City and Hackney Weight Management Programme

Primary Care	**Health and Wellbeing coaches:** Support that takes into account wider issues that may be having a negative impact on health. Further information here **Other Fitness Opportunities** **Local Sports and Leisure Facilities:** Further information here **Park run in Hackney Marshes:** Further information here **Online Resources & Apps** **NHS Weight Loss Plan app:** All residents with overweight/obesity. Further information here **NHS 12 week weight loss plan:** Designed for BMI of 25 or above. Further information here **NHS Live Well**: NHS advice about healthy living, eating a balanced diet, healthy weight, exercise, quitting smoking and drinking less alcohol. Further information here **Couch to 5K:** A running plan for absolute beginners. Further information here
Tier 2 Council	**Hackney Healthier Together** offers Weight management and Physical activity 12 week referral programmes to support personal goals on losing weight or becoming more active. Further information here **City Fusion Lifestyle** offers recreational sport, health and fitness activities. Further information here
Tier 3 Secondary Care	**Specialist Weight Management Programme criteria:** BMI≥30 with Type 2 Diabetes or BMI≥35 plus co-morbidities or BMI≥40 and insufficient change from weight management intervention in the last 2 years. Further information here
Tier 4 Secondary Care	Referral to Tier 3 Specialist Weight Management Programme is a pre-requiste for pre-surgery patients. See EBI policy here. Refer patients requiring post-surgery investigations directly into the service.
Tier 2 Diabetes	**Diabetes Prevention Programme (9 months):** This consists of a mixture of 1-to-1 and group sessions delivered by specially trained health and wellbeing coaches. Throughout the programme participants learn how to prevent diabetes by incorporating healthier eating, physical activity, problem-solving, stress-reduction and coping skills into their daily lives. Further information here **NHS Type 2 Path to Remission (12 months):** Combining specialist nutrition, psychology and physical activity, the NHS Low Calorie Diet programme promotes rapid weight loss, long term behaviour change and type two diabetes remission. Further Information here **NHS Digital Weight Management (12 weeks):** Supports adults living with obesity who also have a diagnosis of diabetes, hypertension or both, to manage their weight and improve their health. It is an online behavioural and lifestyle programme accessed via a smartphone or computer with internet access. Further information here
Pregnancy	**Obesity in Pregnancy guidelines:** Further information here
Children	**Henry Healthy Families Programme**: Support for families, events, free vitamins, free milk, fruit and vegetables. Further information here **Power Up:** A digital and face-to- face 12 week intervention for children, young people and their families, 5-19 year olds who are above a healthy weight (BMI>91st centile). Further information here

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Service	Target Population	Overview	Intervention Length	Inclusion criteria	Exclusion criteria	Who can refer	Referral Route
Healthier Together www.better.org.uk/london/hackney/healthier-together-hackney	All Hackney residents - overweight/obese	Our Tier 2 multi-component group-based lifestyle weight management programme includes dietary advice and physical activity. The Healthier Together team utilises behaviour change techniques to support eligible adults to lose weight and gain the knowledge, skills and confidence to maintain a healthy weight and lifestyle. Weekly 2 hour group-based sessions run for 12 weeks and include nutritional workshops and a physical activity session. Nutrition workshops are led by trained individuals and include interactive sessions using behaviour change techniques to explore key topics such as: • Food groups • Portion sizes • Hunger and triggers • Energy balance • Meal planning and cooking methods • Relapse prevention	12 weeks	• Aged 18 years or over • Hackney resident or registered with a Hackney GP • BMI is equal to or>30, or >27.5 if they are Black or Asian • BMI can be >25, or >23.5 if Black or Asian, if there are other accepted co-morbidities	• Pregnant or breastfeeding • A diagnosed eating disorder • Co-morbidity or underlying medical cause of obesity which requires medical intervention • Unstable/uncontrolled moderate/severe mental health condition • Any type of bariatric surgery within the last 2 years OR if under the care of a bariatric service	• GP	Referrals via e-RS To refer to the service, please send the referral form signed by both referrer and patient to **CAHCCG.Healthwise@nhs.net** or contact 0207 749 7645 or HTHS@GLL.ORG for enquiries. .
City of London Tier 2 Offer – Fusion Lifestyle	All City of London residents – overweight/obesity	Positive Energy – A 12 week weight management programme from fitness experts	12 weeks	• Aged 18 and over • City of London residents or those registered with a City of London GP or low paid/high risk workers working within the Square Mile (working in the following sectors: manufacturing, construction, retail, food service, transport and storage) • Have a BMI>30kg/m2 or if Black or Asian BMI>27.5kg/m2 • BMI >25 kg/m2 (or >23.5kg/m2 if Black or Asian) with other risk factors for diabetes or cardiovascular disease (e.g. hypertension, high cholesterol, family history of disease, 'pre-diabetes') • Initial assessment suggests 'readiness to change' and need for a structured programme. For residents aged over 80 years old, the referrer will need to confirm on the referral form that a weight management programme is considered likely to pose greater benefit than harm. There is no upper level of BMI for the service. Inclusion for the service should be targeted to those who are most likely to be able to achieve clinically beneficial weight loss (at least 3-5% weight loss) through a weight management programme.	• Pregnant or breastfeeding • Diagnosed eating disorder • Co-morbid condition or underlying medical cause for obesity requiring specialist clinical management (e.g newly diagnosed diabetes, obstructive sleep apnoea, metabolic syndrome, hypothyroidism, on medication(s) that cause weight gain) Any referrals with an unstable physical or mental condition must be referred back to their GP to access specialist clinical support, as appropriate.		Exref-CoL@fusion-lifestyle.com

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Service	Target Population	Overview	Inclusion criteria	Exclusion criteria	Who can refer	Referral Route
Homerton Specialist weight management service https://gps.cityandhackneyccg.nhs.uk/service/tier-3-specialist-multidisciplinary-weight-management-service	All City and Hackney residents - overweight/obese	The overall aim of the Specialist Weight Management Service is to achieve a reduction in the obesity-related health burden (including physical and psychological well-being), related system costs, and health inequalities that currently exist due to unmet need in the eligible population. The service will have the following objectives. • Provide a high quality adult Specialist Weight Management Service for individuals with complex obesity related needs, including addressing clinical, psychological and emotional needs as well as diet and exercise. • Offer referred individuals a multidisciplinary assessment and an individualised programme of group and/or 1:1 multidisciplinary interventions with a duration of up to 12 months, with the mix of interventions dependent on need and the capacity of the service. • The service will not be responsible for prescribing orlistat, but will manage patients on the pathway who are using orlistat and advise GPs regarding its appropriate use.	**Expediated Complex Weight Management** • Patients presenting with BMI >50 kgs/m2 or BMI>35 kgs/m2 if of Asian background, diagnosed in the last 10 years • Refer concurrently to Tier 3 and Bariatric Service **Standard Complex Weight Management Service** Patients who do not fall under the Expediated pathway and want to access bariatric surgery or support for weight loss AND have: • BMI>35kgs/m2 with co-morbidities or BMI>40 igs/m2 • Aged 18 years or over • Struggled to achieve or maintain weight loss over last 2 years in spite of intervention offered • Refer to Tier 3 and bariatrics only when completed Tier 3	• Pregnancy • Uncontrolled cardiac conditions including poorly controlled blood pressure (Tier 3 only) • Unable to access the community i.e. housebound • Unstable or severe mental illness including active eating disorder • Active substance misuse (or recent history of in the last 12 months for bariatrics only) • Patients who have undergone bariatric surgery in the past 2 years • Patients with moderate or severe learning disabilities	GP	Referrals via e-RS
Homerton Bariatric services https://gps.cityandhackneyccg.nhs.uk/service/bariatric-service	All City and Hackney residents - overweight/obese	The main clinical aim of a Tier 4 specialist complex obesity service is to achieve a significant reduction in the burden of obesity-related co-morbidities, where all other services have been unable to achieve this. This will be achieved by facilitating a significant, and sustained, weight reduction in the patient. Service Provision includes the following: • Assessment and diagnosis of underlying causes of overweight and obesity where this cannot be identified or managed in primary care or community based medical obesity services. Including but not limited to rare genetic syndromes, endocrine disturbances and abnormalities. • Assessment and treatment on the surgical pathway includes onward referral to other specialties, of those with complex disease states and/or comorbidities that cannot be managed adequately in either primary or secondary care. These will include: • Onward referral to Tier 2 or Tier 3 weight management services if appropriate and available. for those using non-surgical modalities where conventional treatment has failed in primary or secondary care or to future development of Tier 3 when available • Treatment for those where drug therapy is being considered for a person with a BMI more than 50 kg/m2; • Specialist interventions (such as a very-low-calorie diet for extended periods), • Pre-operative preparation, surgical intervention and immediate post-operative follow-up. • Life-long post-operative follow-up and specialist surveillance, in conjunction with community based medical obesity services, and primary care. There are two pathways of care available for each patient; non-surgical and surgical. These pathways will be sequential, not parallel.	A patient will be eligible for bariatric surgery: • With a BMI over 40kg/m2 or 35-40kg/m2 with the presence of other significant disease • With morbid or severe obesity present for more than 5 years • If they have attended a non-surgical tier 3/4 specialist obesity weight management programme for 12-24 months (6 months if BMI over 50). Many GPs that refer patients to the Homerton for bariatric surgery do not operate in CCG localities where Tier 3 services exist. The Homerton Bariatric team therefore consider whether a patient has undergone the equivalent of Tier 3 services prior to their referral and taking into account the NICE guidance. This will be revised, as and when, tier 3 services are set up.	Children (under 18)	GP	Referrals via e-RS

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Service	Target Population	Overview	Intervention Length	Eligibility criteria	Exclusion criteria	Referral Process	Referral Route
NHS Digital weight management https://www.england.nhs.uk/wp-content/uploads/2021/06/NHS-Digital-Weight-Management-Programme-Healthcare-Professional-Toolkit-2022.pdf	Type 2 diabetes with overweight/ obesity and/or hypertension	A 12-week online behavioural and lifestyle programme. People can access it via a smartphone or computer with internet access. This programme offers digital weight management support via a 12 week intervention at 3 intensity levels: • Level 1: Digital support only • Level 2: Digital support + human coaching • Level 3: Digital support + enhanced human coaching A triage tool will be used to assign people to intervention levels based on likelihood of non-completion of the programme. This takes into account: • Age group • Sex • Ethnicity • Socioeconomic deprivation Participants will be assigned to an intervention level, and will select a weight management plan provider	12 weeks	• Over the age of 18 • Has a BMI of 30+ (adjusted to ≥27.5 for people from Black, Asian and ethnic minority backgrounds) • Has a diagnosis of diabetes (Type 1 or Type 2) or hypertension or both.	• Currently pregnant • Has an active eating disorder • Significant unmanaged co-morbidities • Bariatric surgery within the past 2 years • Moderate/severe frailty (as recorded on frailty register) • For patients aged >80, further supporting information requested from GP to ensure suitability • People for whom a weight management programme is considered to pose greater risk of harm than benefit	Trained healthcare professional via GP surgery or community pharmacy	Referrals via e-RS
NHS Type 2 Path to Remission https://oviva.com/uk/en/for-primary-care-t2dr/	Type 2 diabetes with overweight/obesity	A 12 month treatment programme with the aim of achieving diabetes remission. The programme is lifestyle-led health management, rather than a medication first approach. It supports patients to: • Achieve significant weight loss (15 kgs) • Improvements in HbA1c • Reduction in medication needs • Potentially achieve diabetes remission Patients are offered a choice of digital or F2F care and their Oviva clinician supports them in 1:1 sessions through: • Oviva Change - 12 weeks of total diet replacement, 800-900 calories a day. Followed by 4 weeks of food reintroduction, tailored to the patient. • Oviva Sustain – 8 months of establishing new healthy habits Patients are guided to use digital tools and learn content to support their journey and can continue to access these once they have completed the programme. Oviva is accepting referrals until June 2024.	12 months	Criteria is based on DiRECT Trial. • Aged 18 – 65 years • Min BMI of 27kg/m² (adjusted to 25kg/m2 in people of ethnic minority origin). • BMI obtained from self-measured weight is acceptable for referral. If this cannot be obtained, a clinic-measured value within the last 12 months may be used, provided there is no concern that weight may have reduced, such that the individual would not be eligible for the programme at present. • Diagnosed with diabetes within the last 6 years • HbA1c eligibility, most recent value, **which must be within 12 months:** ✓ If on diabetes medication, HbA1c 43-87 mmol/mol ✓ If not on diabetes medication, HbA1c 48-87 mmol/mol ✓ Must have attended for monitoring and diabetes review when last offered, including retinal screening, and commit to continue attending annual reviews, even if remission is achieved. (those newly diagnosed can be referred to LCD while awaiting retinal scan) ✓ Eligible for re-referral 12 months after previous discharge	• Current insulin use • Pregnant or planning to become pregnant within the next 6 months • Current breastfeeding • Significant physical co-morbidities: ✓ Active cancer, ✓ Heart attack or stroke in last 6 months, ✓ Severe heart failure defined as equivalent to the New York heart Association grade 3 or 4 (NYHA), recent eGFR <30 mls/min/1.73m2, ✓ Active liver disease (except non-alcoholic fatty liver disease (NAFLD) ✓ Active substance use disorder ✓ Active eating disorder (including binge eating disorder) ✓ Porphyria ✓ Known proliferative retinopathy that has not been treated • Had bariatric surgery (those on the waiting list not excluded) • Patient has been discharged from the programme previously within the last 12 months • Health professional assessment that the person is unable to understand or meet the demands of the treatment programme and/or monitoring requirements	Trained health care professional via GP surgery	Complete the referral form which is embedded into your clinical system and send it to: ovivauk.t2dr@nhs.net.
NHS Diabetes Prevention Programme **https://healthieryou.org.uk/**	Pre-diabetes	The Healthier You: NHS Diabetes Prevention Programme is a 9-month tailored, personalised programme offering support to reduce risk of type 2 diabetes through holistic wellbeing support underpinned by behaviour change with education around the five pillars of health: nutrition, mindset, movement, sleep & alcohol. Patients can choose from 3 programmes: • In person group programme. • Digital programme delivered by Second Nature. • Tailored remote courses for specific cohorts of patients.	9 months	• Be aged 18 or over. • Has 'non-diabetic hyperglycaemia' (NDH) identified by blood test within the last 12 months. • Non-Diabetic Hyperglycaemia (NDH) • HbA1c of 42-47.9mmol/mol (6.0%-6.4%), • Fasting Plasma Glucose (FPG) of 5.5-6.9mmol/l • If the patient has a history of Gestational Diabetes Mellitus (GDM) then HbA1c can be below 42 or FPG below 5.5	• Pregnant • Has blood results suggesting type 2 diabetes. • Bariatric Surgery within the last 2 years. • Active Eating Disorder.	Trained health care professional via GP surgery Patient can self-register with the following information: • Blood Test Result (**either your HbA1c or FPG reading**) • Date of Blood	Complete the referral form which is embedded into your clinical system and send it to: healthier.you@nhs.net Self-referral: 0333 047 9999 or https://healthieryou.org.uk/register/

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Service Details – Children's Weight Management Services

Service	Target Population	Overview	Intervention Length	Inclusion criteria	Exclusion criteria	Who can refer	Referral Route
HENRY Healthy Families Programme www.henry.org.uk/hackney	Children aged under 5 and their families	The Best Start with HENRY service in City & Hackney is supporting hundreds of local families with children from shortly after birth, right through to starting school – to provide a healthy, happy start in life for their children and the whole family. Providing a healthy, happy start for young children helps lay the foundations for a brighter future where children flourish throughout childhood and beyond. We deliver a range of one off workshops on topics such as Starting Solids, Portion Sizes and Eating Well for Less. We also deliver termly, the HENRY 'Healthy Families: Right from the Start' programme - an 8 week programme for families, covering 5 themes: • Feeling more confident as a parent • Physical activities for the little ones • What children and the whole family eats • Family lifestyle habits • Enjoying life as a family	One-off / 8 weeks	Children aged under 5 years who live or are registered with a GP in the City and Hackney AND one of the following: • Parents/carers who are concerned about their child's weight, eating habits or physical activity levels or • Professionals working with under 5 year olds and their families who are concerned about a child's weight or • A child over two years of age with a BMI >91st centile • A child whose weight is on or above the 99.6th centile • A child whose weight has gone up by more than two centile lines	• Fussy eating/food neophobia where the child is not growing well • Nutritional deficiencies e.g. iron deficiency • Patients on oral nutritional supplements • Constipation and diarrhoea • Non oral feeding • Multiple allergies. Children would require referral to secondary care Homerton allergy service • Children with long-term conditions including diabetes or morbidities	GP / professional working with the family	Send the referral form securely to hcsupport@henry.org.uk or contact 07519 109876 for any queries
Cook & Eat groups	Universal offer – families welcome	Community Kitchen - facilitated cook and eat groups. Group cook and eat sessions, bringing people together to prepare and eat a meal together, taking part in discussions and activities on nutrition and cooking topics and building social connections, confidence, peer support and sharing of community knowledge	Various			Self-referral	See webpage: https://hackney.gov.uk/healthy-eating