NHS Health Scotland

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

the british psychological society
promoting excellence in psychology

Document endorsed by BDA The Association of UK Dietitians

Healthier Scotland
Scottish Government

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Background

The prevalence of obesity in Scotland is one of the highest among OECD (Organisation for Economic Cooperation and Development) countries.[1] The 2018 Scottish Health Survey estimates that two thirds (65%) of adults in Scotland are overweight, of which almost one third (29%) have obesity.[1] The health, social and economic consequences of obesity are profound. These include increased risks of developing a range of diseases including type 2 diabetes,[2] some cancers,[3] and other conditions including cardiovascular disease and hypertension. There are also wider, indirect economic costs arising from sickness absence and premature mortality.[4]

Levels of obesity are strongly associated with the circumstances in which people live, and specifically with the level of resources (financial, power, knowledge and social) that people have.[5] There is evidence of socio-economic inequalities in obesity rates in Scotland, with higher prevalence in those living in the most socioeconomically deprived circumstances.[6] Overall, around 32% of adults living in the most deprived areas have obesity, compared with 20% of those living in the least deprived areas.[7]

Studies have demonstrated a relationship between the occurrence of adverse childhood experiences and adult obesity.[8, 9] It is now well evidenced that survivors of trauma are at higher risk of a range of health, mental health and social difficulties[10, 11, 12] and are almost three times more likely to experience morbid obesity.[13] There is mounting evidence to demonstrate that weight stigma is widespread.[14, 15] Experiences of weight stigma and discrimination have been associated with physical and mental health concerns,[16, 17] avoidance of healthcare[18] and physical activity and exercise settings.[19]

Purpose of the standards

The purpose of these standards is to ensure a consistent, equitable and evidence-based approach to the treatment of overweight and obesity for adults across weight management services in Scotland. The standards model

a tiered approach to weight management services which broadly mirrors The UK Obesity Care Pathway.[20]

Policy context

The pervasiveness and health and economic consequences of obesity mean that reducing its prevalence is a key priority and a major challenge for government, delivery partners and public health professionals.[1, 21]

Most recently, the Scottish Government's Healthier Future: Scotland's Diet and Healthy Weight Delivery Plan, published in July 2018, set out ambitions to reduce the prevalence of obesity in Scotland and to significantly reduce diet-related health inequalities.[22] The plan, which has over 60 actions, has a strong focus on primary prevention, including population-wide approaches that will impact everyone in Scotland. In addition to preventative actions, the delivery plan also recognises the need for 'targeted and tailored support' for adults in Scotland to achieve and maintain a healthy weight. This includes a commitment to working with NHS Health Scotland and partners to 'develop evidence-informed and cost-effective minimum standards and pathways for weight management programmes'.[22]

The establishment of standards for weight management services crucially supports the A Healthier Future: Type 2 Diabetes Prevention, Early Detection and Early Intervention Framework. Also published in July 2018, this framework sets out national-level guidance for Boards and their partners on designing and implementing a specific weight management pathway for people 'at risk' or diagnosed with type 2 diabetes.[23]

The approach set out in the delivery plan is underpinned by a number of other key national policies and work streams. The Public Health Priorities published in 2018 which the Scottish Government, COSLA and a range of partners have committed to – including a priority to create 'a Scotland where we eat well, have a healthy weight and are physically active'.[24] Sitting alongside the diet and healthy weight delivery plan the Scottish Government published A More

Active Scotland: Scotland's Physical Activity Delivery Plan in July 2018. This recognises the importance of both diet and activity in promoting and maintaining healthy weight.[25] The Health and Social Care Delivery Plan (2016) also calls on NHS Boards to integrate the National Physical Activity Pathway into all appropriate clinical settings, including weight management services. Furthermore, reducing overweight and obesity prevalence contributes to the new Scottish National Performance Framework (NPF) outcome that 'we are healthy and active'.[26]

Pertinent too for the evolution of weight management services in Scotland is Scotland's Digital Health and Care Strategy (2018) that stresses the growing imperative for digital to support the way that services are delivered, and to empower people to more actively engage with and manage their own health and wellbeing.[27]

Weight management services in Scotland

All NHS Health Boards in Scotland have established adult weight management services, with most offering a range of preventative and treatment services. Beginning in 2008, this work has been supported by evidence-based guidance issued by the Scottish Government. NHS Boards have continued to be supported to deliver adult weight management interventions through the Outcomes Framework, which sets out clearly defined outcomes that NHS Boards are monitored against.

Guidance notwithstanding, considerable disparities exist in the provision of weight management services for adults in Scotland and this has been identified as something which needs to be addressed.[28] The disparities in adult weight management interventions in Scotland were the subject of a research paper published in 2016, with the authors suggesting that a 'severe lack of published evidence regarding the effectiveness of weight management interventions has led to a great deal of uncertainty regarding the best way to deliver these services across the UK and worldwide'.[28] Differences in referral criteria, referral pathways, provision, length and frequency of follow-up,

dietary intervention, behavioural change components, quantity and type of physical activity intervention and provision of specialist interventions were highlighted. Inadequate provision of tier 2 and tier 3 services and significant variability in the general design and delivery of services were also acknowledged in a mapping exercise undertaken by NHS Health Scotland in 2017–18. Similar findings have been reporting by Public Health England [29] and the All-Party Parliamentary Group on Obesity.[30]

About the standards for weight management services

Informed by local discussion with NHS Boards and the issues highlighted by Logue and colleagues (2016),[28] NHS Health Scotland also carried out a mapping exercise of weight management services across Scotland in 2017–18, which provided a more up-to-date overview of current services. Again, this exercise highlighted the need for a more consistent and equitable approach to the provision and delivery of weight management services for adults.

With broad consensus for the need for development of standards for weight management services, NHS Health Scotland convened an expert reference group which included representation from service leads, dietitians, clinical psychology, physical activity professionals, NHS Health Scotland staff, Scottish Government policy leads and academics. The group undertook consultation on working drafts of the standards (see Appendix 1 for a list of those involved in the development of the standards).

These standards have been informed by best available evidence including the National Institute for Health and Care Excellence (NICE) guidelines, Scottish Intercollegiate Guidelines Network (SIGN) guidelines, Public Health England (PHE) work on commissioning and delivering adult tier 2 weight management services, British Obesity and Metabolic Surgery Society (BOMSS) commissioning guide for weight assessment and management clinics (tier 3) British Dietetic Association (BDA) Dietetic Obesity management interventions in adults, learning from good practice across Scotland and emerging

evidence. These standards have also been subject to peer review by the BDA and are endorsed by the BDA and the British Psychological Society (BPS).

Health Inequalities Impact Assessment

In March 2019, NHS Health Scotland facilitated a Health Inequalities Impact Assessment (HIIA) workshop to identify impacts likely to be affected by the proposals set out in a draft of standards. Participants included representatives from Scottish Government, Obesity Empowerment Network (OEN)*, Obesity UK (formally HOOP UK), the Minority Ethnic Health Inclusion Service (MEHIS), academics, service leads from weight management and NHS Health Scotland.

The findings from the HIIA workshop have been used to further inform and shape the development of the standards. A final report of the workshop will be made available on the NHS Health Scotland website.

Standards for weight management services: expected outcomes

- Improved consistency, equitability and effectiveness of weight management services to support better outcomes for people across Scotland.
- Improved early identification of adult population needs, allowing timely and appropriate responses.
- Improved long-term resource planning to support the development, implementation and delivery of these services.
- Services designed for and delivered to those who need it most – focused on reducing health inequalities, improving health equity and health literacy.

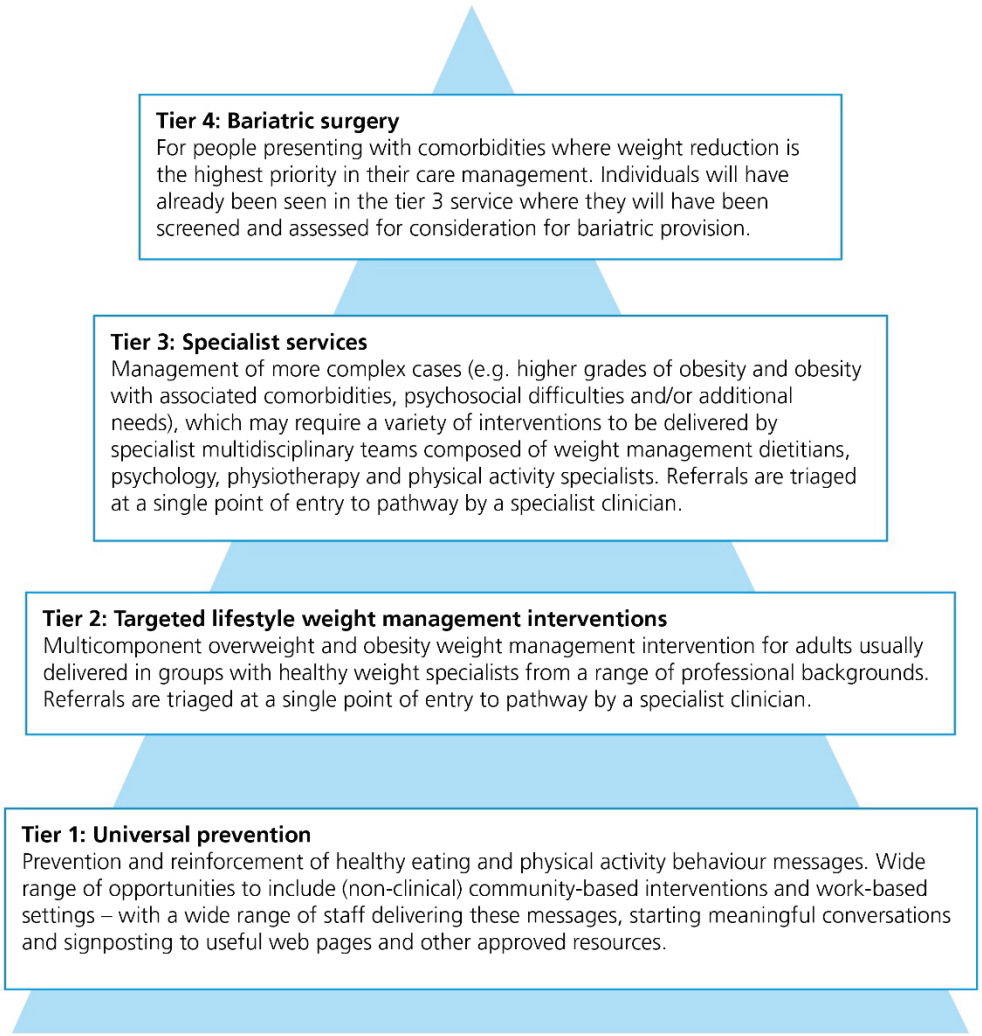
* OEN were unable to attend the workshop on the day but provided feedback to the group ahead of the session.

- People are supported and empowered to make positive and sustainable changes to their health and wellbeing.
- Improved monitoring and evaluating of weight management services for adults.
- Promotion and facilitation of continual Improvement, forward planning and shared learning across NHS Boards.

Scope

This document sets out the expected standards for the delivery of tier 2 and tier 3 weight management services for adults – as described in Figure 1 below.

Figure 1: Tiered approach to prevention and management of overweight and obesity for adults



Source: Adapted from *The UK Obesity Care Pathway* (Department of Health, 2013)[20]

The standards are not intended to replace SIGN[31] and NICE[32, 33] guidance on obesity and weight management for adults. These guidance documents should be used to support the implementation and delivery of these standards.

The standards will be reviewed in light of emerging evidence and to reflect any significant changes in NICE, SIGN guidance, or other related national guidance.

The standards do not cover:

- universal prevention (tier 1 services)
- pharmacological approaches
- surgical treatments for obesity (tier 4 services)
- children and young people* (<18years of age).

Who are the standards for?

The standards are for Health and Social Care Partnerships, NHS Boards and the wide range of professionals involved in the planning and delivery of weight management services for adults in Scotland.

Where delivery of weight management service is contracted out – for example, to leisure services – it is the responsibility of the commissioning service to ensure that the contracted service fully complies with the standards.

Format

Each standard set out in this document includes a statement of the expected level of care or action, criteria describing structures, processes and outcomes necessary to meet the standard, additional considerations and a list of resources for further learning and information. Within these standards, criteria are designated as 'essential' or 'desirable'.

- Essential criteria are the *minimum* required for an effective and equitable weight management service.
- Desirable criteria include some suggested *additional* actions which NHS Boards should consider undertaking to improve the quality of services offered.

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* See Standards for Delivery of Tier 2 and Tier 3 Weight Management Services for Children and Young People in Scotland: www.healthscotland.scot/publications/standards-for-the-delivery-of-tier-2-and-tier-3-weight-management-services-in-scotland

Beyond what is signalled in this document, NHS Boards are strongly encouraged to continue to innovate to develop and test more efficient, responsive, and person-centred approaches to continually improve the quality of the service provided.

Evaluation and core dataset

Additionally, all NHS Boards will be required to record standardised core data. The core dataset will provide a list of data collection criteria and supporting guidance for collecting high quality information that will help to support local evaluation, planning and any future national evaluation of weight management services across Scotland. This data will also be used to support the evaluation of the Type 2 Diabetes Prevention, Early Detection and Early Intervention Framework.[23]

The Scottish Government is currently working with NHS National Services Scotland Information Services Division (ISD), NHS Health Scotland and experts around the requirements for data collection. Separate guidance will be issued in due course.

Standards* for adult weight management services (tier 2 and tier 3)

1. Designing services to meet the needs of local populations

Standard statement

Each NHS Board has a written policy which takes a strategic, coordinated and human-rights based approach to ensure people living with overweight or obesity have access to effective and high-quality weight management support when needed.

Weight management services should:

- ensure programmes and support are tailored to local need. To do this services should undertake a robust assessment of local need and consult with their local population and frontline staff to better understand their needs. This will help to identify any barriers and facilitators to uptake and completion of programmes and ensure that services are designed in a way which better meets the needs of the local populations.[34] **(Essential)**
- focus on engaging with and delivering services to excluded, marginalised, or otherwise vulnerable population groups who are known to be at high risk of developing obesity e.g. minority ethnic groups. Services therefore must be flexible to ensure that they are able to accommodate issues relating to equality and diversity in local populations which might otherwise act as barriers to participation. With a view to improving services in this regard, all services should carry out a Health Inequalities Impact Assessment (HIIA) (or equivalent) and update annually. Findings should be used to target and tailor programmes and support to better meet the needs of the local

* The standards detailed in each section apply to both tier 2 and tier 3 unless otherwise specified.

population. It is paramount that delivery partners (out-with the service) place a special emphasis on reducing inequalities when planning, delivering and evaluating programmes. This should be in line with the Health and Social Care Standards. **(Essential)**

- consider how best to provide weight management services for people with special needs or disabilities (including people who may be housebound) for example, through specific programmes where these are available. Or by making reasonable adaptations to mainstream programmes (including training staff) and evaluating them'.[32] **(Essential)**
- 'offer programmes at a range of times that are convenient. For example, some sessions could be offered in the evenings or at weekends. Where possible, services should adopt a flexible approach so that participants can accommodate other commitments'.[34] **(Essential)**
- be delivered without stigma or discrimination.[35] **(Essential)**
- consider adopting a trauma informed approach within its policies and service delivery practices, given the potential for individuals within weight management services to have an increased likelihood of exposure to trauma. **(Desirable)**

Considerations

- The NHS Education for Scotland (NES) National Trauma Training Framework[36] emphasises that those who would most benefit from support and services are least likely to access or maintain contact with them. There can be difficulties in establishing trust across a range of services, difficulties with procedures that require touch, not feeling understood by services, difficulty in attending services, and frequent disengagement.

Resources for further learning and information

- NHS Health Scotland has produced a briefing on human rights and the right to health. It sets out what the right to health is, what a human rights-based approach (HRBA) to health looks like and gives some suggestions as to how the approach can be used. The PANEL principles of an HRBA offer a way to help the public sector, the third sector, communities and individuals to put rights into practice.
- The ScotPHO Profiles Tool provides access to a range of public health related indicators at different geographies including NHS Boards, council areas and health and social care partnerships in Scotland.
- Analysis Grid for Environments Linked to Obesity (ANGELO) model a useful tool for engaging with communities to help them to identify their priorities for healthy weight.[37, 38]
- The Scottish Health Council has produced The Participation Toolkit to support health and social care staff to more effectively involve patients and service users, carers and members of the public in decisions about their own care and in the design and delivery of local services.
- The Scottish Co-Production Network provides a collection of useful reports, examples, guides and training resources about co-production in Scotland.
- NHS Health Scotland has produced a publication, Maximising the role of NHS Scotland in reducing health inequalities, which explores the practical actions staff can put in place to reduce health inequalities.
- The NHS Health Scotland Learning opportunities to reduce health inequalities brochure details the current online courses on offer which relate to health inequalities.
- For more information on HIIAs visit the NHS Health Scotland website.
- The Scottish Health and Inequalities Impact Assessment Network (SHIIAN) is open to anyone working or planning to work on health impact assessments (HIA) and health inequalities impact assessments in Scotland.
- The Health and Social Care Standards set out what people should expect when using health, social care or social work services in

Scotland. They seek to provide better outcomes for everyone; to ensure that individuals are treated with respect and dignity, and that the basic human rights to which we are all entitled are upheld.

- The Scottish Public Health Observatory (ScotPHO) has created a tool called Informing Interventions to reduce health Inequalities (Triple I). This allows users to compare the estimated health and inequality impact of different interventions. Using the interactive tool you can alter the number of individuals treated, and the targeting strategy (e.g. to deprived areas), and can estimate results for local areas as well as for Scotland. ScotPHO report that weight management services could help to reduce health inequalities if targeted where most needed.
- NHS Boards may want to consider engaging with organisations such as Obesity Empowerment Network and Obesity UK when considering how best to design their services from a user perspective.
- NHS Health Scotland (2017)[39] published an updated health needs assessment of people with learning disabilities in Scotland. The health needs assessment takes into account the growing research evidence base regarding the health of people with learning disabilities, covering a number of health needs, including diet and healthy weight.
- The Royal Environmental Health Institute offers a food and health course aimed at people who care for adults with a learning disability.
- Public Health England have published guidance (2016)[40] on making reasonable adjustments to weight management services for people with learning disabilities. However, it is worth cautioning that the reasonable adjustments guidance case studies provided were solely focussed on the management of weight through diet only or exercise only and not multi-component interventions.
- The Transforming Psychological Trauma Framework[41] is a whole of Scottish workforce document offering defined parameters according to the particular role a service or individual may have in working with people who may have experienced trauma. For example, reception staff may be in the Trauma Informed category, but dietetic practitioners may need to be working at Trauma Skilled level. The Transforming

Psychological Trauma Training Plan[42] offers structure and suggestions around the fulfilment of training needs and organisational readiness in adopting a trauma-informed approach.

2. Equipment and environment considerations

Standard statement

Weight management services for adults are delivered in a suitable environment which promotes equality and avoids prejudice and stigma that those experiencing obesity often face.

Weight management services should:

- ensure equipment and facilities meet the needs of most adults with overweight or obesity.[32] The BDA Obesity Specialist Group (2018) suggest that services should 'anticipate the patient's possible needs and attempt to create a physical environment that welcomes rather than challenges' as it is an important aspect of the care of patients with higher body weights.[43] Suggestions include ensuring 'adequate numbers of bariatric chairs with arm rests or regular chairs without arm rests and with sufficient space between chairs to allow easy movement; consideration should be given to the 'location and size of clinical rooms and the impact this may have on access for those with mobility issues' (for example, ensure door frames are wide enough to allow bariatric wheelchairs/bariatric hospital (porter's) chairs and the 'provision of scales with a wide base that weigh more than 200kg located in a private area and consider how wheelchair users will be weighed'.[44] **(Essential)**
- have a documented health and safety risk assessment regarding the availability of facilities/equipment to care for people with higher body weights. Any service level agreements should also be compliant with these standards. This risk assessment should address the following issues:
    - Accessibility.
    - Safe working loads of equipment, in particular exercise equipment and floors.
    - Availability of, and procurement process for, specific equipment, including sit-on weighing scales and bariatric chairs without arms.

- Consideration should extend to toileting facilities e.g. wall-mounted toilets have lower safe working loads than floor mounted, need for grab rails to assist with standing and so on.
- Services should have a central list of all facilities and equipment required. The list should include details of safe working loads, product dimensions, as well as where specific equipment is located and how to access it.

(Essential)

Note: The training of healthcare professionals and considerations around the language and images used at any time and especially when marketing weight management services are important considerations and are addressed elsewhere in this document (see sections 2 and 9 for further details).

Resources for further learning and information

- The National Association of Equipment Providers has produced guidance for the case management, assessment, prescription and delivery of bariatric equipment for people with higher body weights.

3. Referral pathways and criteria

Standard statement

All NHS Boards have an explicit weight management pathway for adults affected by overweight and obesity.

Weight management services should:

- include both tier 2 and tier 3 services as described by *Figure 1: Tiered approach to prevention and management of overweight and obesity for adults.* Further details are given throughout this document regarding referral criteria and suitable interventions for each tier. **(Essential)**
- adopt the following referral criteria:

  Body Mass Index (BMI):

  - Services should make provisions so that adults with a BMI ≥30 kg/m^2 are eligible for referral to weight management services. **(Essential)**
  - Where there is capacity, adults with a BMI ≥25 kg/m^2 should be able to access the service. **(Desirable)**
  - Lower eligibility criteria should be applied for black African, African-Caribbean and Asian groups. Individuals from these groups are at an increased risk of conditions such as type 2 diabetes at a lower BMI. BMI ≥23 kg/m^2 indicates increased risk and BMI ≥27.5 kg/m^2 indicates high risk.[45] **(Essential)**
  - Services should make provisions so that adults with a BMI ≥25 kg/m^2 who are at moderate and high risk (as identified through risk stratification) of developing type 2 diabetes are eligible for referral to weight management services.[23] (See 'Resources for further learning and information' below for more information on risk stratification). **(Essential)**
  - In cases where BMI entry criteria differs from national guidance, NHS Boards must offer clear justifications for doing so. **(Essential)**

Age range:

- Adult weight management services should be provided to those >18 years of age. There should be no upper age limit for individuals accessing the service. **(Essential)**

- give consideration locally to the services offered and delivered to those aged between 16–18 years. There may be circumstances where, due to type of service provision or developmental age, it may be more appropriate to refer a young person to an adult weight management service. Local child and adult weight management services should work jointly to agree the best approach.[*] **(Essential)**
- ensure that there is no gap in provision of services between children and young people's and adult services. Appropriate pathways should be put in place to ensure, where needed, the continuation of weight management services when a person reaches the age of 18 years. Support and management should be reviewed throughout the transition process and clarity between weight management teams (in the case of separate child and adult services) about who is leading, to ensure continuity of care.[33] **(Essential)**
- provide a single point of entry for a tiered weight management service.[23] Learning from good practice in Scotland suggests that a single point of entry helps to streamline the referral process and remove barriers to access by minimising confusion among professionals referring into services and those wishing to self-refer. **(Essential)**
- consider using a standardised referral form for self-referral and professional referral to better support the process of a single point of entry and triage. **(Desirable)**
- include both the option for self-referral and referral from health and social care and other professionals, including: GPs, practice nurses,

[*] Where young people below the age of 18 years are referred to adult weight management services, be aware that their needs may be different from those of adults. Justification for referral to adult service should be considered on an individual basis and ongoing evaluation to ensure that the young person's needs are being met.

physiotherapists and all other AHPs, diabetes specialists, social care and mental health services, dietetic teams, leisure services, smoking cessation, respiratory care, community link workers and so on. NHS Boards should also actively promote awareness of referral pathways into weight management services, locally (see further detail below). **(Essential)**.

- ensure when referrals are made by professionals, the person needs to have consented to the referral. The informed consent process requires that the individual possesses both the means and the information necessary to make a meaningful decision, is made aware of the risks, benefits, has reasonable expectations, understands what success looks like, what they can reasonably expect for follow-up support and 'what to do when standards fall short of these expectations'.[46] **(Essential)**
- work to develop local relationships and actively engage with and promote awareness of weight management services with potential referrers to the service – in particular, work to strengthen links with primary care.[47] This should also include awareness raising around the option for self-referral.[34] This should include communicating details such as:
    - how to refer to the service (including the option for self-referral)
    - what the service offers
    - who the service is for
    - where the service is run, and what time
    - the training qualifications of staff delivering the service.

  (Essential)
- as part of this awareness raising, NHS Boards may wish to consider offering training on initiating sensitive behaviour change conversations related to weight management (See section 9 below for more detail). **(Desirable)**
- give consideration to those people that would like to self-manage their weight – referrers should be informed of where to signpost to approved digital and other resources to support their weight management,

including the option to self-refer if their circumstances change and/or additional care is required. **(Essential)**

- work to 'raise awareness of weight management services among the local target population and where possible service users should be consulted in the development of resources and messaging'.[34] Be aware of the importance of engaging with community groups/third sector groups in relation to communication of resources, peer support and useful signposting. Marketing materials and resources should be developed in line with the Scottish Government's Health Literacy Action Plan,[48] should be easy to read, in the most appropriate, people-first language[49] and disseminated through media that the target audience engages with.[34] **(Essential)**

Considerations

- Rurality issues may dictate that services in some NHS Board areas may not have the capacity to deliver interventions as group/community-based sessions and in these circumstances it would be appropriate to deliver as a one-to-one intervention. In cases where group sessions are not feasible, services may wish to consider facilitating or (where available) signposting to appropriate peer support networks. NHS Boards may wish to consider offering Attend Anywhere or a mix of one to one/telephone/web-based resources and possible future initiatives to provide regular support. Ideally services would consult with local populations to better understand their preferences.

Resources for further learning and information

- See Framework for the Prevention, Early Detection and Early Intervention of type 2 diabetes (page 17) for further guidance on the risk stratification process and suggested risk assessment tools, which can be used to help identify those 'at risk' of developing type 2 diabetes as well as those who could potentially reverse their condition.

- The Association for the Study of Obesity has produced a position paper on weight bias and stigma and detailed recommendations for the presentation of information about obesity.
- The European Association for the Study of Obesity has produced guidance on the use of people-first language.
- A number of 'obesity image banks' have been created to facilitate free access to non-stigmatising images:
  - www.imagebank.worldobesity.org
  - www.uconnruddcenter.org/media-gallery
  - www.obesityaction.org/oac-image-gallery/oac-image-gallery-categories
  - www.obesitynetwork.ca/images-bank
- The Men's Health Forum, supported by Public Health England, has published an evidence-based How to make weight-loss services work for men best practice guide which demonstrates the ways in which weight management programmes can be tailored specifically for men.
- Other helpful resources and tools can be found on The Health Literacy Place – a knowledge network hosted by NHS Education for Scotland.

4. Triage and assessment

Standard statement

When a person is referred to a weight management service, a systematic process of triage and assessment (as needed) is carried out by an appropriately trained member of staff. A care plan is developed, implemented and evaluated.

Weight management services should:

seek to make initial contact with people in a timely manner. Time from referral to starting the programme* should be no more than 18 weeks in line with National Waiting Time Standards in Scotland. This standard represents the upper limit of how long a patient should expect to wait. Where possible, services should aim to see people much sooner. **(Desirable)**. Where a time lag is unavoidable, consideration should be given to putting in place a plan to maintain engagement until the service can be accessed. This could include signposting individuals to appropriate online weight management resources or information pack, other lifestyle activities and services in their local area such as leisure services and walking groups.[34] **(Essential)**

Triage

- put in place 'a clear and explicit pathway and guidelines for triage and assessment for all people referred to the weight management service'.[23] **(Essential)**
- ensure all referrals are to weight management services are received at a central triage point within a designated Health Board†, where individuals are then referred to the weight management programme best suited to their needs or receive further assessment. **(Desirable)**

* 'Start of the programme' for tier 2 is attendance at the first group session and for tier 3 is the initial assessment appointment.

† In some areas it may be more appropriate to have a central point of triage in a Health and Social Care Partnership.

- consider triaging referrals daily to minimise the wait from referral to treatment. **(Desirable)**
- ensure referrals are triaged in a systematic process by appropriately trained staff with advanced clinical knowledge, for example by a registered dietitian or registered nurse with specialist training in weight management. Good practice in Scotland suggests that this is necessary, given the increasingly complex needs of those referred to weight management services and to ensure that those referred receive the most appropriate level of care. **(Essential)**
- be aware that it may not always be clear which tier of the service is most appropriate from the referral information alone. In these instances, it is considered good practice to have an advanced triage protocol built into service provision i.e. telephone triage with additional questions and screening to clarify suitability. (**Desirable)**
- be aware that weight management programmes will not be suitable for people in the following circumstances:
    - Pregnancy (consider specialist antenatal clinics, where available).
    - Ongoing alcohol and drug misuse that would significantly impair ability to engage with a period of structured weight management intervention.
    - Diagnosed eating disorder (BED)[*] or presenting with active purging behaviours e.g. laxative misuse, self-induced vomiting in the absence of a diagnosed eating disorder (referral to mental health/eating disorder services for specialist assessment should be considered).
    - Uncontrolled hypothyroidism.
    - Untreated Cushing's syndrome.
    - Unstable major psychiatric illness.

  (Essential)

[*] In some cases, for example, binge eating disorder (BED), patients may be supported via a weight management programme, but they will require psychological assessment and treatment, where appropriate, as part of their intervention.

- consider triaging individuals with severe or complex obesity to a tier 3 service in the following circumstances:
    - The person has made several unsuccessful attempts at weight loss in the past through attending structured group education e.g. tier 2 or commercial programmes and requires additional support.
    - The person has complex disease states (for example, metabolic syndrome, CVD risk, diabetes, sleep apnoea) or needs that cannot be managed adequately in tier 2 (for example, the additional support needs of people with learning disabilities).
    - Uncontrolled eating behaviours that are causing clinically significant distress and require further assessment.
    - The person is receiving or being considered for pharmacotherapy.
    - Where specialist interventions may be needed – such a programme including a low-calorie liquid stage.
    - Bariatric surgery is being considered.

  (Essential)

Assessment

- give consideration to the following assessment criteria for tier 2 and tier 3 services:
    - **Tier 2 assessment:** Individuals appropriately triaged into tier 2 programmes can access the service without need for further specialist health professional assessment. Individual assessment for suitability and safety for physical activity as part of the tier 2 programme should however be undertaken using validated measurement tools (to be determined locally) by a trained health coach with REPS Level 3 accreditation or equivalent. (**Essential)**
    - **Tier 3 assessment:** A full specialist assessment should follow for people entering tier 3 services. This should be conducted by

an appropriately trained professional (normally specialist weight management dietitian) and in a timely manner. (**Essential)**

- be aware that an initial tier 3 assessment appointment will normally require 45–60 mins (BDA Obesity guidance 2018)[44] and should be carried out by a weight management specialist. There may be occasions where further follow-up assessment is required over more than one appointment to gather all the relevant information to agree a treatment plan. (**Essential)**
- develop and use a standard assessment pro forma for use in all tier 3 assessments. This documentation should be created with the input from dietetics, physical activity/physiotherapy and psychology (including behaviour specialist). **(Essential)**
- ensure that physical activity, sedentary behaviour, sleep and mobility are addressed as part of this assessment. Local areas should decide on the most appropriately validated assessment tool. **(Essential)**
- be aware that the core components of a tier 3 biopsychosocial assessment[*] should include but not be limited to:
    - The patient story, what brought them here
    - Expectations of treatment
    - Weight, height and dieting history
    - Current medical and physical co-morbidities
    - Prescribed medications
    - Eating patterns
    - Current lifestyle
    - Coping strategies
    - Family and social support
    - Positive psychological factors (motivation, health beliefs, resilience).

  (Desirable)

[*] These are described in more detail in the BDA Obesity guidelines 2018.[44]

- consider the key psychological factors that might influence engagement with an individual in a standard tier 3 assessment* are the history and current experience of:
    - anxiety and depression
    - self-harm and suicide ideation
    - disordered eating and history of eating disorder
    - personality disorder
    - substance misuse
    - trauma and childhood adversity

  (Essential)
- ensure that local, wider referral pathways and signposting procedures are in place for people in need of additional support, including social care services, GPs, housing support, income maximisation and debt advice services, smoking cessation, drug and alcohol services, mental health and so on).[34] These pathways should be written and clearly available within each service and should include: what to look for, an outline of support offered and details of how to refer/signpost. This would help ensure that people in most need receive support. **(Essential)**
- inform people of how they can 'enrol in the future' (including the fact that they have the option to self-refer into the service) if they have identified that they are not ready to attend a programme or have disengaged with the programme. Services should point them to information and advice on healthy eating, physical activity and how to reduce sedentary behaviour.[34] **(Essential)** Services may want to consider offering a follow-up appointment in 3 or 6 months.[34] **(Desirable)**

* Additional face-to-face assessment by psychology may be required to build on the initial service assessment.

Considerations

- Services may wish to consider adopting the Edmonton Obesity Staging System (EOSS) as part of the tier 3 assessment process.* The BDA state that 'in practice many obesity interventions are allocated based primarily on BMI but this measure only provides information on the size of the patient and not on how severely affected they are physically, mentally or functionally by their excess weight. As such BMI is inadequate as the primary determinant of how types and intensity of treatments are allocated. This should not undermine BMI as a useful measure but it is important to recognise its limitations and consider more holistically whether and/or how a person's weight is affecting their physical, mental and functional health.'[50] The BDA goes on to report that 'in studies[51, 52] that have compared the EOSS staging criteria to BMI or waist circumference as predictors of mortality the EOSS tool has emerged as the superior indicator'.[50]

Resources for further learning and information

- Helpful resources and information can be found on the following websites: NHS Inform, Active Scotland, and Eatwell Guide.
- A Local Information System for Scotland (ALISS) is a programme and digital system to help people find and share information about local resources which can help people live well.
- The BDA Obesity Specialist Group Dietetic Obesity management interventions in adults paper provides more detailed descriptions of behavioural and clinical assessment which dietitians may find helpful to reference.

* It should be noted that with some specific intensive interventions for highly targeted groups for example, total diet replacement programmes for type 2 diabetes remission, tools such as EOSS are not recommended for the use of patient selection. These targeted groups should be offered the intervention on the basis of suitability against the specific protocols (see Standard 6 and section 'Total diet replacement programmes for remission of type 2 diabetes', further details).

- The EOSS is a comprehensive tool which is increasingly advocated as part of the assessment process. It has been incorporated into the 5A's of the primary care obesity management framework of the Canadian Obesity Network, adopted by the American Society of Bariatric Physicians in their obesity algorithm and by the Italian Society of Obesity in their obesity treatment algorithm.

5. Intervention design and core components

Standard statement

There are formalised structures and processes in place to plan the delivery of weight management services for adults.

Weight management services should:

- ensure that programmes are 'designed and developed with input from a multidisciplinary team'.[31, 32] Good practice in Scotland suggests that these should include the following professionals:
    - A state-registered weight management specialist dietitian.
    - A physiotherapist or physical activity specialist (on the Register of Exercise Professionals, or equivalent, at REP level 3).
    - Applied psychologists to provide expertise in mental wellbeing and, along with behavioural science input, to understanding general lifestyle, weight related behaviours, self-management, motivational factors and so on. **Note**: Feedback from services in Scotland has identified psychology input both in the design of programmes, and the ability to offer tailored, one-to-one and group support, particularly for the delivery of tier 3 services, a crucial and an indispensable feature of a comprehensive weight management service.

  (Essential)
- provide treatment programmes for adults which are multi-component – that is, they address dietary intake, physical activity (and inactivity) levels and behaviour change.[31, 32] **(Essential)**
- draw on expert advice, evidence and experience to date when agreeing the design of individual components, and the balance between diet and physical activity interventions. However, in order to promote consistency and quality of services across NHS Scotland,

programmes should adhere to and incorporate the following elements: **(Essential)**

- **Dietary approaches** should be individualised, and include the following, as appropriate*:
    - Reduction in total energy intake
    - Portion sizes
    - Improving quality of dietary intake
    - Stabilisation of food intake
    - Food labelling
    - Snacking
    - Information on high fat and sugar food and drinks
    - Meal pattern and planning
    - Healthy eating on a budget
    - Food behaviours e.g. binge eating, eating to appetite, comfort/emotional eating
    - Alcohol consumption
    - Eating out
    - Cooking skills (desirable to offer this as part of the service but at a minimum signpost to local and community organisations who may offer this kind of support)
- **Physical activity** should be offered to everyone† as a core component of any treatment programme.
    - This requirement can be achieved through practical sessions embedded and delivered within the service or through sessions offered out-with the service by delivery partners, such as leisure services or through an exercise on referral scheme.
    - NHS Boards should work to integrate the core elements of the National Physical Activity Pathway into weight management services. This includes

* It is expected that more intensive, person-led dietary support will be needed for tier 3.

† After assessment of suitability for specific type or programme.

upskilling staff to raise the issue of physical activity, undertake physical activity screening to determine current activity status and provide physical activity brief advice and brief interventions as part of a long-term health behaviour change approach to weight management.[53]

- All physical activity sessions for tier 2 should be delivered by suitably trained individuals (REPs level 3 or equivalent). Input or assessment from physiotherapy may be required for patients with more complex physical needs or mobility issues who are attending a tier 3 service and should be considered on a case-by-case basis.
- In addition to the practical sessions individuals should also be supported and empowered to meet the UK Chief Medical Officers' Physical Activity Guidelines within their own lifestyles.
- Consideration of sleep patterns as well as physical activity and sedentary behaviours may also be appropriate.
- Services should discuss with and signpost individuals to the local opportunities available to them.
- Services should offer subsidised or free access, at the point of use, to physical activity sessions for the duration of the active intervention.
- Services may wish to consider (or trial) continuing (ideally for the maintenance period of up to 1 year) to offer subsidised access to physical activity opportunities following the successful completion of the active intervention.

- **Psychological knowledge and skills** are key components of tiered weight management interventions. An understanding of the relationship between cognitions, emotions and behaviours is essential in the promotion of behaviour change and self-

management, while the ability to recognise and appropriately respond to psychological disorders – for example stress and anxiety disorders, depression, disordered eating patterns and eating disorders – is necessary in a patient population where the risk of psychological co-morbidity can be significantly higher than in the general population. A number of psychological models have been demonstrated to be effective in supporting weight management, including health behaviour change approaches, cognitive behavioural therapy and 'third wave' approaches such as mindfulness and acceptance and commitment therapy. Such approaches can be adapted to be offered in a range of modalities/ intensity.[23]

Considerations

- Findings from a recent systematic review which looked at the effectiveness and cost-effectiveness of different approaches to helping change lifestyles suggest that adding an intensive physical activity programme to a weight management programme increased weight loss longer term.[54]

Resources for further learning and information

- NHS Education for Scotland has developed an interactive eLearning module and resources on behaviour change skills, which is open to all health and social care staff.
- The British Psychological Society recently published a report Psychological perspectives on obesity: Addressing policy, practice and research priorities[55] which looks at what psychological evidence and perspectives can add to help improve our response to obesity. The guidance builds on existing services, while identifying areas where further resources, standards, training and staff are required.
- The Psychological Therapies 'Matrix' is a guide to planning and delivering evidence-based psychological therapies within NHS Boards in Scotland. The Matrix is published by NES, in partnership with the

Scottish Government. It provides a summary of the information on the current evidence base for various therapeutic approaches, guidance on well-functioning psychological therapies services and advice on important governance issues.

- The current the UK Chief Medical Officers' Physical Activity Guidelines and supporting materials can be found on the UK Government website.
- NHS Health Scotland published guidance on the National Physical Activity Pathway to support healthcare professionals integrate physical activity into the design and delivery of existing clinical pathways.
- Moving Medicine is a resource designed by the Faculty of Sport and Exercise Medicine to support health professionals raise the issue of physical activity in relation to a number of health conditions.
- To help you plan, deliver or assess your physical activity interventions you can join the Physical Activity Health Alliance (PAHA). It offers a wealth of shared resources and sources of good practice including: new research findings, a monthly e-newsletter, learning exchange events, case studies of best practice.
- Visit NHS Health Scotland for a comprehensive list of the physical activity resources available.

6. Treatment duration, length of consultation and frequency of contact

Standard statement

Weight management services are evidence based and provided in a way that is acceptable to people accessing the service. Services support and empower people to continue to make positive changes to their health and wellbeing.

Active intervention phase

The evidence base is limited on the optimum attendance patterns and frequency and duration of healthy weight interventions for adults.[44, 54] These limitations notwithstanding, based on the current best evidence, all interventions for tier 2 and tier 3 (individual or group) should seek to comply with the criteria outlined below.

Weight management services should:

- ensure all interventions for tier 2 and tier 3 (individual or group) should be at least 1 year in duration and comprise an active weight loss phase and a maintenance phase. The active weight loss phase should be a minimum of 12 weeks in duration. **(Essential)** Local areas are encouraged to trial and evaluate the efficaciousness of longer and/or more intense interventions as there is evidence to suggest that there is a dose-response relationship between volume of intervention and outcome, particularly in a group setting.[54] **(Desirable)**
- ensure sessions are 'delivered either on a weekly or fortnightly basis and include an option to be weighed or self-weigh at each session each session'.[32] Where it is not possible to offer services with this frequency of contact, for example in more rural or remote areas, services should consider alternative modes of delivery, for example through peer support networks and the use of tele-health and digital approaches – at least one service in Scotland has reported

successfully trialling group sessions for adults using Attend Anywhere. **(Essential)**

- look to learning from good practice in Scotland which suggests that one hour is a useful guide for one-to-one specialist appointments in tier 3. Group sessions will be longer when physical activity is delivered as part of the session. Additional sessions will be required to facilitate physical activity where this is being delivered separately. **(Desirable)**

Maintenance phase and ongoing support

There is broad agreement that many people need considerably longer than the active intervention phase to develop the sustainable behaviour changes needed for weight-loss maintenance. A recent systematic review reported that 'long-term weight maintenance was improved by providing telephone or face-to-face follow-up, training in relapse prevention or problem-solving.'[54] Hence, longer-term support is critical.

Weight management services should:

- offer a maintenance programme as key component of a 1-year programme, to all participants, to ensure ongoing support following the active intervention phase.[33] Depending on the length and type of the active intervention and the needs of the individual, follow-up should be at 1- to 3-monthly intervals – i.e. at 3, 6 and 9 months post active intervention. In some circumstances, for example for total diet replacement, follow-up may be required for up to 2 years. **(Essential)**
- offer a range of options including follow-up sessions at different times and in easily accessible and acceptable venues. Consideration should be given to provision of follow-up sessions to housebound patients with the possible use of Attend Anywhere. Inform participants about local services and activities that may provide further support to help them manage their weight, for example, local leisure services and walking or cycling groups.[34] **(Essential)**

- send feedback to the referring GP or healthcare professional on completion of the programme or when the individual is no longer attending.[33] **(Essential)**

Total diet replacement programmes for remission of type 2 diabetes

There is now robust evidence for use of a programme which includes a total diet replacement (TDR) stage using low-energy liquid diets (LELD) in the initial phase (12–20 weeks), in individuals diagnosed with type 2 diabetes within 6 years of the date of the programme starting. Peer review publications show remission rates of 46% and 36% at 12 and 24 months, respectively.[56, 57]

Current evidence does not support the *routine* use of programmes including TDR, low energy or very low energy stages within tier 3 weight management programmes as a weight-loss strategy where the primary aim is weight loss only.[58] NICE[32,33] and SIGN[31] both acknowledge they may be beneficial for weight loss in specific cases, but that patients should be assessed and counselled appropriately on risk versus benefit.

Weight management services should:

- ensure the programme is made available to adults meeting agreed criteria (see DiRECT Study protocol)[58] in accordance with the A Healthier Future: Type 2 Diabetes Prevention, Early Detection and Early Intervention Framework (2018).[23] **(Essential)**
- deliver the programme within tier 3 (or above) weight management services by suitably qualified and trained staff to ensure maximum level of specialist input, clinical and psychological interventions and ongoing supervision and governance. **(Essential)**
- ensure robust assessment including patients' current diabetes control and clinical management plus other co-morbidities. Psychological/behavioural markers to identify eating disorder risk and disordered eating history should also be assessed due to the higher risks associated with more restrictive dietary patterns.[59] **(Essential)**

- be aware that at the time of this publication, Counterweight Plus is the only evidence-based, peer-reviewed programme which incorporates TDR as well as food reintroduction and weight-loss maintenance[60] recommended for use in NHS Scotland.* **(Essential)**
- ensure that patients undertaking a programme of TDR and food reintroduction receive all essential timely appointments and regular follow-up as compulsory participation of the treatment programme – up to 1 year minimum **(Essential)** and ideally continue to have follow-up support in the maintenance phase of the programme up to 2 years. **(Desirable)**
- ensure patients receive ongoing monitoring of weight, blood glucose and blood pressure to assess ongoing diabetes control, potential remission status and importantly review of any medications required – may be provided by dietitian delivering programme or qualified healthcare staff. Professional Protocols for medical monitoring form a key component of Counterweight Plus. **(Essential)**
- ensure systems are put in place to recommence medications where patients drop out of the intensive programme having had medications withdrawn at baseline. **(Essential)**
- ensure participants also have access to aspects of tier 3 weight management throughout this time i.e. physical activity and psychology, as required. **(Essential)**
- adopt the following inclusion criteria for programmes containing an LELD/TDR stage **(Essential)**:
    - Written informed consent
    - Men and women aged 20–65 years, all ethnicities (in line with current evidence – but exception cases may be made)
    - Body Mass Index (BMI) >27 kg/m^2 (in line with current evidence – regarding the increased chance of remission but exception cases may be made)

* This recommendation is subject to revision and be will be reviewed in year 2 (2020) of the type 2 diabetes framework implementation to take into account emerging evidence.

- T2DM of duration 0–6 years (diagnosis as per clinical guidelines)
- HbA1c > 48 mmol/mol within last 12 months
- If HbA1c >42<48mmol/mol patient must be on oral hypoglycaemic agents
- Established medical management of condition and prescribed medications.

Note: It is important to acknowledge that the most desirable outcome would be remission, but patients with type 2 diabetes will achieve clinical benefits of significant weight loss in line with the anticipated outcomes of the Type 2 Diabetes Prevention, Early Detection and Early Intervention Framework (2018).[23] Criteria should take this into account and offer flexibility regarding inclusion.

Tier 4: Going on to surgery

The focus of this standards document is to set out expectations for tier 2 and tier 3 weight management services (see *Scope* above). Although tier 4 (bariatric surgery) is considered out-with the scope of these standards, it is important to highlight the essential role of tier 3 weight management in the preparation and progression for bariatric surgery.

Weight management services should:

- provide participants with explicit guidance on the pathway from tier 3 to tier 4 and work together with bariatric surgery teams to ensure smooth progression and uniformity of information across the tiers. **(Essential)**
- ensure referral criteria for tier 3 (see section 4 above) do not contradict tier 4 criteria, i.e. tier 3 criteria should not exclude referral of patients who would meet the criteria for bariatric surgery in each NHS Health Board area, although it is acknowledged that not all patients entering tier 3 will be suitable for bariatric surgery. **(Essential)**
- ensure clear pathways are in place for patients to return easily to tier 3 services if they do not proceed to bariatric surgery at that point in time. Patients should not have to be re-referred or have a ‘lock-out’ period if

it is agreed mutually by patients and managing clinicians that ongoing weight management support would be beneficial. **(Essential)**

- reference the National Planning Forum document when reviewing and planning tier 4 pathways and services. This document sets out clear, national guidance on priority group patients for referral to tier 4 bariatric surgery. **(Essential)**

Considerations (entire section)

- 'Behavioural weight management programmes commonly have treatment durations of 8–12 sessions/weeks although debate continues about the potential value of extending beyond this minimum time'.[61, 62] In a recent study of primary care referrals to a UK commercial programme an extended 52-week treatment produced greater initial weight loss and clinical benefits together with less weight regain at 2 years compared to the brief intervention and the standard 12-week treatment.[54, 63] Despite the increased costs of delivering this longer programme, modelling suggested it would prove cost effective over the longer term.[63]
- Evidence suggests that 'more contacts with weight management programme personnel (in person or remotely), were usually associated with greater weight loss and better weight maintenance'.[54]
- Individual Board areas may want to work with their local leisure providers and other community organisations to offer subsidised programmes and access to leisure facilities so that individuals can be empowered to continue to maintain their lifestyle changes.
- Services are encouraged to consider other modes of delivery for on-going support, as previously stated to ensure consideration is given to establishing peer support networks and to the use of tele-health and digital approaches such as Attend Anywhere and Florence.
- Services may also wish to consider the findings from a recent systematic review which suggests that 'certain characteristics of behavioural [weight management programmes] were related to increased effectiveness for weight, namely telephone or internet

support after the end of the programme, group support, CBT, motivational interviewing and mindfulness. These intervention components generally produced longer-term weight-loss changes than over 12 months. Participants seemed to value the psychological input integrated into interventions.'[54]

- Evidence[54] also suggests that 'weight-management programmes that were perceived to be novel or exciting (dietary, physical activity or behavioural elements not experienced before) and endorsed by health-care providers tended to be valued most by participants. Both participants and programme providers tended to value some choice and flexibility within various intervention components. Group-based programme activities tended to be valued, along with fairly intensive support from programme providers, who were encouraging and provided regular monitoring. The sense of belonging to a group of people who shared similar issues seemed particularly important, helping to foster a strong group identity and related 'accountability', which aided motivation and continuing engagement'.[54]

Resources for further learning and information

- Attend Anywhere is a web-based platform that helps healthcare providers offer video call access to their services as part of their 'business as usual', day-to-day operations.
- Florence is a text messaging system that sends patients reminders and health tips tailored to their individual needs.
- The British Psychological Society recently published a report Psychological perspectives on obesity: Addressing policy, practice and research priorities[55] which looks at what psychological evidence and perspectives can add to help improve our response to obesity. The guidance builds on existing services, while identifying areas where further resources, standards, training and staff are required.

7. Weight management/intervention goals

Standard statement

Weight management interventions for adults should set appropriate goals, including weight.

Weight management services should:

- ensure weight-loss targets are personalised, based on realistic expectations of weight change and take account of individual preferences, comorbidities and risks, rather than their weight alone:
    - In patients with BMI 25–35 kg/m^2, obesity-related comorbidities are less likely to be present and a 5–10% weight loss (approximately 5–10 kg) is required for cardiovascular disease and metabolic risk reduction.
    - In patients with BMI ≥35 kg/m^2, obesity-related comorbidities are likely to be present therefore weight-loss interventions should be targeted to improving these comorbidities. In many individuals a greater than 15–20% weight loss (will always be over 10 kg) will be required to obtain a sustained improvement in comorbidity.
    - Some patients do not fit these categories. Patients from certain ethnic groups (e.g. South Asians) are more susceptible to the metabolic effects of obesity and related comorbidity is likely to present at lower BMI cut-off points than in individuals of European extraction.
    - The thresholds for weight-loss intervention should reflect the needs of the individual.[31] **(Essential)**
- ensure that staff delivering weight management services are engaged in individual goal setting and monitoring of non-weight related goals and outcomes – including but not limited to, improvements to dietary quality, increased physical activity, reduced sedentary time, improved self-esteem, improved knowledge and skills on longer-term management of individual weight and progress towards personal goals.

NHS Boards will decide locally using current evidence as to the most appropriate tools for measuring progress. **(Essential)**

8. Staff: knowledge, skills and training

Standard statement

Staff are given appropriate education and training to successfully deliver adult weight management programmes.

Weight management services should:

- ensure that sufficient numbers of suitably trained and experienced multidisciplinary staff are in place to deliver weight management interventions for adults. Good practice suggests that regular training for staff should be in place. Ideally this training would be mandatory and on an annual basis. **(Essential)**
- ensure that the staff delivering physical activity components are 'appropriately trained' (on the Register of Exercise Professionals, or equivalent, at level 3 or above) and 'tailor the type, duration, intensity and format of activity to the population needs. This may include, for example, an individual's level of fitness, any form of disability, any pre-existing medical conditions or co-morbidities'.[34] **(Essential)**
- ensure that dietitians delivering Counterweight-Plus have completed the required competency based training programme provided by Counterweight Ltd. (see section 'Total diet replacement programmes for remission of type 2 diabetes' above) **(Essential)**
- be aware that health professionals may find it challenging to approach the subject of weight and can struggle to talk to people about this in a sensitive manner. Barriers include concern about upset, time, extent of their role, lack of knowledge of what to say and of knowledge of local services.[23] NHS Boards should therefore consider providing training to support health and care professionals to have sensitive conversations about weight management. **(Desirable)**
- ensure that staff delivering services should:
    - have up-to-date knowledge and skills in behaviour change, to support weight management, maintenance and promote self-management.

- have an awareness of mental health difficulties that are prevalent among adults with overweight and obesity and how these difficulties influence engagement in weight management.
- recognise when individuals would benefit from professional psychological help with mental health difficulties.
- have an awareness and understanding of skills such as motivational interviewing and cognitive behavioural techniques will be beneficial in supporting adults to have a healthy weight.

(Essential)

- be aware that healthcare professionals can have stigmatising attitudes and, in some cases, fail to provide appropriate advice and access to treatment.[17, 64] Services should offer training and education on weight stigma and bias in order to help remove barriers that may otherwise interfere with provision of care for patients with obesity. This will help to improve treatment accessibility and reduce adverse patient behaviours such as avoiding appointments and not reporting concerns to healthcare providers.[65] **(Essential)**
- be aware that individuals living with obesity experience a range of physical and psychological challenges as a consequence of obesity. It is therefore essential that interventions in weight management integrate psychological awareness and techniques to address this. Clinical and/or health psychologists could be involved in training and supporting staff to develop psychological understanding and developing psychological practice. Appropriate training and in-service support should be used to ensure quality standards across all services.[55] **(Essential)**
- give consideration to training all staff in trauma-informed approaches to delivering weight management services – this will help staff to understand the impact of trauma and learn how to effectively minimize its effects without causing additional trauma.[66] The Transforming Psychological Trauma Training Plan[66] is designed to support the development of the workforce in both recognising existing skills and

knowledge and also helping to make informed decisions about the most suitable evidence-based training to meet gaps. **(Desirable)**

Considerations

- Adopting a trauma-informed approach offers practitioners the opportunity to create a supportive environment with a dynamic and fundamental understanding of the factors which may have contributed directly and indirectly in relation to issues with weight management. In addition, it allows for the development of practices, policies and environmental factors which uphold the key principles of trauma informed practice, namely:
    - Safety
    - Choice
    - Trust
    - Collaboration
    - Empowerment

Resources for further learning and information

- A number of resources currently exist for professionals to assist with these conversations. Online training on general health behaviour change related to long-term conditions and weight management conversations is currently available to all NHS boards through NHS Health Scotland.
- Small Talk Big Difference is a one-hour training course aimed at anyone who is regularly treating patients with type 2 diabetes (primarily GPs and practice nurses). It focuses on the benefits of weight management in type 2 diabetes, how to have a conversation about weight with a patient and how to motivate a patient towards readiness to change, treating diabetes safely during weight loss and links to further training resources. It comes in a package with a patient leaflet, discussion tool, practice checklist and posters.
- NHS Education for Scotland currently provides online and face-to-face MAP (motivation, action, prompts) behaviour change training for health

and social care professionals, and others working in prevention, including local government and third sector employees.

- For further training on awareness and prevention of weight bias see the free online training courses offered by World Obesity Federation.
- Visit ChooseLife for more information about the range of courses on the issue of mental health and suicide prevention. More information can be found on the range of training courses offered by NHS Health Scotland here.
- Obesity Action Coalition has produced a brochure which discusses the many forms of stigma and provides readers with options for dealing with stigma and ways to educate others.
- The Transforming Psychological Trauma Framework[36] is a whole of Scottish workforce document offering defined parameters according to the particular role a service or individual may have in working with people who may have experienced trauma. For example, reception staff may be in the Trauma Informed category, but dietetic practitioners may require to be working at Trauma Skilled level. The Transforming Psychological Trauma Training Plan[66] offers structure and suggestions around the fulfilment of training needs and organisational readiness in adopting a trauma-informed approach.

9. Monitoring, evaluation and reporting

Standard statement

Weight management interventions for adults are effectively monitored and evaluated. NHS Boards work to continually improve services.

Weight management services should:

- record standardised core data. The core dataset will provide a list of data collection criteria and supporting guidance for collecting high quality information that will help to support local monitoring and evaluation, planning and any future national evaluation of weight management services across Scotland. Separate guidance will be issued by Scottish Government in due course. **(Essential)**
- be aware that the core dataset will also be used to inform the evaluation of the Prevention, Early Identification and Early Intervention Framework for Type 2 Diabetes.[23] The dataset will therefore include specific requirements for data collection for moderate and high risk groups and those with established pre-diabetes conditions, gestational diabetes mellitus and type 2 diabetes. **(Essential)**
- report back on service delivery, funding, health outcomes for adults on an annual basis to Scottish Government, as requested. **(Essential)**
- evaluate their adult weight management services. NHS Health Scotland will also consider, with the Scottish Government, the need for a further national evaluation. This, combined with the development of the core dataset, should enhance the potential for learning from delivery and implementation. **(Essential)**
- ensure participants are invited to provide feedback on services. NHS Boards should consider and explore a range of communication methods to engage with participants in order to shape future services and collect feedback and these should be tailored to participant preferences, as groups may prefer different methods. Also consider developing case studies and record patient stories to use to evaluate the service. Feedback should be taken into account when considering

how best to improve the service. This will help ensure that services are accessible, available, acceptable and of a high quality.[67] **(Essential)**

- audit reasons for non-engagement – this is an important consideration. This can help to ensure that services are being designed to meet the needs of the local service users. Feedback is essential to ensure that services are reactive to poor attendance or disengagement, to help improve engagement and impact of the service.[*] **(Desirable)**
- utilise (where possible) local resources, such as Local Intelligence Support Teams (LIST) and look to develop partnerships with academic centres to assist with data analysis and local evaluation. **(Desirable)**

[*] It is recognised that auditing reasons for non-engagement is likely to be difficult given that these are non-engaged individuals. However, if local user involvement in the development of services can effectively be put into place, it may be that buy-in will be improved over time.

10. Sharing learning and good practice

Standard statement

All NHS Boards actively share learning and good practice more widely.

Weight management services should:

- share learning and good practice with colleagues in other localities and more widely. This should include any learning from less successful approaches, so that replication can be minimised. Suggestions for sharing learning include via peer-reviewed journals, case studies, conferences and through NHS Health Scotland's Healthy Weight Leads Network. This will help to improve services overall. **(Essential)**

Glossary

Body mass index (BMI): BMI is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of their height in metres (kg/m^2).

Comorbidity: This is the co-occurrence of one or more disorders in the same child or young person either at the same time or in some causal sequence.

Health inequalities: The unfair and avoidable differences in people's health across social groups and between different population groups.

Health Inequalities Impact Assessment (HIIA): HIIA is a tool to assess the impact on people of applying a proposed, new or revised policy or practice. HIIA goes beyond the public sector's legal duty of the Equality Act 2010 to assess impact (EQIA) by assessing the impact on health inequalities, people with protected characteristics, human rights and socioeconomic circumstances.

Human rights-based approach: A human rights-based approach is about empowering people to know and claim their rights and increasing the ability and accountability of individuals and institutions who are responsible for respecting, protecting and fulfilling rights.

Obesity: Defined as having a BMI greater than or equal to 30 kg/m^2 (see body mass index, above).

Overweight: Defined as having a BMI greater than or equal to 25 kg/m^2 (see body mass index, above).

People-first language: This is the standard for respectfully addressing people with chronic conditions, rather than labelling them by their illness.

People-first language involves putting the person before the condition, for example using ‘people affected by obesity’ instead of ‘obese people’.

Service level agreement (SLA): A service level agreement defines the provision of a service between provider(s) and purchaser/recipient.

Appendix: Consultation and peer review

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Peer review

British Dietetic Association Obesity Specialist Group

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