RCGP SCOTLAND

Care and treatment of eating disorders - national specification: consultation

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

RCGP Scotland welcomes the opportunity to respond to this consultation. As the membership body for general practitioners in Scotland, we exist to promote and maintain the highest standards of patient care.

The College recognises the importance of this work. Eating disorders are relatively common and also carry the highest mortality of any mental illness, particularly in younger age groups. It is crucial to have accessible services which provide clear treatment pathways for patients and clinicians alike.

As GPs, we are keenly aware of the huge impact that EDs can have both on patients and their families and carers.

We agree that this specification should improve care, but would make the following suggestions:

- The role of the GP is key, especially for early diagnosis and referral, as well as where presentations may be subtle or hidden. Unfortunately, this is not supported in the consultation document in terms of emphasis, training needs or resource.
- The document highlights the need for education and training for all those involved in Eating Disorder (ED) care however this is only spoken of in regard to specialist services. Primary Care team education and support is key as outlined above, and in the consultation itself. Referrals almost always involve GPs, who are also the most likely clinicians to have an established relationship with the patient or their family member.
- It is critical to ensure people are supported to open up about an area of emotional difficulty that often remains hidden because of the nature of EDs and the commonly associated feelings of shame and guilt. This is where continuity of care is key. Patients may present to a GP with another health concern to establish if they feel trust and can confide further. The new multi-disciplinary team (MDT) does not generally bring these options, with the focus on a single care episode and with few team members having training in mental health. The ongoing loss of GP capacity compromises the ability to facilitate these delicate conversations, which rely on adequate workforce and systems support and which strongly benefit from continuity of care.

It is also not stated in the consultation that GPs may be involved in lifelong care, and that knowing the family or carers can be crucial especially for children and adolescent care.

We welcome the emphasis on involving patients, families and carers. GPs will be involved at some key points in the patient journey; postnatal care for instance, where SIGN[1] highlights that eating disorders may worsen at what is a very crucial time both for mother and baby, and where there are multiple barriers to accessing care, including stigma and concerns about exposure. It is also crucial, particularly during pregnancy and afterwards, that GPs are able to liaise with their wider team including midwives and health visitors where needed, particularly in view of the harms that infants and older children can suffer as a result of their mother's ED (evidence outlined in SIGN). Team fragmentation and loss of GPs can also compound difficulties.

Both SIGN and the specification highlight the extent of mental co-morbidity with EDs, and the vast majority of the former is managed entirely in general practice.

GPs have no regular, adequately resourced Protected Learning Time (PLT), and the services outlined in the consultation document represent yet another ask of them without support to facilitate it. We welcome a specification but without a thorough assessment of the resource and workforce available to meet such standards, we are worried that it will promise something that cannot be delivered. This is a difficult challenge, as clearly GPs want standards to be raised, but if there is not the workforce to meet this need it can demoralise staff, as well as produce promises to patients and their families of services which cannot be delivered. This has been a recurring theme in mental healthcare planning in Scotland and may have negative consequences on patient expectations and clinician morale.

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

While we welcome the comprehensive delivery goals as outlined, there are concerns regarding the ability to provide such services in the midst of the present mental health and GP workforce crisis. Care must be shown to not overpromise and under deliver.

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

While we appreciate that this clearly outlines expectations, we are concerned that they will not be met. The following are not currently in place, and we are keen to know if estimates have been done on the new work they will generate, and how much additional staff and resource will be needed to close any waiting time gaps.

Self-referral is welcome in many ways for such a worrying condition. Unlike other conditions in which self-referral may lead to patients with lower levels of need or risk reducing access for others, this is less likely to happen for ED. Despite this, we would wish to see further estimates of what additional workload might be generated from this.

Triage times are ambitious and probably necessary, but it would be useful to assess current lengths facing patients to measure how these might be improved with further emphasis on reducing them. A move to one week (urgent) and four weeks (routine) is far removed from the prolonged waits GPs tend to see at present.

We would also note that there are patients who currently do not access services outlined in SIGN – especially those from minority ethnic groups, men, LGBQT+ and so on. It is important that services are accessible to all people affected by ED.

As the primary and secondary care mental health workforce in Scotland now falls far short of what is required to meet demand, every new standard needs to be considered in terms of what other mental health services might be ceased in order to meet it.

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

We believe that specifications do help in standardising outcomes and reducing unwarranted variation. What we feel is not clear is whether we have the resource and workforce to achieve them.

Clarity regarding monitoring in primary care is welcome, and we agree that this should only be expected when there is a specified shared care agreement which is negotiated with and clear to all parties. We would like further specification though, namely that GPs are not expected to monitor patients after referral and before they are seen by specialist services, as is currently being asked of some. This is high risk clinical activity where roles and boundaries must be very clear to ensure safe care.

Because of the ongoing workforce, workload and investment challenges in general practice, we consider that any shared care agreements also need to be fully resourced to recognise not only the amount of work involved, but that it is clinically risky, and sometimes involves patients who are reluctant to engage or remain engaged. There is a system-wide and ongoing transfer of unresourced work from secondary to primary care.

The document outlines that both mental and physical health is poorer in deprived communities, and of course in those with severe and enduring mental illness. We suggest that outcomes for each of these groups be specifically measured, including in regard to referral rates.

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:

We suggest that this also be aligned to the Mental Health & Wellbeing Strategy Delivery plan and mental health workforce planning more generally, as that is key to successful implementation.

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?

We would welcome engagement specifically with LGBQT+ and ethnic minority communities for their views on the consultation, using translated summaries where needed.

Schools are an important avenue for identifying ED in children and adolescents and we would suggest specifically asking for views from the educational sector regarding communication style and pathways.

Brief comments on outcomes:

Outcome 1:

We note “People accessing services should benefit from partnership working at a local, regional, and national level” and that “all aspects of the patient journey” should be covered by accountability and governance (page 14). We often, including in this document, see little reference to the crucial aspect of the patient journey which takes place in general practice. We also would suggest that partnerships are strengthened by Interface Groups – particularly when transitions are key. For eating disorders, the risks at points of transition are especially high (as outlined in SIGN). There is reference to educational approaches, data and information sharing and all of these should consider general practice too.

Outcome 2 – Service structure. 2.5 – clear protocols for unattended appointments.

These generally do not exist for high-risk mental health patients, the default usually being that the GP is left to manage often the most vulnerable or at-risk patients. We welcome this recommendation but would like to see it implemented more widely across mental health outpatient services. We would want GPs involved in pathway protocol development, wherever possible, and resourced for that work.

Outcome 3 – access to care.

We note: "Individuals with a primary diagnosis of Binge Eating Disorder (BED) are seen in specialist eating disorder services and not weight management services". We know that over two thirds of the adult Scottish population is overweight, with 30% being obese.2 While public health and societal influences, including poverty, are profoundly important in determining this, a high prevalence of BED may also be present in this group. SIGN (Chapter 11) outlines that there is a poor evidence base for interventions for those with BED, and outcomes with currently recommended treatments are generally poor. The principle recommended approach is Cognitive Behavioural Therapy (CBT) which can help reduce binge episodes and help with factors which improve quality of life.

Perhaps this section should be considered through the lens of Realistic Medicine and public health principles. With psychological therapies and services limited in Scotland, and with even profoundly mentally ill patients facing significant wait times, we suggest more work is needed first to assess the cost-effectiveness of treatments for BED in view of their likely high prevalence, the currently poor evidence base for treatments and their limited outcomes. The current mainstay of treatment is helping individuals move away from the 'diet' approach – at present, the cost effectiveness of population-level interventions is unknown. Obesity has huge consequences for health, at both individual and population level, as well as imposing very high cost on the NHS: it is crucial that interventions are both effective in terms of health outcome and cost-effective.

As mentioned earlier, our impression is that there is a big attainment gap between current waiting times, and the objective of 1 and 4 weeks respectively for urgent and routine cases; especially as that is not only in regard to assessment but also to treatment.

Outcome 4 - Co-morbidities.

We suggest there might be a lack of awareness amongst clinicians and service providers of the association between T1 diabetes and EDs, and the particular associated dangers. A wider educational campaign as well as new joined-up services would be welcome to resolve this.

Outcome 5.

"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 Medical Emergencies in Eating Disorders (MEED)(2022) and access to consultation with specialist services when required". Again, this emphasises the need for both GP involvement in referral pathways and time for educational opportunities.

Outcome 6 – Transitions.

We welcome that the risks of transitions are recognised, especially child and adolescent to adult services, and that those are planned for and do not rely on the GP for re-referral.

Outcome 7 – Discharge.

We support these approaches, but they will need additional resource and capacity to achieve.

Outcome 8 – Education and training.

The outcome is for “Organisations demonstrate commitment to the education and training of all staff involved in eating disorder services, appropriate to roles and workplace settings”. We agree with this, but the descriptors seem to be aligned to specialist settings with no indication of how this is going to be achieved in general practice.

Outcome 9 – Shared and supported decision making.

We agree with these approaches – and support that “People awaiting treatment and care are updated on anticipated timelines and delays”. It needs to be defined who will do this as in general terms. Not relating specifically to EDs, this seems to fall to general practice, representing an additional aspect of workload on an already overstretched workforce.

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[1] Throughout this document’ SIGN’ refers to SIGN 164; Eating Disorders. A national clinical guideline; published January 2022, updated August 2022

[2] https://www.obesityactionscotland.org/media/locdychb/obesity_prevalence_causes__impact_202122_data_f.pdf