SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement
Optional headings 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	**Out Patient Eating Disorder Service Step 4**
Commissioner Lead	**West Lancashire CCG** [redacted]
Provider Lead	**Lancashire Care Foundation Trust (Laurence Halpin)**
Period	**February 2015 – 31st March 2016**
Date of Review	**September 2015**

1. opulation Needs

1.1 ional/local context and evidence base

- Guidance, Clinical Guideline 9, (NICE 2004): Eating Disorders - Core interventions in the eatment and management of anorexia nervosa, bulimia nervosa and related eating disorders
- ction in numbers of admissions to in-patient Eating Disorder services
- o provide a responsive, appropriate and locally accessible service to patients.
- revention of delay in treatment.
- laborative working with Core Mental health Services and the Eating Disorder service

The maj y of people with eating disorders fall into the following three categories:

1. norexia Nervosa
2. ulimia Nervosa
3. ating Disorder not otherwise specified (EDNOS) which includes Binge Eating Disorder.

2. utcomes

2.1 Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**X**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**X**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**X**
Domain 4	**Ensuring people have a positive experience of care**	**X**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**X**

2.2 Local defined outcomes

3. Scope

3.1 Aims and objectives of service

To limit the physical and psychiatric morbidity, social disability and mortality levels caused by an eating disorder by providing an out patient Eating Disorder service to the population of West Lancashire CCG for complex presentations of eating disorders, supporting Eating Disorder interventions across other services across the stepped care approach, which is NICE guidance compliant.

The service will aim to improve the quality of life and life expectancy for service users by making timely and accurate diagnosis, providing high quality proactive treatment and supporting patients to manage their eating disorder independently.

All relevant agencies in the community (education, youth services, voluntary agencies, social services, primary health care teams) will know how to access help for someone with an eating disorder.

Relevant staff within each agency will have been offered training on early identification and intervention. Those staff will also have a basic understanding of the causes and consequences of eating disorders.

General Practitioners will have access to advice on clinical management within primary health care from Lancashire Care NHS Foundation Trust.

The general public and community agencies will have easy access to information and advice on eating disorders

The eating disorder team will develop Eating Disorders Association support groups within West Lancashire.

Guidelines for dealing with young people with eating disorders in school will have been established and reviewed.

The quality and effectiveness of these interventions will have been evaluated by eliciting the views of service users and relevant agencies.

3.2 Service description/care pathway

This service covers community eating disorder treatments commissioned by West Lancashire CCGs. It does not cover intensive treatments (inpatient and intensive day patient services) commissioned by NHS England.

The Out Patient Eating Disorders Service will target more complex presentations of Eating Disorder which are currently likely to receive a Step 4-level service within the Stepped Care model of mental health service provision (see appendix A). These cases will typically have input and monitoring from a multi-disciplinary team, and be at risk of needing intensive daycare treatment for their eating disorder.

The service will treat and manage anorexia nervosa, bulimia nervosa and related eating disorders using the following therapy methods;

- Cognitive Behavioural Therapy
- Cognitive Analytic Therapy
- Dialectical Behavioural Therapy
- Compassion Focussed Therapy
- Motivationally-Enhanced Therapy

There can be serious and sometimes fatal medical complications such as circulatory problems, gastric problems, and electrolyte imbalance leading to heart failure, infertility, kidney failure, osteoporosis and possibly epilepsy. Mortality is the highest of any mental health problem usually from these medical complications. It can also be as a result of suicide, the rate of which is 200 times greater than in the general population.

Approximately three–quarters of patients with eating disorders can be helped within an outpatient setting alone (Palmer 2000, Nice Guidelines 2004). Patients should expect to have access to local generic Mental Health Services and specialist Provision as required. (NICE 2004)
The primary intervention for these patients is psychological therapy. The NICE guidelines recommend self-help and CBT as a first line intervention for those patients with Bulimia Nervosa and Binge Eating Disorder. For those with Anorexia Nervosa the recommendation is for CAT, Psychodynamic psychotherapy, Family/Systemic Therapy or CBT.

In order to provide a safe effective and co-ordinated service, nutritional and dietetic skills, medical input and administrative support are required.

The staffing requirements are based on the assumptions concerning incidence as above, length and complexity of treatment for all the types of eating disorders and takes into account dropouts and non-attendance.

Links with Primary Care

Responsibility for monitoring of physical health issues related to eating disorders (e.g. bloods, weight) will remain with the GP. GPs will be offered support if needed from the Out Patient service in terms of management advice (such as that in line with Kings College Guidance, see GP Guidance Appendix B). There will be regular written updates to GPs regarding their patients in the service.

Links with Steps 2 and 3 of the Stepped Care Model of Mental Health Services

The Out Patient Service will provide case consultation to Primary Care Mental Health Teams managing mild to moderate eating disorder presentations.

Links with Step 5 of the Stepped Care Model of Mental Health Services

The Out Patient Service will provide case consultation and management advice to local inpatient teams managing admissions where an eating disorder forms part of the clinical presentation, both in terms of dietetic advice and psychologically-informed management plans.

Links with the Lancashire care Eating Disorders Network

The West Lancashire Out Patient Eating Disorder clinicians will link in with the county-wide network of similar specialists and a dedicated Clinical Lead for Eating Disorders, ensuring access to high quality clinical supervision and training opportunities.

Days/hours of operation

9 – 5 Monday to Friday

Referral Process

GP referrals go direct to the eating disorder hub, however will also be forwarded by the Single Point of Access if they are referred via this route. A referral form which includes details of height, weight and relevant history must be completed. The Single Point of Access will determine likely level of severity and signpost to the relevant step of care. See the referral pathway Appendix C.

Response Times

4 weeks from referral to assessment for urgent cases and 12 weeks to assessment for routine.

Discharge Process

For non-CPA cases: review with therapist, discussion in multi-disciplinary team as appropriate and discharge to GP; for CPA cases: CPA meeting and discharge to GP or identified team as appropriate

Training/ Education/ Research Activities

Training and consultation on assessing and managing Eating Disorders for West Lancashire Primary Care Mental Health Teams

3.3 Population covered

In line with the "who Pays" guidance all patients who are registered with a GP in West Lancashire or reside within West Lancashire are eligible for this service.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

The service will accept referrals from the age of 16 with no upper age limit. Age (younger age) and recent onset of presentation are among the indicators of severity and appropriateness of referral to the Out Patient service. The service will be most effective if targeting cases of recent onset with higher risk indicators. It will be possible to offer consultation advice regarding pre 16 year olds within agreed parameters.

The CAMHS/AMHS Transition Protocol will form the basis of transfer of under 16-year olds from Children's Services into the Out Patient Adult Service when needed

Exclusion Criteria

Mild –to-moderate presentations of eating disorders will be treated within step 2/3 services. These services will be supported via consultation by the Out Patient Eating Disorders Service.

This service does not include inpatient care and bespoke packages of care for intensive day care (as an alternative to admission). These are specialised services commissioned by NHS England.

3.5 Interdependence with other services/providers

Close liaison with external providers around more intensive daycare or inpatient needs. Staff to attend CPA meetings to keep up to date with discharge dates and work closely to ensure a smooth transition back to outpatient services. People leaving inpatient services to be picked up by the service on an urgent basis, to be seen by a member of the team within two weeks of discharge or less.

Maintaining close working relationships with GPs involved in medical monitoring and management of service users, offering consultancy and training as required.

To form links with acute hospitals as per MARSIPAN guidance to improve patient experience when admitted for medical complications of their eating disorder.

To liaise with NHS Staffordshire and Lancashire Commissioning Support Unit to ensure appropriate referrals to the service are not placed elsewhere.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

http://www.nice.org.uk/nicemedia/live/10932/29218/29218.pdf

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

This service should adhere to all relevant standards, guidelines and local formulary. The service should notify commissioners should any benchmarking against these standards identify gaps in commissioned services.

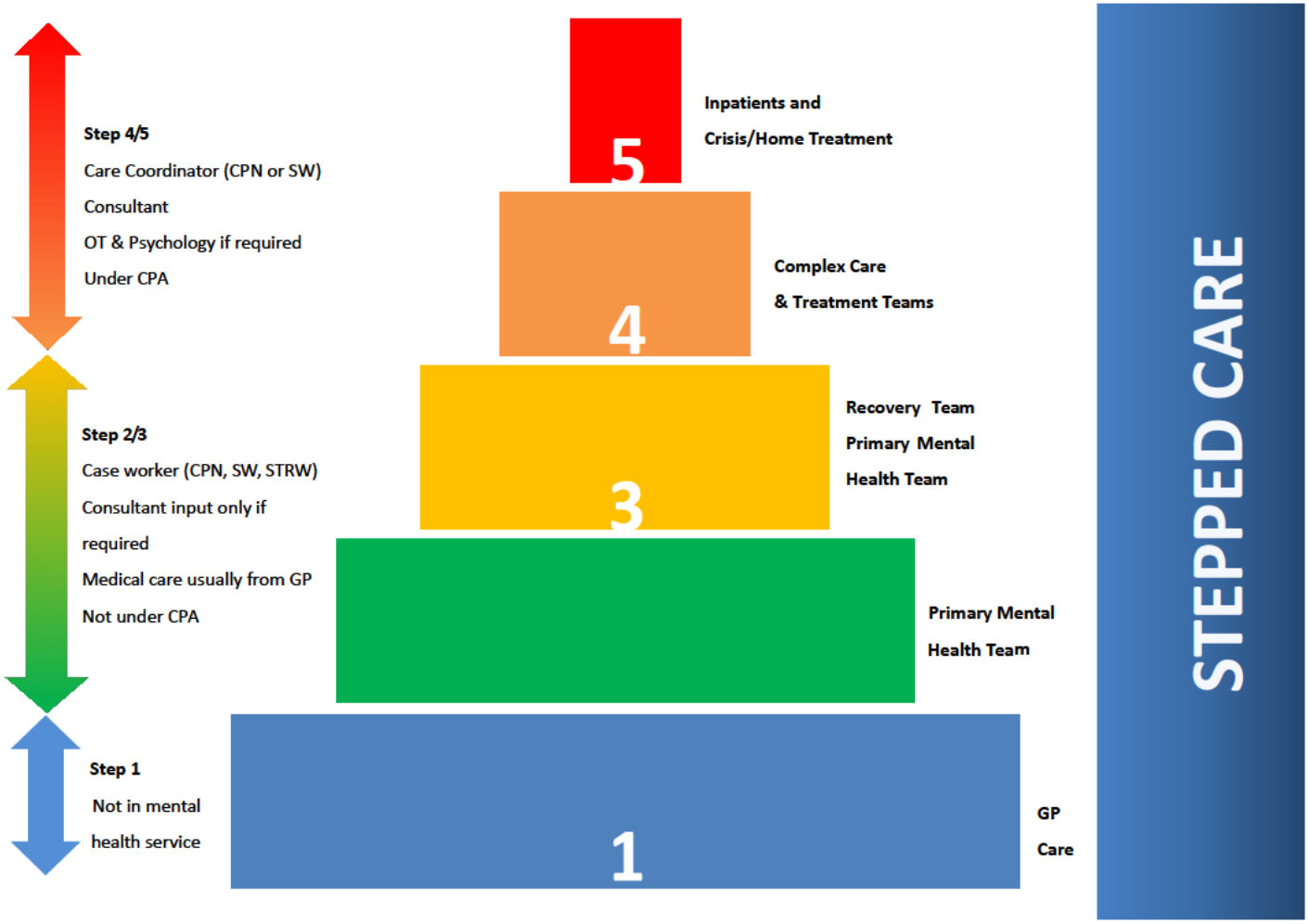
5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

See Appendix D

5.2 Applicable CQUIN goals (See Schedule 4 Part E)
6. Location of Provider Premises
The Provider's Premises are located at: The Provider's Premises are located at Bickerstaffe House, Ormskirk & General District Hospital, Wigan Road, Ormskirk, L39 2JW, however LCFT with work with the CCG to establish alternative locations across West Lancashire in suitable community settings.
7. Individual Service User Placement

APPENDIX A


Step 4/5
Care Coordinator (CPN or SW)
Consultant
OT & Psychology if required
Under CPA
5
Inpatients and
Crisis/Home Treatment
4
Complex Care
& Treatment Teams
Step 2/3
Case worker (CPN, SW, STRW)
Consultant input only if
required
Medical care usually from GP
Not under CPA
3
Recovery Team
Primary Mental
Health Team
Primary Mental
Health Team
Step 1
Not in mental
health service
1
GP
Care
STEPPED CARE

APPENDIX B

KING'S College LONDON
Section of Eating Disorders
Institute of Psychiatry
Eating Disorders Unit
South London and Maudsley NHS Foundation Trust

A GENERAL PRACTITIONER'S GUIDE TO EATING DISORDERS

What are eating disorders?
What is my caseload?
How may a patient with an eating disorder present?
When should I be worried about someone's loss of weight?
What questions should I ask?
What signs and symptoms should I look out for in someone with severe weight loss?
What signs and symptoms should I look out for in someone who is bingeing, vomiting or abusing laxatives?
What should I look out for in the physical examination?
What investigations should I consider?
What abnormal results might I expect?
How can I manage someone with anorexia nervosa in the practice?
How can I manage someone with bulimia nervosa in the practice?
Are there any special circumstances that I should know about?
When should I refer to the psychiatric services?
Where can I get further help?

What are eating disorders?

Eating disorders are a range of illnesses characterised by psychological and behavioral disturbances associated with food and weight. Traditionally there are three main types:

- Anorexia nervosa
- Bulimia nervosa
- Obesity

Viewed as a spectrum:
Adolescent preoccupation ..... Dieting ..... Eating disorders with food and weight

What is anorexia nervosa?

Triad of:
1. Weight, measured as Body Mass Index (BMI) < 17.5kg/m2 due to controlled eating.
2. Distorted body image and abnormal attitudes to food and weight.
3. Amenorrhoea and often other signs of starvation.

What is bulimia nervosa?
Triad of:
1. Binge eating real or perceived excessive amounts of food with loss of self-control.
2. Desire for thinness and preoccupation with food and weight.
3. Strategies aimed at weight reduction – vomiting, laxative and /or diuretic abuse, excessive exercising

What is binge eating disorder?
Binge eating real or perceived excessive amounts of food with loss of self-control.
No use of extreme weight control strategies therefore often associated with obesity.

What is my case load?
On your list you are likely to have:
• 1-2 patients with anorexia nervosa
• 18 patients with bulimia nervosa
• About 5-10 per cent of the adolescent girls in your practice will have used weight-reducing
techniques other than dieting, i.e. vomiting, laxative or diuretic abuse, excessive exercising.
4 per cent of younger women will have an eating disorder in their lifetime.
Women with eating disorders outnumber men by 10 to 1.

What outcome should I expect?

30 per cent of cases of anorexia nervosa have a chronic course. The morbidity and mortality of this group is considerable.

Patients who have suffered with anorexia/bulimia nervosa for than 20 years stand a 20 per cent chance of dying from their illness, either by suicide or emaciation

How may a patient with an eating disorder present?
Eating disorders can present in a wide variety of ways and it may be the patient or a member of her family who first expresses concerns.

Physical
1. Loss of weight
2. Amenorrhoea
3. Other physical complications
Psychological
1. Low mood
2. Anxiety/irritability
3. Obsessional symptoms, particularly related to food and weight

Social
1. School or work problems
2. Problems in the family and /or with relationships
3. Arrests (usually for stealing) or other police contact

When should I be worried about someone's loss of weight?
In assessing someone's weight loss, the Body Mass Index (BMI) is a useful tool as shown below.

BMI = weight in kg / (height in m)2
However on its own, this is insufficient and we have a short risk assessment tool, available to download from www.eatingresearch.com , on the for health professionals page.

Aside from weight loss, there is a range of questions that you may want to ask someone who you suspect has an eating disorder to further clarify the diagnosis and to plan management.

What questions should I ask?
The SCOFF questionnaire was developed by John Morgan at Leeds Partnerships NHS Foundation Trust to aid early detection of eating disorders and is available to download from www.eatingresearch.com on the for health professionals page.

1. Eating and anorexic behavior
• Do you avoid eating with others?
• Which foods feel 'safe' and what do you avoid?
• Do you ever vomit, exercise, abuse laxatives and /or diuretics? If so how much and when?
• Do you ever lose control or binge? How often and what do you eat?

2. Eliciting psychopathology
• What do you think of your current weight?
• What do you see as your ideal weight?
• How would you feel if you were the normal weight for your height?
• How much of the day do you spend thinking of food and your weight?
• Do you ever get depressed or guilty? Do you ever feel suicidal?
• Has your life become more ritualised?
• Do you have compulsions to do things e.g. binge, over exercise?

3. Screening of Important physical symptoms
• When was your last period?
• Have you noticed any weakness in your muscles? What about climbing stairs or brushing your hair?
• Are you more sensitive to the cold than others?
• What is your sleep like?
• Have you fainted or had dizzy spells?
• Have you problems with your teeth (hot/cold sensitivity etc) ?
• Have you had any problems with your digestive system?

What signs and symptoms should I look out for in someone with severe weight loss?
1. Reproductive function: loss of menstruation, fertility and pregnancy difficulties.
2. Musculoskeletal: myopathy particularly of the limb girdle muscles, pathological fractures, teeth problems.
3. Cardiovascular: palpitations, syncope, postural & resting hypotension, bradycardia.
4. Renal: nocturia, renal stones, acute failure.
5. Skin and hair: loss of head hair, increase in body hair, dry skin, acrocyanosis, chilblains.
6. Metabolic: hypoglycaemia, liver dysfunction, hypercholesterolaemia, hypothermia.
7. Gastrointestinal: delayed gastric emptying, constipation.
8. Central nervous system: poor concentration, difficulty in undertaking complex thought

What signs and symptoms should I look out for in someone who is bingeing, vomiting or abusing laxatives?

1. Gastrointestinal tracts: teeth, salivary gland hypertrophy, upper and lower intestinal tract bleeding, abdominal distension, constipation.
2. Renal: oedema, dehydration, stones, failure.
3. Cardiovascular: dysrythmias, postural hypotension.
4. Central nervous system: tetany, fits.
5. Metabolic: dehydration, hypokalaemia, hyponataemia.
6. Drug effects: caffeine, slimming tablets such as diethylpropion, amphetamines and ecstasy can be abused.

What should I look out for in the physical examination?

• Skin for lanugo hair, Raynaud's, chilblains, callus on hand, self mutilation.
• Mouth for teeth protheses, loss of enamel, abrasions.
• Lying and standing blood pressure for dehydration and reduced autonomic nervous system function.
• Ability to rise from a squat for proximal myopathy.

What investigations should I consider?
What abnormal results might I expect?

Blood chemistry: urea and electrolytes are usually sufficient unless there are other indications.
Potassium <3.5mmol/l – vomiting or laxative abuse
Bicarbonate >30mmol/l – vomiting
Bicarbonate <18mmol/l – laxative abuse
Blood count: may be helpful if low weight.
Anaemia (Hb 9-12g/100ml – usually normochromic normocyctic)
White cell count 2-4 x 10/l
Platelet deficiency (rare)
ESR normal
Urinary drug screen:
Laxative abuse

How can I manage someone with anorexia nervosa in the practice?

• **Step 1: Establishing the therapeutic relationship**

1. Help to move the patient into the position where they are interested in considering change (usually people with anorexia nervosa do not want to change but may have been advised to come from family, friends or work colleagues.
2. A motivational interviewing approach can help with patient's ambivalence about change. See downloadable information on www.eatingresearch.com
3. Offer an expert resource about starvation effects, nutrition and eating disorders. Books for patients and carers are available – see the resources listing on www.eatingresearch.com Information is also available on websites listed on the site.
4. Counseling of other issues – eg relationship problems, perfectionist, rigid and anxious traits.
5. Information sharing with carers can be invaluable and should be encouraged even if the index case herself will not come. See www.eatingresearch.com for resources for carers.

• **Step 2: Focus on establishing nutritional health and managing the risk of malnutrition**

Weigh the patient regularly and chart the progress.

Give dietary advice – healthy diet, trial of 'safe' and 'unsafe' foods.
See www.eatingresearch.com for downloadable resource about risk management.

• Step 3: Family work

1. It is helpful to include the family in any plan about treatment especially in younger patients. Parents need information and knowledge about eating disorders. See www.eatingresearch.com for resources for carers.
2. Relatives need to be clear about treatment goals.
3. Educating the parents - anorexia is an illness and is not caused by stubbornness on the part of the patient.
4. Parents need to be firm, consistent and empathic.
5. Teaching parents reflective listening and motivational interviewing skills can be helpful. See www.eatingresearch.com

How can I manage someone with bulimia nervosa in the practice?

There are self-treatment books and CDs on CBT treatment available. See for health professionals and resources pages on www.eatingresearch.com.

• Step 1: Focus on regular eating

1. Aim to eat three regular meals per day, which reduces the urge to binge.
2. Aim for a diet with low glycaemic index food to keep blood sugar levels constant.
3. Gradual goals to minimise weight-reducing behaviors (vomiting, laxatives, etc).
4. Education as to medical consequences of weight reducing behaviors and the fact that the brain becomes addicted to food (and other substances) if there is (a) starvation (b) intermittent consumption of high sugar/fat food (c) stress (d) vomiting.
5. Advice as to healthy balanced diet.

Step 2: Establishing the therapeutic relationship

1. Aim for a collaborative approach to the disturbed behavior.
2. Acknowledge that there will be many relapses and difficulties on the path to regular eating.
3. Counselling of other issues – eg sexual abuse, relationship problems, alcohol and/or drug abuse.

Step 3: Specific strategies

1. Keeping food diaries.

These are the mainstay of help in bulimia nervosa (see example on the next page). It may take weeks for the patient to be able to do this because it is often difficult to confront painful reality.

Time	Food and liquid consumed	Place and circumstances/how I felt before	Bingeing/vomiting/laxative use	How I felt after
7.45	3 bowls of cereal and mike	Kitchen, felt worried about the day and felt fat	Binged/vomited in the toilet/took 10 laxative tablets	Depressed. Bound to be a terrible day. I'm not going to eat anything else all day
9.45	Apple	Office at work felt hungry but not panicky	None	Guilty & depressed because I wasn't going to eat anything all today

2. Behavioral Strategies
Using the diary, the patient should be encouraged to see her behavior and how she may change this, eg:
• Decide that she will try not to vomit before 9am, and then 10am, etc.
• Decide on certain foods that feel 'safe' and eat those at times that feel more difficult.
• Plan to do something immediately after eating to take her mind off vomiting.
• Decide before she starts eating how much she is going to eat and try to stick to that.
• Only keep so much food in the house.
• Only go shopping with preplanned lists and limited money and avoid the sight and smell of highly palatable foods when hungry.
3. Cognitive approaches
• Identify beliefs (using the diary), eg 'if I eat a chocolate bar I will put on a stone', and underlying assumptions, eg 'all people who are fat are worthless'.
• Challenge beliefs by discussion and support from literature.
• Change beliefs by consistent approach.

Are there any special circumstances that I should know about?
1. Medication
In anorexia nervosa, medication does not usually help associated symptoms of anxiety and/or depression. These will lift as the patient's weight improves. In bulimia nervosa, antidepressants, especially 5HT reuptake inhibitors, can be helpful in the short term. Suppression of symptoms rather than abstinence is out come but compliance is likely to be erratic and there is a possible risk of overdose in this patient group.
2. Compulsory admission
If a patient is severely ill, particularly with medical complications or suicidal ideation, as described above, inpatient treatment may be needed to save a patients' life.
Rarely the patient will have lost insight into the severity of her illness and will resist inpatient
treatment. In these circumstances the Mental Health Act will need to be used, and a Section 3 (Treatment Order) will probably be the most appropriate.
3. Pre-adolescent anorexia nervosa
Anorexia nervosa can occur in children even as young as 7 or 8 although this not very common. In such cases, failure of growth or weight gain rather than loss of weight is seen and specialist advice should be sought early.
4. Anorexia nervosa in males
When this does occur, it often presents with excessive exercising and a desire for 'healthiness'. The prognosis is worse than for females but that may be because they are diagnosed later.

When should I refer to the psychiatric services?
Indications for urgent referral to psychiatric services include:
1. Medical complications
(see www.eatingresearch.com downloadable resources on the for health professionals pages).
2. Psychological complications:
• Moderate to severe depression, especially with suicidal ideation.
• Uncertainty about the diagnosis.
• Complicating factors, eg associated substances or alcohol abuse.
3. Failure of current management.
4. Diagnostic uncertainty.

Where can I get further help?

1. Local Psychiatric Service

In you local district here may be one consultant who has a special interest in eating disorders.

2. Specialist Eating Disorders Unit

This may be a national or a regional centre.

3. beat (formerly the Eating Disorders Association)

This is a nationwide organisation that offers a number of services including telephone advice, self-help groups, family groups and individual counseling, training courses and information on service provision. www.b-eat.co.uk.

Reference List

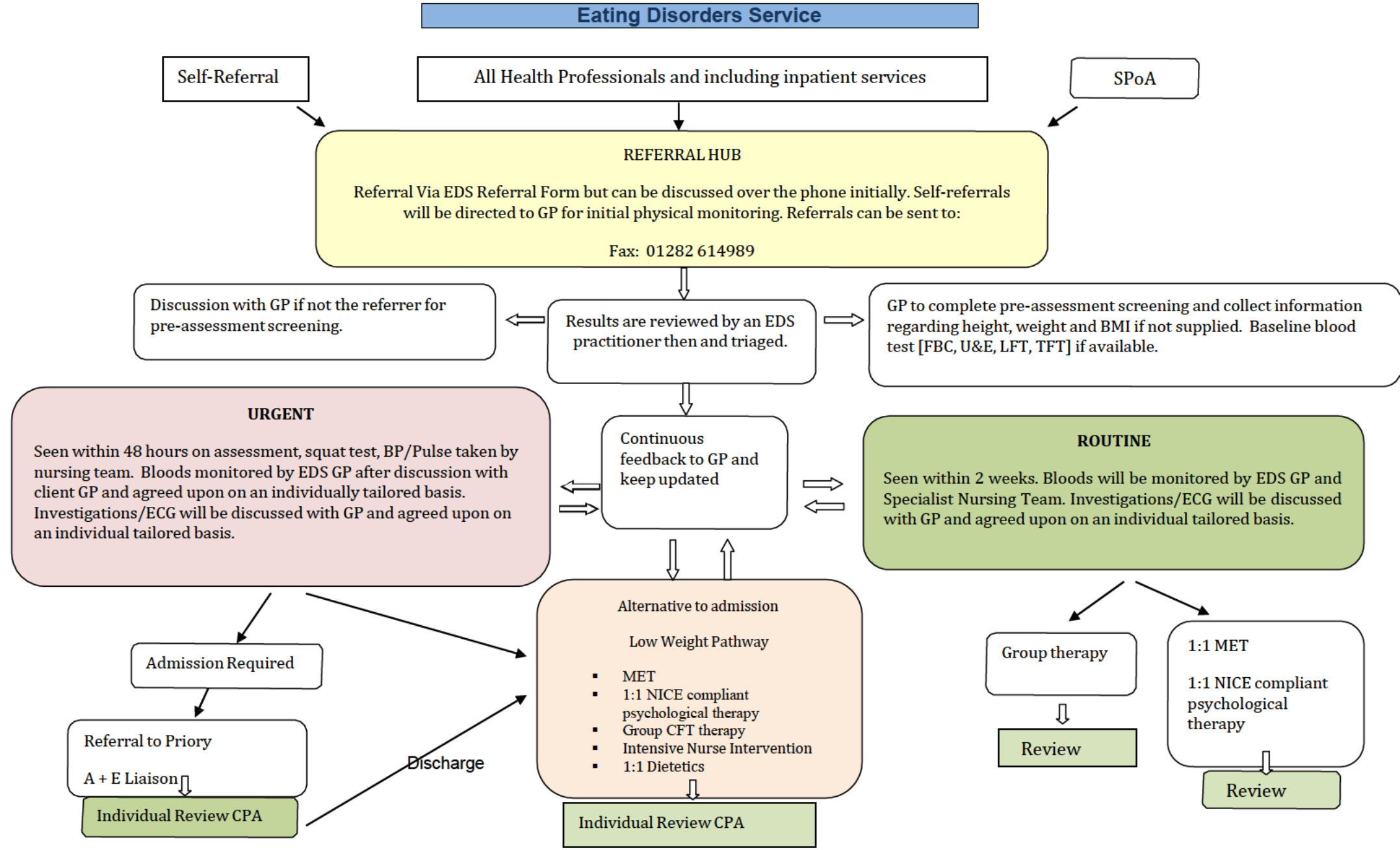
Cotton MA, Ball C & Robinson P (2003). Four simple questions can help screen for eating disorders. J Gen.Intern.Med., 18, 53-56.

Luck AJ, Morgan JF, Reid F, O'Brien A, Brunton J, Price C, Perry L & Lacey JH (2002). The SCOFF questionnaire and clinical interview for eating disorders in general practice: comparative study. BMJ, 325, 755-756.

Morgan JF, Reid F, & Lacey JH (1999). The SCOFF questionnaire: assessment of a new screening tool for eating disorders. BMJ, 319, 1467-1468.

Perry L, Morgan J, Reid F, Brunton J, O'Brien A, Luck A, & Lacey H. (2002). Screening for symptoms of eating disorders: reliability of the SCOFF screening tool with written compared to oral delivery. Int J Eat Disord., 32, 466-472.

APPENDIX C


Eating Disorders Service
Self-Referral
All Health Professionals and including inpatient services
SPoA
REFERRAL HUB
Referral Via EDS Referral Form but can be discussed over the phone initially. Self-referrals will be directed to GP for initial physical monitoring. Referrals can be sent to:
Fax: 01282 614989
Discussion with GP if not the referrer for pre-assessment screening.
Results are reviewed by an EDS practitioner then and triaged.
GP to complete pre-assessment screening and collect information regarding height, weight and BMI if not supplied. Baseline blood test [FBC, U&E, LFT, TFT] if available.
URGENT
Seen within 48 hours on assessment, squat test, BP/Pulse taken by nursing team. Bloods monitored by EDS GP after discussion with client GP and agreed upon on an individually tailored basis. Investigations/ECG will be discussed with GP and agreed upon on an individual tailored basis.
Continuous feedback to GP and keep updated
ROUTINE
Seen within 2 weeks. Bloods will be monitored by EDS GP and Specialist Nursing Team. Investigations/ECG will be discussed with GP and agreed upon on an individual tailored basis.
Admission Required
Referral to Priory
A + E Liaison
Individual Review CPA
Discharge
Alternative to admission
Low Weight Pathway
MET
1:1 NICE compliant psychological therapy
Group CFT therapy
Intensive Nurse Intervention
1:1 Dietetics
Individual Review CPA
Group therapy
Review
1:1 MET
1:1 NICE compliant psychological therapy
Review

APPENDIX D

Quality Requirements

Activity Performance Indicators	Threshold	Method of measurement	Report Due
Number of new referrals	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Source of referrals to the service	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Numbers of clients on caseload	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Number of clients receiving 1:1 contact	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Number of clients receiving group therapy	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Access to service - waiting time from referral received to clients first attendance	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Number of re referrals	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Number of inappropriate referrals and source	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Number of clients discharged from service	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Diagnosis	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Median length of treatment	100%	Quarterly report	Quarterly report from Service Manager to include this information.
DNA rates total and %	100%	Quarterly report	Quarterly report from Service Manager to include this information.
% Staff vacancy rate (difference between staff in post and budgeted establishment)	100%	Quarterly report	Quarterly report from Service Manager to include this information.
% Staff sickness rates	100%	Quarterly report	Quarterly report from Service Manager to include this information.

SUIs – number of SUIs	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Number of complaints and compliments received	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Service User Experience An evaluation survey is offered to all attendees - Survey offered to 100% of patients and a return rate of greater than 15%	100%	Quarterly report	Quarterly report from Service Manager to include this information.
Breakdown of service users engaging with service from local population in terms of: Age, Ethnicity, Gender	100%	Quarterly report	Quarterly report from Service Manager to include this information