NICE National Institute for
Health and Care Excellence

NICE quality standard

Eating disorders

Quality standard
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This standard is based on NG69.

This standard should be read in conjunction with QS140, QS6, QS125, QS53, QS48, QS34 and QS8.

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Quality statement 1: Early assessment and treatment

Quality statement

People with suspected eating disorders who are referred to an eating disorder service start assessment and treatment within 4 weeks for children and young people or a locally agreed timeframe for adults.

Rationale

People with eating disorders have better recovery rates and a reduced risk of relapse when they receive early intervention in eating disorder services. Early intervention may also reduce the need for hospitalisation, which would be cost saving. Delays in starting assessment and treatment can affect response to treatment, with a longer delay having a greater effect on outcomes.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence that local referral pathways are in place for people with suspected eating disorders to start assessment and treatment within 4 weeks for children and young people or a locally agreed timeframe for adults.

Data source: Data can be collected locally by healthcare professionals and provider organisations, for example, service specifications. NHS England's 2015 commissioning guide, Access and waiting time standard for children and young people with an eating disorder, includes details of referral to assessment and treatment times for children and young people with suspected eating disorders.

Process

a) Proportion of children and young people with suspected eating disorders who start assessment and treatment within a maximum of 4 weeks from first contact with a designated healthcare professional.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, audit of electronic records. NHS Digital's Mental health services dataset (MHSDS) v3.0 and NHS Digital's Strategic Data Collection Service include data items on access and waiting time for children and young people. NHS England's 2015 commissioning guide, Access and waiting time standard for children and young people with an eating disorder, includes details of referral to assessment and treatment times for children and young people with suspected eating disorders.

b) Proportion of adults with suspected eating disorders who are assessed and start treatment within locally agreed timeframes.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, audit of electronic records.

Outcome

a) Length of time from referral to assessment and start of treatment at an eating disorder service for children and young people with suspected eating disorders.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, audit of electronic records, NHS Digital's Mental health services dataset (MHSDS) v3.0 and NHS Digital's Strategic Data Collection Service include data items on access and waiting time for children and young people. NHS England's 2015 commissioning guide, Access and waiting time standard for children and young people with an eating disorder, includes details of referral to treatment times for children and young people with suspected eating disorders.

b) Length of time from referral to assessment and start of treatment at an eating disorder service for adults with suspected eating disorders.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, audit of electronic records.

c) Rate of recovery for people with eating disorders.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, using the eating disorder examination questionnaire (EDE-Q 6.0).

What the quality statement means for different audiences

Service providers (such as community eating disorder teams and secondary adult mental health services) ensure that referral pathways are in place for people with suspected eating disorders to access assessment and treatment services within 4 weeks for children and young people, or within a locally agreed timeframe for adults. Service providers should also ensure that healthcare professionals have training in assessment and treatment referral, and have supervision with monitoring of competency.

Healthcare professionals (such as specialists within community eating disorder teams) ensure that children and young people with suspected eating disorders who have been referred to an eating disorder service start assessment and treatment within 4 weeks; adults should start assessment and treatment within a locally agreed timeframe.

Commissioners ensure that they commission eating disorder services with the capacity and expertise to deliver assessment and treatment within 4 weeks for children and young people referred to the service with suspected eating disorders. Adults should start assessment and treatment within a locally agreed timeframe.

Children and young people with suspected eating disorders who are referred to an eating disorder service have an assessment of their symptoms and risk factors and start treatment within 4 weeks.

Adults with suspected eating disorders who are referred to an eating disorder service have an assessment and start treatment within a time agreed by the local service.

Source guidance

Eating disorders: recognition and treatment. NICE guideline NG69 (2017, updated 2020), recommendations 1.2.1 and 1.2.10

Equality and diversity considerations

People with eating disorders may feel vulnerable when accessing care. Equal access to services and treatment (including through self-referral) for people with eating disorders and their parents or carers (as appropriate) is therefore important regardless of considerations such any physical or mental health problems or disabilities.

Quality statement 2: Discussion about psychological treatment options

Quality statement

People with eating disorders have a discussion with a healthcare professional about their options for psychological treatment.

Rationale

Discussing psychological treatment options with people with eating disorders (and their parents or carer as appropriate) enables healthcare professionals to tailor care to suit the person's individual needs and preferences. Patient choice is important during these discussions. However, for some people there may be an additional need for clinical opinion, for example, people with high-risk anorexia nervosa can have avoidant behaviour so may have difficulty deciding on their treatment.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to provide psychological treatments for people with eating disorders.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service specifications.

Process

Proportion of people with eating disorders who have a documented discussion with a healthcare professional about their options for psychological treatment at diagnosis.

Numerator – the number in the denominator who have a documented discussion with a healthcare professional about their options for psychological treatment at diagnosis.

Denominator – the number of people diagnosed with eating disorders.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local audit of electronic records.

What the quality statement means for different audiences

Service providers (such as community eating disorder teams, primary care, secondary care, tertiary care and non-NHS units) ensure that pathways are in place for people with eating disorders to have a discussion with a healthcare professional about their options for psychological treatment. Service providers should also ensure that healthcare professionals have training in discussing these options and have supervision with monitoring of competency.

Healthcare professionals (such as therapists specialising in eating disorders) discuss options for psychological treatment with people with eating disorders and support them in making a decision.

Commissioners ensure that they commission services with the capacity and expertise to deliver options for psychological treatment for people with eating disorders.

People with eating disorders (such as anorexia nervosa, binge eating disorder, and bulimia nervosa and other types of eating disorder) talk about their options for psychological treatment (talking therapy) with a healthcare professional. These options may also be discussed with their family members or carers if appropriate. Treatments aim to help people to manage their thoughts and feelings around food and to improve their mental wellbeing so that they can maintain their nutritional health and meet energy needs.

Source guidance

Eating disorders: recognition and treatment. NICE guideline NG69 (2017, updated 2020), recommendations 1.3.4 to 1.3.17, 1.4.1 to 1.4.8 and 1.5.2 to 1.5.10

Definition of terms used in this quality statement

Psychological treatments for people with eating disorders

NICE's guideline on eating disorders gives details of psychological treatment options for children, young people and adults with anorexia nervosa, binge eating disorder and bulimia nervosa. [NICE's guideline on eating disorders, recommendations 1.3.4 to 1.3.17, 1.4.1 to 1.4.8 and 1.5.2 to 1.5.10]

Equality and diversity considerations

Patient choice is important during these discussions. However, for some people there may be an additional need for clinical opinion, for example, people with high-risk anorexia nervosa can have avoidant behaviour so may have difficulty deciding on their treatment.

Family therapy may not be an appropriate psychological treatment option for children and young people who have been abused by family members or looked-after children and young people.

Quality statement 3: First-line psychological treatment for binge eating disorder

Quality statement

People with binge eating disorder participate in a guided self-help programme as first-line psychological treatment.

Rationale

Guided self-help programmes for adults, young people and children with binge eating disorder can improve recovery rates and reduce binge eating frequency. They can also have a long-term impact on physical and psychological health. If guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks, group eating-disorder-focused cognitive behavioural therapy (CBT-ED) can be provided as part of a stepped care approach.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to provide a guided self-help programme as first-line psychological treatment for people with binge eating disorder.

Data source: Data can be collected locally by healthcare professionals and provider organisations, for example, service specifications.

Process

Proportion of people with binge eating disorder who participate in a guided self-help programme as first-line psychological treatment.

Numerator – the number in the denominator who participate in a guided self-help programme as first-line psychological treatment.

Denominator – the number of people diagnosed with binge eating disorder.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local audit of electronic records.

Outcomes

a) Binge eating frequency for people with binge eating disorder.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, using the eating disorder examination questionnaire (EDE-Q 6.0).

b) Rate of relapse for people with binge eating disorder.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, using the eating disorder examination questionnaire (EDE-Q 6.0).

What the quality statement means for different audiences

Service providers (such as community providers, primary, secondary and tertiary care and non-NHS units) ensure that they have teams in place to deliver a guided self-help programme as a first-line psychological treatment for people with binge eating disorder, and to monitor the response to treatment. They should also ensure that healthcare professionals have training in delivering these programmes, and have supervision with monitoring of competency.

Healthcare professionals (such as non-specialist support workers) provide support for people using a guided self-help programme for binge eating disorder and monitor the response to treatment. They establish a good therapeutic relationship with the person and, if appropriate, with their family members or carers. They support and encourage the family to help the person to recover by self-monitoring binge eating behaviours and involving them in discussions.

Commissioners ensure that they commission services with the capacity and expertise to deliver guided self-help programmes as first-line psychological treatment for people with binge eating disorder, and to monitor treatment response.

People withbinge eating disorder take part in self-help programmes as the first psychological treatment. This includes working through a book about binge eating and having short sessions with a healthcare professional to look at progress. Usually there are between 4 and 9 sessions that last about 20 minutes each.

Source guidance

Eating disorders: recognition and treatment. NICE guideline NG69 (2017, updated 2020), recommendations 1.4.2 and 1.4.8

Definition of terms used in this quality statement

Guided self-help programme for binge eating

A guided self-help programme for binge eating should:

- use cognitive behavioural self-help materials
- focus on adherence to the self-help programme
- supplement the self-help programme with brief supportive sessions (for example, 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first)
- focus exclusively on helping the person follow the programme.

[NICE's guideline on eating disorders, recommendation 1.4.3]

Equality and diversity considerations

Self-help materials should be supplied in a format that suits the person's needs and preferences. They should be accessible to people who do not speak or read English, and should be culturally appropriate, age appropriate and gender appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Quality statement 4: Bulimia-nervosa-focused family therapy

Quality statement

Children and young people with bulimia nervosa are offered bulimia-nervosa-focused family therapy (FT-BN).

Rationale

FT-BN has a positive effect on remission, binge eating frequency and reducing hospitalisation rates.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to offer FT-BN to children and young people with bulimia nervosa.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service specifications.

Process

Proportion of children and young people with bulimia nervosa who are offered FT-BN.

Numerator – the number in the denominator who are offered FT-BN.

Denominator –the number of children and young people diagnosed with bulimia nervosa.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local audit of electronic records.

Outcomes

a) Binge eating frequency for children and young people with bulimia nervosa.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example using the eating disorder examination questionnaire (EDE-Q 6.0).

b) Purging frequency for children and young people with bulimia nervosa.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, using the eating disorder examination questionnaire (EDE-Q 6.0).

c) Rate of recovery for children and young people with bulimia nervosa.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, using the eating disorder examination questionnaire (EDE-Q 6.0).

What the quality statement means for different audiences

Service providers (such as community providers, secondary and tertiary care and non-NHS units) ensure that they have teams in place to offer FT-BN for children and young people with bulimia nervosa, and to monitor treatment response. They should also ensure that healthcare professionals have training in offering this therapy and have supervision with monitoring of competency.

Healthcare professionals (such as therapists) offer FT-BN to children and young people with bulimia nervosa and monitor the response to treatment. They establish a good therapeutic relationship with the child or young person and, if appropriate, with their family members or carers. They support and encourage the family to help the child or young person to recover by supporting self-monitoring bulimic behaviours and involving them in discussions. Later and final treatment phases will also entail therapists supporting and encouraging family or carer involvement in plans for appropriate independence and relapse prevention.

Commissioners ensure that they commission services with the capacity and expertise to offer FT-BN to children and young people with bulimia nervosa, and to monitor treatment response.

Children and young people with bulimia are offered a type of treatment called bulimia-nervosa-focused family therapy (or FT-BN for short). It involves working with a practitioner (for example, a therapist) to explore the effects of bulimia nervosa and how their family can support them to get better. Usually there are between 18 and 20 sessions that last for 6 months.

Source guidance

Eating disorders: recognition and treatment. NICE guideline NG69 (2017, updated 2020), recommendation 1.5.6

Definition of terms used in this quality statement

Bulimia-nervosa-focused family therapy

FT-BN for children and young people with bulimia nervosa should:

- typically consist of 18 to 20 sessions over 6 months
- establish a good therapeutic relationship with the person and their family members or carers
- support and encourage the family to help the person recover
- not blame the person, their family members or carers
- include information about:
  - regulating body weight
  - dieting

  - the adverse effects of attempting to control weight with self-induced vomiting, laxatives or other compensatory behaviours

- use a collaborative approach between the parents and the young person to establish regular eating patterns and minimise compensatory behaviours
- include regular meetings with the person on their own throughout the treatment
- include self-monitoring of bulimic behaviours and discussions with family members or carers
- in later phases of treatment, support the person and their family members or carers to establish a level of independence appropriate for their level of development
- in the final phase of treatment, focus on plans for when treatment ends (including any concerns the person and their family have) and on relapse prevention.

[NICE's guideline on eating disorders, recommendation 1.5.7]

Equality and diversity considerations

Family therapy may not be an appropriate psychological treatment option for children and young people who have been abused by family members or looked-after children and young people.

Quality statement 5: Coordinated care across services

Quality statement

People with eating disorders who are being supported by more than one service have a care plan that explains how the services will work together.

Rationale

A lack of coordination of services can cause confusion, add to the burden of the person with eating disorders and their family or carers, and has the potential to delay recovery. A care plan that explains how services will work together ensures that healthcare professionals all know about the person's care needs and their responsibilities for ongoing management. This will help to prevent treatment and support being compromised by poor coordination. This is particularly important when more than one healthcare service is involved because poor communication between services can mean inconsistent messages and management approaches, as well as lack of clarity about clinical responsibilities.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of joint working arrangements, including regular liaison and meetings to discuss care plans, between eating disorder services and other services, using formal processes of care planning, such as the Care Programme Approach (CPA).

Data source: Data can be collected locally by healthcare professionals and provider organisations, for example, contracts and service specifications. NHS England's NHS standard contract for specialised eating disorders (adults) (2013) includes details on care planning and collaborative working using the CPA.

Process

a) Proportion of people with eating disorders who are supported by more than one service who have a care plan that explains how the services will work together.

Numerator – the number in the denominator who have a care plan that explains how the services will work together.

Denominator – the number of people diagnosed with eating disorders who are supported by more than one service.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local audit of electronic records.

b) Proportion of people with eating disorders who are supported by more than one service and have CPA meetings to discuss their care plan.

Numerator – the number in the denominator who have their care plan discussed in their last CPA meeting.

Denominator – the number of people diagnosed with eating disorders who are supported by more than one service and have a care plan.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local audit of electronic records.

Outcomes

a) Rate of relapse for people with eating disorders who are supported by more than one service.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local audit of electronic records.

b) Service user experience of eating disorder services.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, using patient surveys.

What the quality statement means for different audiences

Service providers (such as specialist inpatient and outpatient eating disorder services, community-based eating disorder teams, child and family services, general mental health teams, primary care services or separate healthcare services treating other conditions) ensure that joint working arrangements are in place between eating disorder services and other services as detailed in the agreed care plan.

Healthcare professionals (such as GPs, case managers or care coordinators within a specialist eating disorder service) coordinate care by communicating the care plan to all services involved in care for a person with an eating disorder and mediating between services. There will be a combination of care planning meetings and regular written updates on care needs and how the services will work together to address these. Clear roles and responsibilities will need to be defined for all relevant healthcare professionals involved and shared with the person.

Commissioners ensure that care plans on joint working arrangements for services caring for people with eating disorders are developed, shared and delivered within and across the services involved.

People with eating disorders who are supported by more than one service (such as when moving from one area to another, for example, from home to university) have a care plan that explains how the services will work together to provide the care and support needed. The plan explains clearly the roles and responsibilities of the healthcare professionals involved in the person's care.

Source guidance

Eating disorders: recognition and treatment NICE guideline NG69 (2017, updated 2020), recommendation 1.1.11

Definition of terms used in this quality statement

Care plan

The care plan should be developed in collaboration with the person, their family members or carers (as appropriate), and the services involved.

It should include details of:

- joint working service arrangements
- all healthcare professionals and services involved, and their roles and responsibilities
- preadmission care (including frequency and responsibility for monitoring medical and psychiatric risk)
- urgent or emergency admission (indications, procedure and location)
- defined clear objectives and outcomes for inpatient treatment
- how the person with the eating disorder will be discharged from inpatient care, how they will move back to community-based care, and what this care should be.

[Adapted from NICE's guideline on eating disorders, recommendation 1.11.11 and NHS England's NHS standard contract for specialised eating disorders (adults)]

Equality and diversity considerations

Care planning should take account of the needs of the person with an eating disorder, their families and carers.

Care plans should be supplied in a format that suits the person's needs and preferences. They should be accessible to people who do not speak or read English, and should be culturally appropriate, age appropriate and gender appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Quality statement 6: Risk assessment when moving between services

Quality statement

People with eating disorders who are moving between services have their risks assessed.

Rationale

People with eating disorders might need to move from services for children and young people to adult services, between inpatient and outpatient services, between different geographical areas (common for students) or back to primary care after specialist treatment.

Particular care should be taken when people move between services because poor communication between services can lead to inconsistent messages and management approaches. Transition protocols, including risk assessment and monitoring, will ensure that treatment and support is not compromised and healthcare professionals all know about the person's care needs and plans for ongoing management.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of joint transition protocols between eating disorder services and other services, using formal processes of care planning such as the Care Programme Approach (CPA).

Data source: Data can be collected locally by healthcare professionals and provider organisations, for example, contracts and service specifications. NHS England's NHS standard contract for specialised eating disorders (adults) (2013) includes details of transition and care planning using the CPA.

b) Evidence of joint working arrangements, including regular liaison and meetings, to discuss risk assessment and monitoring at transition between eating disorder services and other services providing care for people with eating disorders.

Data source: Data can be collected locally by healthcare professionals and provider organisations, for example, contracts and service specifications. The Royal College of Psychiatrists' Managing transitions when the patient has an eating disorder (2017) includes details on transition management. Also The Royal College of Psychiatrists' Junior MARSIPAN: Management of really sick patients under 18 with anorexia nervosa (2012) and MARSIPAN: Management of really sick patients with anorexia nervosa (2014) include details of risk assessment and transfer between services.

Process

a) Proportion of people with eating disorders moving between services who have a care plan that includes a risk assessment before transfer.

Numerator – the number in the denominator who have a care plan that includes a risk assessment before transfer.

Denominator – the number of people with eating disorders who are moving between services.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local audits of care plans.

b) Proportion of people with eating disorders moving between services who have a care plan that includes a risk assessment after transfer.

Numerator – the number in the denominator who have a care plan that includes a risk assessment after transfer.

Denominator – the number of people with eating disorders who are moving between services.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local audits of care plans.

Outcomes

a) Proportion of people with eating disorders who have moved between services and did not attend their first meeting or appointment.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local audit of electronic records.

b) Relapse rate of people with eating disorders who move between services.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local audit of electronic records.

c) Service user experience of eating disorder services.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, using patient surveys.

What the quality statement means for different audiences

Service providers (such as specialist inpatient and outpatient eating disorder services, community-based eating disorder teams, services for children and young people, and adult services) ensure that processes are in place between eating disorder services and other services at transfer for risk assessment and monitoring, with ongoing management recorded in the agreed care plan.

Healthcare professionals (such as GPs, case managers or care coordinators within specialist eating disorder services) perform risk assessments when people with eating disorders move from one service to another. At the time of transfer, they communicate the care plan at a recorded meeting with all the services involved and the person and their family or carers, if appropriate. It is clear what will happen during and after transfer of care, with clear roles and responsibilities to all relevant healthcare professionals involved as well as to the person. Risk assessment and monitoring will be highlighted as a key area of concern at transfer.

Commissioners ensure that the services they commission work together at transfer of care to deliver risk assessment and monitoring for people with eating disorders.

People with eating disorders who are moving between services (including from services for children and young people to adult services, inpatient to outpatient services, stepping up or down between intensity of treatments, and moving from one area to another, for example, from home to university) have a risk assessment at the time of transfer. The risk assessment is explained at a meeting, recorded in their agreed care plan and monitored over time. Also clear roles and responsibilities are defined to all relevant healthcare professionals as well as to the person.

Source guidance

Eating disorders: recognition and treatment. NICE guideline NG69 (2017, updated 2020), recommendation 1.1.11

Update information

Minor changes since publication

October 2024: Changes have been made to align this quality standard with the NICE guideline on eating disorders: recognition and treatment. Links and source guidance references have been updated throughout.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal College of Paediatrics and Child Health
- Royal College of General Practitioners (RCGP)
- Beat Eating Disorders