over 950 square miles with an under 18 population of around 135,000. The service can be accessed easily by families and referrers and responds rapidly to ensure the child's needs are assessed and managed safely, by suitably trained staff. The service can operate Monday to Friday 8am-8pm (usual working hours are 9am-5pm) and occasional weekends if clinically required. The service is closed all public/bank holidays.

Children and Young People (under 18 years) who are referred with a suspected eating disorder or eating disturbance should receive a comprehensive assessment and treatment package based on current recognised evidence, which is in line with best available evidence, professional knowledge and NICE Guidance for Eating Disorders (NG69 2017, updated December 2020).

The purpose of this local service guidance is to clarify the processes and support clinicians and allied professionals with their assessment and care pathway decision-making in the treatment and care management of childhood onset eating disorders, in accordance with current national guidelines.

All care delivered by the service needs to take into account the preferences and individual needs of the child or young person and in addition the wishes of their parents and carers, in acknowledging their key role in providing for their child or young person's health and welfare needs.

Good communication between clinicians and the child or young person and their family or carer is essential, and this is supported by the provision of accurate, sensitive and age appropriate information on the care, treatment and likely outcomes of various treatment options along with up to date information and guidance relevant to eating disorders in children and young people.

All information provided needs to be appropriate to the child and young person's culture, general ability and level of development and communication needs and be able to be made accessible to those who may not speak or read English.

2. REFERRAL CRITERIA AND PROCESS

www.nice.org.uk/guidance/ng69 supports early intervention and prevention for children and young people so the Eating Disorders Service will assess presentations where the primary difficulty is around eating with associated concerns that may suggest a suspected eating disorder (anorexia and bulimia nervosa and binge eating disorder – see Appendix 1 for definitions).

Children and young people can be referred directly to the service. For professionals this can be via the phone (01482 347886), email hnf-tr.camhsed@nhs.net or the online referral form (<http://camhs.humber.nhs.uk/wp-content/uploads/2021/07/Contact-Point-Referral-Form-Professionals-Version-v-1.docx>). Families or young people (over 16) can refer directly via telephone 01482 347886.

Young people already receiving intervention from the CAMHS teams can also be referred to the service and this will usually be a joint assessment with the current key worker in the first instance to determine a suitable care and intervention plan.

The team has a duty clinician available each afternoon to process referrals and respond to questions around referrals (or those being considered for referral).

The service recognises there are young people that experience challenges with eating that may be associated with other difficulties such as anxiety, low mood and ASC. These young people may not meet the criteria for, or require full intervention from the CAMHS ED Team but professionals may

benefit from a detailed mutual discussion with an experienced member of the team in order to help formulate plans or consider options.

If it is felt to be beneficial to have this consultation then it can be requested through the usual team contact number, where brief details will be taken, and the practitioner will make contact as soon as possible.

If consultation is agreed, then a mutual time and date for this meeting will be made and the consultee will be required to complete the consultation document prior to the meeting to bring with them.

This should not prevent professionals from making urgent/routine referrals or having usual discussions with the duty clinician.

Service criteria and definitions are detailed in Appendix 1.

3. TRIAGE

Young people referred to the service will receive a telephone triage within 24 working hours. This is conducted by a member of the Eating Disorder Team and where possible and required will include a discussion with the referrer, young person and parent/carer. There is a process in place if contact cannot be made with a family which includes further attempts and letters to both family and referrer/GP.

The purpose of triage is to determine the current difficulties in relation to eating patterns, weight, body image, physical health, social/psychological and emotional concerns and risk assessment.

The aim of triage is to:

- begin an engagement process with families;
- indicate if further in-depth assessment by the team is required and the urgency of this;
- develop an immediate safety plan, and
- determine further information/investigations required.

A request for further physical investigations from the young person's GP may be requested at this time – there is a template letter for this purpose on the Trust electronic system (see Appendix 2).

If during triage it is determined that the young person's health is seriously compromised there is a pathway for direct referral to Hull Royal Infirmary for further investigation and treatment (see Appendices 3, 4 and 5).

If on commencement of triage it is immediately clear that the referral is not one of a suspected eating disorder, the referral will be closed and redirected to CAMHS contact point for a generic mental health triage.

If on completion of full triage, it is not deemed necessary to undertake a face to face Eating Disorder Assessment or intervention, the family will be referred or redirected to more appropriate teams or services (including Core CAMHS intervention teams, EHASH etc.) Support with alternative service options can be sought from CAMHS Contact Point. A summary letter with ongoing arrangements will be sent to the referrer and family and the referral will be closed.

The triage process should be recorded on the electronic patient record and the contact logged as 'Initial Assessment'.

4. ASSESSMENT

- For young people in mental health crisis requiring a response within four hours a referral to the CAMHS Crisis Team is made.
- For young people with immediate physical health concerns please refer to guidance and pathway in Appendices 3, 4 and 5.
- Urgent referral – will be offered an assessment and seen within five working days.
- Routine referrals – will be offered an assessment and seen within twenty working days.

Levels of capacity and consent will be agreed (and forms signed) at assessment.

Staffing for assessments:

The assessment appointment will be carried out by two specialist Eating Disorder staff.

Assessment and Formulation Process

All children and young people referred with suspected eating disorders should be seen with their parent(s) or carer(s) as this is the model implemented by the team and underpins all interventions offered. As is always the case, it may be appropriate to offer an individual appointment at the request of the child or young person, in which case assessment and consideration of capacity and risk should be made by the assessing clinician. Parental involvement should be discussed with the young person and planned for as soon as possible.

All clinicians assess according to their own particular style and use a range of recognised engagement and therapeutic skills appropriate to the client's age and development. The assessment will include gathering information on the history of the presenting difficulties, plus exploration on the following:

- Current and historical food and fluid intake, purging/compensatory behaviours, level of exercise and changes in weight. (If assessment suggests likelihood of re-feeding syndrome an immediate discussion with a Dietitian/GP/Paediatrician is required.)
- Potential co-morbidities
- Social, educational, family history and circumstances
- Relationships with family, friends and peers (including any bullying and history of abuse).
- Past or current mental health difficulties for carer(s)/parent(s), e.g. mood disorders or eating disorders.
- Self-harm (including any drug/alcohol use) or suicidal ideas.

The young person should be given the opportunity for a discussion separate from their parent/carers during the assessment process if required.

Information gathered in the assessment will be used to help inform a psychological formulation which is developed collaboratively with the young person and their family. This will provide a framework for making sense of the current difficulties and help to inform the interventions offered within the package of care.

The formulation and subsequent care plan will be recorded in the electronic patient record and reviewed with the young person and family on an ongoing basis.

Physical observations will also be taken at assessment including weight, height, BP and pulse.

The team dietitian may provide a dietary assessment and advice at this stage, or this can be planned for at a future date by the key worker.

If required, the team Psychiatrist and Paediatrician (or the Consultant Gastroenterologist for some over 16 year olds) will be consulted and their involvement will be included in the care plan.

Consideration may be given to using screening tools to support assessments.

Following assessment the eating disorder clinicians will complete the Trust-identified relevant documentation (including risk assessment) on the electronic patient record.

Feedback to the Young person and Family

Details of the assessment will be shared at the weekly team MDT meeting. The family will then be contacted by phone to share any outcome of this. A summary letter of the assessment with an outline of proposed care will be sent to the child/young person and their parent(s) with a copy to the referrer and GP. A key worker will be appointed at the MDT meeting or as soon as possible.

Care Planning

The formulation and care plan will be created in collaboration with the young person and their family and recorded in the electronic patient record. This may also include other professionals if their input is appropriate to the care package. All young people would more than likely have at least one appointment with the team dietitian following assessment. The young person and family will sign the care plan and retain a copy for their records. The care plan will be reviewed every three months or twelve sessions whichever is sooner along with the risk assessment. The case will also be discussed periodically in the team MDT meeting, details of which will be recorded on the electronic patient record.

Incidents that fall outside the scope of the care plan should be considered for a safeguarding referral and/or DATIX reporting. (See additional policies on Trust Intranet)

5. THE TEAM AND OTHER PARTNERS

Effective team work and consultation form an important part of delivering high quality services to children, young people and families.

The team includes:

Role	WTE
Consultant Psychologist	1 x Band 8C
Clinical Team Lead (nurse)	1 x Band 7
Specialist Nurses/ Practitioners	8 x Band 6 (6.3 WTE)
Family Therapist	3 x Band 7
Dietitian	0.8 x Band 7 (with the additional 0.2 provided to East Riding Adult mental health teams)
Clinical Psychologist	0.6 x Band 8A
Consultant Psychiatrist/Specialist Doctor	0.2
Consultant Paediatrician	0.2
Administrator	1 x Band 3

The team works closely with GPs and paediatric services (see appendices 3, 4 and 5).

Referrers and clinicians are able to request consultation and seek advice at any stage via the duty worker each day.

The team works closely with colleagues from other CAMHS intervention teams and inpatient units; these working relationships and processes are referred to throughout the document.

Supervision Process

Annual staff development reviews and supervision (clinical, managerial and safeguarding) will take place as per Humber Teaching NHS Foundation Trust Policy and Guidelines and there is a structure in place to support this.

6. CARE PROGRAMME APPROACH (CPA)

Children, more than adults, are likely to be subject to multiple care plans and review mechanisms from multiple agencies, e.g. Looked After Child Reviews, Special Educational Needs Reviews, or social care assessments. All professionals and agencies need to work together to ensure minimum duplication of information, meetings and clarity of roles (especially who is leading) to avoid confusion and risk. CPA needs to be seen in the context of other planning mechanisms for children with complex needs and agreement must be made case by case on how to co-ordinate multi-agency care planning.

Use of the CPA process should be considered based on the guidelines and other information contained within the Trust CPA Policy and procedural guidance document.

Young people returning from a CAMHS inpatient stay may have been reviewed using CPA and as such clinicians should follow this framework until the next review where a decision can be made about the appropriateness of its continued use.

7. INTERVENTIONS AND TREATMENT

If, following assessment the young person and family require intervention from the Eating Disorder Service, they will be allocated a key worker and usually a co-worker.

The allocated key worker will be the main contact person for the family and will have the following responsibilities:

- Co-ordination and implementation of the overall care and treatment package and liaison with other relevant agencies.
- To convene and lead the reviews as appropriate and ensure that the care plan and risk assessments are up to date and that outcome measures are used as indicated.

The team follows the Maudsley family-based approach which can mostly be explained as an intensive outpatient treatment where parents play an active and positive role in order to:

- Help restore their child's weight to normal levels expected given their adolescent's age and height;
- hand the control around eating back to the adolescent; and
- encourage normal adolescent development through an in-depth discussion of these crucial developmental issues as they pertain to their child.

In addition to the family-based work the NICE guidelines state that there is "clinical consensus that children and adolescents with anorexia nervosa should be offered individual appointments with a health care professional separate from those with their family members or carers". Individual work is therefore also considered as a possible intervention alongside the family work.

Medical admission to an acute hospital will be considered if there is at least one 'red' or two or more 'amber' risk factors according to the MEED risk assessment. This should continue until the child or young person is deemed medically fit by a hospital physician for discharge back into the community or transfer to a CAMHS inpatient unit for ongoing specialist care and treatment and then discharge at the earliest appropriate time.

If a young person is admitted directly to a medical ward prior to involvement with CAMHS EDT, a referral to the team will be made as soon as possible. These young people still require an assessment within the timescales, but it is acknowledged the focus of this is on immediate physical health needs and engagement whilst in hospital. It may be deemed appropriate for some interventions to be delivered whilst an inpatient (mainly around carer support and preparing for home) but the care plan will be reviewed once discharged back to the community (see Appendix 5 for process).

If referral to a CAMHS general or specialist eating disorders inpatient unit is required, this is done following NHSE guidelines and procedures. During admission the key worker will continue to maintain contact with the family, liaise with the unit, represent at inpatient reviews (this may be via conference call) and support discharge at the earliest possible appropriate time. Following any admission, the Specialist Eating Disorder Service (or other identified relevant CAMHS team) will remain involved for at least 12 months.

8. OUTCOME MEASURES AND FEEDBACK

The following outcome measures will be routinely used:

EDE-Q

Score 15

SDQ

%BMI – this 'form' is located in the care plans/care pathways tab of the clinical chart on the EPR

RCADS and other outcome measures can be used if clinically appropriate.

These will be completed at the first session following allocation and then every six months and again at discharge.

Feedback tools are periodically given to families and always following discharge and the information is collated and used for both individual and service development.

9. DOCUMENTATION

The team uses the following CAMHS documentation directly onto the EPR:

- A triage document is used if the young person is not already open to CAMHS – if they are open or already have a triage completed by Contact Point then relevant additional information is recorded on a communication sheet.
- At assessment the CAMHS Eating Disorder assessment documentation and Young Persons FACE (risk assessment) are completed.
- The care plan will be formulated with the family as soon as this is agreed and reviewed as required using the care plan review form.
- Planned interventions are recorded on an Intervention sheet and any other communication (phone calls etc.) is recorded on an ED communication sheet.
- Height, weight, BP and pulse are recorded as required on the physical health recording sheet located in the care plans/care pathways tab – 'notes' on the EPR

10. TRANSFER OF CARE, INCLUDING TRANSITION TO ADULT MENTAL HEALTH SERVICES AND DISCHARGE

If, following assessment or intervention by the eating disorder team it is determined that further CAMHS intervention from another team would be beneficial then the CAMHS transfer, and allocation procedures should be followed to ensure effective handover and transfer.

When a young person is in receipt of treatment for an eating disorder and is approaching 18 years old, discharge from CAMHS or transfer to adult services should be considered. By the age of 17 and six months, and following the guidelines set out in the Transition Policy, a Transition or Discharge Care Plan should be formulated by the key worker in conjunction with the young person and their parents. A 'Leaving CAMHS passport' will also be offered to young people for completion.

Children and young people who have had an eating disorder may require ongoing support following discharge which should be planned for with relevant services. On completion of team interventions, the key worker should liaise with the GP and other involved agencies to ensure that any recurrence of symptoms is detected at an early stage and referred back for a swift appointment to the Eating Disorders Service at the earliest opportunity.

At discharge the key worker should ensure that the young person and parents/carers are clear on reasons for and the importance of speedy contact with services should early signs of a reoccurrence of the eating disorder become evident and give clear details on how and to whom they may refer.

11. CONSENT, CAPACITY AND CONFIDENTIALITY

Consent from the young person is essential where the young person is 16 or above as per the Mental Capacity Act 2005. There is no formal lower age limit for Gillick competency and so the guidance set out by the Department of Health (DoH 2001) and the National Institute for Health and Care Excellence (NICE 2020) should be followed when assessing competency and consent for under 16's. Consent can be given verbally or in writing and should be reviewed and revisited regularly.

Despite the obvious severity of an eating disorder, many young people are reluctant to engage in treatment, especially if treatment entails a focus on increased food intake and weight gain.

There may be times where it is unclear if the young person has capacity to consent to a referral to, or intervention with our team and in these instances it is the responsibility of the qualified practitioner to assess this as required.

If a child or young person lacks capacity, their physical health is at serious risk and they do not consent to treatment, parents or carers will be encouraged to consent on their behalf and if necessary, use an appropriate legal framework for treatment (such as the Mental Health Act 1983/2007 or the Children Act 1989).

If a mental health act assessment is indicated, then the relevant Trust procedure and policy will be followed.

In accordance with the Trusts Confidentiality Code of Conduct (N061) all staff must adhere to the Code of Conduct issued by the professional body to which they are affiliated. All staff have a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately (NMC 2015).

Appendix 1: Service Criteria and Definitions

Definitions of Eating Disorders

The following are diagnosis accepted by the team and are taken from NHS England Access and Waiting Time Standard for Children and Young People with an Eating Disorder, Commissioning Guide

Anorexia nervosa

Anorexia nervosa is characterised by extreme restriction of food intake, resulting in low body weight. In children and young people, it can slow or halt growth and pubertal development. Despite being at a low weight, individuals with anorexia nervosa tend to experience fear of gaining weight or of becoming overweight. Consequently, excessive exercising, self-induced vomiting, misuse of laxatives, or other behaviours, with the intention of preventing weight gain, may accompany dietary restriction. People with anorexia nervosa often see themselves as larger or heavier than they really are and tend to judge their self-worth in terms of their own weight or shape. This can cause significant distress and contribute to restriction of food intake. Individuals with anorexia nervosa are often unable to recognise the extent of their low weight or the seriousness of their condition, which means they do not think they have a problem or need help. Long-term physical consequences can affect height, brain development and bone density. In a minority of cases, death occurs; most fatalities are due to the consequences of malnutrition or suicide.

People with anorexia nervosa present in clinical settings from around the age of eight years upwards. The majority of children and young people seen in clinics are female, with an estimated 10-20% being male (Muise et al., 2003). There is a critical window for intervention because recovery is less likely if the disorder has remained untreated or inadequately treated for more than three to five years (Von Holle et al., 2008).

Bulimia nervosa

Bulimia nervosa is characterised by two main types of behaviour: recurrent 'binge eating' and 'compensatory' behaviours. Binge eating refers to eating large amounts of food associated with an accompanying sense of lack of control. Compensatory behaviours are intended to militate against the consequences of overeating. They typically include 'purging' behaviours (self-induced vomiting and laxative misuse) but also dietary restriction, excessive exercising or misuse of other types of medication. Such behaviours can lead to serious physical problems, and in a few people can be fatal (most often caused by the consequences of purging behaviour or suicide). As with anorexia nervosa, people with bulimia nervosa tend to judge their self-worth in terms of their own body shape and weight. Body weight in people with bulimia nervosa tends to be in the normal range or above, and so the disorder is often less obvious than anorexia nervosa. Individuals with bulimia nervosa are often embarrassed and ashamed about their behaviour, which can lead to reluctance to seek help.

Bulimia has a slightly later typical age of onset than anorexia nervosa, with presentations to clinical settings from around the age of 12 or 13 upwards. Some people have anorexia nervosa before developing bulimia nervosa. The majority of children and young people with bulimia nervosa are female, with an estimated 5-15% being male (Muise et al., 2003).

Binge eating disorder

Binge eating disorder is characterised by recurrent binge eating, but without compensatory behaviours. Body weight is usually above the normal range. Binge eating is mostly solitary, often occurring in the absence of hunger and typically accompanied by feelings of shame or disgust. Individuals with binge eating disorder often experience marked distress about their behaviour.

Typical age of onset of binge eating disorder is generally thought to be in later adolescence or early. Therefore, prevalence rates for binge eating disorder in children and young people in the UK are unclear, as many CAMH services do not see people with this disorder. However, the

prevalence of obesity is increasing in children and young people in the UK and the cost to the individual in terms of quality of life, and to NHS resources, is high (Wang et al., 2011).

The team may also see young people that do not meet full diagnostic criteria but are deemed at risk of developing this.

The team acknowledges that there are other food related difficulties that do not fit the criteria above. For these cases the team may still offer consultation or assessment but it may be that the intervention required is more suitably delivered by another CAMHS pathway (e.g. anxiety) or an alternative service.

Appendix 2: GP Letter to Request Physical Monitoring

CONFIDENTIAL

GP details & address

Dear Dr

Re: Child's name – DOB – NHS – Address

We have received a referral for the above-named young person. They are either currently awaiting or have been assessed by the CAMHS Eating Disorder Team.

Please can we request that you undertake the following investigations in order to complete our holistic assessment and possible diagnosis of an eating disorder?

- Baseline blood tests including Full Blood count, U&Es, Bone profile, Magnesium and Liver function tests. The rationale for each of these investigations is detailed at the end of this letter.
- Thyroid Function Test, Haematinics and Coeliac screen can also be considered if these have not been measured recently or if clinically indicated.
- Height and weight to give a clear indication of BMI.
- Sitting and standing blood pressure.
- Sitting and standing pulse
- Any other physical investigation that you feel necessary based on their past and current medical history and presentation.

If you wish to discuss this further, please contact the Eating Disorder Team on 01482 347886.

Yours sincerely

On behalf of the CAMHS Eating Disorder Team

Rationale for individual blood tests (for further information, please see www.marsipan.org.uk)

Full blood count- looking mainly at neutrophils which may be low in patients with eating disorders.

U&Es- looking at the level of 'dehydration' (if urea raised), the level of the creatinine which should be low, bicarbonate which may be high and potassium low in those who are vomiting. Young people who water load may have a low sodium.

Bone profile- looking at the alkaline phosphatase which may be falsely low for the young person's stage of growth and the phosphate which falls in early refeeding.

Magnesium- If low alongside low potassium will need correcting (otherwise potassium supplements alone are not likely to effectively restore potassium levels).

Liver function tests- looking for any abnormal transaminases which can occur in starvation.

Appendix 3: Risk Rating Table (to be used to determine need for immediate physical health monitoring)



2. Risk assessment: evaluating the impending risk to life due to the patient's illness

Appendix 4 contains an eating disorder checklist for frontline staff to use in emergencies.

It is important to note that risk parameters for adults cannot be applied to children and young people without adjustment for age and gender.

This is a guide to risk assessment and cannot replace proper clinical evaluation. However, a patient with one or more red ratings or two or more amber ratings should probably be considered high risk.

Table 1: Risk assessment framework for assessing impending risk to life

	 Red: High impending risk to life	 Amber: Alert to high concern for impending risk to life	 Green: Low impending risk to life
Medical history and examination			
Weight loss	Recent loss of weight of ≥ 1 kg/week for 2 weeks (consecutive) in an undernourished patient ³⁴ Rapid weight loss at any weight, e.g. in obesity or ARFID	Recent loss of weight of 500–999g/week for 2 consecutive weeks in an undernourished patient ²⁶	Recent weight loss of <500g/week or fluctuating weight
BMI and weight	<ul style="list-style-type: none"> Under 18 years: m%BMI³⁵ <70% Over 18: BMI <13 	<ul style="list-style-type: none"> Under 18: m%BMI 70–80% Over 18: BMI 13–14.9 	<ul style="list-style-type: none"> Under 18: m%BMI >80%³⁶ Over 18: BMI >15
HR (awake)	<40	40–50	>50
Cardio-vascular health^{37 38}	Standing systolic BP below 0.4th centile for age or less than 90 if 18+, associated with recurrent syncope and postural drop in systolic BP of >20mmHg or increase in HR of over 30bpm (35bpm in <16 years)	Standing systolic BP <0.4th centile or <90 if 18+ associated with occasional syncope; postural drop in systolic BP of >15mmHg or increase in HR of up to 30bpm (35bpm in <16 years)	<ul style="list-style-type: none"> Normal standing systolic BP for age and gender with reference to centile charts Normal orthostatic cardiovascular changes Normal heart rhythm

³⁴ Patients losing weight at higher BMI should be assessed for other signs of medical instability and weight loss strategies to determine risk.




³⁵ Also known as weight for height percentage.

³⁶ Note these do not denote a healthy weight but rather a weight above which other parameters in this risk framework may better reflect risk.

³⁷ <https://pubmed.ncbi.nlm.nih.gov/24067349/>

³⁸ https://www.nhlbi.nih.gov/files/docs/guidelines/child_tbi.pdf

2. Risk assessment: evaluating the impending risk to life due to the patient's illness




	 Red: High impending risk to life	 Amber: Alert to high concern for impending risk to life	 Green: Low impending risk to life
Assessment of hydration status	<ul style="list-style-type: none"> Fluid refusal Severe dehydration (10%): reduced urine output, dry mouth, postural BP drop (see above), decreased skin turgor, sunken eyes, tachypnoea, tachycardia 	<ul style="list-style-type: none"> Severe fluid restriction Moderate dehydration (5–10%): reduced urine output, dry mouth, postural BP drop (see above), normal skin turgor, some tachypnoea, some tachycardia, peripheral oedema 	<ul style="list-style-type: none"> Minimal fluid restriction No more than mild dehydration (<5%): may have dry mouth or concerns about risk of dehydration with negative fluid balance
Temperature	<35.5°C tympanic or 35.0°C axillary	<36°C	>36°C
Muscular function³⁹: SUSS Test	Unable to sit up from lying flat, or to get up from squat at all or only by using upper limbs to help (Score 0 or 1)	Unable to sit up or stand from squat without noticeable difficulty (Score 2)	Able to sit up from lying flat and stand from squat with no difficulty (Score 3)
Muscular function: Hand grip strength⁴⁰	Male <30.5kg, Female <17.5kg (3rd percentile)	Male <38kg, Female <23kg (5th percentile)	Male >38kg, Female >23kg
Muscular function: MUAC⁴¹	<18cm (approx. BMI<13)	18–20cm (approx. BMI<15.5)	>20cm (approx. BMI >15.5)
Other clinical state	Life-threatening medical condition, e.g. severe haematemesis, acute confusion, severe cognitive slowing, diabetic ketoacidosis, upper gastrointestinal perforation, significant alcohol consumption	Non-life-threatening physical compromise, e.g. mild haematemesis, pressure sores	Evidence of physical compromise, e.g. poor cognitive flexibility, poor concentration

³⁹ No muscle function test has been researched in patients <18 years.

⁴⁰ <https://pubmed.ncbi.nlm.nih.gov/19129352/>




⁴¹ <https://pubmed.ncbi.nlm.nih.gov/12765671/>

2. Risk assessment: evaluating the impending risk to life due to the patient's illness

	 Red: High impending risk to life	 Amber: Alert to high concern for impending risk to life	 Green: Low impending risk to life
ECG abnormalities	<ul style="list-style-type: none"> • <18 years: QTc >460ms (female), 450ms (male) • 18+ years: QTc >450ms (females), 430ms (males) • And any other significant ECG abnormality 	<ul style="list-style-type: none"> • <18 years: QTc >460ms (female), 450ms (male) • 18+ years: QTc >450ms (females), >430ms (males). • And no other ECG anomaly • Taking medication known to prolong QTc interval 	<ul style="list-style-type: none"> • <18 years: QTc <460ms (female), 450ms (male) • 18+ years: QTc <450ms (females), <430ms (males)
Biochemical abnormalities⁴²	<ul style="list-style-type: none"> • Hypophosphataemia and falling phosphate • Hypokalaemia (<2.5mmol/L) • Hypoalbuminaemia • Hypoglycaemia (<3mmol/L) • Hyponatraemia • Hypocalcaemia • Transaminases >3x normal range • Inpatients with diabetes mellitus: HbA1C >10% (86mmol/mol) 		
Haematology	<ul style="list-style-type: none"> • Low white cell count • Haemoglobin <10g/L 		
Disordered eating behaviours	Acute food refusal or estimated calorie intake <500kcal/day for 2+ days		

⁴² <https://www.rcpch.ac.uk/sites/default/files/rcpch/HTWQ/Reference%20ranges%20Jan%2018.pdf>

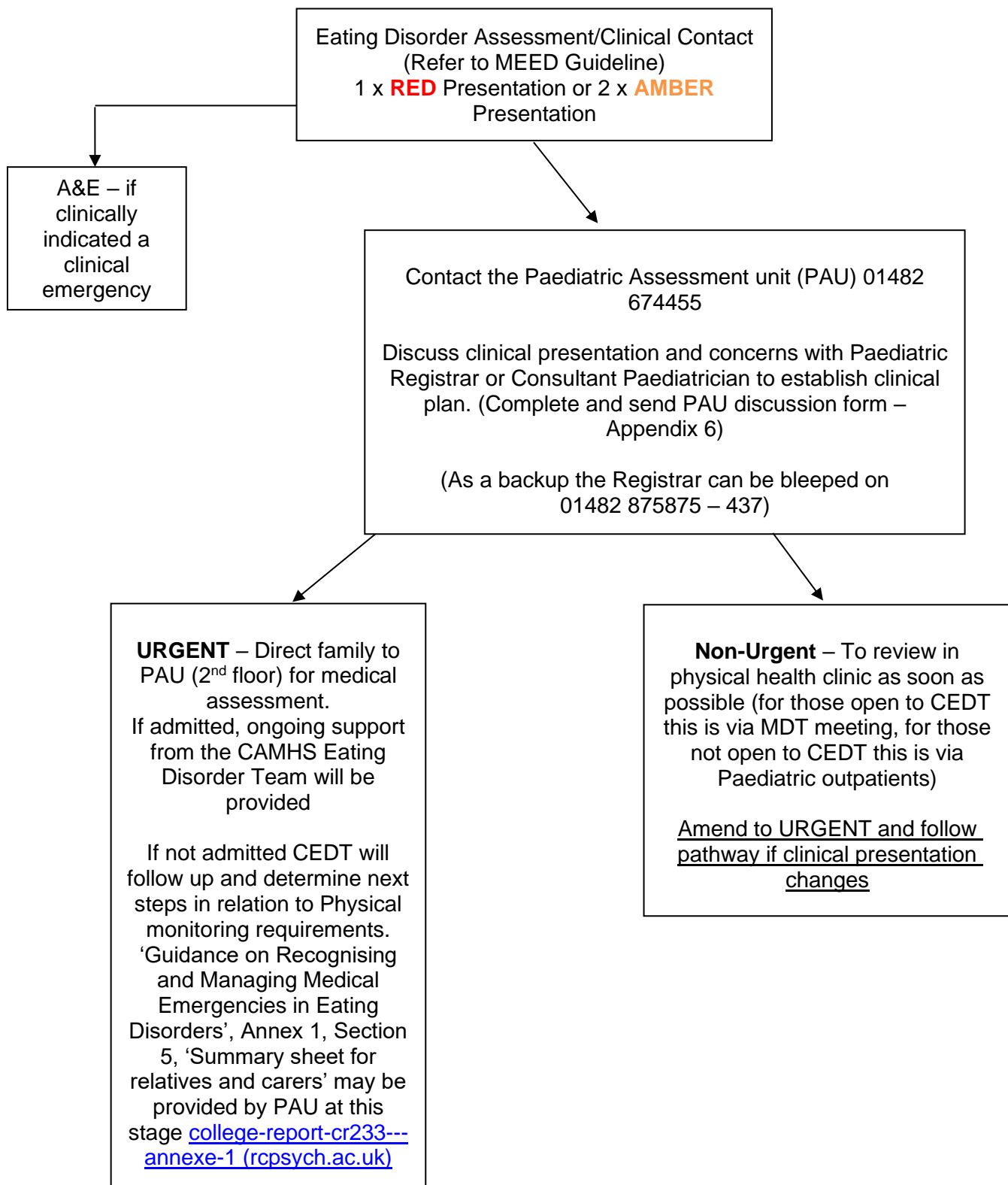
2. Risk assessment: evaluating the impending risk to life due to the patient's illness

	 Red: High impending risk to life	 Amber: Alert to high concern for impending risk to life	 Green: Low impending risk to life
Engagement with management plan	<ul style="list-style-type: none"> Physical struggles with staff or parents/carers over nutrition or reduction of exercise Harm to self Poor insight or motivation Fear leading to resistance to weight gain Staff or parents/carers unable to implement meal plan prescribed 	<ul style="list-style-type: none"> Poor insight or motivation Resistance to weight gain Staff or parents/carers unable to implement meal plan prescribed Some insight and motivation to tackle eating problems Fear leading to some ambivalence but not actively resisting 	<ul style="list-style-type: none"> Some insight and motivation to tackle eating problems May be ambivalent but not actively resisting
Activity and exercise	High levels of dysfunctional exercise in the context of malnutrition (>2h/day)	Moderate levels of dysfunctional exercise in the context of malnutrition (>1h/day)	Mild levels of or no dysfunctional exercise in the context of malnutrition (<1h/day)
Purging behaviours	Multiple daily episodes of vomiting and/or laxative abuse	Regular (=>3x per week) vomiting and/or laxative abuse	
Self-harm and suicide	Self-poisoning, suicidal ideas with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide	

Key: °C = degrees Celsius; ARFID = avoidant restrictive food intake disorder; BMI = body mass index; BP = blood pressure; bpm = beats per minute; cm = centimetre; ECG = electrocardiogram; g = grams; h = hour; HR = heart rate; kcal = kilocalories; kg = kilogram; L = litre; mmHg = millimetres of mercury; mmol = millimole; mol = mole; ms = millisecond; QTc = corrected QT interval; SUSS Test = Sit Up-Stand-Squat Test.

Appendix 4: Flowchart to Indicate Process of Referral for Physical Risk Management

(Agreed June 2018 between CAMHS ED team and HUTH Paediatric team, reviewed July 2022)



Appendix 5: Physical Risk Management – Referral, Care Planning and Discharge Agreement

Whilst all care is individually tailored the following are general principles to follow...

Agreed aims of admission to Hull Royal Infirmary are for medical stabilisation, safe refeeding, and discharge as soon as safely possible with a community care plan in place.

Agreed discharge aim is to have stable blood results, no longer in the red risk categories and gaining adequate weight.

Clear admission and discharge aims can help avoid delayed discharges.

On admission

If the CAMHS Eating Disorder Team (CEDT) are not already aware of the admission (i.e., if it was direct from GP/ A&E), they should be informed by staff on Woodland/ Acorn wards. (Tel...347886). Written information can also be sent to the CEDT email address; hnf-tr.camhsed@nhs.net

Young people will commence the medically prescribed menu and care plans following ward-based processes and guidance. The menu plan will be reviewed and amended as required by the ward team including HUTH dietitians.

A joint discussion is arranged as soon as possible following admission between the CEDT key or link worker and the ward Sister, deputy or nurse in charge. This may be by phone or email initially but followed up with a ward visit by CEDT as soon as possible (ideally same or next working day).

The purpose of this discussion is to....

- share relevant history (including recent assessment documentation if relevant),
- share current community care plan,
- develop discharge plan based on aims above,
- agree contact plan (How often and for what purpose will CEDT staff visit young person/ family whilst on the ward)

During admission/ Pre-discharge

Following the agreed contact plan; CEDT staff on entering the ward will....

- request an update from staff,
- view the notes,
- complete visit as planned,
- feedback details of the visit to the Nurse in Charge (if not possible a follow up email may be helpful)
- put an entry in the purple (safeguarding) sheet in the CARDEX file.

MDT reviews take place weekly to ensure the aims for admission and discharge plan are on track and the role in-reach is explored (this includes both CEDT and HUTH staff)

Discharge

If for whatever reason discharge/ leave takes place outside of the planned reviews as highlighted above, Ward staff should inform CED on above contact methods as soon as possible.

Post Discharge

Follow up Paediatric outpatient appointments should be discussed as part of the community discharge plan and booked into the relevant clinic.

Appendix 6: PAU discussion form

PAU discussion Information form

(Record of discussion between CAMHS Eating Disorder Team (CEDT) and Paediatric Assessment Unit (PAU))

Young person's name:	NHS no:
Date of Birth:	Conversation took place following CEDT Initial phone triage/ face to face assessment/ Session *
<u>Discussion held with PAU</u> Date: Time: CEDT clinician: PAU Clinician:	
Concerns and links to Jnr MARSIPAN guidelines:	
Has consideration of management by GP been made?	
Other areas of concern/ risk:	
Outcome of conversation with PAU Clinician:	

Please note if assessment by PAU is agreed this does not necessarily mean admission to the ward is required. This decision should be made based on clinical outcome of assessment.

If admission is required there should be clear rationale and aims for this.

Once completed please forward this information sheet on to;

hannahtownsend@nhs.net k.buttle@nhs.net anne.dalby2@nhs.net

Please also include relevant PAU clinician/ward clerk on the distribution list and copy ED admin in so this document can be uploaded to Lorenzo.

Appendix 7: Performance Indicators

	Performance Indicator	Result	Comments/actions
1	Number of referrals received per quarter		
2	Percentage of new referrals seen within one week for urgent		
3	Percentage of new referrals seen within four weeks for routine		
4	Percentage of new referrals accepted for treatment within quarter		
5	Number of new cases admitted to Paediatrics in the quarter, also shown as a percent of new referrals		
6	Number of new cases referred to Tier 4 via Paediatrics per quarter (also as a percent of new referrals)		
7	Number of new cases referred to Tier 4 directly in quarter (also as a percent of new referrals)		
8	Total number of all open cases admitted to Paediatrics in quarter (also as a percent of all open cases)		
9	Total number of all open cases admitted to Tier 4 directly in quarter (also as a percent of all open cases)		
10	Total number of all open cases admitted to Tier 4 via Paediatrics in quarter (also as a percent of all open cases)		
11	Number of cases discharged in quarter (shown as a percent of total cases)		
12	Total number of referrals to adult services in quarter (shown as a percent of all discharges)		
13	Clinical Outcome Measures for discharges in quarter and Clinical Outcome Measures for new cases in quarter (see separate tables).		
14	ED Team Evaluation forms		
15	Friends and Family Test		

Appendix 8: References

- Eating disorders: recognition and treatment - NICE guideline (NG69) Published date: May 2017 (updated December 2020) www.nice.org.uk/guidance/ng69
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders: DSM-IV- TR, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000.
- Oxford University Press: The Oxford Handbook of Eating Disorders, New York, Oxford University Press, 2010.
- Cole, T.J. (1979). A method for assessing age-standardised weight-for-height in children seen cross-sectionally. *Annals of Human Biology*, 6, 249-268.
- Frampton, I. & Austin, (1997). W4H (computer programme).
- Gowers, SG., Clark, A., Roberts, C., Griffiths, A., Edwards, V., Bryan, C., Smethurst, N., Byford, B., barrett, B. & Harrington, RC. (2007). Two-year outcomes of a randomised controlled trial for adolescent anorexia nervosa. *British Journal of Psychiatry*.
- [Medical emergencies in eating disorders \(MEED\): Guidance on recognition and management \(CR233\) \(rcpsych.ac.uk\)](http://www.rcpsych.ac.uk)
- Lask, B. & Bryant-Waugh, R. (2002). Anorexia Nervosa and related Eating Disorders in Childhood & Adolescence.
- Access and Waiting Time Standard for Children and Young People with an Eating Disorder [NICE Guideline Template \(england.nhs.uk\)](http://www.england.nhs.uk)
- Waiting times and clinical waiting priorities SOP [Cornwall Partnership Trust Child & Adolescent Mental Health Service Operational Policy \(humber.nhs.uk\)](http://www.humber.nhs.uk)