Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title

Title: Identification & Management of Obesity in Adult & Older People Services Policy

Version: 5

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Supersedes

Supersedes: Version 4

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P7, 10 and Appendix 1. Procedure – Referral to the dietitians –procedure.
P12 Change of references
P14-20 New appendices
Appendix 1, 2 and 4

Originator

Originated By: Joanna Connor

Designation: Specialist Mental Health Dietitian

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: Catherine Forman

ERA Undertaken on: 23.2.2012

ERA approved by EIA Work Group on: 2.3.2012

Where policy is deemed relevant to equality: Yes

EIA Undertaken by: Catherine Forman

EIA Undertaken on: 23.2.2012

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Approval

Referred for approval by: **Physical Health Steering Group**

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Executive Director Lead: Medical Director

Circulation

Issue Date: **22nd April 2015**

Circulated by: **Performance and Information**

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trusts External Website? Yes

Review

Review Date: March 2017

Responsibility of: Joanna Connor,

Designation: Specialist Mental Health Dietitian

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 22nd April 2015

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Contents Page

1. Aim

This policy has been developed to assist all staff in Pennine Care NHS Foundation Trust (PCNFT) to identify and manage obesity in Adult, Rehabilitation and High Support (RHSD) and Older People's inpatient services. Furthermore it will ensure that individual care is undertaken with dignity and respect.

2. Background

The first National Institute for Health and Clinical Excellence (NICE) guideline for Obesity was published in 2006 it states "Multi-component interventions are the treatment of choice. Weight management programmes should include behaviour change strategies to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of a person's diet and reduce energy intake" (NICE, 2006). The guideline also states that behavioural interventions should aim to include the following strategies where appropriate; "…self-monitoring of behaviour and progress, stimulus control, goal setting, slowing rate of eating, ensuring social support, problem solving, assertiveness, cognitive restructuring (modifying thoughts), reinforcement of changes, relapse prevention, and strategies for dealing with weight regain" (NICE, 2006).

In adults obesity is defined as a Body Mass Index (BMI) of 30kg/m^2 or more, and 40kg/m^2 as morbidly obese. Adult obesity is associated with a wide range of health problems such as coronary heart disease, stroke, type 2 diabetes, high blood pressure and cancer (DH, 2008). Obesity reduces life expectancy by 3-11 years depending on the severity. Levels of obesity are set to increase in future years (Foresight, 2007). Compared with the general population, obesity is said to be 50% higher in people with serious mental health problems. Among the factors contributing to this are the side effects of some anti-psychotic medication, lack of exercise due to poor motivation and a poor diet (NOO, 2011).

The potential health benefits from a moderate reduction in weight can lead to improvements in physical, mental and social well-being. A weight loss of 5-10% can lead to improving pre-existing, or reducing the risk of developing, obesity related co-morbidities. Maintaining weight loss could lead an improvement in lipid profiles, osteoarthritis related disability, cancer and diabetes mortality, blood pressure, glycaemic control, risk of Type 2 diabetes and the potential for improved lung function in patients with asthma (SIGN, 2010).

3. Responsibilities

3.1. ***Executive Directors*** – The Executive Directors of PCNFT will provide leadership and direction to ensure this policy receives the necessary level of commitment.

3.2. ***Managers*** – The general managers are responsible for ensuring the implementation of and adherence to this policy within their respective areas of responsibility. They are also responsible for bringing to the attention of the Directors any gaps in service provision whether that is related to the environment, facilities or skills of the workforce.

3.3. ***Healthcare Professionals*** – All healthcare professionals in contact with patients regardless of whether their contact is planned or incidental, should aim to reinforce and support embracing a healthy lifestyle and seek to promote opportunities for healthy eating and physical activity. Health professional must be aware of the limits of their knowledge and skills and contact other healthcare professionals such as a dietitian, as required.

4. Definitions

4.1 ***Body Mass Index*** – BMI is a measure of the ratio between height and weight is a widely accepted method of assessing underweight or overweight.

$$\frac{\text{Weight (kg)}}{\text{Height (m) x height (m)}} = \text{BMI kg/m}^2$$

NICE (2006) classifies a BMI of 25 to 29.9 kg/m^2 as 'overweight' and 'obesity' as a BMI of 30kg/m^2 or more. These ranges are based on epidemiological evidence demonstrating the link between mortality and BMI in adults (DH, 2008)

4.2 Morbid obesity/Obesity/Overweight **categories are** defined by BMI. Research shows that people of Asian origin have a higher risk of developing weight associated health problems with a lower BMI therefore reference ranges are modified for this cultural group. The term pre-obese can be used in place of the word overweight. Morbid obesity is defined as having a BMI is 40+kg/m^2 (see Section 6 and Appendix 5)

4.3 Waist circumference – measures the central distribution of fat in adults. When used together with an individual's BMI, it can help classify the risk of developing Type 2 diabetes and cardiovascular disease.

4.4 Co-Morbidities – are associated health problems and include diabetes, hypertension, cardiovascular disease and osteoarthritis.

4.5 Health Care Professionals – all appropriately trained health care professionals who can provide health advice (NICE, 2006).

4.6 **Bariatric:** From the Greek root bar-means 'weight' and the suffix –iatr meaning 'treatment' and the suffic-ic meaning 'pertaining to'. The word means 'related to the medical or surgical treatment of obesity'. The word 'heavy' will be used to describe patients weighing over 159kg (25 stone) 'Heavy Person policy'. CO103 (PCNFT, 2015)

5. Procedure

5.1 Person Centred Care

NICE (2006), recommends health professionals follow principles of person-centred care. Throughout the patient's treatment and care, their needs and preferences must be considered and the opportunity for making informed decisions should be provided. Raising the issue of weight can be a sensitive subject for some people and requires handling sensitively. Following the guidance in the tool 'Raising the issue of weight in adults' can help to raise this issue in a person centred way. This tool can be found on the PCNFT intranet (see Appendix 1).

5.2 BMI Assessment

All newly admitted patients must have their weight and height recorded in order to calculate the BMI within 48 hours of admission and on an ongoing basis (see below for details depending upon ward status) If a patient has a BMI of over 30kg/m^2, or over 27kg/m^2 with co-morbidity (Type 2 diabetes, hypertension, cardio vascular disease, osteoarthritis, dyslipidaemia or sleep apnoea), this must be documented in the patients records and the physical health screening must be completed in line with the PCNFT Physical Health Policy CL42.

If the patient has a BMI greater than 25kg/m^2, waist circumference should also be measured to indicate the level of risk of developing co-morbidities such as Type 2 diabetes or cardiovascular disease.

The patient should also be assessed for muscle bulk (for example body builders, weight lifters and rugby players etc. may have greater amounts of muscle) as greater amounts of muscle can cause BMI to be raised as weight measurement does not distinguish fat from muscle and the result misleading. For example body builders, weight lifters and rugby players etc. may have greater amounts of muscle. If the patient is particularly muscular, this must be recorded in the patient's notes along with the waist measurement to indicate this anomaly.

Some ethnic groups, in particular south Asian populations, are at a higher risk of co-morbidities, at a lower BMI due to differences in body shape and fat distribution. Therefore NICE (2006) recommends that health professionals use their clinical judgement when considering risk factors in Asian population groups, including for those individuals not classified as overweight or obese (DH, 2008).

Patients on Adult inpatient and RHSD wards should be screened using the trigger questions on the Physical Health Monitoring Form. If, due to patient compliance or other factors, this has not been completed the reason should be documented and dated. MUST assessment should then be used.

All older adult inpatients will be re-screened at least weekly using MUST by an appropriately trained member of staff, following the recommended advice within the MUST. Fluid balance and food charts must be filled in completely and recorded accurately using Trust approved documentation to enable monitoring for a minimum of three days.

Patients on Adult inpatient wards not considered to be at nutritional risk on admission, should be weighed weekly using the Trust approved weight chart.
Following assessment, adults who fulfil the following requirements, should be re-screened (using MUST) weekly.

- BMI less than 20, and / or any unintentional weight loss
- poor appetite or any general concerns in this area
- who fall into these requirements during admission

RHSD wards will weigh patients monthly unless other indication requires weekly weight and MUST screen.

If BMI is in the healthy/ overweight range, but the weight is increasing, healthy lifestyle advice may be required to prevent the BMI moving into the obese and higher risk categories. Any advice given must be recorded in the patient's notes. Please contact the dietitian for support in helping to manage a patient's weight.

Inpatients identified as morbidly obese (BMI of 40+kg/m^2) that are expected to be on the ward/unit for more than one month, may be referred by the clinical team for specialist weight advice and management from the appropriate dietetic services.

Antipsychotic medication can increase appetite leading to weight gain; therefore the MM068 'Guidelines for the Management of Patients who have Antipsychotic Induced Weight Gain' (PCNFT, 2011a) and MM039 'Guidelines for the prescribing and monitoring of antipsychotics in the treatment of schizophrenia' (PCNFT, 2011b) should be followed. There is a leaflet on the intranet for use with patients commencing antipsychotic drugs and weight management -See Appendix 1 for guidance on accessing documents on the PCNFT intranet.

The clinical team may refer those patients identified at risk of obesity to the dietitian or General Practitioner (GP) for appropriate weight management advice and support services as part of the patient discharge plan.

For the North Division (Bury, Rochdale and Oldham) Adult and Older people's wards, there is a Service Level Agreement (SLA) with Pennine Acute Hospitals NHS Trust for dietetic services for direct patient contacts.
For the North Division RHSD wards– Stansfield Place and Rhodes Place and for the South Division – Adults, Older people and RHSD wards, there are PCNFT mental health dietitians.
For each type of service, appropriate referral forms can be found on the PCNFT Intranet - See Appendix 1.

6. BMI Classification

The outcome of the physical assessment, subsequent management and onward referral should be recorded in the patient's clinical records and on a weight record chart. (For Pennine Trust approved weight and MUST record charts see the PCNFT Intranet and Appendix 1 for access guidelines)

Classification of weight from BMI

Healthy weight	18.5 – 24.9kg/m^2
Overweight	25 – 29.9kg/m^2
Obesity I	30 – 34.9kg/m^2
Obesity II	35 – 39.9kg/m^2
Obesity III	40 or more kg/m^2

7. Weight Management Initiatives and Monitoring

7.1 Motivation to change

Assessing the patient's willingness and readiness to engage in specific changes to lifestyle and behaviour is crucial to understanding the factors that are important to the individual and indicates the approach to take in supporting the patient. (Verheijden et al., (2005) as cited in SIGN, (2010); See Appendix 6).

If a patient appears to have low motivation levels and lacks the readiness to change their lifestyle, health professionals continue to have a duty of care to offer healthy lifestyle advice and to provide and support opportunities for healthy eating and physical activity.

Behavioural interventions should be offered, and integrated into the care provided when deemed appropriate, to support lifestyle change. There is a recognition that motivation and appropriateness of interventions will fluctuate over time. For examples of behavioural interventions see section 7.9 and for resources supporting these interventions see Appendix 1 and 2). Any advice and/or interventions must be recorded in the patient's nursing/medical records.

7.2 Mental capacity

If low motivation appears to be linked to a patient lacking the capacity to make decisions, appropriate assessment of mental capacity will be required.

7.3 Management of Obesity

A comprehensive review of interventions for managing obesity concluded that behavioural and cognitive behavioural approaches make a significant difference to the success of weight management interventions, especially when combined with diet and physical activity (Shaw et al, 2005). Therefore, management of obesity should aim to reduce overall calorific intake (healthy eating advice), increase energy expenditure (physical activity advice) and incorporate some component of behavioural change to bring about long term lifestyle changes.

It is important to be aware, that in many obese individuals there could be a cycle of mood disturbance, overeating and weight gain. Those who struggle to control their weight, particularly when they are sad, anxious, stressed; lonely and frustrated often use food as a coping mechanism. Comfort eating may result in a temporary reduction of a distressed mood, but the subsequent weight gain will then contribute to a negative cycle of behaviour (BPS, 2011).

Co-morbid mental health problems are often associated with being overweight or obese and can often be interlinked. Individuals who suffer from psychological disorders (e.g. depression, anxiety and eating disorders) may have more difficulty in maintaining a healthy weight and display more problematic eating behaviours, for example ‘mindless’ eating, frequent snacking on high calorie foods, overeating, night-eating.

Healthcare professionals should be aware of the possibility of binge-eating disorder in patients who have difficulty losing weight and maintaining weight loss. If a patient is identified as having an eating disorder it is recommended that a referral to a specialist eating disorder service should be made (SIGN, 2010).

Therefore, for some patients, reducing the rate of weight gain or stabilising the weight may be the first aim. For example, if a person is currently gaining weight, it may be unrealistic to expect weight loss. If unrealistic and unachievable changes to lifestyle are attempted, this may exacerbate a mental health condition (NOO, 2011). It is therefore important to consider each patient on an individual basis in terms of their current mental health, whether their weight is stable or increasing, level of motivation, any other potential factors that may be affecting their weight (e.g. medication, any history of eating disorders). If the patient has a stable weight, and losing weight is appropriate, guidelines suggest, an initial aim should be to lose no more than 10% body weight from baseline, at a rate of 0.5-1.0kg (1-2lb) per week.
The intensity of weight management will depend upon the level of risk (see Appendix 5), the appropriateness of interventions and will be linked to length of stay on a ward and must be included as part of the discharge plan.

7.4 Care of Patient

Any patient on adult and older peoples wards with a BMI of over 30kg/m^2 should have their weight monitored weekly. Patients must have their weight re-measured and re-assessed during the course of their inpatient stay to monitor for any gradual increase/decrease in BMI. On older people’s wards weight and MUST screening should be completed weekly. On RHSD wards weight can be measured and recorded monthly. MUST screening must be completed every 6 months. (Note: a patient can have a MUST score of 2 indicating malnutrition despite having a BMI greater than 25kg/m^2.)
Any increases in weight should be reported to the medical team and recorded in the patient’s notes. Observations of blood pressure, pulse, temperature and respirations are also to be recorded as appropriate and any abnormalities reported to the medical team. Refer to the Physical Health policy CL42 (PCNFT, 2011) and the Nutrition and Hydration policy CL85 (PCNFT, 2015).

7.5 Healthy eating advice

All adult inpatients should have access to healthy eating advice via:-
Verbal advice from Health Care Professionals
Patient Information Leaflets: The Mental Health Dietitians have developed resources to support staff and patients with various aspects of nutrition. These can be found on the trust intranet under Physical Health Matters

These can be found on the trust intranet under Physical Health Matters

- Open home page of trust intranet
- Click 'Policies & Clinical Guidelines'
- From the left hand side select 'Department / Service Area'
- Select P / Physical Health Matters
- There is a variety of documents including the referral form and resources covering Malnutrition / MUST, Health and Well Being, Weight Management, Food First, documentation.

These resources have explanatory information about their use, but if you would like more information please contact the Mental Health Dietitians - see Appendix 1.

When discussing dietary change with patients, healthcare professionals should emphasise achievable and sustainable healthy eating. The Eat Well Plate (PHE, 2014) is the nationally recognised model representing a healthy, well balanced diet based on the five food groups. The overall type, quantity and frequency of food and drink consumed should be modified to achieve a lower overall calorie intake, based on patient's personal and cultural preferences (SIGN, 2010).

7.6 Healthy eating opportunities

All adults in inpatient units should have access to healthy food as required

The dietitians and catering departments work together to review menus to ensure that any provided meals are nutritionally balanced. Wherever possible information on the salt and fat content and the calorific value of hospital meals will be readily available at the point of service, to enable individuals to make an informed choice. Any opportunities for patients to prepare their own meals on the units should encourage the preparation of healthy meals.

7.7 Physical activity advice (Appendix 3)

All adult inpatients should have access to physical activity advice via:-

- Verbal advice from Health Care Professionals
- Patient Information Leaflets such as; 'So you want to lose weight for good', from www.bhf.gov.uk and any other relevant locally sourced material.

There is a clear causal relationship between the amount of physical activity people do and all-cause mortality (WHO, 2010). Physical activity has an important role to play in promoting mental health and well-being, by improving the quality of life of those experiencing mental health problems as well as helping with weight control. Even more so, there is a growing body of evidence that raises the concern over the risks of sedentary behaviour (DH, 2010). Health improvements can be achieved with sessions as short as 10minutes in length, and activities such as walking can be incorporated into daily lifestyles. New guidelines 'Start active, Stay active were published in 2011 around physical activity (CMO, 2011)

7.8 Physical activity opportunities

A range of opportunities for physical activity should be made available to all adults in inpatient units and should take account of their lifestyle, interests and level of fitness.

Each unit provides a physical activities programme, and provides both in-house and in the local community activities whether it is provided by local authorities or the private or voluntary sector.

7.9 Behavioural Intervention

It is optimal that some level of behavioural intervention is at the core of any weight management intervention attempted with an individual (BPS, 2011). Motivated individuals actively seeking to make changes, require a different approach from those who are low in motivation. Change can be difficult to achieve and it is not a linear process. It can therefore be expected that people will go backwards as well as forwards (Mental Health Providers Forum, 2009).

NICE (2006) recommends that behavioural interventions should include the following strategies, as appropriate for the individual:

- Self-monitoring of behaviour and progress (e.g. food or exercise diary)
- Stimulus control (identifying triggers of specific behaviours and ways to remove/ avoid triggers)
- Goal setting
- Slowing rate of eating
- Ensuring social support (e.g. family/ friends/ health professionals)
- Problem solving
- Assertiveness
- Cognitive restructuring (changing distorted and negative thinking patterns)

In patients with mental health disorders, in addition to potential differences in motivation, other potential factors that may need to be considered when delivering weight management interventions could be cognitive processes, social support, and financial/social resources (NOO, 2011). Any behavioural interventions should be delivered with the support of an appropriately trained professional.

7.10 Specialist weight management services

There may be occasions where referral to services offering specialist expertise, either within or outside of the organisation, is indicated. Onward referral could be made to:

- Dietetics – for referral forms and referral criteria - see Appendix 1
- Behavioural services
- Specialist obesity management services – especially where medication management and/or surgery is indicated

7.11 Signposting to relevant services on discharge

On discharge, an onward referral to relevant clinical or support services may be required. It would be recommended to refer patients who require weight management support to their GP for further assessment and management of obesity from local specialist or health improvement services depending on services available in local area for example, specialist obesity service, exercise on prescription, and healthy lifestyle programmes.

8. Audit

Current audits relating to obesity and this policy are being piloted on various PCNFT wards. Nutritional screening as part of the Physical Health Screening Tool is reviewed as part of the Quality Schedule.

9. References

1. British Psychological Society (BPS) (2011). Obesity in the UK: A psychological perspective. Obesity Working Group.

2. Chief Medical Officers (CMO) (2004) At least five times a week

3. Chief Medical Officers (CMO) (2011) Start Active, Stay Active. A Report on physical activity for health from the four home countries' Chief Medical Officers.

4. Department of Health, (2004a) At least five a week: Evidence on the impact of physical activity and its relationship to health. A report from the Chief Medical Officer.

5. Department of Health (DH) (2004b). Choosing Health: Making healthier choices easier. London.

6. Department of Health (DH) (2008). Healthy weight, healthy lives: A cross-government strategy for England.

7. Department of Health (DH) (2008) Clinical Care Pathway for adults for the management of overweight and obesity in adults. Accessed from http://www.fph.org.uk/uploads/ HealthyWeight_SectE_Toolkit01.pdf (04.09.14)

8. Department of Health (DH) (2009a). Be active, be healthy: A plan for getting the nation moving.

9. Department of Health (DH) (2009b). Healthy weight, healthy lives progress report.

10. Department of Health (DH) (2010). A vision for Adult Social care: capable communities and active citizens. London.

11. Department of Health (DH) (2011a). Healthy Lives, Healthy people: our strategy for public health in England. London.

12. Department of Health (DH) (2011b). Healthy Lives, Healthy people: our strategy for public health in England July 11 Update

13. Foresight (2007) Tackling Obesities: Future Choices.

14. Marmot, M (2010). Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England.

15. Mental Health Providers Forum (2009). Mental Health Recovery Star (Organisational Guide).

16. National Institute for Health and Clinical Excellence (NICE) (2006). Obesity: The prevention, identification, assessment and management of overweight and obesity in adults and children. NICE version at www.nice.org.uk/page.aspx?o=296573

17. National Institute for Health and Clinical Excellence (NICE) (2010). Type 1 diabetes: diagnosis and management of type in adults.

18. National Institute for Health and Clinical Excellence (NICE) (2011) Review of Clinical Guideline (CG43) – Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children

19. National Obesity Observatory (NOO) (2011). Obesity and Mental Health. Solutions for public health.

20. Pennine Care NHS Foundation Trust (PCNFT) (2011a) Guidelines for the management of patients who have antipsychotic induced weight gain Pennine Care MM068

21. Pennine Care NHS Foundation Trust (PCNFT) (2011b) Guidelines for the prescribing and monitoring of antipsychotics in the treatment of schizophrenia Pennine Care MM039

22. Pennine Care NHS Foundation Trust (PCNFT) (2014) Heavy Person Policy CO103

23. Pennine Care NHS Foundation Trust (PCNFT) (2015) Physical Health Policy CL42

24. Pennine Care NHS Foundation Trust (PCNFT) (2015) Nutrition and Hydration policy CL85.

25. Public Health England (PHE) (2014) The Eat Well Plate.

26. Sedentary Behaviour and Obesity Expert Working Group (2010). Sedentary Behaviour and Obesity: Review of the Current Scientific Evidence. London: Department of Health.

27. Shaw, K., O'Rourke, P., Del Mar, G., Kenardy, J. (2005). Psychological interventions for overweight or obesity. Cochrane Database of systematic reviews, issue 2.

28. SIGN (2010) Management of Obesity, Clinical Guideline 115

29. Verheijden, M.W., Bakx, J.C., Delernarre, I.C., Wanders, A.J., Van Woudenberg, N.M., Botterna, B.J., et al. (2005). GP's assessment of patients readiness to change diet, activity and smoking. British Journal of General Practice, 55(515), 452-7.

30. World Federation for Mental Health (2010). Mental health and Chronic Physical illness: The need for continued and integrated care.

31. World Health Organisation (WHO) (2010). Global Recommendations on Physical Activity for Health.

Appendix 1. Physical Health Matters Resources

All resources are available for download and suitable for use with service users. Please contact the dietitians if you would like more information about the use of these resources after viewing explanation documents to this effect on the intranet.

Dietetic Referral forms.

Type of ward	Referral document required
North Division - Adult	Pennine Acute
North Division - Older people	Pennine Acute
North Division - Prospect Place	Pennine Acute
North Division RHSD – Stansfield and Rhodes Place	Pennine Care
South Division - Adult	Pennine Care
South Division - Older people	Pennine Care
South Division - RHSD	Pennine Care

Referral criteria – Weight management.

Types of patients that can be referred and how to find useful resources to support staff and patients in implementing weight management.

Care plan guidance – Weight management.
Suggestions for writing care plans for weight management interventions.

Resources can be found on the trust intranet under Physical Health Matters

- Open home page of trust intranet
- Click ‘Policies & Clinical Guidelines’
- From the left hand side select ‘Department / Service Area’
- Select P / Physical Health Matters
- There is a variety of documents including the referral form and resources covering Malnutrition / MUST, Health and Well Being, Weight Management, Food First

These resources have explanatory information about their use, but if you would like more information please contact the Mental Health Dietitians

Appendix 2. Weight management Resources list

Your Weight, Your health – 36 page booklet from the department of health. This contains information on weight and health, what a healthy weight is and what a difference weight loss can make, eating well to lose weight and food swaps, sensible advice about exercise, goal setting, motivation and maintaining weight loss. There is also a section about obesity in children and a BMI chart and calculator.

Why Weight Matters -- Department of health starter leaflet of 4 pages, a shortened version of Your Weight Your Health.

Weight reduction – How to lose weight, Patient.co.uk 9 page leaflet with advice on healthy eating, goals and motivation, shopping, eating habits, exercise, and maintain weight loss. Also mentions pharmaceutical and surgical options.

So you want to lose weight for good – British Heart Foundation 32 page booklet including advice on all aspects of healthy eating for weight loss. Advice on portion sizes and suggestions for a 1500kcal and 1800 kcal plan with portion sizes of each food group. Can be downloaded from the website or hard copies can be ordered for free.

Raising the Issue of Weight – Department of health 2 page leaflet, to help staff discuss why weight loss will be helpful.

Pros and Cons of lifestyle changes chart – For individuals to complete after discussion about why they should lose weight.

How to measure waist circumference leaflet

Behaviour Change in Managing your weight – Leaflet written by the dietitians with a checklist of actions which people who have been successful in changing behaviour have found helpful.

Healthy eating to help prevent weight gain - Leaflet written by the mental health dietitians to support people who find that they gain weight when they start taking certain medications as increased appetite leading to weight gain is one of the more common side effects of anti-psychotic medications.

Want 2 lose weight – British Dietetic Association ‘Food Facts’ sheet with ideas and tool to help achievement of weight loss goals.

Appendix 3 - Physical activity – This must be individually assessed for safety.

Advice on physical activity has existed for several years, and the Chief Medical Officer's (CMO) report 'At least five times a week' (CMO, 2004) examined the validity of physical health advice in the light of evidence of the links between physical activity and health, included in NICE guidance (2006). However, new guidelines produced in 2011 included a number of changes. The new Chief Medicals Reports 'Start Active, Stay Active' (CMO, 2011) draws together guidelines for all 4 UK home countries (England, Scotland, Wales and Northern Ireland) to reflect the growing evidence base and to address inconsistencies. For the first time, the importance of physical activity for people of all ages is emphasised. For the purpose of this policy, guidelines for Adults (19-64 years) and Older Adults (65+ years) are summarised in Table 2.

TABLE 2.

Guidelines from 'Start Active, Stay Active' (CMO report, DOH 2011) **Adults (19-64 years)**
1. Aim to be active daily. Activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more per week. One way to approach this is to do 30 minutes, 5 days a week.
2. Alternatively, comparable benefits can be achieved through two sessions 75 minutes of vigorous intensity activity across the week or a combination of moderate and vigorous intensity activity.
3. Include physical activity to improve muscle strength on at least two days a week
4. Minimise the amount of time spent being sedentary (sitting) for extended periods.
Older Adults (65+ years)
1. Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and greater amounts of physical activity provide greater health benefits.
2. Aim to be active daily. Over a week, activity should still aim to add up to at least 150 minutes (2½ hours) of moderate intensity activity, in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
3. For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.
4. Include physical activity to improve muscle strength on at least two days a week.
5. Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.
6. Minimise the amount of time spent being sedentary (sitting) for extended periods.

Types of activity

Moderate-intensity activity increases a person's breathing rate and heart rate and makes them feel warm. A person doing vigorous intensity activity will usually be breathing very hard, be short of breath, have a rapid heartbeat and not be able to carry on a conversation comfortably.

Examples of moderate-intensity activities

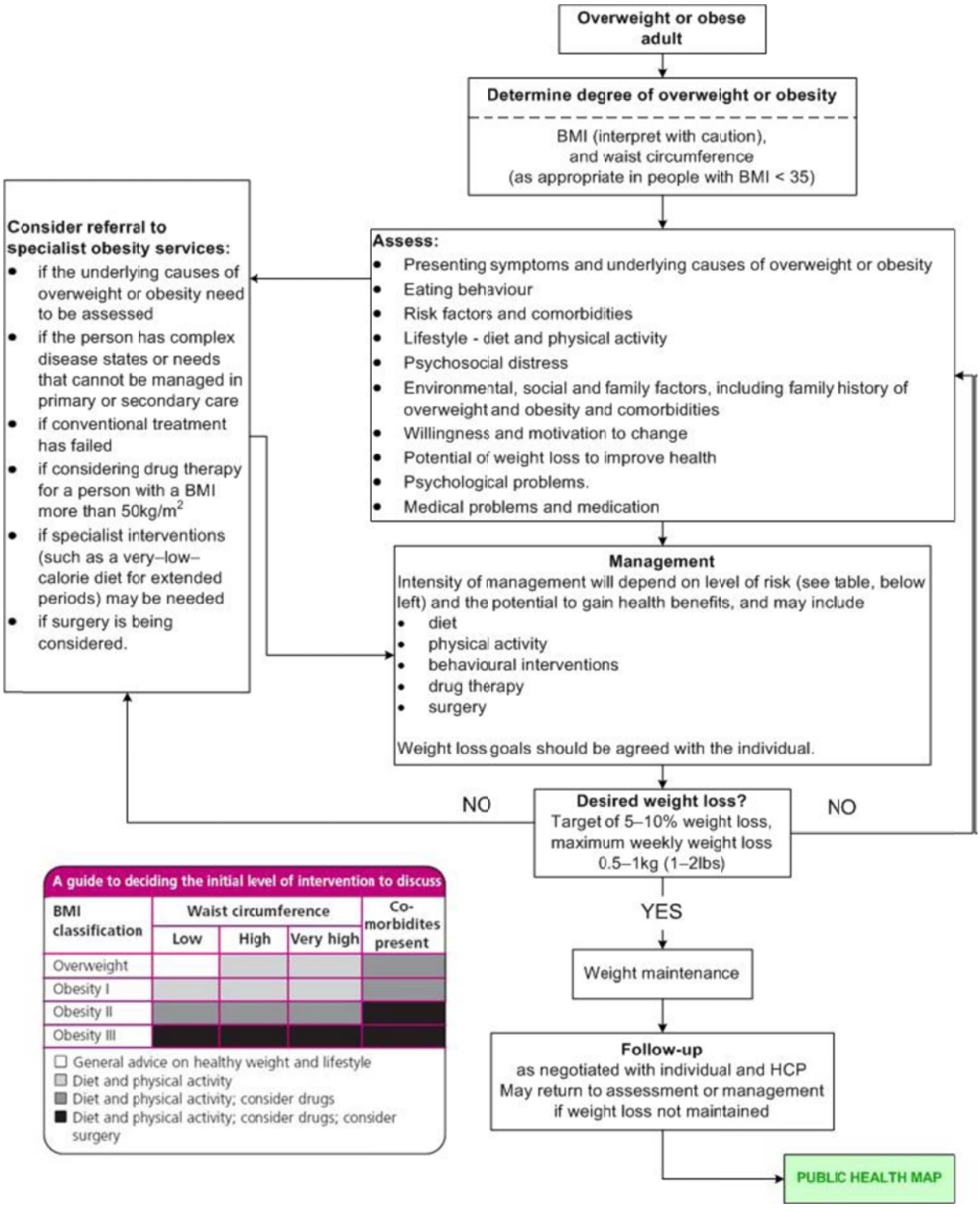
- brisk walking
- cycling
- swimming (with moderate effort)
- stair climbing (with moderate effort)
- gardening – digging, pushing mower or sweeping leaves
- general house cleaning
- painting and decorating
- general callisthenics (sit-ups, push-ups, chin-ups)
- gentle racquet sports such as table tennis and badminton (social)
- golf – walking, wheeling or carrying clubs.

Examples of vigorous activity include aerobic dancing, cycling 12-14mph or running). Muscle strengthening activity involves training with weights equipment or using body weight as resistance, where the body's muscles work against an applied force and can bring about health benefits and should be promoted across the age ranges.

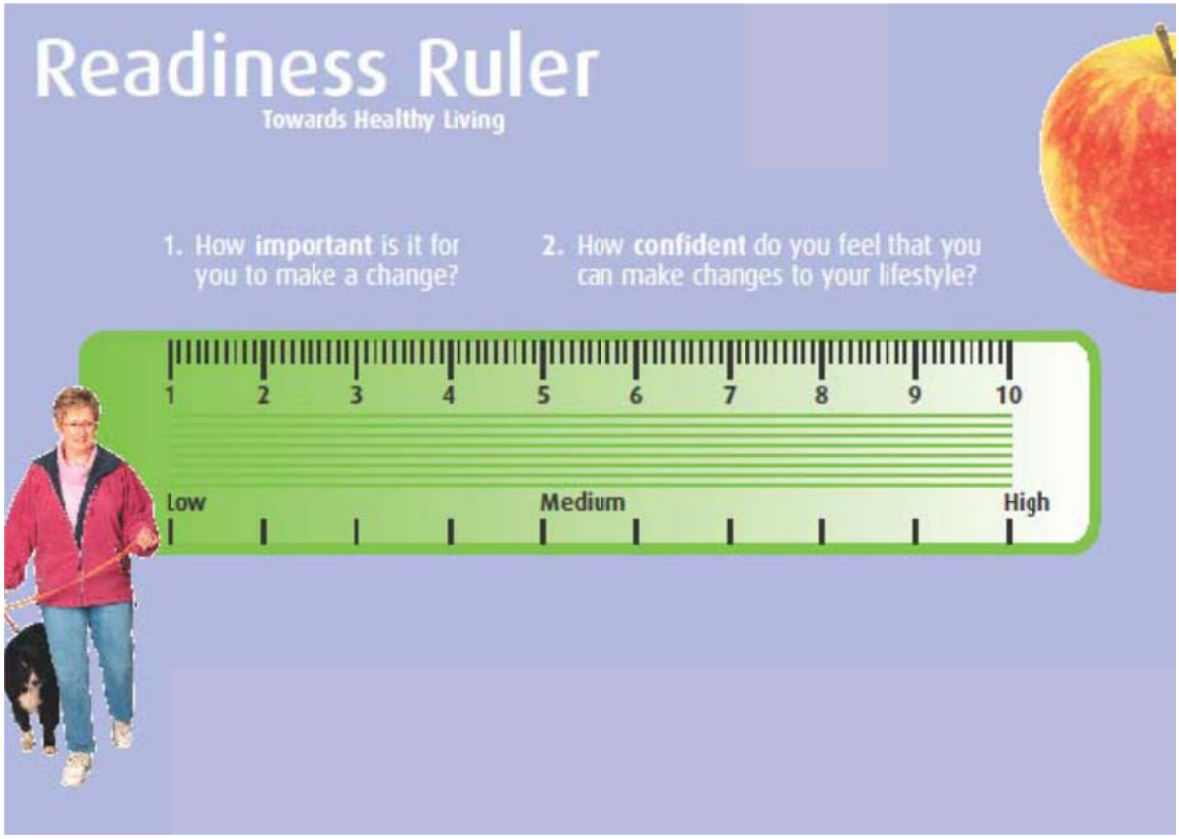
Appendix 4. Sources of Information and useful websites.

- http://new.wales.gov.uk
- http://wales.gov.uk/topics/health/publications/health/guidance/hcwgrant/?lang=en
- www.5aday.nhs.uk
- www.bda.uk.com/foodfacts
- www.bdaweightwise.com
- www.bhf.org.uk
- www.cmo.wales.gov.uk
- www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134408-
- www.fph.org.uk/policy_communication/publications/toolkits/obesity/default.asp
- www.nhs.uk/Change4Life Change 4 Life
- www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx
- www.nhsdirect.nhs.uk
- www.nutritionnetworkwales.org.uk
- www.sportengland.org

Appendix 5. Healthy Weight Healthy Lives Tools - Clinical Care Pathway for Adults



Appendix 6 - Readiness Ruler



Using the Readiness Ruler

When discussing lifestyle with an individual, there are two main questions that provide a lot of information about 'readiness' for change. Ask the individual:

1. How **important** is it for you to make a change?
2. How **confident** do you feel that you can make changes to your lifestyle?

Ask individuals to indicate their best answer to each question (remember they may be at different stages of readiness to change for each lifestyle behaviour you may discuss).

Use the 1–10 scale to help you quantify 'readiness', whereby lower numbers on the **importance scale** represent fewer thoughts about change and higher numbers represent specific plans to change.

1 2 3 4 5 6 7 8 9 10

Pre-contemplators **Few thoughts about change** **Contemplators** **Specific plans to change**

Explore their response.

Importance

Ask what factors made them choose their score and what would help increase their score. This highlights potential obstacles to change. You can discuss these with the individual and help them to consider ways of overcoming these barriers.

Focus as well on why the score was not lower. This brings out the positive aspects of the person's thoughts about their importance and confidence as regards weight management.

Confidence

Sometimes a person scores higher in importance but lower in confidence. The **confidence scale** helps to measure the person's belief in their ability to comply with the changes required to have a healthier lifestyle. A low score requires further discussion. It may be due to a lack of 'weight loss skills' and the patient may need more support in developing a plan of action. Alternatively, you may find that the person is not confident because they have other priorities in their lives at the moment and feel unable to commit to lifestyle behaviour change.

This is not a fixed numerical assessment but a tool to quickly identify readiness.

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