Waltham Forest Weight Management Services

North East London Health & Care Partnership

Commissioned Weight Management Services

Check full eligibility criteria & suitability for programme

Tier 1: NHS Weight Loss Pan app

- WF residents with overweight/obesity

Tier 2: GLL Weight Management

- WF residents with overweight/obesity
- nelondon.gll@nhs.net

Tier 3: Not currently commissioned

Tier 4: Not currently commissioned within Borough, referred across London, if needed.

Diabetes Prevention/Programmes for Patient with Type 2 Diabetes

Check full eligibility criteria & suitability for programme

- **Diabetes Prevention Programme**
  - Pre-diabetes or previous gestational diabetes

HEALTHIER YOU
NHS DIABETES PREVENTION PROGRAMME

- **NHS Type 2 Path to Remission Programme**
  - Diet/tablet-controlled type 2 diabetes diagnosed within past 6 years
- **NHS Digital Weight Management**
  - Type 2 diabetes with overweight/ obesity and/or hypertension for programme

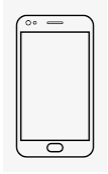
UNIVERSAL SERVICES

Local Sports & Leisure Facilities

- Walthamstow Leisure Centre, Leyton
- Waltham Forest Feel Good Centre, Chingford Road
- Walthamstow Leisure Centre, Leytonstone
- Walthamstow Leisure Centre, Walthamstow

Online Resources & Apps

- NHS 12 Week Weight Loss Plan
- NHS Live Well
- Couch to 5K
- Active 10



Other Fitness Opportunities

- Park run
- Gym in the Park
- Walking Cricket
- Health Walks
- Cycling

Service Details							
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/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	• 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 • Diagnosed eating disorder • Significant unmanaged comorbidity • 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	Trained health care professional via GP surgery or via community pharmacies	Referrals via ERS
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 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: • Oviva Change - 12 weeks of total diet replacement, 800-900 calories a day. Followed by 6 weeks of food reintroduction, tailored to the patient. • Oviva Sustain - 34 weeks of establishing new healthy habits 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.	12 months	Criteria is based on DiRECT Trial. • Min age of 18 and max age of 65 years old • Min BMI of 27kg/m² (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 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 • 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. • 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.	Current insulin use • Pregnant or planning to become pregnant within the next 6 months • Current breastfeeding • 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 <30 mls/min/1.73m2, active liver disease (non-alcoholic fatty liver disease (NAFLD) is not an exclusion), a history of hepatoma or <6 months of onset of acute hepatitis 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 Test (must be within the past 12 months) • NHS Number	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	**Target Population**	**Overview**	**Intervention Length**	**Eligibility criteria**	**Exclusion criteria**	**Referral Process**	**Referral Route**
GLL Weight Management **Until March 2024**	Residents of WF over 18 years of age with overweight/obesity	A 12 week programme including both educational and physical activity components to promote healthy eating and an active lifestyle. The programme utilises behaviour change techniques to support adults lose weight and gain the knowledge, skills and confidence to maintain a healthy weight and lifestyle. Courses are aimed primarily at patients with a BMI>28, but are also available to those with a BMI>25 who have little knowledge of healthy eating and would benefit from guidance. In addition to those participants referred to PARS solely for weight loss/obesity, participants who have other medical conditions may also be signposted to the course as part of their health intervention.	12 weeks	• Residents 18+ years of age • Overweight (BMI >25 - or >23.5 BAME*) with risk factors for Type 2 diabetes or CVD Or Obese (BMI >30 or >27.5 BAME*)	• Unstable angina. • Resting BP +180/100. • Significant drop in BP while exercising. • Resting HR +100bpm. • Ventricular or aortic aneurysm. • Uncontrolled or acute heart failure. • Uncontrolled arrhythmias. • Temporary febrile illness. • Unexplained dizziness or loss of consciousness • Poorly controlled or severe diabetes. • Uncontrolled respiratory conditions (asthma, COPD/Emphysema). • Established symptomatic cerebra-vascular disease. • Recent (- 6months) cardiac event	Trained health care professional via GP surgery	Email referrals to: nelondon.gll@nhs.net 020 8509 9196 For more information, visit better.org.uk/weight-loss, email healthwisewalthamforest@gll.org or speak to your GP today
NHS Weight Loss Plan app Lose weight - Better Health - NHS (www.nhs.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	• Over the age of 18 • Has a BMI of 25+ (adjusted to ≥23.5 for people from Black, Asian and ethnic minority backgrounds) • Barking and Dagenham Resident		Freely available on the App Store and Google Play.	

For universal services outlined in the summary please contact feel.good@walthamforest.gov.uk.

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