South East London Integrated Care System

KING'S HEALTH PARTNERS

Transforming Adult Weight Management Services in South East London

Report and Recommendations (July 2025)

Contents

Executive Summary:

Obesity is a major and growing health challenge linked to serious long-term conditions and rising demand on NHS services. In south east London, prevalence continues to increase, particularly among communities most affected by health inequalities. Current weight management services are fragmented, variable in access and under growing pressure.

In response, a comprehensive system-wide review of adult obesity pathways was undertaken, co-designed with a wide range of south east London system partners, including people living with obesity, public health teams, clinicians and key operational colleagues from all providers of weight management services and other many other stakeholders. The review set out to identify what is working well, where the gaps lie, and how south east London can deliver a more equitable, effective and sustainable model of care.

Our Shared Vision

To deliver consistent, person-centred and future-ready weight management services across south east London while also addressing inequality, managing increasing demand and integrating evolving national policy and pharmacotherapy developments.

Key Recommendations

1. **Adopt a Single Point of Access and Triage model for specialist weight management services (SWMS) referrals ('Tier' 3 and 4 services) across all south east London SWMS providers, with a longer-term consideration for including/ interfacing with community-based weight management services ('Tier' 2 services)**
   - Streamlines referrals and ensures timely, equitable access to appropriate services.
   - Reduces duplication and improves patient navigation across the system.
   - Improves value impact, including potential financial savings

2. **Develop a community 'Wrap-Around' Model of Care, that supports the use of new weight loss medications, builds on the learning from the initial 1-year proof of concept service model (2025/26) and aligns with the work of developing Integrated Neighbourhood Teams**
   - Integrates lifestyle interventions with pharmacotherapy and weight management support within community settings.
   - Builds on local assets and supports long-term engagement and self-management, in line with emerging guidance and policy.

3. **Develop a South East London Network offer for Specialist Weight Management Services (SWMS)**
   - Enhances equitable access to specialist interventions, including bariatric surgery and weight loss medication, through a coordinated and consistent offer.
   - Aligns pathways and processes across providers to improve outcomes and efficiency and remains NICE compliant. Direction and oversight by the Acute Provider Collaborative will be key.

Next Steps for System Leaders

NHS South East London Integrated Care Board (ICB) will be including the recommendations from this review in its commissioning intentions for 2026/27, working with system partners and provider colleagues over the rest of the 2025/26 financial year to develop clear implementation plans that can then be reflected in agreed plans and contracts, including any associated funding required, for 2026/27.

Specifically, over the rest of 2025/26, we will be seeking to work with providers and partners such as the Acute Provider Collaborative to take forward plans to secure three recommendations set out in the review:

- Develop an agreed single point of access (SPOA) model and approach for SWMS, including agreed implementation plans.
- Develop proposals and implementation plans for enhanced community-based weight management services, that align with Neighbourhood and Integrated Neighbourhood Teams (INT) development.
- Develop proposals to secure strengthened specialist service capacity and a coordinated, networked approach across south east London.

This is a critical opportunity to act collaboratively and to deliver a coherent, joined-up weight management offer that better meets the needs of our population now and in the future.

Introduction

The South East London Integrated Care System (ICS) has five strategic priorities with a mission to help people in south east London to live the healthiest lives possible – prevention and wellbeing; ensuring a good start in life; children and young people's mental health; adults' mental health; primary care and people with long-term conditions.

We are committed to enabling all south east London residents to have the same opportunity to lead a healthy life, no matter where they live or who they are, through equitable, convenient and effective access to preventative health and wellbeing services and support.

This includes our work on 'The Vital 5' (alcohol harms, hypertension, mental health, tobacco dependency, and healthy weight) to embed targeted prevention approaches that tackle key risk factors driving burden of disease; which disproportionately impact those most at risk of health inequalities.

As an ICS, partners have come together to shape a system-wide plan for **healthy weight**, with an ambition to **stem the rise of childhood** and **adult obesity** in south east London by 2029/30. This plan includes focused work on maternity, children and young people, and adults and spans four key pillars:

Figure 1: The Four Pillars for Healthy Weight

Healthy places and **health promotion**

More **proactive detection** and **identification of risk factors** associated with excess weight and obesity

Self-management

More **holistic and person-centred pathways** of care with **prevention embedded as core**

In October 2023, an adult obesity and weight management end-to-end pathway review was launched across tiers 2, 3 and 4.

This report sets out:

- The approach to the South East London ICS's adult obesity and weight management pathway review undertaken as part of the healthy weight plan for 2023/24 – including a summary of data, insights and evidence for why change is needed.

- Recommendations for actions we can and should take to transform the adult obesity and weight management model of care in the short and medium to long-term.

*[*Note this work sits alongside work within South East London ICS around Children and Young People, and a recognition that we need to maximise opportunities to deliver a whole family approach to care]*

Obesity is a growing epidemic with significant impacts for individuals, their families, communities and wider society, as well as the health and social care system. A Foresight Report published by GOV.UK in 2007 indicates that by 2050, 60% of adult men, 50% of adult women, and about 25% of all children under 16 could be obese. While we have a range of services to support people living with excess weight and obesity, these are fragmented, there is a significant mismatch between population need, demand and capacity, services aren't always tailored to the needs of our diverse communities from an inequalities perspective, and the model of care is not as efficient and effective as it could be.

Addressing obesity will benefit:

Residents	By reducing morbidity and mortality, increasing quality of life and reducing health inequalities between our diverse communities
System	By improving population health, resulting in more efficient system spend, delivering return on investment from preventative medication spend and more upstream healthcare, and reductions in outpatient appointments and acute events and hospitalisations related to obesity and associated conditions (e.g. cardiovascular disease, diabetes).

As such, transformation is not a 'nice to have' but a 'must have' and needs to not simply consider individual responsibility for diet and exercise but embed prevention and treatment approaches that reflect the multifactorial aetiology of obesity - including the broader societal and environmental factors that influence food choices and physical activity, genetic factors and pre-disposition to clinical obesity, and metabolic factors.

Key Recommendations

We are recommending south east London providers and system partners take forward 3 key actions in light of the obesity pathway review.

1. **Adopt a Single Point of Access and Triage model for specialist weight management services (SWMS) referrals ('Tier' 3 and 4 services) across all south east London SWMS providers, with a longer-term consideration for including/ interfacing with community-based weight management services ('Tier' 2 services)**
    - Streamlines referrals and ensures timely, equitable access to appropriate services.
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2. **Develop a community 'Wrap-Around' Model of Care, that supports the use of new weight loss medications, builds on the learning from the initial 1-year proof of concept service model (2025/26) and aligns with the work of developing Integrated Neighbourhood Teams**

- Integrates lifestyle interventions with pharmacotherapy and weight management support within community settings.
- Builds on local assets and supports long-term engagement and self-management, in line with emerging guidance and policy.

3. **Develop a South East London Network offer for Specialist Weight Management Services (SWMSs)**
    - Enhances equitable access to specialist interventions, including bariatric surgery & weight loss medication, through a coordinated and consistent offer.
    - Aligns pathways and processes across providers to improve outcomes and efficiency and remains NICE compliant. Direction and oversight by the Acute Provider Collaborative will be key.

**Summary reports & full details of the recommendations collated from the two South East London-wide workshops are available on request from DEO@kcl.ac.uk.*

Background

National Picture

Given the alarming projections from GOV.UK, that by 2050, 60% of adult men, 50% of adult women, and about 25% of all children under 16 could be living with obesity, there is an urgent need for a comprehensive and effective approach to healthy weight management.

An observation cohort study looked at access to publicly funded weight management services in England (2007-2020). Routinely collected health data was used to identify 1,811,587 adults who had overweight, or obesity documented in their primary care record during 2007 to 2020. Only 3% of these adults had a weight management referral recorded during the study period and only 1% of the 436,501 adults with severe and complex obesity underwent bariatric surgery.[1]

Children born since 1990 are up to three times more likely to be overweight or living with obesity by age 10 compared with older generations.[2] Pregnant women who are living with obesity are at greater risk of pregnancy-related complications, compared to women with a healthy BMI, including pre-eclampsia and gestational diabetes and an increased risk of caesarean birth. Furthermore, infants born to mothers living with obesity are at a higher risk of experiencing health complications. These can include congenital abnormalities, larger birth size (macrosomia), a higher likelihood of developing diabetes later in life, stillbirth, and neonatal death.[3]

Local Picture

In south east London, 56% of adult residents are carrying excess weight, which increases the risk of serious health problems (e.g., type 2 diabetes, heart and kidney disease and poorer mental health).[4,5] This is also likely to be an under-representation of actual prevalence due to under recording in primary care.

Local audit data shows candidates for bariatric surgery can have severe conditions that may drastically reduce life expectancy. [6] If untreated, the 10-year survival rate is as poor as, is not worse than some cancers.[7,8,9]

Those from black African and Caribbean or Latin American communities, lower socio economical groups and those living with a serious mental illness (SMI) or with a learning disability are at an increased risk of obesity compared to the general population.[10,11,12]

The following are findings from our local population health data analysis (derived from local service audits or the south east London Vital 5 dashboard that includes coded data from patients registered with a GP practice in south east London):

- A culturally tailored weight management programme in Lewisham initiated to serve underrepresented groups, found a higher percentage of residents (19%) from Black African and Caribbean backgrounds were not registered with a GP. This partly stems from individuals lacking trust in the health care system.
- 50% of the Latin American community living in the most deprived areas are living with overweight or obesity compared to 38% living in the least deprived areas of Lambeth. A recent culturally tailored weight management service for people with Latin American heritage in Southwark found that of those that completed the service, 92% achieved weight loss.

- The prevalence of living with overweight or obesity is greater amongst those with Serious Mental Illness (69%) in south east London, when compared to the general population (56%).
- The prevalence of the severe obesity is highest amongst those living in the 20 - 40% most deprived areas.

The significant rise in demand for weight management services has led to several challenges emerging across the system. This has contributed to growing waiting lists, duplication of referrals, disparities in access to care, and delays in patients receiving personalised treatment.

The introduction of new weight loss medications requiring structured treatment has further strained already limited capacity. Access to these treatment modalities is also currently limited by funding and capacity; with those that can afford to often going privately and creating further inequity.

Addressing the Current and Future Needs of Our Local Population

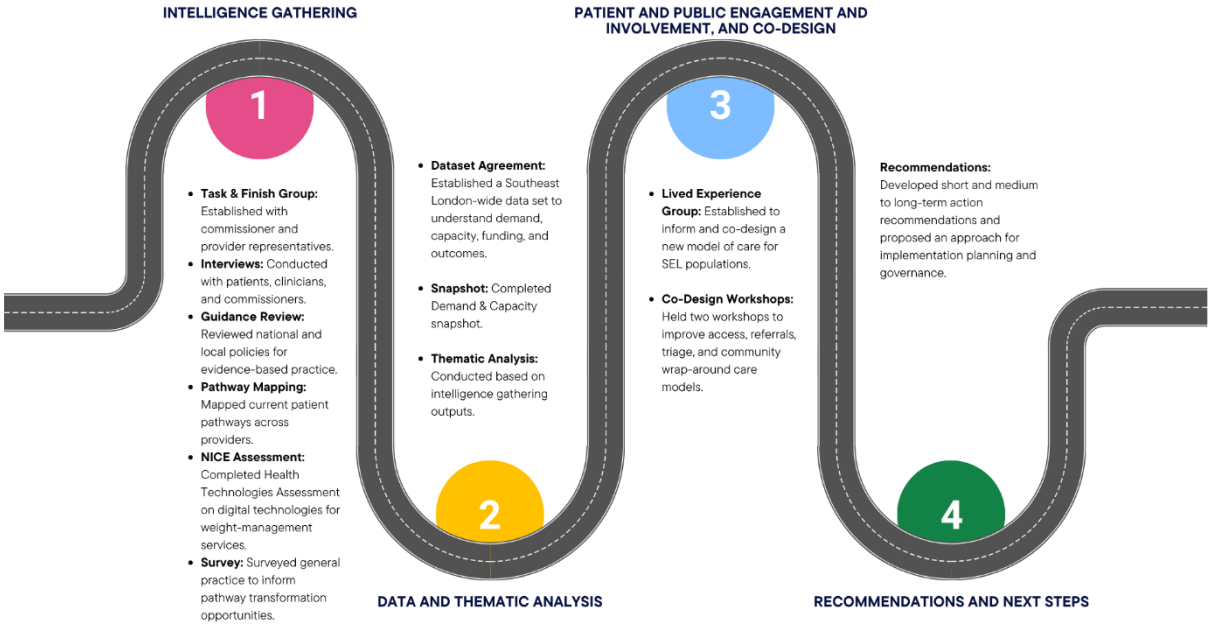
To effectively address obesity and improve health outcomes for our diverse communities, we are focusing on several key areas:

- **Pharmacotherapy:** The south east London approach for the rollout of new and upcoming weight loss medications across primary care and acute setting is under review to help address population need and remain NICE compliant. The rollout of Semaglutide and Tirzepatide are the first of several pipeline medications that need to be made accessible through the NHS.
- **Health inequalities:** Health inequalities are systemic, unfair and avoidable differences in health across the population, and between different groups within society. Our work to transform weight management and obesity services must seek to address these inequalities alongside system sustainability efforts. Examples of work to date, includes use of Vital 5 funding to create and pilot culturally tailored weigh management programmes to serve our underrepresented and underserved groups.
- **Digital:** To meet the needs of service users and provide patient choice, digital options will be essential. The NHS Digital Weight Management Programme is currently underutilised as data shows only 60% of practices have referred in 2024/25 across south east London, compared to the 86% in leading areas.
- **Research:** Extensive mapping has been completed to log key research taking place within the obesity space across south east London. A few examples are listed below.
    - The King's Health Partners (KHP) Lancet Commission on the Definition and diagnostic criteria of clinical obesity proposes a new diagnostic approach to obesity that focuses on other measures of body fat and objective signs and symptoms of ill health introducing two new categories of obesity, pre-clinical and clinical obesity.
    - NIHR Tier 3 Digital intervention (Roczen) verses usual care. A study to determine the clinical and cost effectiveness of digitally enabled tier 3 weight management platform Roczen in south east London.
    - 3-year PhD studentship focussing on how best to support long term behaviour change in people living with complex obesity and have inequalities in access and outcomes

Approach and Methodology

We adopted a comprehensive approach (Figure 2) involving intelligence gathering, and data and thematic analysis. We engaged in Patient and Public Engagement and Involvement (PPEI) to ensure the voices of those with lived experience were heard and incorporated into the co-design process. This collaborative effort led to the development of targeted recommendations and a detailed implementation plan, aimed at creating effective, equitable, and sustainable weight management services for the diverse populations of south east London.

Figure 2: The Four Phases of the Review



Intelligence Gathering, Data and Thematic Analysis

A Task & Finish Group was established, comprising commissioner and provider representatives to inform and oversee the review. In-depth interviews were conducted with patients, clinicians, and commissioners (Appendix 1). National and local guidance was reviewed to understand evidence-based practices, current patient pathways were mapped across providers, a NICE Health Technologies Assessment on digital technologies for specialist weight-management services was completed, and we surveyed general practices to identify pathway transformation opportunities.

A south east London-wide dataset was created to better understand demand, capacity, funding, and outcomes, and a demand and capacity snapshot was completed (Appendix 2).

The insight, data and evidence gathered through the intelligence and data gathering phase of the review highlighted five key themes which needed to be addressed through co-design:

- **Cross-system communication:** Lack of clarity around where to refer, confusion around what tiers are and what different criteria and waiting times were for these. Variable information available to patients on what is accessible. Patient journey fragmented with a lack of feedback for commissioners (e.g., on impact) and providers

feeling commissioners didn't always understand some of the on the ground practicalities of delivery.

- **Pathway Design and Variation:** Different models across south east London and levels of pre and post care available across all tiers with variation in access, experience and outcomes. Bariatric tourism adding a new pressure on services. Current and future weight loss medication need to be better mapped and embedded into pathways as part of an overall service model rather than a 'bolt-on'. Pressures felt from demand outside of south east London by providers. Life course approach needs to be further considered and need for 'whole family' care where appropriate given interplay with wider living context.
- **Person-Centred Approach:** There needs to be a holistic, individualised approach to person centred care, addressing psychological and mental wellbeing which are limited and in parts lacking across south east London. Challenges raised around the need and value of a 'tiered' approach and obesity-related stigma. Recognition that it is key to have those with lived experience at the centre of co-design from an engagement and involvement perspective.
- **Addressing Inequity:** South east London is fortunate to have Tier 2/3 and 4 available in every Borough (this isn't the case nationally) and a commitment has been made to address inequalities. Culturally tailored Tier 2 programmes are available; however, these are typically in pilot form for different population groups in each borough and can be fragmented from weight management commissioning which poses sustainability risks. Marginalised and minoritised community groups have historically been underrepresented and inequity of outcomes exist. There is also a need for more data on inequalities and potential a more consistent approach to capturing inequalities data as a system.
- **Data Insights and Governance:** Reliable and easily accessible baseline data is needed across south east London. There is opportunity to develop and build on existing dashboards for obesity, revise and improve coding; particularly given this is likely to be under-representing actual prevalence. Partnership working with King's Health Partners should offer greater opportunities for the translation of evidence, research and innovation into care for south east London-population benefit. We could be doing more as an academic health sciences and integrated care system to facilitate this alongside an increased capability to demonstrate return on investment from transformation (e.g., ability to track, monitor and evaluate impact). Historic and new policies and guidelines are being developed with pressure felt to remain compliant.

Patient and Public Engagement and Involvement, and Co-design

A lived experience group was established to inform, co-design, and develop a new model of care tailored for current and future populations. They also convened two whole-system co-design workshops aimed at improving access, referrals, triage, and community wrap-around models of care.

'Nothing About Us, Without Us': Co-Production with the Lived Experience User Group

Co-production means working in partnership with those with lived experience of obesity, service users, and other stakeholders to design and deliver services that reflect their needs and preferences. This person-centred approach ensures services are effective, inclusive, and sustainable, and allows us to fully understand the needs of our local population and tailor support that meets the needs of people living with overweight and obesity. With a strong focus on health inequalities, cultural relevance, and the power of language, '*Nothing about us, without us'* has been central throughout this work.

Sarah Le Brocq, founder of All About Obesity, was commissioned to lead on patient and community engagement, aimed at helping us better understand patient and public experiences and views of weight management services. This involved connecting and co-ordinating the expert residents identified across south east London tiers, setting up a sustainable expert lived experience reference group and providing informal training and supervision to enable the group to independently advocate and champion their views, bringing a strong patient voice. Those with lived experience played an essential part in the two south east London-wide co-design workshops held, sharing their individual insights and experiences to inform the discussions. The set up of a Let's Talk page supported this and proved a positive way to increase participation.

Workshop 1 (January 2025): Supporting the Development of a Common Referral Form and Triage Process

In January 2025, over 70 participants from across south east London attended the first workshop aimed at improving equitable access to timely weight management services through a unified referral and triage process.

The workshop raised awareness of recent national NHS changes in obesity care, while grounding discussions in the local context and addressing the impact of health inequalities. Participants explored the principles and care components that will shape the framework for service redesign. The session also examined referral and triage processes, drawing on lived experiences and national best practices to promote a consistent approach. Diverse perspectives were incorporated throughout, and opportunities were identified to enhance care delivery at the interface between primary and secondary care.

During the workshop participants reviewed a sample *referral proforma* and an *illustrative triage process for weight management referrals,* alongside case studies based on lived experiences, then collaborated in groups to co-design and map a new integrated referral and triage pathway.

Key Themes:

Triage Process:

- **Personal Context:** Include social, psychological, and environmental factors, as well as expectations and motivation, to support personalised care and early identification of any barriers to accessing weight management services.
- **Medical and Clinical History:** Ensure relevant clinical information is captured for appropriate triage and care, so referrals are based on a clear understanding of the patient's medical needs.
- **Consent, Readiness and Preferences**: Reflect patient consent, motivation, and treatment preferences, to support shared decision-making and better engagement with services.

Referral Form:

- **Holistic and Personalised Approach:** Address mental health, social circumstances, past experiences, and readiness to change; centering care around personal goals and needs.
- **Clear Criteria and Service Matching:** Define referral criteria, roles, and responsibilities to ensure appropriate service alignment with flexible options to reflect personal preference and clinical need, to reduce inappropriate referrals and avoid a one-size-fits-all model.
- **Integrated Access:** Promote efficient data sharing and smart automation. A Single Point of Access (SPOA) model was recommended, with further refinement needed to ensure seamless information flows between primary care, triage teams and service providers.

Workshop 2: Developing an Integrated, Holistic Community-Based Offer

In April 2025, over 60 participants from across south east London attended the second workshop focussed on weight management and essential wraparound care across in community and primary care settings.

The session aimed to raise awareness of emerging NICE guidance and public health data on the long-term impact of living with obesity, and how these align with Integrated Neighbourhood Teams (INT) approaches. Participants worked to identify gaps in fragmented care pathways, define essential services for a person-centred model, explore how existing roles and services can support integrated care, and clarify how individuals can have a consistent point of contact through their care journey.

Key Themes and Outputs:

1. ### Emerging Vision: Principles of Community Based Wraparound Care
   Participants outlined a vision for care that is person-centred and culturally tailored, with improved integration and communication between services. They emphasised the need for accessible and transparent pathways, clinician and community education to reduce stigma, data-driven evaluation, and proactive community outreach through grassroots networks.
2. ### Unmet Needs
   Service Users and Commissioners: Key needs included early preparation for weight management programmes, prevention-focussed support for younger individuals, and improved awareness of available services. Participants highlighted

the importance of skilled link workers, adaptable and re-accessible services, shared decision making and a networked approach to integrated care. Building and sustaining trust, empowering communities, and ensuring timely access (within six months) were also seen as critical.

Providers: Key needs included clearer engagement in commissioning processes, robust governance, linked IT systems, and standardised data collection. Priorities included improving access for vulnerable groups, enhancing inter-service referrals, ensuring visible outcomes, and allowing flexible service delivery. Continued support post-treatment and a central service directory were also recommended to ensure continuity of care and ease of access.

3. Recommended Actions

	Recommended Action	Suggested Responsible
1.	Encourage more comprehensive and holistic investigations to ensure improved appropriateness of referrals.	GPs
2.	Align patients with services that reflect their individual goals and priorities.	GPs
3.	Improve triage and offer flexible service options to manage waiting lists effectively and ensure timely access to care.	Weight Management Providers
4.	Ensure inappropriate referrals are redirected through proper handovers to the relevant clinician, rather than resulting in disengagement.	Weight Management Provider Network
5.	Provide clear, comprehensive information on preventative options, such as social prescribing and access to local gym or wellbeing facilities.	Weight Management Provider Network
6.	Deliver cross-service training and supervision to equip staff with skills to reduce stigma, minimise shame, and promote patient activation.	Weight Management Provider Network
7.	Map available services and implement robust contracting using standardised language to ensure clarity and consistency across providers.	Weight Management Providers/ICB
8.	Develop innovative approaches to engage service users and explore barriers to access and participation.	Weight Management Providers/ICB
9.	Develop contractual KPIs that are meaningful, measurable, and focused on successful patient outcomes.	Weight Management Providers/ICB
10.	Develop interoperable technology and shared data dashboards to support collaboration across partner organisations.	ICB
11.	Ensure the Vital 5 offer is consistently available across all boroughs to support equitable preventative care.	ICB
12.	Explore and adapt the Bromley by Bow model to support community-led, preventative care and early intervention, focusing on social determinants of health over medical pathways.	ICB
13.	Establish a care coordinator—such as an INT Coordinator within the community hub—as a consistent point of contact throughout the service user's journey.	ICB
14.	Establish community well-being centres integrated within Single Point of Access (SPA) and Community Hubs to provide holistic, accessible support.	Public Health outreach

15.	To agree a common framework of competencies and KPIs to which all Tier 2 services must align	Local authorities

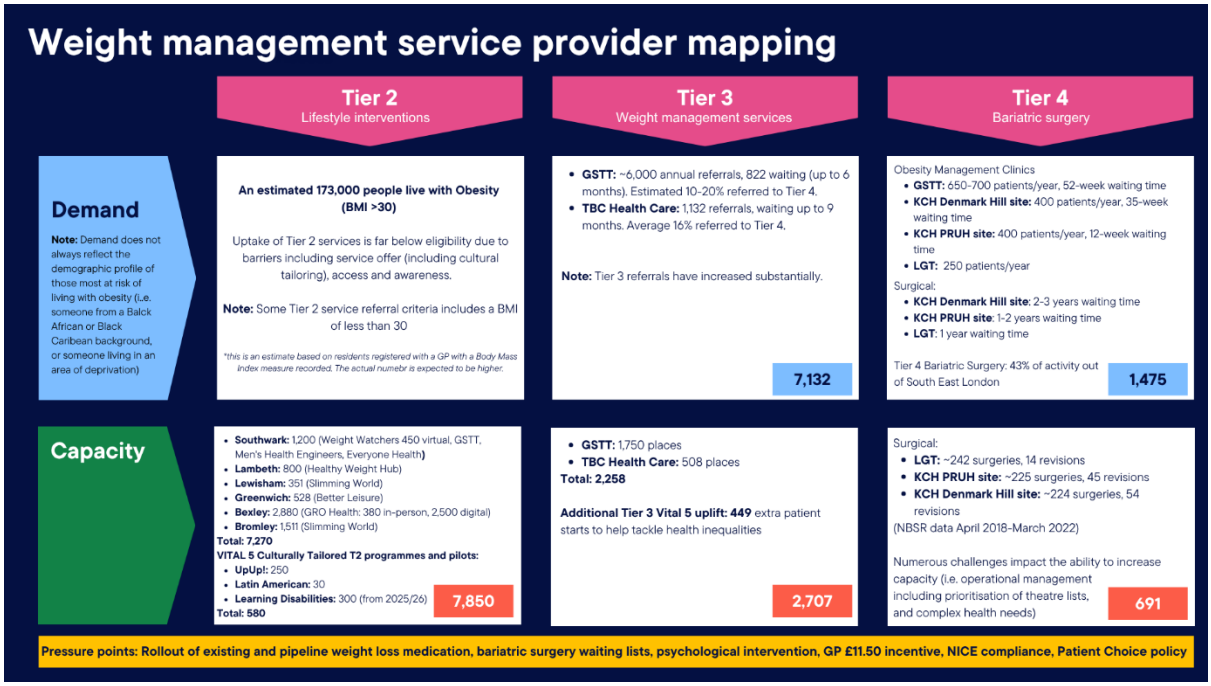
Next Steps

The outputs of review and co-design were translated into a set of recommendations for short and medium-to-long-term action alongside proposed approach to implementation planning and governance. The recommendations are intended to inform service redesign opportunities throughout 2025/26 and future commissioning decisions for 2026/27.

April – July 2025	Following both workshops, emerging recommendations and principles will be validated with senior leaders and stakeholders who were unable to attend, ensuring inclusive input and broad consensus. Additionally, with the Tirzepatide commissioning guidelines now published, we will prioritise accelerating service development between April and June to meet the 23rd of June deadline for launching treatment for the defined Year 1 cohort.
July 2025 onwards	Once the Year 1 service is established, our focus will shift to designing a sustainable, community-based care model for administering future weight loss medications in the community setting. Work with providers will also be started to set up a SPOA (across tier 3 & 4 initially).

Appendix 1: General Practice Reflections and Considerations

Appendix 2: Demand and Capacity Snapshot



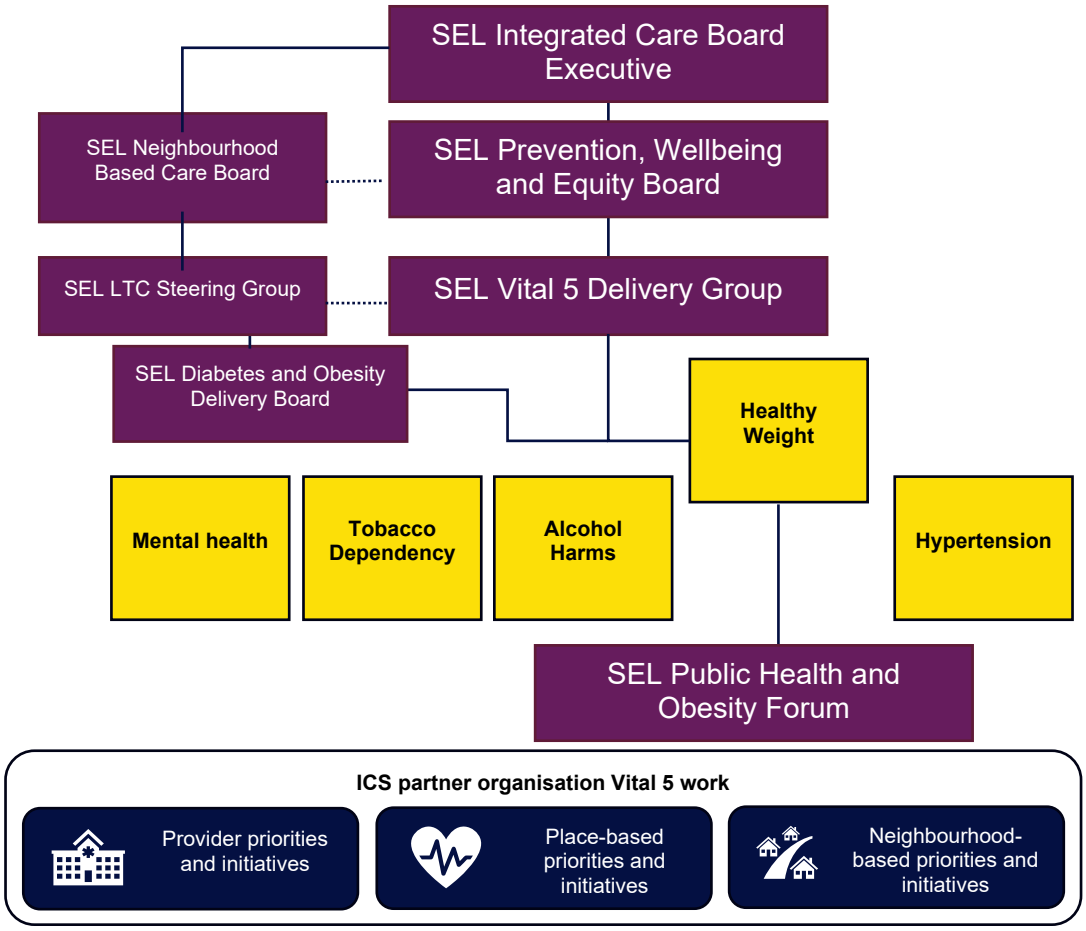
Appendix 3: South East London Weight Management and Obesity Review Core Principles

<u>The model of care should deliver in line with the following principles, based on best practice guidance, findings from the thematic analysis and the pre work groups:</u>

- **Focus should be on what we can do within existing resources across the system in the first instance,** with a roadmap for further development and opportunities should additional funding become available (e.g., long-term plan, health inequalities funding or industry/research funding). South East London ICS is in a challenged financial system, and we need to deliver 'high value care' across our whole system weight management and obesity pathway.
- **Addressing inequality in access, experience and outcomes for our diverse south east London communities:** Recommendations that stem from this work should be done through the lens of addressing health inequalities for our south east London population. Variation in pathway design, commissioning approaches and models is acceptable; provided waiting times and service provision is fair and equitable for all south east London residents.
- **Equitable access to, and provision of, evidence-based interventions in line with NICE guidance – with patients accessing the most suitable interventions for their individual needs:**
    - Lifestyle, behavioural, physical, dietary, pharmacotherapy, surgery and post-surgery follow up, are key interventions recognised by NICE that impact an individual's ability to maintain a healthy weight and improve mental wellbeing. Currently a tiered process is in place.
    - Fair access and provision of services to those living with overweight or obesity in south east London is required, either through a community or specialist care approach.
    - Psychological input should be accessible to every patient who has been assessed and suitably referred to a bariatric surgery service.
    - Rapid translation of research into practice is required to keep current, in an evolving NHS landscape.
    - Digital and in person treatment options are required. This is to give patients an option (depending on their preference), as well as working to manage the growing demand for weight management services.
- **Streamlined referral process and improved communication between providers across the patient journey:** Currently patients experience is impacted by the way referrals are managed and the flow/communication between different services and providers. System flexibility is required to streamline this process for both patients and providers.
- **Patient centred care**: Patient experience and input to be kept at the heart of the co-design process (including informing ongoing service improvement). Patients are to feel valued and encouraged to express their views and considerations in a safe and welcoming environment.

- **Data and insight driven**: A reliable and baseline standard of data is required that can be easily and efficiently collated across south east London to measure impact and change (dashboards identified which could support this) and this should be used alongside clinician and patient/resident insights to inform ongoing service improvement.
- **Taking a life course approach:** It is widely accepted the challenges of living with obesity and overweight span the life-course (maternity, children and young people and adults). Aspects of the '*family approach'* model to be considered and incorporated in future service design and recommendations to improve patient outcomes.
- **Addressing recommendations from pre-work groups:**
    - The **primary and community pre-work group** identified a timely opportunity for cross system working to consider 1) a common triage point for specialist care and 2) community-based holistic wrap around care, inclusive of new pharmacotherapy management
    - The **specialist care pre-work group** recommended the model ensure south east London patients have the right to timely and equitable medical and surgical treatment, regardless of where they are being referred to and from within south east London.
    - There has also been tangible consensus within the **specialist care pre-work group** for a revised South East London Network model to improve a standardised referral process, and development of a proforma to better stratify patient risk (underpinned by the KHP Lancet Commission)
    - The **pharmacotherapy pre-work group** are considering a mixed model approach for referral to weight loss medication; which will soon be made more accessible to patients living with overweight and obesity across south east London (in line with the NICE TA and guidelines and working within the current challenged financial context of South East London ICS). The current model relies primarily on clinical phasing and individual need; however, traditional weight loss medication is only accessible via a Specialist Care acute service, but primary care will soon be able to prescribe pipeline medication requiring a different and more future proofed model of care.

Appendix 4: Healthy Weight Steering Group Governance Structure



Appendix 5: Key Guidelines / Policy

- Overweight and obesity management – NICE guideline update (January 2025)
- Technology Appraisals (TAs) for Wegovy (Sept 2023) Mounjaro (Dec 2024) – plus supporting NHSE Commissioning Guidance (March 2025)
- NHS Neighbourhood Health guidelines – start of a 'Neighbourhood Health Service' (Jan 2025)
- Fuller Stocktake report (2022) – Long-term Conditions care and Integrated Neighbourhood Teams
- New 10-year plan – expected late Summer/ early autumn 2025
- NICE – obesity staging score. CG189
- Guidelines for medicines optimisation in bariatric and metabolic surgery (selondonics.org)

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Acknowledgements

We would like to extend our great thanks to our lived experience group for their invaluable input through this process.

Rima

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