National Specification for the Care and Treatment of Eating Disorders in Scotland Consultation

October 2023

Scottish Government
Riaghaltas na h-Alba

National Specification for the Care and Treatment of Eating Disorders in Scotland Consultation

Overview

We want to hear your views on the draft National Specification for the Care and Treatment of Eating Disorders in Scotland. Answering the questions below will help us refine the Specification.

Background Summary

The National Review of Eating Disorder Services was commissioned in 2020 and published its final report in 2021. This report contained 15 recommendations which were split by short, medium and longer term:

- **Short Term Recommendations** are: 1, Covid-19 Response; 2, Implementation Planning; 4, Lived Experience Panel; 6, Self-Help Resources; and 13, Families and Carers.
- **Medium Term Recommendations** are: 3, Co-ordination of National Activity; 8, Primary Care; 9, Medical Care; and 12, Education and Training.
- **Longer Term Recommendations** are: 5, Public Health; 7, Early Intervention; 10, Specialist Care; 11, Workforce Planning; 14, In-patient Care; and 15; Research.

In August 2021, the National Review of Eating Disorder Services Implementation Group (Recommendation 2) was established and met for the first time to develop the early approach for taking forward the recommendations from the National Review. A priority area for Members was to develop a specification for eating disorder care and treatment in Scotland.

Context

The National Specification for the Care and Treatment of Eating Disorders in Scotland was developed in response to the National Review of Eating Disorder Services (2021). Engagement with individuals with experience of an eating disorder, their families, and clinicians indicated several areas of concern which led to the development of this Specification. In addition, the Scottish Intercollegiate Guidelines Network (SIGN) Guidelines (SIGN 164 for Eating Disorders) and the Medical Emergencies for Eating Disorders (MEED) have informed their development ensuring evidence based advice for best practice.

We recognise that the Specification is ambitious and will require time to fully implement. We also acknowledge that it must complement other ongoing and interlinking work, such as the creation of the National Care Service (NCS) and the findings from the recently published Mental Health Law Review.

Development of the Specification

Through the work of the National Review of Eating Disorder Services Implementation Group, a working group was established to take forward the development of the Specification. The Working Group consisted of a wide range of clinicians, academics, healthcare professionals and people with lived/living experience who offered their professional and personal expertise. The Group developed the Specification using current research evidence and the feedback gathered by the National Review of Eating Disorder Services during which people with lived/living experience were engaged extensively.

In addition, an Eating Disorder Lived Experience Panel has been established, following Recommendation 4 of the National Review of Eating Disorder Services, which has also provided feedback via Panel discussions.

Structure of the Specification

The Specification has been shaped around overarching principles that people with living/lived experience, their families or carers were consulted on, and are aligned with quality healthcare provision (person-centred, safe, effective, equitable, timely, efficient, and supportive relationships). The outcomes are:

- Leadership and Governance
- Service Structure
- Access to Care
- Supporting People with Co-occurring Considerations and Comorbidities
- Assessment and Medical Monitoring
- Transitions
- Discharge
- Education and Training
- Shared and Supported Decision Making

Each section presents the rationale behind the outcome; describes the outcome in action; explains what a person receiving care can expect; clarifies what the outcome means for staff members and the provider; and gives practical examples of how these can be achieved.

This Specification sits within the context of the Core Mental Health and Wellbeing Standards and the National Specification for the Delivery of Psychological Therapies and Interventions in Scotland. It is our intention to ensure that the final version of the Specification aligns with the format and contents of these two documents. Furthermore, we aim to develop a version for patients and their families.

Access and Equalities

A key priority in developing this Specification has been addressing the inequalities in outcomes and experiences for people accessing eating disorder treatment. We know that access to, and experience of eating disorder care and support is not experienced equally across the population.

We want the Specification to support equitable access to eating disorder treatment, as well as equity in the experiences and outcomes of people using services. This is a key focus of our consultation on the Specification.

We acknowledge that as we continue to shape the Specification, there is more we need to do in terms of listening to and learning from people and member-led organisations. In addition, we are undertaking an Equalities Impact Assessment (EQIA) and are using the findings from this to inform our engagement.

Groups of people who experience inequalities include those with protected characteristics such as sex, gender, sexual orientation, race and ethnicity, and disability. Often these are the same groups in the population that are systematically disadvantaged in many different aspects of their lives. We also know that some people with neurodivergent differences will experience a higher risk of poorer physical health and mental health and difficulty accessing the right support.

In addition, individuals living in the most deprived areas report higher levels of common physical health, mental health problems and mental ill health (including suicidal behaviour), with lower levels of wellbeing than those living in the most affluent areas. People can also experience disadvantage due to adverse childhood events such as being a victim of abuse, poor housing, traumatic events, and poor working conditions. These groups have poorer health and mental health than others and face greater barriers in getting help.

We also know that people with severe and enduring mental illness are themselves more likely to experience poverty, homelessness, incarceration, social isolation and unemployment. They are also at greater risk of poor physical health and reduced life expectancy.

Therefore, it is important that inequality is not only considered in terms of single characteristics or experiences. In reality, people's lives are multi-dimensional and complex. We all have distinct experiences of inequality that need to be understood. This is known as “intersectionality”.

Measurement

A key aim of the Specification is to be measurable and to provide assurance that services are delivering for the people that use them. Making the Specification measurable will allow us to understand how they are being implemented and whether they are being met. It will also make it easier for good practice to be shared and for any issues to be identified and addressed, therefore driving improvement in services.

We will work with partners to ensure that we can measure progress against the Specification. We will carry out this work in co-ordination with the implementation of the Core Mental Health and Wellbeing Standards, the National Specification for Psychological Therapies and Interventions, and the development of the National Care Service (NCS). This will ensure that our approach to data and measurement across mental health is joined up, making best use of the data we already collect and minimising the burden on services.

How you can help us / our next steps

In this consultation, we have asked a number of questions about the Specification. On pages 6 to 48, you can find a copy of the draft Specification in its entirety.

Part One of the consultation asks questions about the Specification as an entire document.
Part Two and **Three** ask questions on specific outcomes, and for your thoughts on how we might measure these.

If your time is limited, you may focus on **Part One** of the consultation which contains seven questions. Answering these questions will allow you to feedback on the Specification overall, and includes a space for you to include any additional comments.

Part Two of the consultation consists of more detailed questions on each Outcome.

Part Three asks more detailed and technical questions to gather opinions about how we can support services in order to implement the Specification and how we plan to measure their implementation. This part of the consultation may be most relevant to people who have experience working in, or running services, but we welcome everyone's views.

The views you express will be carefully considered, whether you answer all of the questions or only some of them. In order to show what people have said, a summary will be published of all the responses. We aim to publish the final version of the Specification in early 2024.

Mental Health and Wellbeing Support

People are invited to share their experiences of the eating disorder care and treatment they have received. However, we understand that sometimes it can be hard to talk or write about these experiences, whether your own or someone else's.

It is up to you to decide what questions you want to answer during the consultation. There is no need to respond to them all.

If you are affected by any of the issues covered in this document and need support, help is available:

- Beat – Phone 0808 801 0432
- NHS24 – Phone 111
- Breathing Space – Phone 0800 83 85 87
- NHS24 – Phone 111
- Mind To Mind
- National Trauma Training Program

National Specification for the Care and Treatment of Eating Disorders in Scotland

This part of the document is the draft Specification.

We know that currently not everyone has the same experiences or outcomes when they access services that provide eating disorder treatment. We want the Specification to help make sure that services meet your needs whoever you are and whatever your background.

Introduction

Eating disorders are serious mental health conditions that involve abnormal eating behaviour and preoccupation with food, accompanied in most instances by prominent body weight or shape concerns (ICD-11, 2022). Eating disorders can have a significant impact on an individual's physical health, psychological wellbeing and associated functioning. ICD-11 classification (2022) includes several eating disorder categories including Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), and Other Specific Feeding and Eating Disorders (OSFED). It is estimated that around 1.25 million people in the UK have an eating disorder (Beat, 2022).

Background

The National Specification for the Care and Treatment of Eating Disorders in Scotland has been developed in response to the National Review of Eating Disorder Services (2021), with a working group forming to develop them (see Appendix 2 for membership of the group). The aim of the National Review was to provide an overview of the current system of support for people with eating disorders, and their families and carers in Scotland. This built upon a previous report by the Mental Welfare Commission for Scotland (2020) which included a mapping of national eating disorder service provision. A significant number of stakeholders contributed to the review including individuals with experience of an eating disorder, their families, and clinicians. People with living/lived experience noted that while many services provide excellent care, there are areas for development and improvement:

- it can take a long time to access care
- people can experience barriers to accessing the right treatment
- people experience a postcode lottery with variability in services across the county
- people often experience the transition between child and adolescent services and adult services as being very difficult
- there appears to be a focus on services for Anorexia Nervosa and people with other eating disorders may find it difficult to access appropriate treatment

- carers do not always feel well informed or included in treatment, especially in adult services, even though they provide significant support

National Review of Eating Disorder Services (2021)

The National Review of Eating Disorder Services (2021) identified two main issues: lack of consistency in service provision, and confusion as to whether physical health monitoring was the responsibility of General Practitioners (GPs) or eating disorder services. It was also identified that more training was needed for healthcare professionals to enable earlier detection, prompt referral, and appropriate treatment. (National Review of Eating Disorder Services, 2021). These findings were mirrored by the Mental Welfare Commission for Scotland (2020) who also noted the impact eating disorders can have on the whole family; concern about services using Body Mass Index (BMI) alone as a criterion for access to services; and inequalities in the national provision of eating disorder services.

In parallel to these national reports on eating disorder care, there have been two further prominent published guidelines that have informed the national specification for eating disorder care and treatment. The Scottish Intercollegiate Guidelines Network (SIGN) Guidelines for Eating Disorders (2022) provides recommendations based on the evidence for best practice in the management of people with eating disorders of all ages and gender groups, in any health or social care setting. The Medical Emergencies for Eating Disorders (MEED; 2022) provides comprehensive guidance on the recognition, assessment, and management of all eating disorders that people can present with as a medical emergency. Both documents are referenced throughout the Specification.

The Specification should be read alongside relevant legislation, policies, national health and well-being standards and health, and social care standards including:

- Mental Health and Wellbeing Strategy (Scottish Government, 2023) [Available from: Scotland's Mental Health and Wellbeing: Strategy (www.gov.scot)]

- National Health and Wellbeing Outcomes Framework (Scottish Government, 2015) [Available from: https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/]

- Health and Social Care Standards: My support, my life. (Scottish Government, 2018) [Available from: Health and Social Care Standards: my support, my life - gov.scot (www.gov.scot)]

- Getting it Right for Every Child (GIRFEC National Practice Model) (Scottish Government, 2016) [Available from: https://www.gov.scot/publications/girfec-national-practice-model/]

- The Promise (Independent Care Review. The Promise. 2020 [cited 2021 Nov 1]; Available from: https://www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf]

- Realistic medicine, (Scottish Government 2016) [Available from: https://www.gov.scot/publications/chief-medical-officers-annual-report-2014-15/]

Implementation and Quality Assurance

The Specification supports national consistency in the delivery of eating disorder treatment. It has been developed to support local implementation by services, for example, to reflect local models of delivery and partnership working.

Each outcome within the Specification includes a section that outlines examples of evidence of achievement, and what it means for organisations and staff. These have been included to support internal quality assurance against the outcome. The Specification can also be used to inform organisational self-evaluation and improvement.

It is recognised that some elements of the Specification will involve structural changes to services. It is therefore recommended that implementation occurs over a five-year period and is supported by the National Eating Disorder Network, the development of which has been recommended by the National Review of Eating Disorder Services (2021). This will enable national learning and cross service support on the practical implementation of the Specification in a phased and planned manner.

What the Specification Covers

The Specification outlines a national baseline of eating disorder service provision for the delivery of person-centred, safe, and effective care. It focuses on an optimal model of delivery to improve access to treatment, care, and support. The Specification applies across all levels of service provision from community outpatient teams to more intensive services, including inpatient and day services and the independent sector.

Who the Specification Applies To

The Specification applies to the full developmental range of individuals who may present with eating disorders including children, young people, adults, and older adults. It also incorporates the full range of ICD-11 eating disorder presentations including AN, BN, BED, and Avoidant Restrictive Food Intake Disorder (ARFID) (ICD-11, 2022).

The Specification also includes ARFID, characterised by either: avoidance or restriction of food resulting in significant weight loss; clinically significant nutritional deficiencies; dependence on oral nutritional supplements or tube feeding; compromised physical health; or significant impairment in functioning (ICD-11, 2022). ARFID is not underpinned by a preoccupation with body weight or shape and as a result, is classified as a Feeding Disorder in ICD-11. However, it has been included in the Specification as it is recognised that the expertise of eating disorder professionals may be required to support comprehensive multi-agency treatment pathways in collaboration with a range of other organisations and services to provide the support required to meet patients' needs. This is a position mirrored by SIGN (2022), the National Review of Eating Disorder Services (2021), and MEED (2022).

Principles and Values

The Specification is underpinned by principles and values aligned with quality healthcare provision.

- Person-centred. Providing care that is responsive to individual personal preferences, needs, and values and assuring that patient involvement/ engagement guides and informs all clinical decisions (Healthcare Quality Strategy, NHS Scotland, 2010). The Specification supports patients to uphold their rights, for example through active engagement of individuals with lived/living experience in the design and evaluation of eating disorder services. The Specification has been informed by living/lived experience feedback from the National Review of Eating Disorder Service (2021).

- Safe. Patient safety is fundamental to the delivery of eating disorder treatment and care. Safe treatment for eating disorders addresses all aspects of the illness including physical, psychological, nutritional, and functional. The service structure and underlying protocols and pathways play an essential role in the delivery of safe care.

  Several patients' deaths and other near-miss incidents have occurred following transfer between services at all levels. This includes child to adult mental health services, between two inpatient units, between medical units and specialist inpatient services, and between primary and secondary care (MEED, 2022). Similarly, transitions have been highlighted by stakeholders in the National Review of Eating Disorder Services (2021) as being particularly problematic. This led to the SIGN Guidelines for Eating Disorders (2022) to develop specific recommendations on managing transitions to supplement the existing Royal College of Psychiatrists (2017) Transition Guidelines for Patients with Eating Disorders.

  An aim of the Specification has therefore been to reduce and prevent gaps in care via the provision of clear protocols and service agreements where essential transitions take place (e.g., differing levels of intensity of service provision within eating disorder services) and to change service structure to minimise unnecessary transitions where possible. The National Review of Eating Disorder Services (2021) called for the development of all age eating disorder services across Scotland, an aspiration which has been incorporated into the Specification.

- **Effective.** The recommendations within the Specification are underpinned by scientific knowledge and include the provision of evidence-based interventions as recommended by SIGN (2022) and MEED (2022). The use of person-reported outcomes should be implemented in parallel with the national specification, following guidance by the National Eating Disorder Network.

- **Equitable**. Equitable healthcare involves providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, or socio-economic status. Stakeholders in the National Review of Eating Disorder Services (2021) and the Mental Welfare Commission (2020) report described variability in the availability of services, referring to a "postcode lottery". The Specification aims to reduce this variability while acknowledging the diverse population needs of Scotland and the need for responsive implementation aligned with local models of delivery and partnership working.

- **Timely**. The need for early identification and intervention has been reinforced by the SIGN Guidelines for Eating Disorders (2022) which highlighted the potential accumulation of harm that can take place during an untreated eating disorder. This is partly a consequence of many eating disorders being more likely to develop during adolescence and early adulthood, a sensitive period for brain development (Schmidt, et al., 2016) and a time when an eating disorder can have a significant impact on physical health, social functioning, and educational attainment (Allen, et al., 2020). Treatment outcomes appear to be best during the first three years of illness (Treasure et al., 2015), yet most individuals do not access treatment for their eating disorder until many years after they first develop symptoms, if they access treatment at all (Allen, et al, 2020). SIGN (2022), highlights that our current NHS systems and pathways can compound delays in accessing treatment. Therefore, this Specification will support timely access to specialist eating disorders services, reduce barriers to care, and promote a culture of proactive engagement.

- **Efficient**. An efficient approach to eating disorder care and treatment is aligned with early intervention due to the significant impact this can have on health care use, psychological wellbeing, and quality of life. Initial evidence from First Episode Rapid Intervention for Eating Disorders (FREED) a service model designed to give young people rapid access to evidence-based treatment for eating disorders, suggests that the proportion of FREED patients that went on to require day or inpatient admissions was lower than typical service delivery models, giving cost savings (Allen et al., 2020, Austin et al., 2022; Fukutomi et al., 2020). This is replicated by international modelling analyses that have highlighted the long-term savings from early intervention for eating disorders (Butterfly Foundation, 2014; Bode et al., 2017).

  Efficiency is also aligned with minimising duplication and reducing repetition. The ethos underpinning the Specification has been to change service structure to minimise unnecessary transitions and where possible to reduce obstacles in accessing specialist care e.g., unnecessary gatekeeping and/or multiple assessment processes leading to repetition of a patient’s story.

- **Supportive relationships**. The Specification recognises the impact that eating disorders can have on the support networks around an individual including friends, family, and carers and the essential supportive function that extended interpersonal networks play in supporting recovery. The Specification mirrors the SIGN Guideline (2022) recommendations for the appropriate inclusion of family and/or carers in the support of individuals with eating disorders.

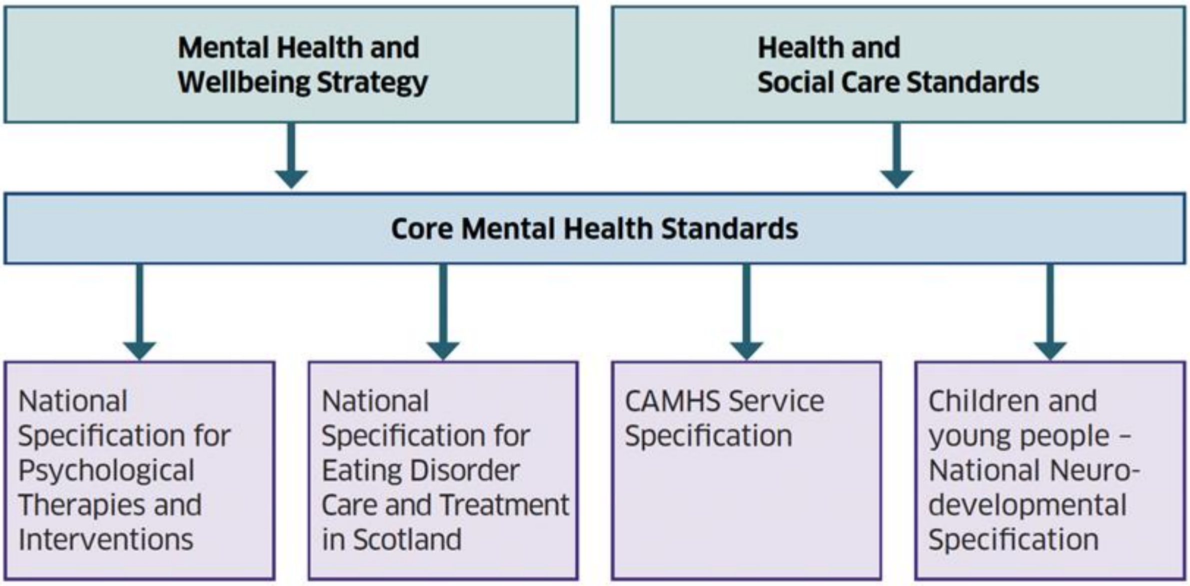
Mental Health and Wellbeing Strategy

This Specification has been published in the context of the new Mental Health and Wellbeing Strategy. The Scottish Government and COSLA published its long-term vision and approach to improving the mental health and wellbeing of everyone in Scotland in June 2023. The Strategy is ambitious and describes what the Scottish Government and COSLA think a highly effective and well-functioning mental health system should look like – with the right support available, in the right place, at the right time, whenever anyone asks for help. (Scotland's Mental Health and Wellbeing: Strategy (www.gov.scot)).

Core Standards

As part of the Scottish Government’s wider work to improve mental health services and care, Core Mental Health Standards were published, which stem from the Strategy. These Standards set out clear expectations for what services will look like, whilst recognising the need for local flexibility, and how we will provide assurance of high-quality care. These Standards have been developed in line with the vision of the new Mental Health and Wellbeing Strategy: Our vision is of a Scotland, free from stigma and inequality, where everyone fulfils their right to achieve the best mental health and wellbeing possible. It is our ambition for these standards to be applicable across a broader range of mental health services. They will initially apply to Adult Secondary Services, Psychological Therapies and Interventions and services that treat those with an eating disorder.

The diagram shows the Core Mental Health Standards and their relationship to the Health and Social Care Standards, Mental Health and Wellbeing Strategy and different specifications, including eating disorders.



Glossary

This Specification, wherever possible, uses generic terminology that can be applied across all eating disorder providers and services.

Throughout the document, we refer to **organisations** implementing the Specification which is inclusive of NHS boards and where relevant these apply to third and independent sector too.

The term **representative** refers to any person, an individual experiencing care chooses to be involved in their care and support. This includes but is not limited to, next of kin, a power of attorney, carers, family, parents, or an independent advocate.

The term **family and/or carers** is inclusive of parents, carers, family, friends, and partners.

The term **co-occurring considerations** has been purposely used to acknowledge that this may be a more appropriate descriptor than comorbidity for some populations such as pregnancy, autistic individuals, etc.

The term **living/lived experience** refers to individuals with current or past experience of an eating disorder.

The term **all age** refers to the full age range, from birth through to older adults.

The term **holistic assessment** refers to an assessment process which takes into consideration the overall health of an individual including physical, psychological, social, spiritual needs and levels of associated risk and functioning.

The term **medical monitoring** is inclusive of both psychiatric and physical health monitoring.

The term **multi-disciplinary** is used to describe a care team involved in the support and/or treatment of individuals that is made up of a variety of professionals.

Summary of Outcomes

Outcome 1: Leadership and Governance

Organisations demonstrate effective leadership, governance, and partnership working in the management and delivery of eating disorder services.

Outcome 2: Service Structure

Organisations deliver a range of services which are safe, effective, and person-centred. High-quality treatment and support are delivered by multi-disciplinary teams working in partnership.

Outcome 3: Access to Care

All individuals have equitable, consistent, and timely access to effective eating disorder health care and services. Services should be flexible and responsive to individual needs.

Outcome 4: Supporting People with Co-occurring Considerations and Comorbidities

All individuals with co-occurring considerations and physical/psychiatric comorbidities have equitable, consistent, and timely access to effective eating disorder services and ongoing treatment and support.

Outcome 5: Assessment and Medical Monitoring

All individuals have a holistic assessment and where clinically appropriate receive ongoing medical monitoring and management.

Outcome 6: Transitions

Clear transition protocols are in place and used routinely to support safe and coherent care.

Outcome 7: Discharge

Discharge from eating disorder services is planned, collaborative, and based on individualised goals of treatment.

Outcome 8: Education and Training

Organisations demonstrate commitment to the education and training of all staff involved in eating disorder services, appropriate to roles and workplace settings.

Outcome 9: Shared and Supported Decision Making

All individuals receive inclusive information to facilitate informed choice and shared and supported decision making.

Outcome 1: Leadership and Governance

Outcome Statement
Organisations demonstrate effective leadership, governance, and partnership working in the management and delivery of eating disorder services.

Rationale

Effective leadership and governance are critical to ensuring safe, person-centred, and high-quality health and social care services. Individuals accessing eating disorder services should have confidence that their care and support is of the highest quality. Services should understand people’s needs and experiences by undertaking meaningful consultation and facilitating codesign.

People accessing services should benefit from partnership working at a local, regional, and national level. Effective planning and partnership work should be underpinned by arrangements and information sharing that facilitate the delivery of high-quality, equitable care.

Public health and clinical leadership should support effective planning and continuous quality improvement. To allow for effective planning and management, organisations must ensure the effective collation, analysis, and review of eating disorder data, such as local and national epidemiological and improvement data.

Outcome in Action

1.1 Organisations can demonstrate robust governance arrangements, with clear lines of accountability, covering all aspects of the patient journey.

1.2 Organisations can demonstrate a commitment to quality planning and assurance through:

- effective data collection, including data on health inequalities
- involving people with living/lived experience at both multi-disciplinary team and leadership level to meaningfully shape service design and delivery
- local and national benchmarking against agreed outcomes, and
- clear alignment of strategic policy objectives and implementation strategies, and routine monitoring of patient outcomes to inform interventions.

1.3 Organisations can demonstrate a commitment to international human rights conventions by:

- taking a rights-based approach to service planning and delivery, and

- routinely informing people of their rights and providing comprehensive training to staff on upholding people’s rights, which is updated when necessary and appropriate to their role and setting.

1.4 People are given meaningful opportunities to participate in the design and evaluation of eating disorder services, and organisations can demonstrate where this feedback has resulted in change.

1.5 There are clear and structured risk management and adverse events processes, which include:

- accountability and responsibility arrangements for reporting any risks, including monitoring people at risk
- accountability and responsibility arrangements for reporting adverse events
- a consistent approach to reporting adverse events
- a documented escalation process for adverse events, and
- organisational learning from adverse events.

1.6 Information management structures and governance processes are in place to support:

- the use of a national IT system for reporting, benchmarking, and performance to improve patient safety and quality of care, where appropriate, and
- the routine sharing, with fully informed consent, of identifiable personal healthcare data between care providers, and the effective collation of anonymised data in support of care governance.

1.7 There are agreed pathways and processes, developed with people with living/lived experience, to ensure:

- accessible and responsive care, including self-referral options
- timely management options are consistently available
- information is shared appropriately between public health and primary care, secondary care, laboratories, third sector, local authority, and independent healthcare sector services
- there are resilience plans for service disruption
- there is clear communication of medical monitoring and test results and onward referral for management and support as necessary
- prioritisation of those most in need

  - individuals with co-occurring considerations such as pregnancy, diabetes, mental health concerns, and autistic individuals are adequately and appropriately supported, and
  - appropriate signposting to additional areas of support, including the third sector, as necessary.

1.8 There are systems in place to ensure that all medical equipment used in the provision of eating disorder care have:

  - planned preventative maintenance, and
  - a mechanism for routine checks and testing, and rolling replacement schedules.

1.9 Organisations support and encourage service evaluation, audit, and research to develop and share best practice.

1.10 There is regular review and audits of clinical environment and resources, making sure these are accessible for those with protected characteristics, sensory, and communication differences.

What does this mean for the person receiving care?

You can be confident that:

- you will receive a safe, equitable, and high-quality service that is personalised to meet your needs
- services committed to quality improvement, have effective leadership and governance, and are engaging effectively with people with living/lived experience of eating disorders and using services
- you will be given meaningful opportunities to participate in decisions about how services are shaped
- information about you and your care will be shared with your consent, where appropriate, and in line with national guidance, and
- that while you wait for access, there will be a process in place to support escalation of concerns in the event of significant deterioration while waiting.

What does this mean for staff?

Staff:

- understand and can access care pathways, standards, and guidance relevant to their role

- actively participate in the multi-disciplinary team and are supported by their organisations to understand their role
- are aware of how to report and escalate adverse events
- are proactive in raising and responding to identified concerns which may impact on patient safety and care, and
- are encouraged and supported to work collaboratively with allied services.

What does this mean for the organisation?

The organisation:

- has governance arrangements in place to determine roles, responsibilities, and lines of accountability, including adverse event management
- supports a culture where concerns can be raised and appropriately acted upon
- ensures co-ordinated person-centred pathways for access and delivery of care are developed and implemented
- performs routine monitoring of outcomes to inform health interventions and improve service delivery
- monitors and responds to areas of concern
- engage with staff, patients, and carers to identify areas for improvement
- record and monitor data
- undertake quality improvement and assurance activities to ensure performance against the Specification
- has planned preventative maintenance, quality assurance checks, and a rolling replacement schedule in place for all equipment and peripherals, and
- encourages research and clinical excellence where research is undertaken and has processes in place to monitor people awaiting services, including how risk and reassessment are managed.

Practical examples of evidence of achievement (NOTE: this list is not *exhaustive)*

- Documentation describing lines of accountability, roles and responsibilities, and escalation of adverse event reporting.
- Documentation describing monitoring and reporting systems for local strategic aims and objectives, quality improvement, and service delivery objectives.

- Care pathways and local and national standard operating procedures demonstrating multi-disciplinary working.
- Improvement work, including action plans, data collection and review of data, such as feedback from service users, staff members, national benchmarking, and evidence of timeliness of processes.
- Documentation describing preventative maintenance, quality assurance checks, and rolling replacement schedules for equipment and peripherals.
- A management system for reporting, reviewing, and learning from all types of adverse events.
- Evidence of research activity.
- Evaluation of clinical effectiveness against national or local standards.
- Evidence of codesigned service plans, innovative engagement with local communities, and good communication with service users.

Outcome 2: Service structure

Outcome Statement

Organisations deliver a range of services which are safe, effective, and person-centred. High-quality treatment and support are delivered by multi-disciplinary teams working in partnership.

Rationale

Patient safety is fundamental to the delivery of eating disorder treatment and care. The service structure and underlying protocols and pathways play an essential role in the delivery of safe care. The aim of the Specification is to reduce and prevent gaps in care via the provision of clear protocols and service agreements and to change service structure to improve patient safety where possible. This includes implementation of the recommendations of all age eating disorder services across Scotland (National Review of Eating Disorder Services, 2021). It is recommended that the National Eating Disorder Network develop specific guidance on the development of all age services to make sure that the developmental needs of younger populations, and associated assessment of risk and specialist intervention, are not lost in the merging of services.

International clinical practice guidelines recommend that most individuals with an eating disorder should be treated in outpatient care (Hay et al., 2019). This is led by the need for efficient use of healthcare resources, patient preference, and greater adherence to outpatient treatment in clinical trials (Freeman, 1992; Gowers, et al., 2007). However, when individuals cannot be managed in the community due to physical or psychiatric risk, there is a need for a range of more intensive service structures inclusive of day patient, intensive outreach, and inpatient treatment.

Stakeholders in the National Review of Eating Disorder Services (2021) described variability in the availability of services. This Specification aims to reduce this variability while acknowledging the diverse population needs of Scotland including remote and rural locations where different models of service delivery, such as regional multi-disciplinary teams and services, may be more appropriate.
Clinical consensus indicates that the optimal model of service delivery for people with an eating disorder is a dedicated, multi-disciplinary eating disorder services (NHS England, 2019).

Outcomes in Action

2.1 Organisations ensure a range of services, with varying intensities of provision, are developed. These should be based on individual assessment and clinical risk, and available to all people who have been assessed as requiring treatment and support.

2.2 Organisations ensure that they provide an all-age specialist eating disorder service which can meet the full range of developmental needs of children, young people, adults, and older adults.

2.3 Organisations ensure a range of options in the delivery of care are offered which are person-centred and responsive. These include:

- inpatient care
- outpatient care
- day services
- outreach including intensive outreach services
- digital and online technology, and
- freely available evidence-based self-help materials.

2.4 Different models and intensity of service provision are integrated with transparent pathways and protocols to enable safe provision of treatment at points of transition and to support individuals to experience their care as connected, coherent, and recovery-focused.

2.5 Clear protocols are in place to manage:

- risk and safety, and
- unattended appointments.

2.6 Assertive and proactive follow-up protocols are in place that are designed to prevent inappropriate discharge and support engagement in treatment and care.

2.7 Organisations ensure that services are delivered by multi-disciplinary teams who work in effective partnerships with other agencies and the third sector.

2.8 Where health boards have smaller populations, creation of regional specialist eating disorder multi-disciplinary teams may be appropriate. Appropriate protocols should be developed to ensure seamless information exchange (within the parameters of information governance and informed consent) and consistency in care and treatment.

2.9 As a minimum, essential outpatient care should include:

- psychiatric assessment and review
- SIGN recommended psychological interventions
- medical monitoring
- medication, and
- dietetic intervention.

2.10 An ideal staffing mix for a comprehensive eating disorder all age service should include:

- administrative staff
- dietitians
- family therapists
- medical professionals (e.g. clinical nurse consultant, GP, physician, paediatrician)
- nursing staff
- occupational therapists
- peer support workers
- physiotherapist
- psychiatrists
- applied psychologists (including assistant psychologists)
- psychological therapists
- social workers, and
- support workers.

Where appropriate, people are supported to access speech, language or communication assessment and support, and art and creative therapies.

What does this mean for people?

You:

- will receive safe and high-quality eating disorder treatment from a multi-disciplinary team

- can be confident that while the majority of eating disorder treatment is provided on an outpatient basis, you can access a range of higher intensity eating disorder services if required, and
- will have an opportunity to feedback on the service you have received without any negative impact on your care and treatment.

What does this mean for staff?

Staff:

- are well supported in a multi-disciplinary eating disorder team
- receive appropriate training and receive effective clinical supervision appropriate to their role and workplace setting, and
- understand and can access care pathways, standards, and guidance as appropriate

What does this mean for the organisation?

The organisation:

- develops an all age range specialist eating disorder service
- routinely assesses service capacity to implement the Specification, and develops associated staff training plans to meet the need for evidence-based care
- participates in national reporting of routine outcomes
- can access higher intensity specialist eating disorder service provision including day services, intensive treatment services, and inpatient, and
- has clear protocols in place to manage risk and safety, and transition between services.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

- Development of an all age eating disorder service.
- Regional specialist eating disorder multi-disciplinary teams in health boards with smaller populations.
- Cross-health board protocols to facilitate seamless information exchange and consistency in care and treatment.
- Details of staff mix and referral pathways.

Outcome 3: Access to Care

Outcome Statement

All individuals have equitable, consistent, and timely access to effective eating disorder health care and services. Services should be flexible and responsive to individual needs.

Rationale

The need for early identification and intervention has been reinforced by the SIGN Guidelines for Eating Disorders (2022). It highlighted the potential accumulation of harm that can take place during an untreated eating disorder and that our current NHS systems and pathways can compound delays in accessing treatment.
This has also been reiterated by stakeholder feedback to the National Review of Eating Disorder Services (2021) that identified several areas of concern around access to care in Scotland. Specifically:

- stakeholders drew attention to how long it can take to access specialist eating disorder care
- individuals reported experiencing barriers to accessing the right treatment
- stakeholders highlighted a predominant service focus on Anorexia Nervosa, meaning individuals with other eating disorders could find it difficult to access appropriate treatment.

There is therefore a clear need for this Specification to be underpinned by the values highlighted in the Scottish Government's Mental Health Strategy (2017) including a focus on early intervention and equal access to the most effective, evidence-based, and safest care and treatment for individuals experiencing a range of eating disorder presentations.

Outcome in Action

3.1 Organisations ensure equitable and consistent access to services, treatment, and care regardless of a person's:

- age
- gender
- ethnicity
- geographical location, or
- economic circumstances.

3.2 Eating disorder services are accessible to individuals with the full range of eating disorders including OSFED, BED and as part of a multi-agency pathway for ARFID, and access is equal and consistent irrespective of the episode of presentation.

3.3 Individuals with a primary diagnosis of BED are seen in specialist eating disorder services and not weight management services.

3.4 Organisations should reduce barriers to care and promote a culture that enables outreach, proactive engagement, and enhances accessibility.

3.5 Specialist eating disorder services are supported to accept self-referrals and referrals from any relevant professional, including counsellors, school nurses, and the third sector.

3.6 Each service has clear accessible information in a range of languages and formats that includes:

- accessible contact details that are easy to find
- clear instructions on how to contact the service or submit an online self-referral form, and
- ‘first line advice’ while individuals wait to be seen.

3.7 A range of methods of self-referral are available for those unable to access online referral forms. Clear and accessible guidance on alternative methods of referral should be available.

3.8 People have access to services and treatment as soon as they are needed with immediate access to treatment and support, where appropriate. This includes people who present:

- early in the development of the illness
- early in help-seeking, or
- early in recurrent episodes of illness or relapse.

3.9 Organisations ensure that decisions on accepting a referral (including self-referral) should be based on a holistic assessment and review of an individual’s circumstances, needs, and preferences and not based solely on clinical measurements such as BMI.

3.10 Individuals with an eating disorder should receive SIGN concordant treatment in specialist eating disorder services within appropriate timelines:

- maximum of four weeks from receipt of a referral for routine cases, and
- within one week from referral for urgent cases.

3.11 All eating disorder services are accessible and safe for individuals in larger bodies including access to specialist equipment for monitoring physical health and the clinical environment.

What does this mean for the person receiving care?

You will:

- be able to see the right person in the right place at the right time
- be able to self-refer to specialist eating disorder services, if think you might have an eating disorder, and
- be seen by people with appropriate skills, knowledge, and competencies.

What does this mean for staff?

Staff:

- in collaboration with those with living/lived experience, develop an action plan to reduce barriers to accessing specialist services and implement associated mechanisms, including the use of self-referral, and
- have the skills and capacity to deliver timely evidence-based interventions for the full range of eating disorders.

What does this mean for the organisation?

The organisation:

- develops an all-age range specialist eating disorder services
- assesses service capacity to embed the national specification, and develop associated staff training plans to meet the need for evidence-based care
- undertakes regular audits of referral data to understand representation aligned with prevalence rates and local population demographics, with associated action plans to reduce inequalities, and
- participates in national reporting of standardised waiting time data.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

- An annual audit of eating disorder referrals to a local specialist eating disorders team using standardised data collection.
- Comparison of referral data nationally and with prevalence rates and local population demographics.
- Identification of potential areas of health inequalities (e.g. lack of males being referred) and an action plan developed, in partnership with individuals with

living/lived experience including individuals from that particular demographic, to reduce inequalities.
- An easily accessible website with clear information on service criteria and accessible first link advice.
- Information is available in a range of languages relevant to the local population and in accessible formats.

Outcome 4: Supporting people with Co-occurring Considerations and Comorbidities

Outcome Statement

All individuals with co-occurring considerations and physical/psychiatric comorbidities have equitable, consistent, and timely access to effective eating disorder services and ongoing treatment and support.

Rationale

Individuals with eating disorders frequently experience a high level of co-occurring considerations in addition to the physical health problems experienced because of the disordered eating symptomatology. The term **co-occurring considerations** has been purposely used to acknowledge that this may be a more appropriate descriptor than comorbidity for some populations including people who are pregnant or autistic.

It has been estimated that over 70% of individuals with an eating disorder experience at least one other psychiatric disorder and that this is linked with increased severity of eating disorder symptoms (Spindler and Milos, 2007). Eating problems are twice as common in people with type 1 diabetes than in people without diabetes (SIGN, 2022). Research indicates that 20-30% of individuals with AN display diagnostic features characteristic of autism (Westwood et al, 2017). Individuals who report more autistic features are more likely to present with more severe ED psychopathology (Kerr-Gaffney et al, 2019); are more likely to require inpatient or intensive day programme treatment (Stewart et al., 2017), and report poorer global outcomes post treatment (Nazar, et al., 2018; Nielsen et al., 2022).

When supporting individuals with co-occurring considerations and/or comorbidity, eating disorder services should work with individuals to deliver responsive and person-centred care. Staff should also work in partnership with other services, agencies, and the third sector to provide joint integrated care. Where possible, a lead service should be identified/nominated to coordinate care. A focus should be on continuity of care, with supported information sharing to enable shared treatment. NHS eating disorder services should ensure specialist pathways for individuals with comorbidities and/or co-occurring considerations to promote person-centred care, and treatment should be flexible to ensure that individual needs and goals are of utmost consideration.

It may be appropriate for support to be provided on a longer-term basis to ensure that individuals can maintain progress made in treatment. Clinical expertise would suggest that pathways to support people with co-occurring considerations should include the capacity to access diagnostic pathways, multi-disciplinary assessments (including sensory assessment, communication assessments, and medical assessments), and adaptations to treatment delivered by appropriately trained staff.

Outcome in Action

4.1 People with co-occurring considerations and/or comorbidity have equitable access to care, treatment, and support. In addition, there should be no delay to referral or treatment.

4.2 Organisations ensure that eating disorder services follow SIGN (2022) and MEED (2022) guidelines for the assessment and treatment of eating disorders for individuals with co-occurring considerations and/or comorbidity.

4.3 Patients with type 1 diabetes and eating disorders receive shared care from diabetic professionals and mental health specialists and appropriate physical health monitoring as recommended by SIGN (2022) and MEED (2022).

4.4 Eating disorder services have specialist pathways, that include joint working with other services, developed in partnership with people with living/lived experience, for individuals with specific considerations including:

- diabetes
- pregnancy and those in the postnatal period
- individuals with long standing eating disorder presentations
- autism and neurodivergence (whether formally diagnosed or not), and/or
- ARFID.

4.5 Organisations ensure that when joint working takes place between services, that service provision is integrated with transparent pathways and protocols, including a clear agreement on clinical responsibility and information sharing (with appropriate consent).

What does this mean for the person receiving care?

You will:

- receive a comprehensive assessment
- be supported to consider different treatments or options, including joint working with other services appropriate to your needs
- be fully involved in developing your treatment plan which will take into account your personal views and preferences, and
- be seen by people with appropriate skills, knowledge, and competencies, including staff who have specialist training aligned with your needs.

What does this mean for staff?

Staff:

- will receive appropriate training and support to effectively assess common comorbidities and co-occurring considerations as part of a holistic eating disorder assessment, and
- can understand and can access specialist pathways for individuals with common co-occurring considerations, and
- support people to access health, social care, and third sector support, and
- will receive appropriate training to develop skills in the treatment of individuals with eating disorders and comorbidities/co-occurring considerations.

What does this mean for the organisation?

Organisations:

- have clear protocols in place for joint working between services including diagnostic assessments
- ensure specialist pathways are developed in partnership with people with living/lived experience, for individuals with co-occurring considerations, and
- perform regular audits of adherence to protocols and pathways.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

- Pathways (co-produced with people with lived/living experience) to support joint working to facilitate early identification and intervention, appropriate assessment, and suitably adapted and effective intervention led by trained staff.

  For example:
    - pathway for people with diabetes which integrates with diabetes services
    - pathway for autistic individuals (whether formally diagnosed or not) using best practice principles recommended by the PEACE pathway including adaptions to the clinical environment, adaptions to treatment and care, screening, and associated referral pathways for neurodevelopmental assessment if required
- Regular audit of adherence to pathways including patient experience feedback.

Outcome 5: Assessment and Medical Monitoring

Outcome Statement

All individuals have a holistic assessment and where clinically appropriate receive ongoing medical monitoring and management.

Rationale

This outcome is aimed at the generic assessment process within specialist eating disorder services and associated risk assessment and medical monitoring in both primary care and specialist services.

Assessment in specialist eating disorder services should be holistic, covering physical health, mental health (including comorbidities), social factors, and co-occurring considerations. This should be completed by an experienced and appropriately trained clinician. An assessment should not be based on single measures (for example BMI) and instead should identify the full range of eating disorder symptomatology and comprehensively review an individual’s circumstances. Screening tools and physical observations should never be used in isolation to determine whether someone has an eating disorder.

A holistic assessment should result in a shared understanding of the presenting problem and the person’s needs. This will enable a review of available evidence-based treatment options to support the individual in making an informed and collaborative decision about their treatment and care. Assessment is a continuous process and any changes to an individual’s presentation should be monitored and reviewed with care plans regularly updated to reflect current needs.

Assessment in eating disorder services should be proactive using an outreach approach to support engagement. Clinicians should be prepared that they may at times support individuals with some uncertainty about engaging in treatment. Although patients may have a good understanding, reasoning, and appreciation of their illness, the change in values and sense of identity that can result from their illness can impact on decision making. The issue of treatment acceptance and patient autonomy is therefore complex and not static. MEED highlight that the common factors in successful services seem to be cooperation, trust, shared protocols, regular networking, and intensive, proactive (rather than reactive) care (MEED, 2022).

Responsibility for outreach and follow up to support engagement with assessment lies with the service, and clear time frames and service expectations should be set to support this. This approach should be person-centred supporting appropriate service flexibility in times and locations of assessment appointments. As part of this engagement and assessment process, family and carer support can be provided without breaching patient confidentiality and should be offered to families or carers, when appropriate, even if an individual is not accessing services (SIGN, 2022). Peer support workers could also be used as a tool for supporting engagement with treatment for adults with eating disorders.

Medical monitoring refers to both psychiatric and physical health monitoring. It is essential that eating disorder services have the capacity to monitor and manage the physical health of people with eating disorders including having the skills, equipment, and systems required to provide safe and efficient medical monitoring. Along with physical monitoring, it is essential that the clinician assesses risks in psychological and social domains while paying attention to matters of insight, motivation, consent, and the legal framework for intervention. Thus, risk assessment in eating disorders needs to be multidimensional. When a patient is very unwell or highly distressed, they may lack capacity/competence in relation to particular decisions. Also, the nature of the illness and associated eating disorder cognitions may affect the capacity to provide an accurate account of presentation; this can also falsely assure clinicians of risk. Teams should document the nature and level of risk, and the nature of the best interest decision and act to reduce risk and preserve life (MEED, 2022). The need for emergency medical or psychiatric admission for anyone at risk of serious physical complications, suicide or serious self-harm should also be considered.

Initial physical and psychiatric risk assessment in primary care allows specialist eating disorder service to prioritise referrals and for a referrer to indicate the urgency of care that is required. Clear guidance should be in place for primary care based on MEED (2022) and access to consultation with specialist services when required. In some instances, a shared care approach may be used between specialist eating disorder services and primary care. If this has been formally agreed, clear protocols should be in place for medical monitoring based on the detailed guidance supplied by MEED (2022). This protocol should be collaboratively developed at an organisational level including clear documentation of the responsibilities for each service in the undertaking of medical monitoring, checking results, and actioning any escalation that may be required in a timely manner. Clear service protocols should also be in place detailing the process and clinical responsibility for monitoring changes in presentation or risk while an individual is waiting to be assessed or being supported to engage in this process. This should include documenting who holds clinical responsibility at this time, and the associated processes for monitoring changes in presentation and risk. All individuals involved in medical monitoring should have the necessary skills and training to identify monitor and manage eating disorder behaviours, symptomatology, and associated risk.

Primary care practitioners should not be required to hold medical responsibility for significant or severe eating disorders, except where this is appropriate for specific cases in partnership or agreement with specialist medical practitioners.

Outcome in Action

5.1 Holistic assessments are completed by an experienced and appropriately trained clinician.

5.2 Clear service protocols and pathways are in place while an individual is waiting to be assessed or is being supported to engage in this process detailing:

- who holds clinical responsibility, and
- associated processes for monitoring changes in presentation or risk, who is responsible for this and how this is escalated if appropriate.

5.3 Clear clinical practice guidelines for medical monitoring are in place and easily accessible for referrers and clinicians within the service that:

- align with MEED (2022)
- are followed by risk assessment and documented escalation processes, as appropriate, and
- detail potential challenges to accurate risk assessment.

5.4 Where a shared care approach is used between specialist eating disorder services and primary care for ongoing medical monitoring, a clear protocol exists including:

- agreement and documentation of which service holds clinical responsibility, and
- associated expectations for medical monitoring including who undertakes the medical monitoring, checks results, and associated risk assessment. There should be protocols for escalating if required.

5.5 Organisations ensure health care professionals have the necessary training and skills appropriate to their role, responsibilities, and workplace setting, to identify, monitor and manage eating disorder behaviours.

5.6 Organisations ensure that staff have the appropriate skills and competencies to predict and monitor early biochemical signs of refeeding syndrome and how to manage medical risk in line with MEED (2022).

5.7 Organisations ensure services use protocols for refeeding within acute and community settings that emphasise the need to avoid under-nutrition and refeeding syndrome.

5.8 Organisations ensure that there are protocols in place to establish baselines as part of physical health monitoring. Baseline data should be considered in the context of, and following discussion with, the person.

5.9 Patients with purging behaviour, are supported to access regular dental visits for dental monitoring and treatment.

5.10 Clinicians should consider whether the Mental Health (Care and Treatment) (Scotland) Act 2003 needs to be invoked when a patient (of any age) declines treatment. There may be a responsibility to provide compulsory treatment if there is a risk to the person's life or to prevent significant deterioration health and wellbeing (SIGN, 2022).

5.11 Organisations ensure services have access to psychiatric and/or acute inpatient treatment for stabilisation when indicated for those at immediate risk. Specialist eating disorders teams should establish close links and shared care during inpatient admission for continuity of patient care.

5.12 Organisations ensure that services provide robust physical health monitoring and appropriate referral during antenatal, perinatal and postnatal periods.

5.13 Organisations ensure the provision of accurate, reliable, and responsive information and support on excessive training and exercise and misuse of steroids.

5.14 Organisations ensure that patients with a long standing eating disorder, experience a person-centred approach to medical monitoring.

5.15 Organisations demonstrate they are implementing MEED (2022) and SIGN (2022).

What does this mean for the person receiving care?

You:

- will receive a comprehensive assessment by a specialist eating disorder clinician to support a shared understanding of the presenting problem and your individual needs
- will be supported to engage in the service to meet your needs
- are safely medically monitored throughout the course of your wait, assessment, and treatment with the service.

What does this mean for staff?

Staff are:

- provided with the necessary training to support the provision of a holistic assessment and safe and effective medical monitoring
- can access physical health monitoring equipment to safely and effectively provide medical monitoring within the service, and this is regularly audited and maintained
- supported to take a proactive outreach approach to support individuals to engage with/in the service, and
- aware of service protocols on medical management and shared care clinical responsibilities of each service if appropriate.

What does this mean for the organisation?

The organisation ensures:

- there is clear and easily accessible guidance on medical management for primary care colleagues to support risk management
- medical monitoring protocols are based on MEED (2022) guidance, and
- that if shared care with primary care is used, that this is agreed at an organisational level, with clear documented protocols detailing clinical responsibilities

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

- Shared care agreements between the specialist eating disorder service and primary care to support medical monitoring in a remote and rural location.
- Protocol detailing who holds clinical responsibility and associated processes for each step of the monitoring process.

- Protocol outlining outreach approaches to support engagement.
- Details of training and support available to staff.
- Evidence of implementation of SIGN and MEED guidance.
- Evidence of information (in a range of languages and formats) to support patients in their decision making including the use of steroids.

Outcome 6: Transitions

Outcome Statement

Clear transition protocols are in place and used routinely to support safe and coherent care.

Rationale

Transitions are points of increased risk for individuals with eating disorders and can adversely affect quality of care and patient safety. Transitions have been highlighted as being a significant problem for individuals with eating disorders (National Review of Eating Disorder Services, 2021). The ethos underpinning transitions should be to remove gaps in care and delays in treatment for the benefit and safety of the patient, rather than protocols based on service needs. Development of all age community eating disorder services in Scotland (as recommended by the National Review of Eating Disorder Services, 2021) will minimise transitions due to age. However, individuals with eating disorders will still experience essential transitions of care e.g., differing levels of intensity of service provision depending on the provider, and/or geographical moves.

Transitions protocols should be in place to support good communication between and within services and providers with clear lines of responsibilities to support safe and coherent care. Careful consideration should be made to reduce repetition and/or unnecessary service barriers (e.g. a transfer of care needing to be assessed by a primary care mental health team prior to specialist eating disorder services).

SIGN Guidelines for Eating Disorders (2022) propose specific recommendations on managing transitions to supplement the existing Royal College of Psychiatrists (2017) Transition Guidelines for Patients with Eating Disorders. This is in addition to existing guidance from Healthcare Improvement Scotland on Transition Planning from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (2018).

When a transition of care takes place, the transition should be identified early, prepared, managed, and followed up by clinicians in both services (SIGN, 2022). Where appropriate, services should work collaboratively for six months before the planned transition to ensure seamless care (Royal College of Psychiatrists, 2017). A written transition plan should be drawn up in collaboration with the patient (and representative, where appropriate) and clinician(s). This plan should be readily accessible and shared appropriately, following consent. (SIGN, 2022). Transition plans should include risk assessment and consider medical assessment and monitoring (MEED, 2022) with clear lines of clinical responsibility documented.

Outcome in Action

6.1 Organisations ensure that transition protocols are in place to support effective communication between services. This includes external and internal service transitions with clear lines of responsibilities to support safe and coherent care.

6.2 Organisations ensure that transfers of open and active cases to other eating disorder services, will not be placed on a waiting list again and should be seen immediately without delay.

6.3 Eating disorder services should collaboratively develop a written transition plan with an individual and where appropriate their representative. Where appropriate, services should work collaboratively for six months before the planned transition and written plans should include risk assessment and consider medical monitoring, with clear lines of clinical responsibility documented.

6.4 For patients in, or moving to Higher Education, eating disorder services should work closely with primary care and University/College mental health services to support consistent and integrated care and minimise delays in treatment.

The option to retain treatment with services in an individual's home board could be considered while an individual attends Higher Education in another locality if this supports consistency in care, with clear risk assessment and medical monitoring responsibilities agreed.

6.5 Eating disorder services should provide the person's representative with information and advice around the transition where appropriate and with consent.

What does this mean for the person receiving care?

You:

- will experience continuity and consistency in your care
- will develop a joint plan with your clinicians which will support you if you move between services, and
- will not be put back onto a wait list when moving between services in Scotland if you are receiving active eating disorder treatment.

What does this mean for staff?

Staff:

- understand and can access transitions protocols for within and between services, and
- will know who is responsible for medical monitoring and has clinical responsibility for care at all points of the transition.

What does this mean for the organisation?

The organisation:

- has an all-age range specialist eating disorder service
- ensures clear protocols are in place for transitions within and between services
- has transition protocols which are person-centred and reduce repetition and/or unnecessary service barriers e.g. individuals being placed back on a waiting list or needing to be assessed by a primary care mental health team prior to accessing their new specialist eating disorder service)
- ensures transition protocols stipulate clinical responsibility for care and medical monitoring for each point of service transition, and
- performs regular audits of adherence to transition protocols.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

- Clear transition protocols for each level of common transition pathways within and between services.
- Standardised information is available for individuals with eating disorders and their carers or representatives, where appropriate, to explain the transition process and relevant information on the services they are transitioning to.
- Audit to demonstrate regular transition meetings between services that experience frequent transitions with each other to support good working relationships and to resolve any areas of concern or unmet needs.
- Feedback from individuals who have recently experienced service transitions to support learning and continued development of co-produced transition protocols.

Outcome 7: Discharge

Outcome Statement

Discharge from eating disorder services is planned, collaborative, and based on individualised goals of treatment.

Rationale

Effective and person-centred discharge from services is important for people experiencing services, as well as for staff and organisations. Discharge can be a point of anxiety for individuals with eating disorders and their representatives and wider support networks. It can also be influenced by service pressures and clinical demands, meaning discharge processes have the potential to become service-led rather than person-centred.

In parallel to the requirements to access eating disorder services, discharge should never solely be based on a person's BMI, weight, or frequency of binge and purge episodes. Instead, discharge should be planned and based on a continuous holistic assessment of an individual's needs and person-centred treatment goals. A co-produced discharge plan should include a detailed relapse management plan, advice on the process and expectations of re-entering treatment if required, and signposting for ongoing support in the community from health, social care, and third sector on discharge. For individuals who have had a long duration of illness, it might be preferable for services to provide flexible 'light touch' contact as a means of maintaining the quality of life they have reached, rather than full discharge to external community support. This is of particular importance for patients who have been involved with services for many years and for whom the transition from services will require support.

Outcome in Action

7.1 Organisations ensure that discharges from care are:

- based on a holistic assessment and review of an individual's circumstances, needs, and preferences
- not be based solely on clinical measurements such as BMI
- planned following informed decision making involving patients and their representatives where appropriate, and
- phased with the ability to re-engage directly with the same service if there is a need to do so.

7.2 Organisations ensure that there are options for ongoing support with the service as an alternative to full discharge to the community which are responsive to need, for example, for individuals who have had a long duration of illness and who benefit from ad hoc checking in/support.

7.3 NHS services work with social care and third sector organisations to facilitate any ongoing support that may be required post discharge from specialist eating disorder services.

What does this mean for the person receiving care?

You can be confident that:

- discharge from treatment will be planned with you, and your representative as appropriate, and with your consent
- discharge will be based on your need not on your behaviour or clinical measures such as weight
- you will be able to re-engage directly with the same service within an agreed time frame rather than being referred and waiting to be assessed again, and
- if you have been involved with services for a long period of time and have experienced a longer-term eating disorder, any ongoing contact you have with the service will be right for you and agreed with you.

What does this mean for staff?

Staff are:

- supported to co-produce discharge plans which are responsive and flexible to the person's individual needs, preferences, and goals
- able to signpost people for ongoing support in the community from health, social care, and third sector support, and
- supported to be creative in co-designing alternatives to full discharge to best support people who require person-centred and responsive ongoing support.

What does this mean for the organisation?

The organisation:

- ensures that discharges are planned collaboratively with patients, and their representatives where appropriate, and with consent
- develops protocols to ensure discharge plans are person-centred, flexible, responsive to needs, and based on holistic assessment of preferences and individual goals
- has systems in place for people to re-engage directly with services within an agreed time frame after discharge, and
- ensures there is a specific care pathway for people who require long-term support as an alternative to discharge into the community.

Practical examples of evidence of achievement (NOTE: this list is not *exhaustive)*

- An eating disorder service develops flexible and person-centred discharge pathways enabling individuals to be supported to re-engage with the service via self-referral within 6 months if they experience deterioration in their eating disorder symptoms.

- An eating disorder service develops pathways as an alternative to full discharge for individuals who have had a long duration of illness and who may benefit from irregular check-ins to support personalised recovery process.
- Clinical audit of discharge pathways with documentation of information and support to enable people to re-engage with services and have irregular check-ins.

Outcome 8: Education and Training

Outcome Statement

Organisations demonstrate commitment to the education and training of all staff involved in eating disorder services, appropriate to roles and workplace settings.

Rationale

To ensure that eating disorder health care is safe, effective, and person-centred, all staff should have access to high-quality skills and competency-based training, supervision, and opportunities for personal development (National Review of Eating Disorder Services, 2021). This training should enable a specialist eating disorder team to effectively deliver evidence-based treatment and care aligned with SIGN (2022) and MEED (2022). Living and lived experience voices should be embedded at every level of training and its delivery via experts by experience. The National Eating Disorder Network would be well placed to deliver this training in collaboration with training and education providers.

High-quality care, treatment, and support should be delivered by an appropriately trained and well-supported multi-disciplinary team equipped to provide the diverse range of interventions required to support individuals with eating disorders.

Outcome in Action

8.1 The organisation implements a comprehensive and multifaceted education and training programme that:

- includes an assessment of staff training needs that is responsive to staff roles, responsibilities, and workplace setting
- supports continuous professional development
- promotes the use of quality improvement methods and tools
- is aligned to professional development frameworks
- embeds the voices of people with living and lived experience, and

- includes an evaluation of the provision, quality, and uptake of training.

8.2 Comprehensive training plans are developed to ensure that continuous professional development for eating disorder services is available to clinical and non-clinical staff in public-facing roles.

8.3 Staff are supported to access and attend training and education (including continuous professional development) appropriate to their roles and are allocated appropriate time and resources to participate.

8.4 Staff have access to training which includes:

- An overview of eating disorder presentations, risk factors, comorbid and co-occurring considerations, and treatment
- medical monitoring and risk assessment/management aligned with MEED (2022)
- SIGN (2022) recommended treatment and associated therapy specific supervision
- delivering person-centred care and support for individuals with comorbidity and co-occurring considerations
- the Mental Health Act (2003)
- trauma-informed care
- responsive engagement mechanisms for people and their representatives, where appropriate, and
- safeguarding vulnerable adults and children.

8.5 Organisations support staff to attend and participate in relevant training, support, and supervision.

What does this mean for the person receiving care?

You can be confident that:

- you are receiving care from individuals with a high level of training in effective and safe treatment approaches, and
- you will be treated with respect and compassion, listened to, and fully supported to make informed choices.

What does this mean for staff?

Staff:

can access and attend role appropriate training and supervision to enable the effective and safe delivery of treatment and care

- maintain the required competencies and qualifications for their roles and responsibilities, and
- know their role within multi-disciplinary teams and are supported to fulfil their responsibilities.

What does this mean for the organisation?

The organisation:

- implements a comprehensive and multifaceted education and training programme that is aligned with the requirements of MEED (2022) and SIGN (2022) and supports staff to complete this training, and
- evaluates the provision, quality, and uptake of training, and ensures staff have capacity to undertake relevant training.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

- Regular review and assessment of training needs and mapped to MEED (2022) and SIGN (2022).
- Regular feedback and audit on the quality and uptake of provided training.

Outcome 9: Shared and Supported Decision Making

Outcome Statement

All individuals receive inclusive information to facilitate informed choice and shared and supported decision making.

Rationale

The provision of high-quality, inclusive information is essential to empower and support people to make decisions, which are right for them about what matters to them. Decision making is an ongoing process and requires people to be fully informed and taken seriously, at all stages of their treatment journey and pathway. People accessing eating disorder services should be given appropriate time and resources to discuss their treatment in full, with their choices and concerns listened to and addressed. Organisations should provide high-quality, inclusive information on eating disorder services which is in a format and language responsive to their needs.

People should receive sufficient information about treatment options and reasonable alternatives. People should also have access to accurate information and choices on treatment and management, including digital or home treatment options.

The collection, use, and sharing of personal data should be fully explained to people accessing eating disorder services and be shared in line with national policies and procedures.

Outcome in Action

9.1 People using eating disorder services are provided with inclusive information on all aspects of their care, including any onward referrals or interventions which is responsive to their individual needs.

9.2 People awaiting treatment and care are updated on anticipated timelines and delays.

9.3 People are listened to and are fully involved in all decisions about their health and care.

9.4 People receive information that is timely, relevant, and in a language and format that is right for them.

9.5 People can discuss risk, results, treatment, and management options with appropriately trained staff, and are supported to participate as equals in shared decision making.

9.6 Where appropriate and following consent as required, information should be sought from the person’s representative when assessing risk.

What does this mean for the person receiving care?

You will:

- be listened to and fully involved in all decisions about your care
- receive information to support shared and informed decision making in a language and format that is right for you

- be given information on a diagnosis if given, and any test results
- have your data treated with confidentiality and shared where appropriate to improve quality of care
- be offered support and time to discuss treatment options available to you, and
- be given an opportunity to discuss any aspect of your care, raise questions or concerns, and discuss how any results or ongoing treatment/referral will be communicated to you.

What does this mean for staff?

Staff:

- offer a responsive, person-centred service
- are impartial, without judgement, and can demonstrate compassionate communication that is appropriate to the individual
- have access to evidence-based information in a range of formats and languages appropriate to the needs of the individual accessing support
- can support individuals to reach informed decisions, and
- have a clear understanding of any outcomes or results which can be communicated to individuals.

What does this mean for the organisation?

Services and organisations have systems and processes in place to ensure:

- the availability of appropriate, easily accessible, and timely information access to consistent support resources including guided self-help materials, and
- access to accurate and reliable resources.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

- Evidence of information provided in alternative formats and languages, taking account of the needs of people who may be digitally excluded.
- Clinical audit of consultations with documentation of signposting or written information being provided.
- Evidence of patient involvement in decision making, tools for shared decision making, and effective communication.
- Tailored resources for children and young people, representatives, and those with co-occurring considerations.

Appendix 1: Development of the Specification

This Specification has been informed by current evidence and best practice and was developed by group consensus. The group was multi-disciplinary and multi-agency and included representation from people with lived/living experience. The working group was chaired by Ms Ellen Maloney and Dr Fiona Duffy. Membership of the Group is detailed in Appendix 2

Evidence Base

A review of existing standards and underpinning research literature was carried out including Scottish Government, PHS, NICE, SIGN, NHS Evidence, and Department of Health websites. This was combined with stakeholder knowledge, including those with lived/living experience. This evidence was also informed by equality impact assessments.

Quality Assurance

The working group members had individual and collective responsibility to sign off and provide relevant assurance, including clinical assurance of the Specification. All group members agreed to the working group's Terms of Reference.

Healthcare Improvement Scotland have been involved throughout the Specification development and have provided guidance and assurance on the processes for developing the Specification, including approaches to minimise bias.

Consultation Process

This Specification will be published for public consultation in October 2023. The consultation period will last for 12 weeks until January 2024. Everyone will be able to offer their opinion which will be considered carefully. The results will be analysed by an external research analysis provider and the finalised Specification will be published following careful consideration of the consultation results in early 2024.

To participate in the consultation please click here.

If you have any questions, please contact:
EatingDisordersNationalReview@gov.scot

Appendix 2: Membership of the Group

- Dr Fiona Duffy - Consultant Clinical Psychologist NHS Lothian, Senior Lecturer University of Edinburgh - Co-Chair of the national specification Working Group
- Ellen Maloney - Lived Experience - Co-Chair of the national specification Working Group
- Dr Marie Boilson - Consultant Psychiatrist, Clinical Director, NHS Fife
- Julie Coppola - Charge Nurse, NHS Ayrshire and Arran
- Kat Dixon-Ward - Clinical Advice Coordinator, BEAT
- Hazel Elliot - Advanced Dietetic Practitioner, NHS Lothian
- Dr Joy Olver - Consultant Psychiatrist, North of Scotland CAMHS Tier 4
- Amzu Parpia - Advanced Specialist Dietitian, NHS Fife
- Dr Annabel Ross - The Royal College of GPs
- Dr Fiona Wardell - Healthcare Improvement Scotland

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PART 1: QUESTIONS ON THE OVERALL SPECIFICATION DOCUMENT

In this section of the consultation the questions focus on the Specification overall. If your time is limited, you could consider answering these eight questions. This part may be of the most interest to people who have experience of accessing eating disorder treatment.

1. How far do you agree that the Specification will improve the experiences of people accessing eating disorder care and treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

2. How far do you agree that the Specification will improve the outcomes for those accessing support and treatment for an eating disorder?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

3. How far do you agree that the Specification successfully set out to individuals, their families and carers what they can expect when they access eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

4. We know that currently not everyone has the same experiences or outcomes when they access eating disorder treatment. We want the Specification to help make sure that your needs are met, whoever you are and whatever your background. How far do you agree that the Specification will help do this?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

5. This Specification sits underneath the new Core Mental Health and Wellbeing Standards. In the draft Specification document, we have provided a link to the Core Mental Health Standards. Do you think it would be helpful to include the full Core Mental Health and Wellbeing Standards in the document or only provide a link to them?

    a. The link to the Core Mental Health Standards for Scotland is sufficient.
    b. It would be better to include the full Core Mental Health and Wellbeing Standards.
    c. Other, please explain:

6. We want the Specification to be as accessible and as easy to understand as possible. Do you have any suggestions on how this could be improved? For example we are planning to develop an easy read version of this document.

7. Do you have any other comments on the Specification overall?

PART 2: QUESTIONS ON THE SPECIFIC OUTCOMES

This part of the consultation focuses on each specific outcome to allow us to learn more about your thoughts on each.

Questions on Outcome 1: Leadership and Governance

The detail of Outcome 1 can be found on page 15.

8. How far do you agree that the statements within "Outcome 1 - Leadership and Governance will improve the experiences of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

9. How far do you agree that the statements within "Outcome 1 - Leadership and Governance" will improve the outcomes of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

10. Reading the "Outcome in Action", which is intended to describe how the "Outcome 1 - Leadership and Governance" will be delivered, do you have any other comments about the Outcome?

Questions on Outcome 2: Service Structure

The detail of Outcome 2 can be found on page 19.

11. How far do you agree that the statements within “Outcome 2 - Service structure” will improve the experiences of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

12. How far do you agree that the statements within “Outcome 2 - Service structure" will improve the outcomes of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

13. Reading the “Outcome in Action”, which is intended to describe how the “Outcome 2 - Service structure” will be delivered, do you have any other comments about the Outcome?

Questions on Outcome 3: Access to Care

The detail of Outcome 3 can be found on page 23.

14. How far do you agree that the statements within “Outcome 3 – Access to care” will improve the experiences of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

15. How far do you agree that the statements within “Outcome 3 – Access to care” will improve the outcomes of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

16. Reading the “Outcome in Action”, which is intended to describe how the “Outcome 3 – Access to care” will be delivered, do you have any other comments about the Outcome?

Questions on Outcome 4: Supporting People with Co-occurring Considerations and Comorbidities

The detail of Outcome 4 can be found on page 26.

17. How far do you agree that the statements within “Outcome 4 - Supporting people with co-occurring considerations and comorbidities" will improve the experiences of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

18. How far do you agree that the statements within “Outcome 4 - Supporting people with co-occurring considerations and comorbidities" will improve the outcomes of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

19. Reading the “Outcome in Action”, which is intended to describe how the Outcome will be delivered, do you have any other comments about the Outcome?

Questions on Outcome 5: Assessment and Medical Monitoring

The detail of Outcome 5 can be found on page 29.

20. How far do you agree that the statements within “Outcome 5 - Assessment and medical monitoring" will improve the experiences of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

21. How far do you agree that the statements within “Outcome 5 - Assessment and medical monitoring" will improve the outcomes of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

22. Reading the “Outcome in Action”, which is intended to describe how “Outcome 5 - Assessment and medical monitoring" will be delivered, do you have any other comments about the Outcome?

Questions on Outcome 6: Transitions

The detail of Outcome 6 can be found on page 34.

23. How far do you agree that the statements within “Outcome 6 - Transitions" will improve the experiences of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

24. How far do you agree that the statements within “Outcome 6 - Transitions" will improve the outcomes of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

25. Reading the “Outcome in Action”, which is intended to describe how the “Outcome 6 - Transitions" will be delivered, do you have any other comments about the Outcome?

Questions on Outcome 7: Discharge

The detail of Outcome 7 can be found on page 36.

26. How far do you agree that the statements within “Outcome 7 - Discharge" will improve the experiences of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

27. How far do you agree that the statements within “Outcome 7 - Discharge" will improve the outcomes of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree		Disagree	Strongly Disagree

28. Reading the “Outcome in Action”, which is intended to describe how “Outcome 7 - Discharge" will be delivered, do you have any other comments about the Outcome?

Questions on Outcome 8: Education and Training

The detail of Outcome 8 can be found on page 39.

29. How far do you agree that the statements within “Outcome 8 - Education and training" will improve the experiences of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

30. How far do you agree that the statements within “Outcome 8 - Education and training" will improve the outcomes of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

31. Reading the “Outcome in Action”, which is intended to describe how “Outcome 8 - Education and training" will be delivered, do you have any other comments about the Outcome?

Questions on Outcome 9: Shared and Supported Decision Making

The detail of Outcome 9 can be found on page 41.

32. How far do you agree that the statements within “Outcome 9 - Shared and supported decision making" will improve the experiences of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

33. How far do you agree that the statements within “Outcome 9 - Shared and supported decision making" will improve the outcomes of people accessing eating disorder treatment?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

34. Reading the “Outcome in Action”, which is intended to describe how “Outcome 9 - Shared and supported decision making" will be delivered, do you have any other comments about the Outcome?

PART 3: IMPLEMENTATION AND MEASUREMENT

The questions in this section are seeking initial views on what support services will need to implement the Specification, as well as how to measure implementation.

This part of the consultation may be most relevant to people who have experience working in or running services, but we welcome everyone's views.

Implementation

35. Overall, what support do you think services will need to implement the National Specification for the Care and Treatment of Eating Disorders in Scotland?

Measurement

A key aim of this Specification is that it is measurable. Being able to measure service delivery against the Specification, allows sharing good practice, celebrating successes, identifying any issues and driving service improvement. It is important that measurement does not add unnecessary burden to services.

We are proposing that the implementation of the Specification is measured in two ways:

Firstly, by services across the country filling out a self-assessment tool to collect information and data to find out how the Specification is being implemented across their services.

A self-assessment tool is a way for services to gather information to allow them to evaluate how well they are delivering against the Specification. The tool will allow services to provide evidence to show that they are meeting the Specification, supporting them to recognise good practice and make necessary improvements to the services that they deliver. It is proposed that this self-assessment would be a continual way to drive improvement in services over time. The number and frequency of self-assessments is still to be decided.

Secondly, we propose another way to measure performance, by collecting and publishing data on a number of indicators.

An indicator is information collected across the country that provides a measure of how well services are delivering against the Specification. Service providers will be asked to submit data on these indicators, which will be analysed and published to allow the Scottish Government to understand how services are performing against the Specification and how well they are delivering for the people who use them.
It is proposed that this data on indicators would be collected, analysed and published on a regular basis. The frequency of collection is still to be decided. Examples of potential indicators include questions such as: “I was asked about my needs and my personal circumstances and requirements and these were considered in planning care and treatment” or “I was treated with kindness, compassion, dignity empathy, and respect when accessing services”.

36. How far do you agree that the Specification should be measured using a validated self-assessment tool?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

37. How far do you agree that the Specification should be measured using a range of indicators?

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

38. Do you have any other comments on the possible questions to include in the self-assessment, including any further suggestions?

39. We know that currently not everyone has the same experiences or outcomes when they receive treatment for an eating disorder. We want this Specification to help make sure that services meet your needs whoever you are and whatever your background. How would you suggest that we support services to reduce inequalities in the outcomes and experiences of people who use services, including in the measurement of the Specification?

Part 4: Responding to this Consultation

We are inviting responses to this consultation by 26 January 2024.

Please respond to this consultation using the Scottish Government's consultation hub, Citizen Space (http://consult.gov.scot). Access and respond to this consultation online at Activity Unavailable - Scottish Government consultations - Citizen Space. You can save and return to your responses while the consultation is still open. Please ensure that consultation responses are submitted before the closing date of 26 January 2024.

If you are unable to respond using our consultation hub, please complete the Respondent Information Form to:

Iro Arvanitidou
CAMHS Improvement and Eating Disorders Policy
Mental Health Directorate
Scottish Government
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

Handling your Response

If you respond using the consultation hub, you will be directed to the About You page before submitting your response. Please indicate how you wish your response to be handled and, in particular, whether you are content for your response to published. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

If you are unable to respond via Citizen Space, please complete and return the Respondent Information Form included in this document.

To find out how we handle your personal data, please see our privacy policy:
https://www.gov.scot/privacy/

Next Steps in the Process

Where respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public at http://consult.gov.scot. If you use the consultation hub to respond, you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us. Responses will be published where we have been given permission to do so. An analysis report will also be made available.

Comments and Complaints

If you have any comments about how this consultation exercise has been conducted, please send them to the contact address above or at EatingDisordersNationalReview@gov.scot

Scottish Government Consultation Process

Consultation is an essential part of the policymaking process. It gives us the opportunity to consider your opinion and expertise on a proposed area of work.

You can find all our consultations online: http://consult.gov.scot. Each consultation details the issues under consideration, as well as a way for you to give us your views, either online, by email or by post.

Responses will be analysed and used as part of the decision making process, along with a range of other available information and evidence. We will publish a report of this analysis for every consultation. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

Scottish Government
Riaghaltas na h-Alba

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Any enquiries regarding this publication should be sent to us at

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