

Adult Healthy Weight Services (≥18 years)

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NHS Shetland Document Development Coversheet*

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Examples of reasons for presenting to the group	Examples of outcomes following meeting
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***To be attached to the document under development/review and presented to the relevant group**

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1. Background

Combined overweight and obesity rates in Scotland and Shetland remain high, at 65% and 72% respectively (Scottish Government, 2019). There is clear evidence of the associations between obesity; health risks, including weight based stigma and discrimination; and the wider economic costs arising from sickness absence and premature mortality (NHS Health Scotland, 2019).

The release of the national Healthier Futures frameworks; Public Health Priorities and the Standards for Weight Management Services aim to reduce the prevalence of overweight, obesity and type 2 diabetes which is an ongoing challenge for government, delivery partners and health professionals.

2. Purpose, Context and Scope

Currently there is no local guideline for the management of overweight and obesity in adults. The following new guideline outlines the services and pathway for adults aged 18 years or more with overweight or obesity.

This document should be used in conjunction with pathways and guidelines to manage co-morbid conditions related to weight management, for example the Management of Diabetes. It is not intended to replace SIGN or NICE guidance on obesity and weight management for adults, these documents should be used to support the implementation of this local guideline.

This document will be reviewed and updated in line with local adherence to the national frameworks; new emerging evidence and to reflect any significant changes in related guidance.

This guideline does not cover:

- Children and young people, less than 18 years of age
- Delivery of pharmacological interventions
- Management of underweight or malnutrition
- Weight management during pregnancy

3. Summary of Key Drivers

This guideline supports the implementation of the following national documents:

A Healthier Future: type 2 diabetes prevention, early detection and intervention: framework

- This framework sets out national-level guidance for boards and their partners on designing and implementing a clear healthy weight pathway for people at risk or diagnosed with type 2 diabetes within integrated healthy weight services.

A Healthier Future: Scotland's diet and healthy weight delivery plan

- Sets out ambitions to reduce prevalence of obesity and reduce diet-related health inequalities. A strong focus on primary prevention, including population-wide approaches and targeted tailored support.
- Outcome 3 – People have access to effective weight management services
- Outcome 5 – Diet-related health inequalities are reduced
- This approach is underpinned by:
 - Scotland's Public Health Priorities, particularly Priority 6 – A Scotland where we eat well, have a healthy weight and are physically active
 - Active Scotland Delivery Plan which emphasises the importance of both diet and physical activity in maintaining a healthy weight.

Standards for the delivery of Tier 2 and Tier 3 weight management services in Scotland

- These standards are intended to ensure a more consistent, equitable and evidence based approach to the treatment of overweight and obesity in Scotland.
- These standards cover how services are designed; how individuals are referred, assessed and supported through interventions; the skills and training staff require and how the standards will be monitored and evaluated.

3.1. Type 2 Diabetes Prevention

There is a strong emphasis on the importance of clear, standardised pathways for the management of overweight and obesity with type 2 diabetes prevention and early intervention.

In Scotland, the incidence and prevalence of type 2 diabetes has steadily increased to 257,000 in 2016 and it is estimated around 10% of cases remain undiagnosed (NHS Health Scotland, 2018). In 2018, Shetland had 989 people living with type 2 diabetes which accounted for 86.7% of the diabetes population (Scottish Diabetes Data Group, 2019). Locally there is an average of 64 new cases of type 2 diabetes each year, this figure is an average of new cases between 2011 and 2017. There are also over 300 people with pre-diabetic conditions in Shetland which

place people at a higher risk of developing type 2 diabetes. These conditions include previous or current gestational diabetes; impaired fasting glucose and impaired glucose tolerance.

As type 2 diabetes prevention and early intervention is one of the key drivers in the development of this document, scoping activity was completed in March 2019 in an attempt to establish baseline numbers of those at risk. The Diabetes UK “Know Your Risk” tool has been developed with the University of Leicester and the University Hospital of Leicester NHS Trust. This combines non-modifiable and modifiable risk factors to highlight a person’s risk of developing type 2 diabetes in the next 10 years. It is not a diagnostic tool, for individuals at moderate or high risk, clinical judgement should be used to determine if diagnostic testing should be used (Diabetes UK, 2018).

Using primary care EMIS data and the Diabetes UK “Know Your Risk” tool criteria it is estimated 4,549 people, approximately 19.8% of Shetland population, are at increased risk of developing type 2 diabetes in the next 10 years. This figure is likely to be an underestimation due to the lack of full data items. The scoping activity included adults without diabetes aged 18 years who had a BMI coded in the previous 3 years. The following criteria were then scored: gender, BMI, hypertension status to establish those at increased risk over developing type 2 diabetes. The following data items were unable to be collated as part of the scoping due to the nature of EMIS and data recording: ethnicity, family history and waist circumference.

The “Know Your Risk” tool is a validated type 2 diabetes risk assessment tool which enables conversations towards change. As Adult Healthy Weight Services are a key part of type 2 diabetes prevention and management, the tool has been incorporated into healthy weight services screening and assessment process and will be used as an additional measure of ongoing healthy weight service evaluation.

4. Communication and Monitoring

The overall responsibility for the dissemination and implementation of this guideline lies with NHS Shetland’s Healthy Weight Leads and the Director of Public Health. The local leads have responsibility for reviewing and updating this guideline. It will be circulated through relevant groups and discussed within operational teams. This guideline will also be available electronically on NHS intranet, Dietetics and Healthy Shetland websites.

The implementation of this guideline is included in local Type 2 Diabetes Framework plans which is reported on a quarterly basis to Scottish Government to detail local work on the Healthier Futures Framework.

5. Adult Healthy Weight Services

The UK Obesity Care Pathways, detailed in the table below, alongside the documents in section 3 outline the tiered approach to Adult Healthy Weight Services (Department of Health, 2013).

Tiers	Eligibility and Aims	Example of Commissioned Services
Tier 1: Universal Prevention	Prevent future occurrences through information giving	Environmental health promotion
Tier 2: Lifestyle Intervention	Encourage people with overweight and obesity to have healthier lifestyles	Multicomponent weight management
Tier 3: Specialist Services	Management of severe obesity and obesity in people with complex needs	Multidisciplinary intervention
Tier 4: Surgery	Only considered for people with severe morbid obesity and a serious health condition	Bariatric Surgery

The local Adult Healthy Weight Services are detailed in the following sections. The appendices provide infographics of this information including the Tiers, a Summary Services Pyramid and Service flowchart.

5.1. Target groups

This guideline has a strong focus on prevention and early intervention therefore potential target groups have been identified for consideration and risk assessment. These groups include, but are not limited to, those who:

- Have low physical activity levels
- Have pre-diabetic conditions, including impaired fasting glucose; impaired glucose tolerance; previous or current gestational diabetes
- Cardiovascular disease risk factors, including dyslipidaemia and hypertension
- Central obesity

It is important that everyone engaging with these target groups; including workplaces, communities and staff, have access to and confidence to deliver information on achieving and maintaining a healthy lifestyle. A selection of hyperlinked websites are available in the appendices.

5.2. Recording Baseline Data

Accurate data recording and coding is essential within patient management systems, including EMIS and TrakCare, to ensure accurate data and information sharing as appropriate. The measurements used to assess suitability to healthy weight programmes include body mass index (BMI), waist circumference, blood pressure (BP), medical history and physical activity and wellbeing scores. All clinical areas should have access to suitable equipment and training to accurately obtain these measurements. If this is not available, please raise this with line management.

The above measurements are also used as part of cardiovascular disease and type 2 diabetes risk screening tools to follow the appropriate guidance. This data, in addition to practitioner and patient feedback, will be used to evaluate programme effectiveness and service delivery.

Patients can enter into adult healthy weight services with a BMI of 25 or more, or a BMI of 23 or more for black, Asian and other minority ethnic groups, due to increased risk of health conditions at lower BMI (NHS Health Scotland, 2019).

During 2020-21 local healthy weight leads are developing a single point of referral for adult healthy weight services, this guideline will be updated in line with this development.

5.3. Pathway Considerations

5.3.1. Pregnancy

Weight management interventions during pregnancy are contraindicated and weight loss is not recommended. Maternity, Health Improvement and Dietetics teams will therefore work collaboratively to ensure appropriate health behaviour change and healthy lifestyle support is provided during pregnancy. Post-pregnancy support will then be offered through the adult healthy weight services pathway, as appropriate.

5.3.2. Pharmacotherapy

Currently the only licensed drug approved in NHS Scotland for weight management is Orlistat, SIGN 115 guidelines outline Orlistat should only be used where diet, physical activity and behavioural changes are supported (SIGN, 2010). Under the new standards for adult weight management services, patients receiving or being considered for pharmacotherapy should be engaged with Tier 3 Specialist Services.

Therefore under this local pathway, clinicians should use their clinical judgement and discuss appropriate weight management intervention with the dietitian, for patients who are receiving or being considered for pharmacotherapy. This ensures the most effective use of the medication and the best outcome for patients. Patients receiving or being considered for pharmacotherapy will not receive support by Tier 2 services.

5.3.3. Disengaging Patients

It is important patients engage with the right support at the right time for them. If a patient is not ready to engage with services: provide support, signposting and details of how they can engage in the future.

5.3.4. Exclusion Criteria

This guideline, associated documents and appendices outline the inclusion and exclusion criteria for each service tier. These criterion ensure NHS Shetland begins to align with adult service standards therefore it is important to become familiar with these tiers. The following exclusion criteria apply across all healthy weight tiers:

- Pregnancy
- Alcohol and drug use that would significantly impair ability to engage with a period of structured weight management intervention
- Diagnosed Binge Eating Disorder or active purging behaviours, including laxative use and self-induced vomiting
- Uncontrolled hypothyroidism
- Untreated Cushing's Syndrome
- Acute infections or acutely unwell
- Unstable medical or psychiatric condition
- Chronic long term condition which increases nutritional requirements, for example Chronic Obstructive Pulmonary Disease (COPD) or Motor Neurone Disease (MND); unplanned weight loss or malnutrition risk

Additional tier-specific exclusion criterion are detailed in the following sections of this guideline.

5.4. Tier 1: Universal Prevention and Early Intervention

Universal prevention and early intervention messaging is applicable throughout the pathway. This includes prevention of overweight and obesity messages and reinforcement of healthy lifestyle. There are a wide range of opportunities to engage the public including community-based, work-based activities and opportunistic contacts within services. Prevention and early intervention messages are to be delivered throughout services and communities alongside signposting to useful resources and approved websites.

Hyperlinked website resources to support messaging and signposting are available in the appendices.

5.4.1. Delivering Brief Interventions

Brief interventions are short, evidence-based, structured conversations with a patient or service user. These conversations seek, in a non-confrontational way, to motivate and support individuals to think about and plan a change in their behaviours.

Physical Activity Brief Interventions (PABI) and Alcohol Brief Interventions (ABI) are part of Tier 1 delivery and it is appropriate for all patient-facing staff to be trained in these. If you require training, discuss this with your line manager and contact the Health Improvement Department.

Hyperlinked website resources to support brief intervention training and delivery are available in the appendices.

5.4.2. Assessing Type 2 Diabetes Risk

The 'Know Your Risk' tool, as discussed in Section 3, is a validated risk assessment tool used to highlight a person's risk of developing type 2 diabetes in the next 10 years. It is not applicable for those with a current diagnosis of diabetes. The tool incorporates non-modifiable and modifiable risk factors to developing type 2 diabetes, enabling conversations towards change (Diabetes UK, 2018).

The 'Know Your Risk' tool is available on the Diabetes UK website and an A4 format is available in the appendices. The tool can be completed as a self-assessment or incorporated as part of a clinical care review. It is not a diagnostic tool, for individuals at moderate or high risk, clinical judgement should be used to determine if diagnostic testing should be used (Diabetes UK, 2018).

5.5. Tier 2: Lifestyle Interventions

Tier 2 consists of multicomponent healthy weight interventions including dietary approaches and physical activity delivered by trained professionals. Programmes available run for 12 months with a 3-4 month active intervention phase followed by the maintenance phase.

Programmes available:

- Counterweight Programme
- Healthy Shetland with SRT, a pilot group programme 2020/21

Patients cannot be directly referred into a specific programme – patients must be referred, or self-refer, to the Health Improvement Team where a screening appointment will be completed and the practitioner will agree appropriate support with that patient.

Tier 2 Referral Criteria:

- BMI 25 – 34.9kg/m²
- Minimal co-morbidities: those controlled via lifestyle or minimal medical management
- Physically mobile and safe for physical activity: in line with physical activity guidelines
- 5-10% weight loss targets

Tier 2 Exclusion criteria:

In addition to the exclusion criteria for all tiers:

- Those who do not meet the referral inclusion criteria
- Those unable to commit to regular review
- Where specialist intervention, including pharmacotherapy or bariatric surgery, is being considered
- Lack of capacity, includes learning disability, additional support needs or dementia
- Limited mobility and/or frailty, including unsafe for moderate physical activity, falls risk
- Those whose condition requires clinical or therapeutic nutrition prior to weight intervention, including poorly controlled or unmanaged: diabetes, coeliac disease, IBD

Healthy Shetland – Pilot Projects in 2020-21

The NHS Health Improvement Team also known as 'Healthy Shetland' have developed the Healthy Shetland Programme. The programme is designed to meet the standards for tier 2 services, with fortnightly sessions over 4 months during the active intervention phase with the remaining 8 months as the maintenance phase which includes 2 review appointments.

During 2020-21, the programme is being piloted in a group setting by Shetland Recreational Trust (SRT) staff in leisure centres; where participants will engage in a 45 minute education session, followed by a 45 minute physical activity session. Due to the pilot nature of the project, spaces are capped in line with leisure service capacity. Following the pilot evaluation, ongoing programme delivery will be agreed and implemented.

Those who meet the Tier 2 criteria, but are unable to attend a group, will complete the Counterweight Programme on a one-to-one basis with a trained Health Improvement Practitioner.

Access to leisure services: patients engaging with tier 2 services will receive discounted access to SRT during their programme as part of this pilot phase.

Healthy Shetland Pilot Project Leads:

Lauren Peterson and Claire Morris, Health Improvement Team.

5.5.1. Referring to Tier 2 Lifestyle Interventions

Referrals are accepted from healthcare professionals or self-referrals. The referral form detailing the essential and desirable referral criteria is attached below.

The referral form should be emailed to shet.healthyshetland@nhs.scot or directly to the practitioner attached to the patient's registered health centre.

Health Improvement Team contact details:

Email: shet.healthyshetland@nhs.scot

Phone: (01595) 807494



HI - Weight
Referral.docx

5.6. Tier 3: Specialist Services

Management of more complex cases, including higher grades of obesity and obesity associated with co-morbidities, psychosocial difficulties and/or additional needs. May require a variety of interventions within a multidisciplinary team, currently this aspect is a gap in local delivery. Currently nutritional interventions and lifestyle change is delivered by dietitians. The programmes detailed below run for up to 2 years, typically with a 3-6 month active intervention phase followed by a maintenance phase.

Programmes available:

- Counterweight Plus
- Low Carbohydrate Diet (developed by NHS Tayside)
- Tailored Dietary Advice

Patients cannot be directly referred into a specific programme – patients must be referred to the Nutrition & Dietetics Service where a screening appointment will be completed and the Dietitian will agree appropriate support with that patient.

Tier 3 Referral Criteria

- BMI 35 and over
- Over 10% weight loss goal
- May be less physically mobile
- May have more complex health needs or disease states, including
 - Metabolic syndrome; CVD risk; Sleep apnoea; Diabetes (all types)
 - Uncontrolled eating behaviours that cause clinically significant distress and require further assessment
 - Several unsuccessful attempts at weight loss, including weight loss groups, tier 2 service - consult with Health Improvement if patient has engaged with their service
 - Where specialist intervention is being considered: Pharmacotherapy, Bariatric Surgery, Very Low Calorie Diet (VLCD) or Total Diet Replacement (TDR)

Tier 3 Exclusion criteria

In addition to the exclusion criteria for all tiers:

- Those who do not meet the referral inclusion criteria
- Those unable to commit to regular review

5.6.1. Referring to Specialist Services

Referrals are accepted from healthcare professionals no self-referrals. Electronic referrals via SCI Gateway or completing the referral form attached below. Referrals via clinic letters will be accepted if this provides details of referral criteria met.

Dietetics Team contact details:

Email: shet.dietetics@nhs.scot

Phone: (01595) 743203



ReferralFormDieteti
cs-V2.doc

5.7. Tier 4: Bariatric Surgical Services

For people presenting with comorbidities where weight reduction is highest priority in their care. Individuals have already been seen within tier 3 services where they will have been screened and assessed for bariatric surgical consideration. NHS Grampian deliver this service for NHS Shetland patients.

Patients who meet the referral pre-requisites; the priority criteria and have support of the dietitian can be referred to the NHS Shetland Medical Director for local triage and funding agreement. Do not refer directly to NHS Grampian. In cases where patients meet the pre-requisites but are out with the priority criteria an Individual Patient Treatment Request (IPTR) panel will be convened. Following local referral triage, the outcome letter will advise appropriate onward guidance, for example patient referral to NHS Grampian.

Bariatric Surgery: Pre-requisites – must be met

- Has been receiving intensive support within Tier 3 services - consult with tier 3 practitioner, if patient has engaged with service
- Ideally meets priority criteria
- All appropriate non-surgical measures have been completed
- Has 2 years of psychological stability as reviewed by appropriate healthcare professional, for example GP or Mental Health Team – if current patient or recent input
- Fit for anaesthesia and surgery – screened for obvious red flags to bariatric surgery
- You have fully discussed the NHS Grampian bariatric surgery leaflet
- Patient commits to life-long follow up

Bariatric Surgery: Priority Criteria

The National Planning Forum document – Obesity Treatment: Best Practice Guide outlines the below criteria (National Planning Forum, 2012).

- Priority 1 Criteria
 - Age: 18-44yrs
 - BMI: ≥ 35 -40kg/m²
 - Recent onset type 2 diabetes (<5yrs)
- Priority 2 Criteria
 - Age: 18-44yrs
 - BMI: >40-50kg/m²
 - Recent onset type 2 diabetes (<5yrs)

Tier 4 Exclusion criteria

In addition to the exclusion criteria for all tiers:

- Those who do not meet the inclusion criteria
- Lack of capacity, for example a severe learning disability, or dementia
- Patients who have been actively engaging in self-harm behaviours or suicide attempts in the past 2 years.

5.7.1. Referring to Bariatric Surgical Services

NHS Grampian deliver Bariatric Surgical Services on behalf of NHS Shetland and the referral process consists of 2 stages. The first stage is a written referral letter to the NHS Shetland Medical Director for local triage and funding agreement. This referral letter must contain the information in the table below and appropriate documentation.

Following local triage, an outcome letter with onward guidance will be sent to the referrer. For onward referral to NHS Grampian, this is completed electronically through SCI Gateway. Do not refer directly to NHS Grampian without local NHS Shetland triage and agreement.

Referral Content:

Demographics: <ul style="list-style-type: none">• Name• 10 digit CHI number• Referrer details• Registered health centre• Patient has agreed to data sharing/referral	Clinical: <ul style="list-style-type: none">• Clear identification of criteria met• Clear reason for referral, especially if out with priority criteria• Height, weight, BMI, weight history• Medical history; co-morbidities (include date of diagnosis)• Details of previous weight management interventions
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Bariatric Surgery: Patient Journey

Following referral to NHS Grampian Surgical Services, patients will undergo clinical assessment. This multi-disciplinary assessment deems a patient appropriate for surgical intervention and enables a patient to access the surgical pathway. Patients approved for surgical intervention will then attend group education lead by the multi-disciplinary team, which includes psychological review, pre-operative assessment and surgical review.

Patients will be placed on the surgical waiting list and receive local dietetic support during this time. Following surgery patients will remain on NHS Grampian caseload for 2 years, followed by life-long local follow up review.

If a patient is not suitable for surgery, as agreed either in NHS Shetland or NHS Grampian, appropriate onward guidance will be provided.

6. References

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Scottish Diabetes Data Group, 2019. Diabetes in Scotland. [Online] Available at: <http://www.diabetesinscotland.org.uk/Publications.aspx> [Accessed 30 January 2020].

Scottish Government, 2019. Scottish Health Survey 2018. [Online] Available at: <https://www.gov.scot/publications/scottish-health-survey-2018-volume-1-main-report/> [Accessed 30 January 2020].

SIGN, 2010. Management of Obesity. [Online] Available at: <https://www.sign.ac.uk/sign-115-management-of-obesity.html> [Accessed 30 January 2020].

7. Appendices

7.1. Rapid Impact Checklist – NHS Shetland

An Equality and Diversity Impact Assessment Tool:

<p>Which groups of the population do you think will be affected by this proposal? Other groups:</p> <ul style="list-style-type: none"> • Minority ethnic people (incl. Gypsy/travellers, refugees & asylum seekers) • Women and men • People with mental health problems • People in religious/faith groups 	<ul style="list-style-type: none"> • Older people, children and young people • People of low income • Homeless people • Disabled people • People involved in criminal justice system • Staff • Lesbian, gay, bisexual and transgender people
<p>N.B The word proposal is used below as shorthand for any policy, procedure, strategy or proposal that might be assessed</p>	<p>What positive and negative impacts do you think there may be? There will be positive impacts on all groups in accessing healthy weight services.</p>
	<p>Which groups will be affected by these impacts? Patients, NHS staff</p>
<p>What impact will the proposal have on lifestyles? For example, will the changes affect:</p> <ul style="list-style-type: none"> • Diet and nutrition • Exercise and physical activity • Substance use: tobacco, alcohol and drugs? • Risk taking behaviour? • Education and learning or skills? 	<p>This guideline is designed to support people to access appropriate services to make sustainable long term changes to their lifestyles, including changes to diet, physical activity and ultimately their weight and/or body composition. Through implementing this guideline staff within these services will support appropriate patients for that service.</p>

<p>Will the proposal have any impact on the social environment? Things that might be affected include:</p> <ul style="list-style-type: none"> • Social status • Employment (paid or unpaid) • Social/Family support • Stress • Income 	<p>There will be little impact on the social environment</p>
<p>Will the proposal have any impact on the following?</p> <ul style="list-style-type: none"> • Discrimination? • Equality of opportunity? • Relations between groups? 	<p>This guideline will counteract discrimination and provide equal opportunity to access appropriate services as needed. This guideline includes lower entry criteria to the pathway for those whose ethnicity or genetics place them at possible increased risk of weight related co-morbidities.</p>
<p>Will the proposal have an impact on the physical environment? For example, will there be impacts on:</p> <ul style="list-style-type: none"> • Living conditions? • Working conditions? • Pollution or climate change? • Accidental injuries or public safety? • Transmission of infectious disease? 	<p>There will be little impact on the physical environment.</p>
<p>Will the proposal affect access to and experience of services? For example,</p> <ul style="list-style-type: none"> • Health care • Transport • Social services • Housing services • Education 	<p>This guideline should have a positive impact on access to healthy weight services, it is acknowledged during implementation a waiting list will be in place for some services which could impact patient's experiences of the services. Best efforts will be made to ensure access to information and signposting during these waiting times. This ensures appropriate caseload management for staff and patients will have access to appropriate self-management information.</p> <p>This guideline is presented in line with NHS Shetland Communication Strategy and the Framework for Document Development</p>

Rapid Impact Checklist: Summary Sheet

Positive Impacts (Note the groups affected)

There will be positive impacts on all groups in accessing healthy weight services. Patients, NHS staff

This guideline is designed to support people to access appropriate services to make sustainable long term changes to their lifestyles, including changes to diet, physical activity and ultimately their weight and/or body composition. Through implementing this guideline staff within these services will support appropriate patients for that service.

This guideline will counteract discrimination and provide equal opportunity to access appropriate services as needed. This guideline includes lower entry criteria to the pathway for those whose ethnicity or genetics place them at possible increased risk of weight related co-morbidities.

This guideline should have a positive impact on access to healthy weight services. Best efforts will be made to ensure access to information and signposting during these waiting times. This ensures appropriate caseload management for staff and patients will have access to appropriate self-management information.

This guideline is presented in line with NHS Shetland Communication Strategy and the Framework for Document Development

Negative Impacts (Note the groups affected)

It is acknowledged during implementation a waiting list will be in place for some services which could impact patient's experiences of the services. Patients, NHS staff

Additional Information and Evidence Required

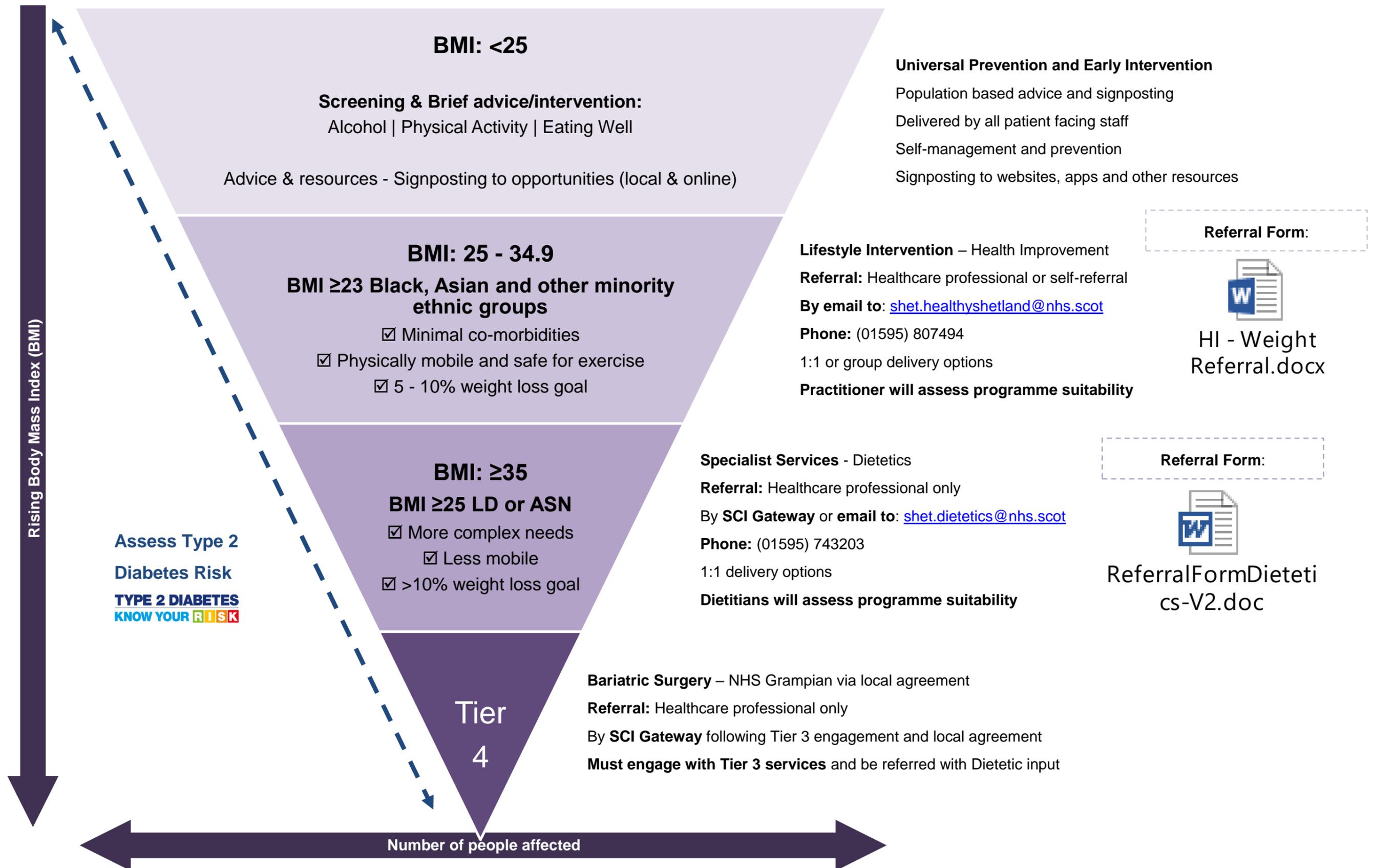
Recommendations

Services with a waiting list in effect will include signposting to self-management resources for patients to access during the waiting period.

From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?

No negative impacts for race or other equality groups have been identified therefore a full EQIA is not required

7.2. Summary Pyramid: Adult Healthy Weight Services



7.3. Tier 1: Universal Prevention and Early Intervention

7.3.1. Hyperlinked Websites and Resources

Health Improvement Team Website – [Healthy Shetland](#) 

NHS Inform – [Healthy Living Section](#)

Topics include:

Alcohol	Contraception	Dental Health	Drugs and drug use
Food and Nutrition	Immunisations	Keeping active	Mental wellbeing
Outdoor health	Preventing falls	Ready Steady Baby	Screening
Stopping smoking	12 week weight management programme		

Public Health England – [One You Quiz](#)

Diet & Healthy Weight Resources

- [Healthy Living Resources](#) – British Heart Foundation
- [Know Your Risk tool](#) – Diabetes UK
- [12 week weight management programme](#) – NHS Inform

Physical Activity Resources

- [Infographics](#) – UK government guidelines
- [Health Walks](#) – Healthy Shetland website
- [Community Sport Hubs](#) – Shetland Islands Council
- [Leisure Centres](#) – Shetland Recreational Trust
- Local independent fitness professionals, services and groups

Alcohol and Other Drugs

- Alcohol Brief Interventions – see next section for resources
- [Harm Reduction Advice](#) – Crew
- [Unit Generator tool](#) – Count 14

7.3.2. Brief Advice and Brief Interventions

Delivering Physical Activity Brief Interventions

- [Brief advice and brief intervention scripts](#)
- [Person centred physical activity advice](#)
- E-learning: [Raising the issue of physical activity](#)

1 In the past week, on how many days have you been physically active for a total of 30 minutes or more?

Physical activity may include: walking or cycling for recreation or to get to and from places; gardening; and exercise or sport which lasts for at least 10 minutes.

0 1 2 3 4 5 6 7

Go to Question 2 Positive reinforcement

2 If four days or less, have you been physically active for at least two and a half hours (150 minutes) over the course of the past week?

No Yes

Go to Question 3 Positive reinforcement

3 Are you interested in being more physically active?

No Yes

Literature (physical activity leaflet) Brief advice and or brief intervention



Delivering Alcohol Brief Interventions

- [ABI Resources](#)
- [Delivering an alcohol brief intervention briefing paper](#)

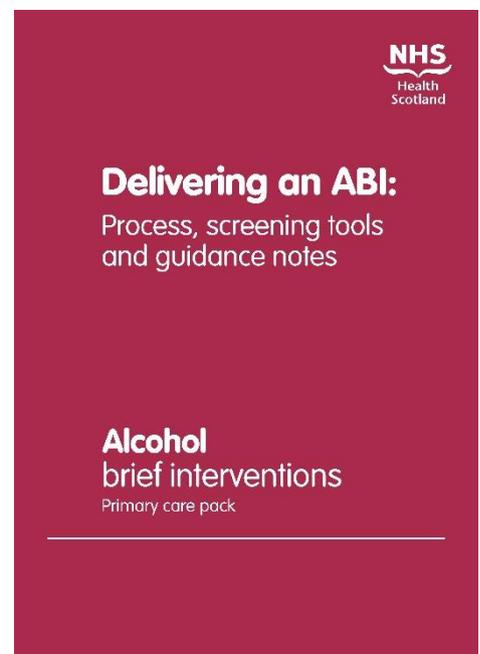
Training in Delivering Brief Interventions

All staff, particularly patient-facing staff, can be trained in delivering and recording brief interventions. If you require training, discuss this with your line manager and contact the Health Improvement Team.

Contact details:

Email: shet.healthshetland@nhs.scot

Phone: (01595) 807494



Online training and e-learning available through [TURAS](#) and Public Health Scotland's [Virtual Learning Environment](#).

7.3.3. Assessing Type 2 Diabetes Risk **TYPE 2 DIABETES** **KNOW YOUR RISK**

These are risk factors that we cannot change so it is important to focus on the factors we can change or maintain:

Age:		Gender:	
49 or younger	0	Female	0
50-59	5	Male	1
60-69	9		
70 or older	13		
Ethnicity:		Relatives with diabetes:	
Only white European	0	No	0
Other ethnic group	6	Yes	5

These are risk factors that we can change. Even small changes can help reduce your risk of developing type 2 diabetes:

Waist measurement: _____		Body Mass Index (BMI): _____	
Less than 90cm (35.5 inch)	0	Less than 25	0
90-99.9cm (35.5-39.3 inch)	4	25-29.9	3
100-109.9cm (39.4-43.3 inch)	6	30-34.9	5
110cm (43.4 inch) or above	9	35 or above	8

Has a doctor told you that you have high blood pressure or given you medication for it?

No	0
Yes	5

Type 2 diabetes risk score: _____
(low 0-6 | increased 7-15 | moderate 16-24 | high 25+)

What does my risk score mean?

You can't change your age or genes but small changes can make a big difference. See where you are scoring points and if you can make any changes.

Low risk (0-6):

- 1 in 20 people will develop Type 2 diabetes in the next 10 years.
- It's great you're low risk, make sure you know the risk factors to keep your risk low for as long as possible.

Increased risk (7-15):

- 1 in 10 people will develop Type 2 diabetes in the next 10 years.

Moderate risk (16-24):

- 1 in 7 people will develop Type 2 diabetes in the next 10 years.
- Your health is at risk. You need to visit your GP practice to be tested for Type 2 diabetes.

High risk (25+):

- 1 in 3 people will develop Type 2 diabetes in next 10 years.
- Your health is at risk. You need to visit your GP practice be tested for Type 2 diabetes.

7.4. Tier 2: Lifestyle Interventions



Programmes available

Counterweight Programme	Healthy Shetland (2020/21 Pilot)
<ul style="list-style-type: none"> • 1:1 or groups • Delivered by trained Health Improvement Practitioners • 12 month duration • 3 month active intervention <ul style="list-style-type: none"> ○ Fortnightly appointments • 9 months maintenance phase <ul style="list-style-type: none"> ○ Review every 3 months 	<ul style="list-style-type: none"> • Groups • Delivered by trained SRT staff • 12 month duration • 4 month active intervention <ul style="list-style-type: none"> ○ Fortnightly appointments • 8 months maintenance phase <ul style="list-style-type: none"> ○ Review every 4 months

Additional referral considerations:

- ✓ Meet the criteria above
- ✓ Minimal disease states or health needs
- ✓ Controlled via lifestyle measure or minimal medical management
 - E.g. patient with T2DM meeting the criteria above and does not require, or patient declines, intensive dietary intervention for possible remission.

Do not refer:

- ✗ Those who do not meet the above criteria
- ✗ Those unable to commit to regular review
- ✗ Where specialist intervention (pharmacotherapy or bariatric surgery) is being considered
- ✗ Lack of capacity (includes learning disability, additional support needs or dementia)
- ✗ Limited mobility and/or frailty (e.g. unsafe/unable for moderate physical activity, falls risk)
- ✗ Those whose condition requires clinical or therapeutic nutrition prior to weight intervention (e.g. poorly controlled/unmanaged: diabetes, coeliac disease, IBD)

Please note: The Health Improvement Team are not nutritional specialists and do not provide specialist tailored nutritional interventions. Practitioners are skilled in Health Behaviour Change, Motivational Interviewing and the evidence-based programmes delivered within the service.

7.5. Tier 3: Specialist Services



Programmes available

Tailored 1:1 Support	Counterweight Plus Programme
<ul style="list-style-type: none"> • 1:1 by trained dietitians • 12 month duration, up-to 2 years • 3-6 month active intervention • Followed by maintenance phase <p>Includes the delivery of the Low Carbohydrate Diet developed by NHS Tayside</p>	<ul style="list-style-type: none"> • 1:1 by trained Dietitians • 2 year programme • Phases include: <ul style="list-style-type: none"> ○ Total Diet Replacement (TDR) ○ Food Reintroduction (FR) ○ Maintenance • Frequent follow-up during active phases with review appointments during maintenance phase

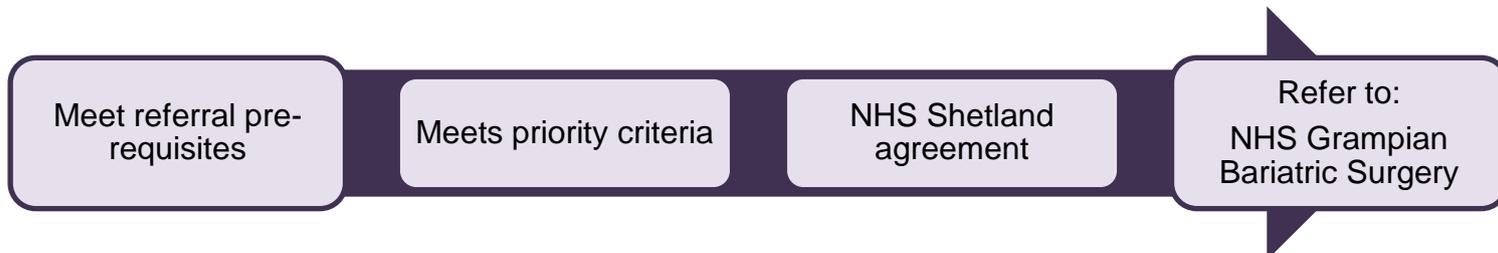
Additional referral considerations:

- ✓ Meet the criteria above
- ✓ Those with complex disease states or health needs
 - e.g. Metabolic syndrome; CVD risk; Sleep apnoea; Diabetes (all types)
- ✓ Uncontrolled eating behaviours that cause clinically significant distress and require further assessment
- ✓ Several unsuccessful attempts at weight loss (e.g. weight loss groups, tier 2 service)
 - Consult with Health Improvement if patient has engaged with their service
- ✓ Where specialist intervention is being considered
 - e.g. Pharmacotherapy, Bariatric Surgery, Very Low Calorie Diet (VLCD), TDR
- ✗ Those who do not meet the above criteria
- ✗ Those unable to commit to regular review

Exclusion criteria across all healthy weight services:

<ul style="list-style-type: none"> ✗ Pregnancy ✗ Alcohol and drug use that would significantly impair ability to engage with a period of structured weight management intervention. ✗ Diagnosed Binge Eating Disorder or active purging behaviours ✗ Uncontrolled hypothyroidism 	<ul style="list-style-type: none"> ✗ Untreated Cushing's syndrome ✗ Acute infections or acutely unwell ✗ Unstable medical or psychiatric condition ✗ Chronic long-term condition which increases nutritional requirements; unplanned weight loss or malnutrition risk
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7.6. Tier 4: Bariatric Surgical Services



Referral pre-requisites	<ul style="list-style-type: none"> • Has been receiving intensive dietetic support (Tier 3 services) • Consult with Dietetics, if patient has engaged with service • Ideally meets priority criteria below • All appropriate non-surgical measures have been completed • Has 2 years of psychological stability as reviewed by appropriate healthcare professional (e.g. GP or Mental Health Team – if current patient/recent input) • Fit for anaesthesia and surgery – screened for obvious red flags to bariatric surgery • You have fully discussed the NHS Grampian bariatric surgery leaflet • Patient commits to life-long follow up 	
Priority criteria	<p>Bariatric surgery referrals are prioritised as per NHS Health Scotland criteria.</p> <p>Subject to all priority 1 & 2 patients being offered treatment and local board agreement. An IPTR panel will be convened to review referrals for those who meet the pre-requisites but are out with the priority criteria detailed below.</p>	
	<p>Priority 1 criteria:</p> <ul style="list-style-type: none"> • Age: 18-44yrs • BMI: ≥ 35-40kg/m² • Recent onset type 2 diabetes (<5yrs) 	<p>Priority 2 criteria:</p> <ul style="list-style-type: none"> • Age: 18-44yrs • BMI: >40-50kg/m² • Recent onset type 2 diabetes (<5yrs)
Exclusion criteria	<ul style="list-style-type: none"> • Exclusion criteria for all healthy weight services on previous page • Those who do not meet the above criteria • Lack of capacity, for example a severe learning disability, or dementia • Patients who have been actively engaging in self-harm behaviours or suicide attempts in the past 2 years. 	
Essential Referral Content	<p>Demographics:</p> <ul style="list-style-type: none"> • Name • 10 digit CHI number • Referrer details • Registered health centre • Patient has agreed to data sharing/referral 	<p>Clinical:</p> <ul style="list-style-type: none"> • Clear identification of criteria met • Clear reason for referral, if out with priority criteria • Height, weight, BMI, weight history • Medical history; co-morbidities (include date of diagnosis) • Details of previous weight management interventions
How to refer	<p>Do not refer directly to NHS Grampian without local NHS Shetland agreement.</p> <ul style="list-style-type: none"> • Write referral letter to NHS Shetland Medical Director with details above • Patient MUST meet referral pre-requisites • Discuss referral with dietitian (Tier 3) and relevant HCP's involved with patients care <p>Following local review of referral, written onward guidance will be provided.</p>	

7.6.1. Bariatric Surgery: Patient Journey

NHS Shetland

(prior to NHS Grampian input)

- Referral letter to NHS Shetland Medical Director
- Referral reviewed: ITPR panel if out with criteria



NHS Shetland

If not suitable for bariatric surgery, support will be provided by appropriate service

Outcome advised to referrer

Clinical assessment:

- NHS Grampian clinic with consultant, dietitian or nurse specialist
- Review weight interventions: identify any gaps
- Identify red flags to continuing with pathway
- Outline bariatric process
- If patient ok to proceed: begin patient education as part of Bariatric Surgery Pathway



Attend group education:

- 8 x fortnightly appointments: in NHS Grampian. In-person attendance preferable, flexibility available
- Lead by: nurse specialist, dietitian, psychologist, surgeons and former patient
- 5% weight loss encouraged
- Psychological review; pre-op assessment anaesthetic assessment; surgical review

Placed on surgical waiting list:

- 12 week referral to treatment: bariatric surgery prioritised as category 2
- 12-18 months: patient full journey through NHS Grampian pathway
 - If no issues during preparation stages
- Local Dietetic support (Tier 3): while on pathway, awaiting surgery

Lifelong follow-up:

- 6 weeks post-op: patient must travel for surgical consultation
- 3, 6, 9 month review: coordinated between NHS Grampian and local dietetics department
- 12 month post-op: patient is offered psychological review and patient support group
- 2 year post-op: patient discharged from NHS Grampian caseload
- Post discharge: patients must be offered annual monitoring of nutritional status and appropriate supplementation as part of shared care model of chronic disease management. Guidance provided by NHS Grampian.

7.7. Flowchart: Adult Healthy Weight Services

