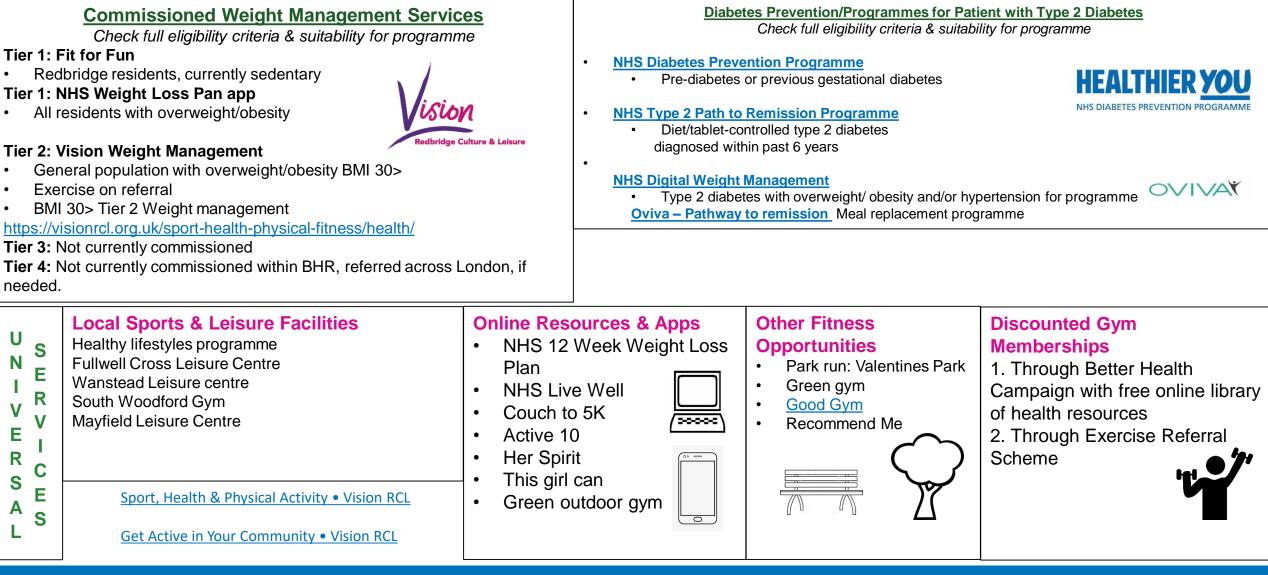


## **Redbridge Weight Management Services**





Updated November 2023

Service Details												
Service	Target Population	Overview	Intervention Length	Eligibility criteria	Exclusion criteria	Referral Process	Referral Route					
NHS Digital weight management https://www.engla nd.nhs.uk/wp- content/uploads/2 021/06/The-NHS- Digital-Weight- Management- Programme- General-Practice- Toolkit.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 The 'Referral Hub' triages patients to one of three levels of intervention based on demographic features associated with greater likelihood of non-completion of a weight management programme (based on evidence from the NHS Diabetes Prevention Programme). Service users will have a choice of provider for a 12-week digital weight management service.	12 weeks	<ul> <li>Over the age of 18</li> <li>Has a BMI of 30+ (adjusted to ≥27.5 for people from Black, Asian and ethnic minority backgrounds)</li> <li>Has a diagnosis of diabetes (Type 1 or Type 2) or hypertension or both.</li> </ul>	<ul> <li>Currently pregnant</li> <li>Diagnosed eating disorder</li> <li>Significant unmanaged comorbidity</li> <li>Bariatric surgery within the past 2 years</li> <li>Moderate/severe frailty (as recorded on frailty register)</li> <li>For patients aged &gt;80, further supporting information requested from GP to ensure suitability</li> </ul>	Trained health care professional via GP surgery	Referrals via ERS					
NHS Type 2 Path to Remission https://oviva.com/ uk/en/for-primary- care-t2dr/	Type 2 diabetes with overweight/obesity	<ul> <li>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 with significant weight loss (15kg), improvement in HbA1c and reduction in medication needs. Patients are offered a choice of digital or F2F care and their Oviva clinician supports them in 1:1 sessions through:</li> <li>Oviva Change - 12 weeks of total diet replacement, 800-900 calories a day. Followed by 6 weeks of food reintroduction, tailored to the patient.</li> <li>Oviva Sustain - 34 weeks of establishing new healthy habits</li> <li>Patients are guided to use our unique digital tools and Oviva learn content to support their journey and can continue to access these once they have completed the programme.</li> </ul>	12 months	<ul> <li>Criteria is based on</li> <li>Min age of 18 and max age of 65 years old</li> <li>Min BMI of 27kg/m<sup>2</sup> (25kg/m2 in people of ethnic minority origin).</li> <li>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.</li> <li>Diagnosed with within the last 6 years</li> <li>HbA1c eligibility, most recent value, which must be within 12 months: <ul> <li>If on diabetes medication, HbA1c 43-87 mmol/mol</li> <li>If there is any concern that HbA1c may have changed since last measured, such that repeat testing may indicate that the individual would not be eligible for the programme at present.</li> </ul> </li> <li>If on diabetes medication, HbA1c 48-87 mmol/mol</li> <li>If there is any concern that HbA1c may have changed since last measured, such that repeat testing may indicate that the individual would not be eligible for the programme at present, HbA1c should be rechecked before referral is considered.</li> <li>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. This does not exclude newly diagnosed patients.</li> </ul>	<ul> <li>Current insulin use</li> <li>Pregnant or planning to become pregnant within the next 6 months</li> <li>Current breastfeeding</li> <li>Significant physical comorbidities: 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 &lt;30 mls/min/1.73m2, active liver disease (non-alcoholic fatty liver disease (NAFLD) is not an exclusion), a history of hepatoma or &lt;6 months of onset of acute hepatitis Active substance use disorder</li> <li>Active eating disorder (including binge eating disorder)</li> <li>Porphyria</li> <li>Known proliferative retinopathy that has not been treated</li> <li>Had bariatric surgery (those on the waiting list not excluded)</li> <li>Patient has been discharged from the programme previously within the last 12 months</li> <li>Health professional assessment that the person is unable to understand or meet the demands of the treatment programme and/or monitoring requirements</li> </ul>	Trained health care professional via GP surgery	Complete the referral form which is embedded into your clinical system and send it to: <u>ovivauk.t2dr@nhs.n</u> <u>et</u> .					
NHS Diabetes Prevention Programme <u>https://xylahealt</u> <u>handwellbeing.c</u> <u>om/our-</u> <u>services/diabete</u> <u>s-prevention/</u>	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 structured education on healthy eating, weight management and lifestyle, including physical exercise component. Patient information available in 16 languages	9 months	<ul> <li>Aged 18 or over</li> <li>Registered with an NEL GP</li> <li>Able to take part in light/moderate physical activity</li> <li>HbA1c 42-47 mmol/mol (6.0-6.4%) or fasting plasma glucose</li> <li>5.5-6.9 mmols/l within the last 24 months</li> <li>Women with a past diagnosis of gestational diabetes mellitus (GDM) and a normoglycaemic blood reading within the last 12 months</li> </ul>	• Currently pregnant	Trained health care professional via GP surgery OR Patient self-referral (requires calculation of Diabetes UK risk score)	Complete the referral form which is embedded into your clinical system and send it to: <u>healthier.you@n</u> <u>hs.net</u> Self-referral: 0333 577 3010 or <u>https://preventing- diabetes.co.uk/self- referral/</u>					

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Service	Target Population	Overview	Intervention Length	Eligibility criteria	Exclusion criteria	Who can refer	Referral Route					
Fit For Fun https://www.redb ridgecvs.net/wha t-we- do/health/fit-fun	Redbridge residents, currently sedentary, minimum groups of 10 required.	20 funded weeks of physical activity for groups in the community.	20 weeks	Redbridge residents, currently sedentary, minimum groups of 10 required.		Self- referral	Tracy Hall Andrews - Tracy tracy@redbridgecvs.net					
Vision Weight Management	General population with overweight/obesity	The service aims to support people to lose at least 5% of their body weight. 12 sessions of healthy eating and nutrition support	12 sessions	BMI 30 and over and Prediabetics		Trained health care profession al obesity and diabetes managem ent - via GP surgery	Steve Smith ssmith@vision-rcl.org.uk					
Exercise on Referral https://visionrcl. org.uk/sport- health-physical- fitness/health/	Individual with physical or mental health conditions	A face-to-face programme consisting of 12 physical activity sessions. The Exercise on Referral (EOR) Scheme is available to Redbridge residents aged 16 yrs+ who suffer with physical health condition which would benefit from increased physical activity. The EOR Scheme offers 12 gym sessions for £12 with our specialist instructors.	12 sessions	<ul> <li>CHD</li> <li>Diabetes Type 1 and 2. (Oviva programme should be offered first)</li> <li>Hypertension.</li> <li>Obesity.</li> <li>Mental Health.</li> <li>Pulmonary Conditions.</li> <li>Musculoskeletal conditions (vision)</li> <li>Post-surgery</li> <li>Prediabetes</li> </ul>	<ul> <li>Unstable angina.</li> <li>Resting BP +180/100.</li> <li>Significant drop in BP while exercising.</li> <li>Resting HR +100bpm.</li> <li>Ventricular or aortic aneurysm.</li> <li>Uncontrolled or acute heart failure.</li> <li>Uncontrolled arrhythmias.</li> <li>Temporary febrile illness.</li> <li>Unexplained dizziness or loss of consciousness</li> <li>Poorly controlled or severe diabetes.</li> <li>Uncontrolled respiratory conditions (asthma, COPD/Emphysema).</li> <li>Established symptomatic cerebra-vascular disease.</li> <li>Recent (- 6months) cardiac event</li> </ul>	Trained health care profession al via GP surgery	Steve Smith ssmith@vision-rcl.org.uk					
	General population with overweight/obesity	free 12-week diet and exercise plan. The plan, which has been downloaded more than 7 million times, is designed to help you lose weight safely – and keep it off.	12 weeks	<ul> <li>Over the age of 18</li> <li>Has a BMI of 25+ (adjusted to ≥23.5 for people from Black, Asian and ethnic minority backgrounds)</li> </ul>		Freely available on the App Store and Google Play.						