



Weight Management Enhanced Services CEG Fact File 2023/24 (EMIS)

Outline

This Weight Management Enhanced Service runs from 1st April 2023 to 31st March 2024. Practices are to refer patients, on the obesity register, to a weight management programme. Obesity, for the purpose of this service, is defined as the latest BMI ≥ 30 or ≥ 27.5 for patients of BAME ethnicity recorded in the last 2 years.

Which programmes qualify?

- **National Diabetes Prevention Programme (NDPP)** – for those with non-diabetic hyperglycaemia
- **Digital Weight Management** – for those on the Diabetes and/or Hypertension register who have internet access
- **Total Diet Replacement (T2DR formerly known as Low Calorie Diet)** – for those diagnosed with Type 2 Diabetes in the last 6 years)
- **Specialist Weight Management Services:** Tier 3 or Tier 4

How do I claim?

Practices need to make monthly manual submissions to their commissioners and will receive a payment of £11.50 per referral. Each referral will need to be coded in the patient's record.

CEG Resources

Referral Documents are integrated into your clinical system (for EMIS the weight management code is attached to the document and will automatically be entered into the patient's record when the document is saved.)

- NHS Diabetes Prevention Programme referral NEL CEG
- NHS T2DR (Low calorie diet) Referral CEG
- Digital weight management NEL CEG

The **Lifestyle Intervention** page, which you will find on the LTC and other templates, has the Referral to weight management service codes. There is also a link to a weight management document listing all available services in your borough.

There is a **NDPP section** on either the LTC or Health Check template where you can find the invitation and decline codes.

There is a specific template for Total Diet Replacement called "**Low Calorie Diet Referral (T2DR) CEG**" which has all the invitation, referral/decline and outcome codes.

We have several **Support Searches** for identifying eligible patients, incorrect coding and claiming payment

- **Weight management - coding update:** helps identify patients that need correct coding
- **Weight Management CQRS Claim:** helps practices claim for activity done.



- **MLCSU Weight Management ES [NHSEI]:** identifies eligible patients for Digital Weight Management programme.
- **Low Calorie Diets (T2DR) Eligibility:** identifies eligible patients for the Total Diet Replacement (T2DR) programme.

- 📁 # Practice Support 2023-2024
 - ▷ 📁 1. LES Contracts
 - ▷ 📁 2. Public Health Contracts
 - ▷ 📁 3. PCN Contracts
 - ▲ 📁 4. QOF, DES & CQRS Support
 - ▷ 📁 Cancer Support
 - 📁 CQRS HPV Doses v1
 - ▷ 📁 Diabetes Structured Education Support 23-24 v1
 - 📁 Expiring exceptions QOF v1
 - ▷ 📁 Prevalence Improvement Support v1
 - ▲ 📁 **Weight Management Service (Including CQRS Claim)**
 - ▷ 📁 Low Calorie Diets (T2DR) Eligibility v11
 - ▷ 📁 MLCSU Weight Management ES [NHSEI v3]
 - 📁 Weight management - coding update v2
 - 📁 Weight Management CQRS Claim v2
 - ▷ 📁 5. Immunisations & Vaccinations
 - ▷ 📁 6. Risk Stratification
 - ▷ 📁 7. Miscellaneous

We have created the **APL-NDPP Tool**, which lists all eligible patients and enables practices to filter patients and prioritise who to refer. Click [here](#) for more information or contact your [local facilitator](#) to request the tool.

APL - National Diabetes Prevention Tool

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This tool has been created to present clinical information coded in the patient health record. It is not a diagnostic tool or intended to replace clinical judgement.

Select Clinical System: EMIS SystemOne

Press to locate CSV file

Filters	Practice Summary	Risk Factors																																			
Referral: <input type="checkbox"/> Not yet referred <input type="checkbox"/> Referred <input type="checkbox"/> Declined Age: <input type="checkbox"/> < 65 <input type="checkbox"/> ≥ 65	<table border="1"> <thead> <tr> <th></th> <th>Number</th> <th>Referred</th> <th>Not Referred</th> <th>Declined</th> </tr> </thead> <tbody> <tr> <td>Entire cohort</td> <td>0</td> <td>0.0%</td> <td>0.0%</td> <td>0.0%</td> </tr> <tr> <td>% BMI < 30</td> <td>0</td> <td>0.0%</td> <td>0.0%</td> <td>0.0%</td> </tr> <tr> <td>% BMI 30 - 34</td> <td>0</td> <td>0.0%</td> <td>0.0%</td> <td>0.0%</td> </tr> <tr> <td>% BMI 35 - 39</td> <td>0</td> <td>0.0%</td> <td>0.0%</td> <td>0.0%</td> </tr> <tr> <td>% BMI ≥ 40</td> <td>0</td> <td>0.0%</td> <td>0.0%</td> <td>0.0%</td> </tr> <tr> <td>% South Asian/Black</td> <td>0</td> <td>0.0%</td> <td>0.0%</td> <td>0.0%</td> </tr> </tbody> </table>		Number	Referred	Not Referred	Declined	Entire cohort	0	0.0%	0.0%	0.0%	% BMI < 30	0	0.0%	0.0%	0.0%	% BMI 30 - 34	0	0.0%	0.0%	0.0%	% BMI 35 - 39	0	0.0%	0.0%	0.0%	% BMI ≥ 40	0	0.0%	0.0%	0.0%	% South Asian/Black	0	0.0%	0.0%	0.0%	Ethnicity - Black or South Asian = 1 Deprivation - IMD score Q4/5 = 1 BMI - 35-39 = 1, ≥ 40 = 2 Vulnerability - LD or SMI = 1 Pre-existing CVD - IHD, Stroke/TIA, AF = 2 Pre-existing Hypertension = 1 Age ≥ 65 years = 1
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Entire cohort	0	0.0%	0.0%	0.0%																																	
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Ethnic Group: <input type="checkbox"/> South Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other Risk Factors: <input type="checkbox"/> 0-4 <input type="checkbox"/> 5-9																																					
BMI: <input type="checkbox"/> < 30 <input type="checkbox"/> 30-34 <input type="checkbox"/> 35-39 <input type="checkbox"/> ≥ 40 Interpreter Needed? <input type="checkbox"/> Yes																																					
Disease: <input type="checkbox"/> CVD (IHD/Stroke/TIA/PAD/AF) <input type="checkbox"/> Hypertension <input type="checkbox"/> Gestational Diab? <input type="checkbox"/> Yes																																					



NEL Weight Management Services

Service	Overview	Eligibility	Exclusions
NHS Digital Weight Management Programme	12 week online program that gives diet, exercise and lifestyle advice	<ul style="list-style-type: none"> • Aged over 18 years • BMI \geq 30 (or \geq 27.5 for patient with BAME ethnicity) • Has diabetes and/or hypertension • Must be able to access the internet (via smartphone, tablet, or computer) 	<ul style="list-style-type: none"> • 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
NHS Diabetes Prevention Programme	9-month lifestyle change programme. Patients can join an In-person group, App based or Tailored Remote sessions	<ul style="list-style-type: none"> • Aged 18 years or over • HbA1c 42.0-47.9 mmol/mol or fasting plasma glucose 5.5-6.9 mmols /l within the last 12 months • Women with a past diagnosis of gestational diabetes • Able do light/moderate exercise 	<ul style="list-style-type: none"> • Currently pregnant • On Palliative Care Register • Has Type 2 Diabetes or HbA1c \geq 48 mmol/mol or FPG \geq 7 mmol/l • Diagnosed eating disorder • Moderate/severe frailty • Bariatric surgery within the past 2 years
NHS Type 2 Diabetes Path to Remission Programme (T2DR) (formerly known as Low Calorie Diet)	12 month digital programme led by specialist healthcare professionals using total diet replacement for patients recently diagnosed with Type 2 diabetes	<ul style="list-style-type: none"> • Aged between 18-65 years • Type 2 diabetes diagnosed within the last 6 years • BMI \geq 27 (or \geq 25 for patients with BAME ethnicity) • HbA1c within the last 12 months, with values as follows: <ul style="list-style-type: none"> ○ if on oral agents, HbA1c 43-87 mmol/mol ○ if diet controlled, HbA1c 48-87 mmol/mol • Attends diabetes monitoring reviews, including retinal screening (if newly diagnosed do not need to have attended retinal screening) • Commit to continue attending annual reviews, even if remission is achieved 	<ul style="list-style-type: none"> • Currently on insulin treatment • Pregnant or planning to become pregnant within the next 6 months or currently breast feeding • Has at least one of the following significant co-morbidities; <ul style="list-style-type: none"> ○ active cancer ○ heart attack or stroke in last 6 months, ○ severe heart failure (defined as NYHA grade 3 or 4), ○ severe renal impairment (most recent eGFR less than 30mls/min/1.73m²) ○ active liver disease (not including NAFLD) ○ active substance use disorder ○ active eating disorder, ○ Porphyria ○ known proliferative retinopathy that has not been treated • Has undergone bariatric surgery (if awaiting surgery not excluded) • Health professional assessment that patient is unable to understand or meet the demands and monitoring requirements of the programme