North Yorkshire County Council

NHS North Yorkshire Clinical Commissioning Group

Identification & assessment of health risk

Measure and interpret

BMI
CVD risk
Diabetes / Diabetes risk
Other obesity-related co-morbidities

Assessment of intervention required

General principles of care

Discuss choice of interventions
Readiness to change
Moving Medicine Tool

Long term condition management

Management (see appendix 1 for service details for tiers 2 and above, including how to make a referral)

Universal prevention community activities (Tier 1)
NHS Choices Weight Loss Programme (12 weeks)
North Yorkshire Connect
North Yorkshire County Council health and wellbeing information and advice
North Yorkshire Sport Activity Finder

NHS Digital Weight Management Service (Tier 2)

18yrs+
Diagnosis of diabetes (Type 1 or Type 2) &/or hypertension
AND
BMI 30+
(BAME 27.5)

NY Adult Weight Management Service (Tier 2)
(see appendix for how to refer)

18yrs+
BMI 30+
OR
BMI 25+ AND BAME OR with diabetes, hypertension or CVD

NHS Diabetes Prevention Programme (Healthier You Programme)

18yrs +
Identified as pre-diabetic

NHS Low Calorie Diet Programme

18-65yrs

Diagnosis of Type 2 diabetes within the last 6 years AND BMI >27 (or >25 AND BAME)

Specialist Weight Management Service (Tier 3)
18yrs+
BMI 40+ OR BMI 35-40 with significant co-morbidities

Bariatric surgery (Tier 4)
18yrs+
BMI 40+ OR BMI 35-40 with significant co-morbidities

Transitions:

Referrals into Tier 2 WM services and the National Diabetes Prevention Programme (NDPP) can be via a HCP or self referral.

The primary reason for referral and the service offer i.e. face to face/hybrid/fully digital, needs to be considered with/by the individual requiring support.

Depending on the level of need and eligibility, individuals could receive support through one or more services i.e. completion of NDPP onto a referral into the NY AWM Service or NHS Digital Service.

Consideration needs to be given for eligibility and level of specialist support. Clients must have accessed a tier 2 service prior to referral into tier 3.

Clients must have accessed a tier 3 service prior to referral into tier 4.

It is expected that individuals will transition up and down the pathway between tier 1 and tier 4 depending on their needs and individuals journeys.

Appendix 1 – Service details

North Yorkshire CCG Weight Management Services (Tiers 2 and above)

The Weight Management Enhanced Service includes payment for referral (£11.50 per referral) to any of the following eligible services:

Service	Eligibility criteria for the service	Service Description	How to refer into the service
NHS Digital Weight Management Programme	• BMI over 30 or 27.5 for those of Black, Asian and other minority ethnic groups • Aged 18 years and over • Not pregnant • Patients with hypertension and/or diabetes. This service should be the default option for this cohort of patients.	Summary (description, cost, format and location) A free 12-week digital weight management programme. Service users can participate via an App or web-based platform The service is delivered across 3 levels of intensity. Level 1 – access to digital content only. Levels 2 and 3 – access to digital content, plus a minimum of 50mins (level 2) or 100mins (level 3) of human coaching. The system triages service users to the most appropriate level of support.	Referral by a suitably trained and competent GP practice or PCN healthcare professional. Referral via the existing e-referral System (e-RS). Further information on the programme and how to refer: https://www.england.nhs.uk/digital-weight-management/ .
National Diabetes Prevention Programme (*Healthier You Programme*)	• Aged 18 years and over • Not pregnant • HbA1c must be between 42-47 mmol/mol or Fasting Plasma Glucose between 5.5-6.9 mmols/l and dated within the last 24 months. • If the patient has a history of Gestational Diabetes Mellitus (GDM) then HbA1c can be below 42 or FPG below 5.5. Any adult with a blood test within the last 24 months indicating NDH (and not known to	Summary (description, cost, format and location) • Programme is free and delivered over a 9-month period. • Behavioural intervention is underpinned by three core goals: ➢ achieving a healthy weight ➢ achievement of dietary recommendations ➢ achievement of CMO physical activity recommendations • The programme is made up of at least 13 sessions, with at least 16 hours	GP referral via primary care and self-referral available until September 2021 through Diabetes UK know your risk. Diabetes UK – Know Your Risk of Type 2 diabetes A free-to-access e-module on the Healthier You programme is available for healthcare professionals. https://elearning.rcgp.org.uk/nhsdpp

	have diabetes) can be directly referred to the Healthier You programme.	face to face contact time, spread across a minimum of 9 months, with each session lasting between 1 and 2 hours. • Currently being delivered via telephone or group video conference, or online through apps and websites	
National Diabetes Prevention Programme – Low Calorie Diets	• Minimum age of 18 years, Maximum age of 65 years • Diabetes & BMI >27 + within first 6 years of diagnosis (attract incentive payment where BMI is >30). • If on diabetes medication, HbA1c 43 mmol/molor higher • If on diet alone, HbA1c 48 mmol/mol or higher • In all cases, HbA1c must be 87 mmol/molor lower • Those referred onto programmes should have attended for monitoring and diabetes review in the last 12 months, including retinal screening, and commit to continue attending annual reviews, even if remission is achieved. *PLEASE NOTE – due to COVID HBA1C not currently needed* **Exclusion criteria** • Current insulin use • Pregnant or planning to become pregnant during next 6 months. • Currently breastfeeding.	The NHS low calorie diet (NHS LCD) programme consists of total diet replacement (TDR) approaches that have been shown in RCTs to help some people with Type 2 diabetes achieve non-diabetic glycaemic levels when being off all diabetes medication (commonly referred to as remission). Free to service user, NHS England covers Provider costs so no cost to ICS. Service users will follow a diet composed solely of nutritionally-complete TDR products, with total energy intake of up to 900 calories, for up to 12 weeks, followed by a period of food reintroduction and subsequent weight maintenance support, with total duration of 12 months. For Humber Coast & Vale ICS, this is a DIGITAL offer.	Referrals will come predominantly from GP practices (identified through system searches).

	• Significant co-morbidities • Cancer • heart attack or stroke in last 6 months • severe heart failure (defined as New York Heart Association grade 3 or 4) • severe renal impairment (most recent eGFR less than 30mls/min/1.73m2) • active liver disease (not including non-alcoholic fatty liver disease (NAFLD)) • active substance use disorder / eating disorder • porphyria • known proliferative retinopathy that has not been treated. • Recent weight loss greater than 5% body weight / on current weight management programme / had or awaiting bariatric surgery (unless willing to come off waiting list)		
LA commissioned Tier 2 Service(s)	• Aged over 18 years • Body Mass Index (BMI) >30 or >25 for people from BAME groups or with co-morbidities such as cardiovascular disease, type 2 diabetes, hypertension, respiratory disease.	<u>Summary (description, cost, format and location)</u> • Local community weight management services, providing community-based diet, nutrition, lifestyle and behaviour change advice, normally in a group setting environment. • The services are free to use to the local population that meet the access criteria, but access is for a limited time period only. • This is usually a 12-week standard offer, with an additional 12 weeks subject to successful weight loss of 5% body weight.	Referral route is predominantly via self-referral, although a GP practice healthcare professional may also make the referral. Further information on the programmes **and how to refer** can be found by clicking on the individual service website links in the service description (middle) column.

		Harrogate & Rural Districts – Fit4Life **Hambleton** – Take That Step **Richmondshire** – Choose to Lose **Scarborough, Ryedale & Whitby** – NHS Weight Management Service (NHS Health Trainers) **Craven** – Healthy Lifestyles	

Tier 3 Specialist Service	• Aged over 18 years
	• BMI of ≥40 or a BMI ≥ 35 with significant co-morbidities
	• Have maximised primary care and community conservative management including:
	  • Receiving healthy weight and lifestyle advice in primary care
	  • Evidence of active participation in modification to exercise and diet, which is patient- or GP-led, or delivered by an independent commercial service or Tier 2 service, depending on local availability
	  • Have been offered a trial of pharmacological interventions, where there are no contra-indications
		Summary (description, cost, format and location)
		
		• 12-month, secondary-care based, programme that is clinician-led and has a multidisciplinary team (MDT) approach (may be 6-months where focus is on preparation for bariatric surgery)
		
		• Includes a range of interventions including psychological approaches and dietary changes
		
		• The service is designed to support adults with severe obesity and complex needs who require a more individualised approach than the Tier 2 service has previously been able to offer them
			GP referral using appropriate referral form
			
			GPs will be required to provide some specific information regarding the patient, which will be detailed on the referral. This, for example, might include the patient's HbA1C result

	• Understanding of the commitment required for the Tier 3 programme and willingness to engage	• MDT likely to include a physician (either consultant or GP with a specialist interest), specialist nurse, specialist dietitian, psychologist, psychiatrist, and physiotherapist.	
Tier 4 Specialist Service	• The individual is considered morbidly obese – classified as adults with a BMI of 40kg/m2 or more; OR • The individual is between 35 kg/m2 and 40kg/m2 in the presence of other significant diseases; AND • There must be formalised MDT led processes for the screening of co-morbidities and the detection of other significant diseases. These should include identification, diagnosis, severity / complexity assessment, risk stratification / scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway. *(This will be done by Tier 3 service)* AND • The individual has recently received and complied with a specialist obesity service weight loss programme (non-surgical Tier 3 / 4) for a duration of 12-24 months. For patients with BMI > 50 attending a specialist bariatric service, this period may	<u>Summary (description, cost, format and location)</u> • Where all other tiers of support have failed, for some complex patients bariatric surgery may be a suitable option • MDT assessment and support pre and post op	Referral is via Tier 3 service or GP referral following recommendation of Tier 3 service

	include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months.		