



# How a new era of weight management services can reduce obesity-related health inequalities

A White Paper from Future Health Research –  
commissioned and funded by Voy

# 00 Executive summary

**The UK is at an inflection point in how it treats obesity. After decades of modest clinical progress and widening inequality, the arrival of GLP-1 and dual GIP/GLP-1 receptor agonists has changed what is achievable.**

The treatment paradigm has shifted from short-term weight loss attempts to long-term, multimodal management of a chronic condition. The decisions taken on how the NHS rolls out these medicines over the next 18 months will determine whether this becomes the moment obesity-related health inequalities begin to narrow, or the moment they are entrenched for a generation.

## THE RISK

Obesity is one of the most unequal public health challenges facing the UK, and the inequality is deepening. It costs the economy £126 billion a year, and the burden falls hardest across deprivation, ethnicity, disability and childhood, and on the populations the existing system has historically been least able to reach.<sup>1</sup>

Early evidence on access to new weight management treatments suggests the same pattern is repeating: people in the most deprived areas are accessing 32% fewer GLP-1 prescriptions than those in the least deprived, despite carrying a substantially higher obesity burden.<sup>2</sup>

Without deliberate action, the most significant clinical advance in obesity treatment in a generation risks excluding the populations who need it most.

## THE OPPORTUNITY

The clinical, technological and delivery infrastructure required to transform obesity care is maturing in parallel. New pharmacotherapy delivers weight loss at a magnitude previously achievable only through surgery. Digital infrastructure has matured into a credible national delivery channel, capable of reaching working-age adults, those in deprived areas and those geographically distant from specialist services. Community-anchored providers have demonstrated reach into underserved populations that standard pathways miss.

Used together, these capabilities make it possible to deliver effective treatment to the populations carrying the greatest burden, with outcomes that match or exceed those seen in the general population, at the scale population-level impact requires. This directly supports the Ten Year Health Plan's three shifts: hospital to community, analogue to digital, and sickness to prevention.<sup>3</sup>

## THE ASK

What stands between the clinical possibility and the equitable outcome is implementation. Provider readiness, inclusive digital infrastructure, operational design, and the visibility of equity duties are all solvable with existing policy levers.

This white paper sets out six commissioning reforms for NHS England, DHSC and Integrated Care Boards to ensure the rollout narrows the obesity inequalities gap rather than widening it.

## What we are calling for

01

**A national equity dashboard for GLP-1 commissioning.**

NHS England should publish programme uptake, completion and outcomes by deprivation, ethnicity, sex and disability, with automatic regional review triggered where disparities widen for two consecutive quarters.

02

**Primary care incentives that reward equitable referral.**

The 2026/27 GP contract should reward practices specifically for reaching patients experiencing the greatest health inequalities, with capacity matched to the under-resourced practices serving those communities.

03

**NHS England and ICBs should pilot a digitally enabled obesity prescription pathway in which approved digital providers can initiate GLP-1 prescribing following a GP referral.**

As with NHS Pharmacy First, clinical suitability would be assessed within the pathway against agreed criteria and care would be co-ordinated with GPs through the shared care record.<sup>4</sup> Evaluation of the pilot programme should compare the reach into underserved groups and clinical outcomes against the existing pathway.

04

**An Obesity Transformation Fund.** DHSC and NHS England should establish a time-limited fund to commission integrated obesity care, combining pharmacotherapy with behavioural and digital wraparound, distributed equitably and tracked against health-inequalities metrics.

05

**Barrier-based triage piloted alongside clinical-complexity triage.** NHS England and ICBs should pilot need-based triage models that match support intensity to the barriers holding patients back, not solely based on clinical complexity – with evaluation of cost per outcome and patient experience.

---

06

**Formal commissioning of the maintenance phase.** NHS England and ICBs should commission the Stage 3 maintenance phase already identified in the tirzepatide pathway as a funded service beginning at BSOP completion or pharmacotherapy down-titration, with 12-month and 24-month outcome reporting stratified by deprivation, ethnicity, sex and disability.

---

01 A national  
challenge, unequally  
borne, and a rollout  
that could deepen  
the gap

# Obesity is now a significant driver of ill-health, NHS demand and lost economic output in England.

## £126bn

is the estimated total annual cost of obesity and overweight in the UK, according to Frontier Economics' 2025 analysis. This is comprised of:

## £81.4bn

in informal care and quality-of-life losses<sup>5</sup>

## £30.8bn

in lost productivity

## £12.6bn

in direct NHS treatment

## £1.2bn

in formal social care<sup>5</sup>

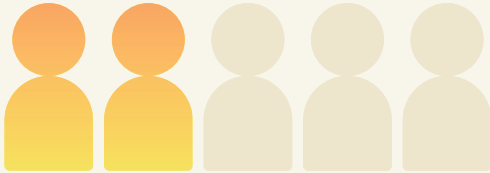
Rates of adult obesity have nearly doubled in a generation.

The Health Survey for England 2024 found that around 30% of adults are living with obesity, with two-thirds living with either overweight or obesity – broadly double the prevalence recorded in the early 1990s.<sup>6</sup> Pressures on the NHS have also grown: hospital admissions where obesity was a factor rose from 617,000 in 2016/17 to 1.24 million in 2022/23, a doubling in six years, with the trend continuing to rise.<sup>7</sup>

The burden of obesity is influenced by factors including deprivation, ethnicity and disability.

## 2/5

adults in the most deprived areas are living with obesity compared with less than 1 in 4 in the least deprived.<sup>8</sup>



A third of Black adults are living with obesity compared with 27.8% among White British adults;<sup>9</sup> and 37% of those with learning disabilities are living with obesity compared with 30.1% among those without.<sup>10</sup>

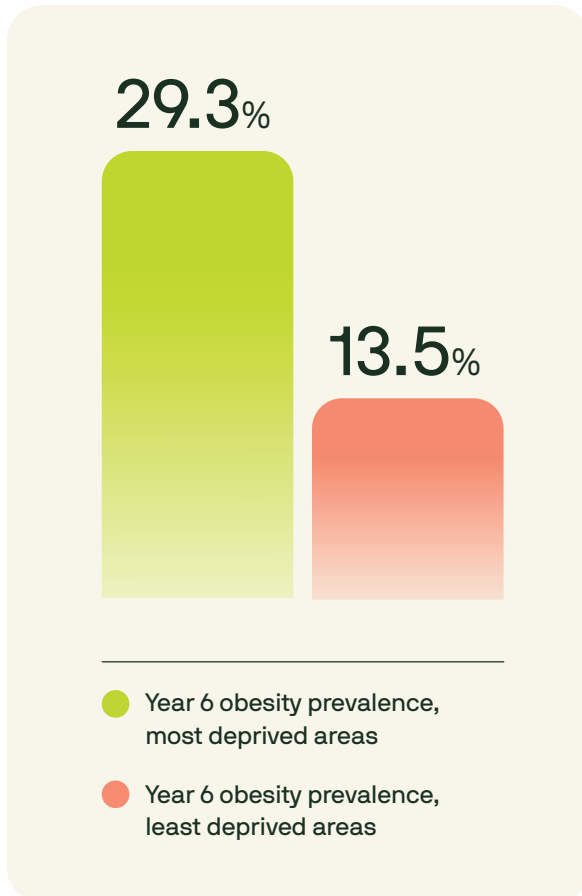
The geography of costs from obesity mirrors the geography of the disease: approximately £440,000 per 1,000 people in the most deprived 20% of neighbourhoods, against £360,000 per 1,000 in the least deprived.<sup>11</sup>

Future adult obesity trends look set to follow a similar pattern as childhood obesity is also widening along deprivation lines.

Year 6 obesity prevalence stands at 29.3% in the most deprived areas, against 13.5% in the least deprived — a gap that has grown from 9.6% to 15.8% since 2007–08.<sup>12</sup>

Early evidence on access to new weight management treatments suggests that those in less deprived areas are far more likely to be accessing these new treatments. The Health Foundation’s analysis of more than 113,000 patients of the digital provider Voy finds that people in the most deprived areas are accessing 32% fewer GLP-1 prescriptions than those in the least deprived, despite carrying a substantially higher burden of obesity.<sup>13</sup>

There is danger that the rollout of these new medications reinforces rather than narrows health inequalities.



# 02 A system under strain: why current services cannot deliver equitable access

# NHS weight management services have not been treated as a priority commensurate with the rising challenge of obesity in England.

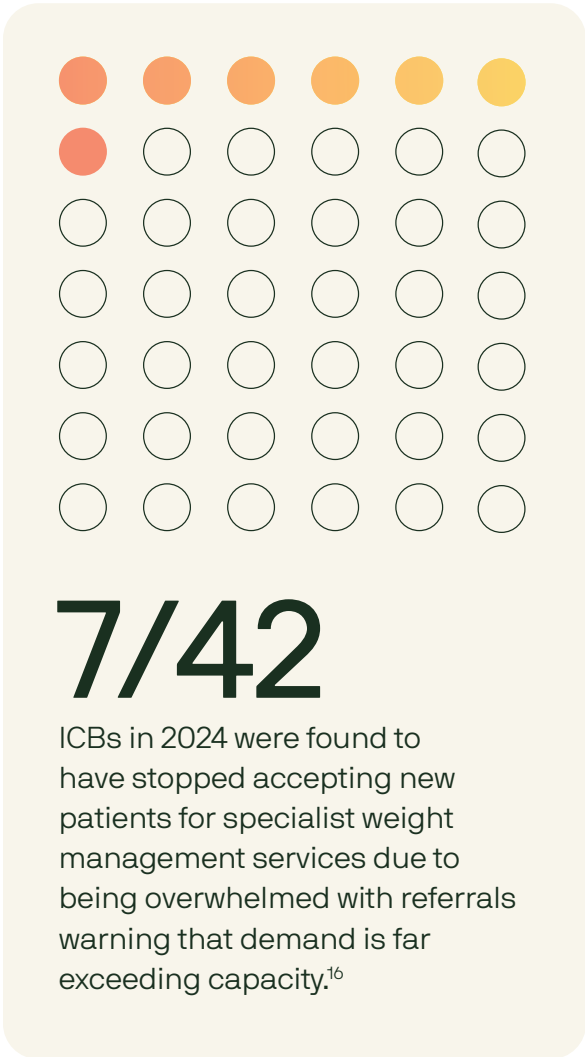
Commissioning has been inconsistent, investment has lagged behind disease burden, and the tiered model that underpins specialist provision has not been meaningfully reformed and expanded in over a decade.

### The NHS tiered system has been starved of investment:

The All-Party Parliamentary Group on Obesity has consistently called for the tiered weight management pathway to be reviewed and rationalised.<sup>14</sup>

Hazlehurst and colleagues' 2020 critique of NHS England policy identified pathway rigidity, uncertain treatment outcomes and weight stigma as the major barriers to improved care, and noted that Tier 3 services support only around 20% of patients to achieve 10% weight loss, with no robust data on whether that loss is sustained (as this is neither funded or evaluated).<sup>15</sup>

### Demand for care is significantly outpacing capacity:



National workforce shortages persist in dietetics, clinical psychology and weight management consultants.<sup>17</sup>

**Geographical variation is stark and access is restricted:**

Only a small minority of ICBs identify obesity as a priority in their Joint Forward Plans.<sup>18</sup> A 2025 freedom-of-information mapping of Integrated Care Systems (ICs) found 13 using bariatric eligibility criteria more onerous than NICE guidance.<sup>19</sup>

**0%–1.1%**

of the eligible population have been referred to Tier 3 services where they exist.<sup>20</sup> Where services do exist access is restricted.

---

A study by Coulman et al of 1.8 million adults with overweight or obesity recorded in primary care, found that only 3.1% received a referral to a weight management service, with approximately 60% of people with a BMI  $\geq 40$  kg/m<sup>2</sup> not having any weight management intervention recorded. Certain groups faced higher access barriers.

Black and Asian participants were less likely to have a weight management referral and a three fold geographical variation was recorded in access to bariatric surgery.<sup>21,22</sup>

**New pharmacotherapy is arriving into a system that cannot yet deliver it equitably:**

NICE's December 2024 technology appraisal TA1026 recommends tirzepatide for the management of overweight and obesity, with mandatory wraparound behavioural support, alongside a reduced-calorie diet and increased physical activity.<sup>23</sup> Phase 1 NHS criteria - BMI  $\geq 40$  plus four of five specified comorbidities - has been described as "arguably the strictest medication rollout in NHS history."<sup>24</sup>

NHS England plans to treat approximately 220,000 patients in the first three years of phased rollout, scaling to 1.6 million eligible patients by 2036. This is against a NICE-estimated total eligible population of 3.4 million.<sup>25</sup>

Even on the NHS's own published timeline, the great majority of those who will eventually qualify will wait years for access.

**8/42**

of the ICBs were providing tirzepatide for obesity as of August 2025, with access highly restricted.<sup>26</sup>

---

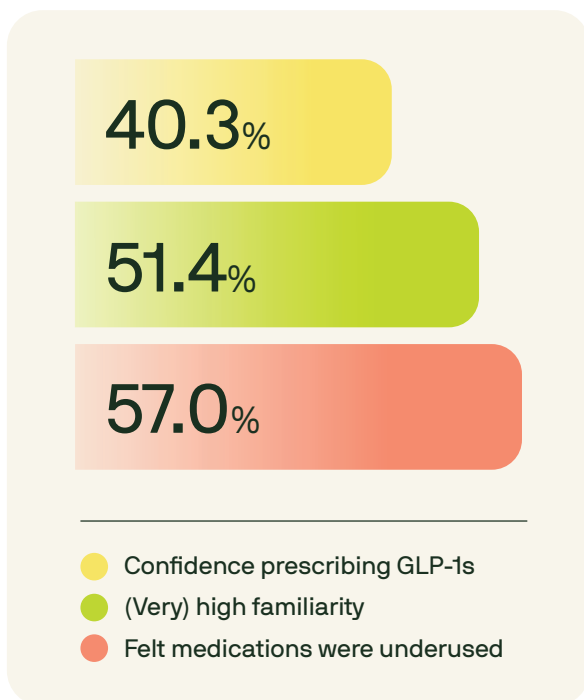
Studies have noted that rationing therapy to a small subset of patients creates substantial diagnostic and treatment barriers, particularly for vulnerable groups.<sup>27</sup>

**The site of pharmacology delivery is itself a driver of inequity:**

NHS-prescribed weight management pharmacotherapy in England has, until recently, been delivered almost exclusively through Trust-based specialist services - the majority routed through hospital outpatient settings. For populations who already have limited trust in healthcare institutions and face disproportionate barriers to hospital-based care - those in the most deprived deciles, minority ethnic communities, and people with mental health needs - requiring travel across a county to a hospital outpatient appointment compounds existing access inequalities before any clinical intervention has begun.

**Provider readiness is itself an equity issue:**

A mixed-methods study of UK healthcare professionals conducted between January and April 2025 found that, among 72 respondents:<sup>28</sup>



Qualitative themes identified through thematic analysis of follow-up interviews included system barriers and access inequities, professional knowledge gaps and training needs, obesity stigma within healthcare, and "silver-bullet" misconceptions about pharmacotherapy as a standalone solution.<sup>29</sup>

The implication for equity is direct. Where prescribing confidence is low and multidisciplinary capacity is constrained, the populations carrying the greatest obesity burden - those in deprived areas, with higher comorbidity, or attending under-resourced practices - are the populations least likely to receive the medication, the wraparound, or both.

Closing that gap requires structured clinician education, accessible specialist advice, and pathways that allow primary care to refer rather than carry the full weight of GLP-1 prescribing alone.

## Phased access decisions are being poorly communicated:

Pressures and mixed levels of understanding in primary care combined with the use of incentives to refer can lead to inconsistent referrals and confusion amongst patients. A mixed-methods study of 167 adults eligible for GLP-1 therapy under NICE criteria but not receiving pharmacotherapy under local prioritisation thresholds found that 163 of 167 reported feeling let down by not accessing the medication, and 49 reported wanting GLP-1 therapy but being unable to afford private access.<sup>30</sup>

Qualitative work in a specialist weight management service in the South East confirmed that dissatisfaction was driven by expectation misalignment rather than opposition to clinical prioritisation itself: participants accepted constrained capacity but reacted strongly when expectations of progression had previously been formed and not met.<sup>31</sup>

## Summary

NHS weight management services have not been a historic priority for the NHS. Services are in many cases too remote and challenging for patients to access and the groups living with and at most risk of obesity are those less likely to get the support they need.

Changing weight management services can serve as an exemplar for delivering the Government's three shifts in the Ten Year Health Plan:

- Moving obesity care from hospital outpatients into communities and around the needs of patients
- Supporting earlier intervention, patient engagement and greater prevention of obesity and obesity related complications
- Using a combination of digital support and medical innovation to reach greater numbers and reduce obesity related inequalities

03 The opportunity:  
clinical and  
technological  
advances create an  
opportunity to deliver  
more equitable  
higher quality obesity  
services

# The clinical, technological and delivery infrastructure required to transform obesity care is maturing in parallel.

New pharmacotherapy delivers weight loss at a magnitude previously achievable only through surgery; digital infrastructure has matured into a credible delivery channel at population scale. Used together, they create the conditions to widen access to effective treatment, reach populations the existing system has historically underserved, and improve outcomes.

## **Effective new pharmacotherapy is the most significant change in obesity treatment in a generation:**

The SURMOUNT-1 trial showed mean weight loss of up to 22.5% with tirzepatide (15 mg dose) at 72 weeks.<sup>32</sup> NICE TA875 (semaglutide) and TA1026 (tirzepatide) make wraparound behavioural support a mandatory component of treatment, recognising that pharmacotherapy alone is not the intervention.<sup>33</sup>

The treatment paradigm has shifted from short-term weight loss attempts to long-term, multimodal management of a chronic condition — and the magnitude of clinical benefit now on offer raises the equity stakes of who is able to access it.

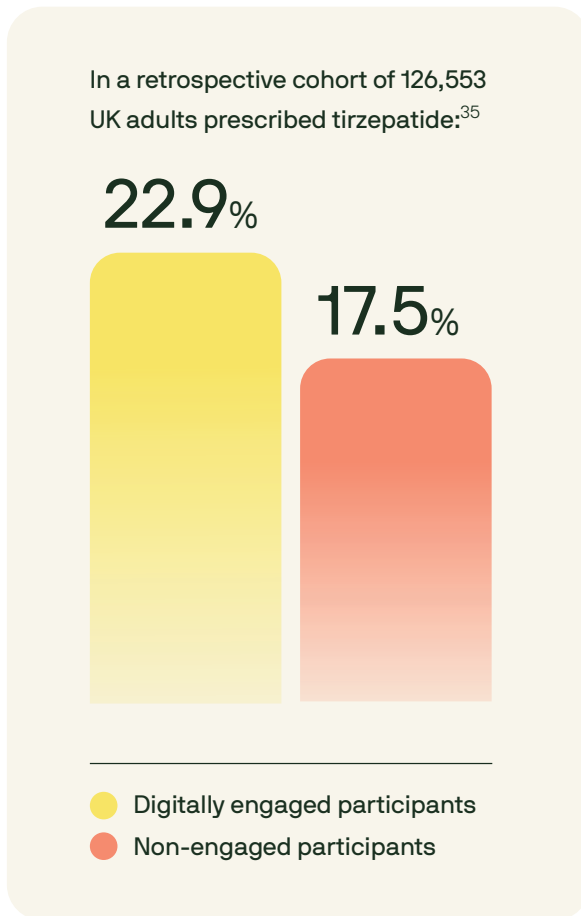
## **Digital support has matured into a credible delivery infrastructure that can reach populations the existing system does not:**

UK platforms now combine app-based self-monitoring, structured behavioural content and clinician oversight at scale, with regulated prescribing, identity verification and clinical governance built in.

This is additive infrastructure that does not currently exist in the NHS: capable of reaching working-age adults, those in deprived areas and those geographically distant from specialist services — the same groups that hospital outpatient pathways have historically failed to engage.<sup>34</sup>

The obvious counterpoint is concerns about digital exclusion. Contact is not digital only, but both available by telephone as well as in-app. Within an NHS framework the model must meet accessibility and digital-inclusion standards. Digital delivery will not reach everyone but against current service provision it will reach a large group current pathways do not.

Pharmacotherapy combined with digital behavioural support delivers strong real-world outcomes:



In a separate analysis of 66,846 UK adults on tirzepatide, medication-only outcomes reached approximately 88% of those seen in the SURMOUNT-1 trial, while digitally engaged participants exceeded SURMOUNT-1 results by 10%.<sup>36</sup>

Real-world outcomes can therefore match or exceed trial conditions when pharmacotherapy is paired with structured digital behavioural support - and at the volumes required for population-level impact.

Taken together, these advances make a more equitable, higher-performing model deliverable:



GLP-1 and GIP/GLP-1 receptor agonists have shifted what is clinically achievable. Remote digital platforms now enable safe titration, side-effect management and behavioural support without requiring hospital attendance, and the evidence base for embedding behavioural change within everyday digital interactions is rapidly maturing.<sup>37</sup>

Obesity treatment can increasingly be delivered through community-anchored, digitally enabled pathways rather than hospital outpatient settings - closer to the populations carrying the greatest burden, with fewer of the structural barriers that drive the existing access gap.

This directly supports the NHS Ten Year Health Plan's three shifts - hospital to community, analogue to digital, and sickness to prevention.<sup>38</sup>

**Yet the maturity of this infrastructure exposes potential tensions in current commissioning:**

The 2026/27 GP contract increases the demand placed on primary care for weight management and obesity-related work, while the NHS simultaneously invests – through NHS Pharmacy First, the Community Pharmacy Independent Prescribing Pathfinder and Healthier You – in infrastructure designed to support that work.

The challenge is not a contradiction to be resolved by any single part of the system, but a question of alignment: these levers currently sit in separate parts of a fragmented pathway, and their combined value is only realised when they operate as one. This is a neighbourhood health responsibility, in which primary care, community pharmacy and digital providers are jointly accountable for routing demand to the most appropriate setting.

Realising the value of the available infrastructure is therefore a question of system coordination, not clinical readiness.<sup>39</sup>

# 04 How pairing community- anchored reach with digital delivery at scale can close the equity gap

The evidence shows how current weight management services struggle to:

- Reach populations in greatest need
  - those from more deprived areas, ethnic minority groups, those with limited GP trust or contact
- Deliver pharmacotherapy without requiring the hospital outpatient attendance or overburdened primary care that compounds existing access barriers for the populations carrying the greatest burden
- Use modern day digital tools that service users access in their everyday lives

Addressing this will require services that are both anchored in communities but also that are digitally enabled to support scale and access.

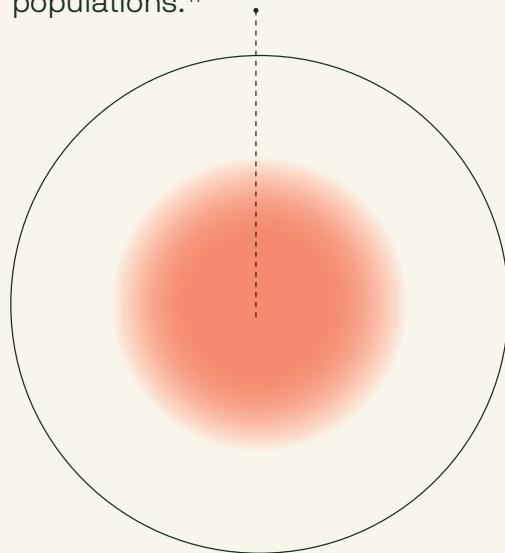
## COMMUNITY ANCHORED SERVICES

The contribution of community anchored programmes within contemporary obesity services is clear from evaluations of services such as Morelife which is commissioned across multiple Integrated Care Boards in England. Its core delivery model - which includes nine months of structured maintenance support, delivered both online and face-to-face - has been designed to engage populations most affected by obesity.

Across 10,512 adults completing a 12-month Morelife programme, 33.2% lived in the most deprived areas, 21% were male, 30.2% were aged 18–40 and 24% were aged 65 or older.<sup>40</sup>

**59%**

of service users in Greater Manchester were from non-white and the two most deprived decile populations.<sup>41</sup>



These are demographic groups consistently underrepresented in UK weight management services and where access to care is more challenging.<sup>42</sup>

For services to be anchored in communities they need to be culturally appropriate, built in partnership with local people and accessible. The following sets out some examples of such approaches.

### **Working with trusted community leaders:**

Populations most affected by obesity are often those least likely to access formal services because of mistrust of institutions, language differences, caring responsibilities, transport constraints and limited culturally aligned provision.<sup>43</sup>

Morelife's workforce is deliberately diverse and its resources are co-developed with the communities they serve. Morelife has co-designed an eight-week pilot programme for Bengali-speaking women, working with existing clients with shared lived experience and local Bangladeshi organisations, supported by interpreters and Muslim practitioners.

Participants in Morelife's Bengali-speaking pilot similarly reported the value of culturally aligned delivery, citing "having a practitioner who is Muslim, they felt understood", small adaptations such as portion control guidance for rice, the value of group support and a sense of community, and improvements in mental wellbeing and confidence.<sup>44</sup>

### **Using familiar community settings:**

Face-to-face weight management groups in North and West London are run from carefully selected community venues usually with activator partners who already reach target communities and at venues that are familiar and trusted.

This includes local community spaces, GP-aligned settings and partner organisation sites in Camden and Islington rather than clinical environments, with online Zoom delivery used as a complementary option for those facing transport, childcare or shift-work barriers.<sup>45</sup>

### **Enhancing accessibility and engagement for different groups:**

My Life Plan is an interactive digital platform, built by Morelife, consisting of 12 weekly sessions with educational videos, recipes, podcasts and other nutrition, physical activity and psychology resources.

The platform is accessible through mobile phones and computers. It has Auto-translation to 98 languages and ReachDeck assistive technologies: text-to-speech, translations, Picture Dictionary, Screen Mask (reduces visual stress/ improves focus), text magnifier, webpage simplifier (removes potentially distracting content), and multiple formats including Easy Read. Recipes on this platform reflect a variety of cultures, religions, beliefs and financial pressures.

The platform has progress and interactive goals/exercise trackers, motivational and personalised nudges and interactive challenges. 72% of those engaged through the programme lost 3% of their initial body weight.<sup>46</sup>

### **Building capability and capacity in local VCFSE orgs:**

Reaching into underserved communities is amplified through formal partnerships with VCFSE organisations already trusted by the populations they serve. A notable example has been work supporting culturally tailored physical activity provision such as Bollyfit Active, a women-only South Asian and BAME fitness community that uses cultural music and dance in a strictly women-only environment to address the barriers many South Asian women face accessing mixed-gender gyms or generic weight management settings.<sup>47</sup>

### **Tailored programmes to population health needs:**

Obesity prevalence is higher among those adults with learning disabilities than those without.<sup>48</sup> A Suffolk County Council funded 12-week tailored programme co-designed with organisations supporting people with learning disabilities, delivered through mixed group and one-to-one formats, achieved a statistically significant pre-post weight reduction among 15 completers (mean weight loss 3.26 kg, range 0.40–11.10 kg); 80% of participants rated themselves “very likely” to recommend the programme.<sup>49</sup>

### **DIGITAL DELIVERY & ENGAGEMENT**

Digital delivery alongside GLP-1 medications is now a powerful tool to tackle obesity related health inequalities. The following sets out some of the evidence for how digital support alongside medication can close the inequalities gap.

### **Digital delivery improves weight loss and other health outcomes:**

Across a study of 57,975 participants a 53% greater weight loss was recorded for those engaged digitally when compared with those on the medication alone. Medication adherence rates (50%) were twice that of the market average at 6 months (25%).<sup>50</sup> After one year of the programme, every patient reported an improvement in their quality of life, with 74% improving their depression scores and 94% improved binge eating scores.<sup>51</sup> Improvements were also noted across wider health markers, showing benefits beyond weight loss alone:

**100%**

of prediabetic HbA1c readings returned to a healthy range

---

**72%**

saw improvements in elevated LDL cholesterol, with more than 30% fully normalising

---

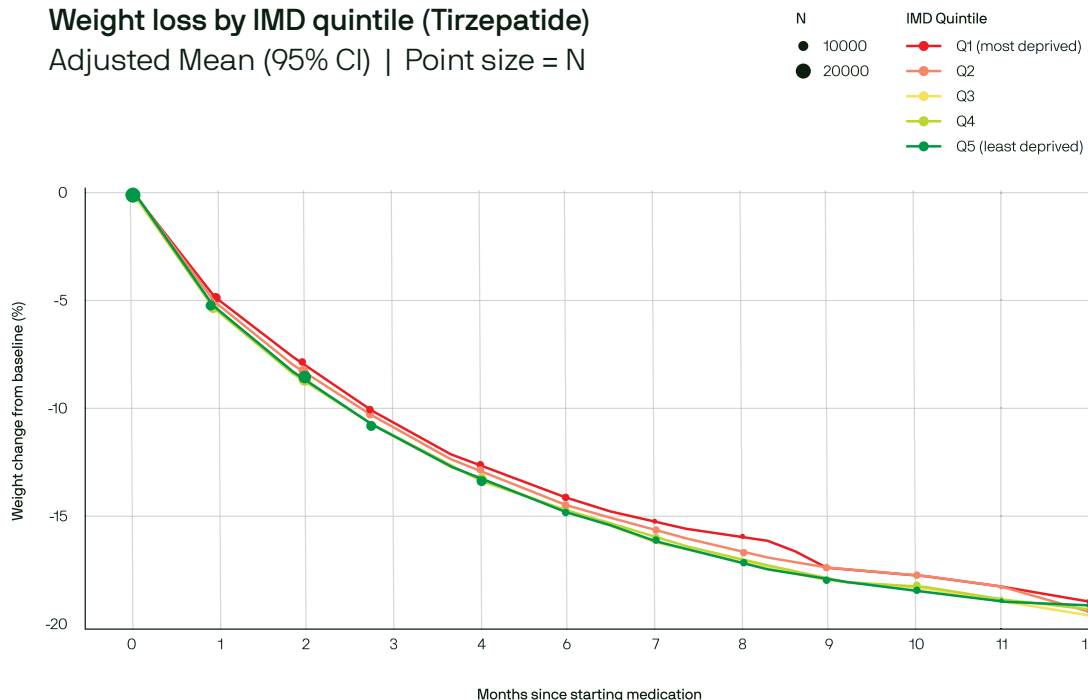
**6.5%**

drop in systolic blood pressure<sup>52</sup>

---

### Weight loss by IMD quintile (Tirzepatide)

Adjusted Mean (95% CI) | Point size = N



### Digital engagement is a critical success factor for delivering weight loss right across the population:

A retrospective analysis of 124,043 adults with a large UK-based digital weight loss platform and on tirzepatide found adjusted weight loss trajectories converged across deprivation quintiles by month 12.

Engaged participants from the most deprived quintile lost 22.7% of body weight at 12 months, nearly identical to the least deprived, 22.6%.<sup>53</sup>

Evidence across ethnicities shows that engagement is a dose response modifier that operates uniformly, with significant gaps between engaged and non engaged participants.

Analysing tirzepatide patients at month 12, the data show:

- White patients with full engagement lost 18.7% versus 14.8% without full engagement - **a gap of 3.9%**
- Black patients with full engagement lost 16.3% versus 12% without - **a gap of 4.3%**
- Asian patients with full engagement lost 17.8% versus 12% without - **a gap of 5.8%**
- Mixed and Multiple ethnicity patients with full engagement lost 20.5% versus 13.3% without - **a gap of 7.2%**
- Middle Eastern patients with full engagement lost 24.8% versus 15.4% without - **a gap of 9.4%**<sup>54</sup>

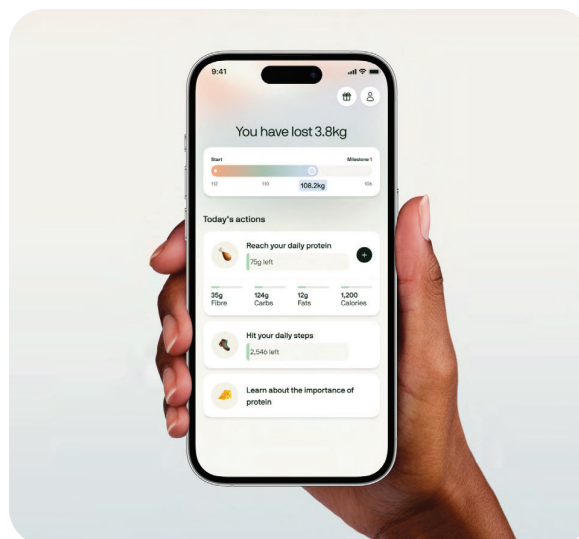
Engagement effects are at least as large as the drug effect, and possibly larger in minority groups. Mixed at 20.5%, Middle Eastern at 24.8% all exceed the White engaged equivalent of 18.7%. The directional signal across multiple groups is consistent.

These data show that digital engagement is not just additive to the drug effect, it appears to amplify it more strongly in minority patients. This shows that the equity challenge is not differential treatment response but differential access to engagement.<sup>55</sup>

### Digital engagement supports superior retention:

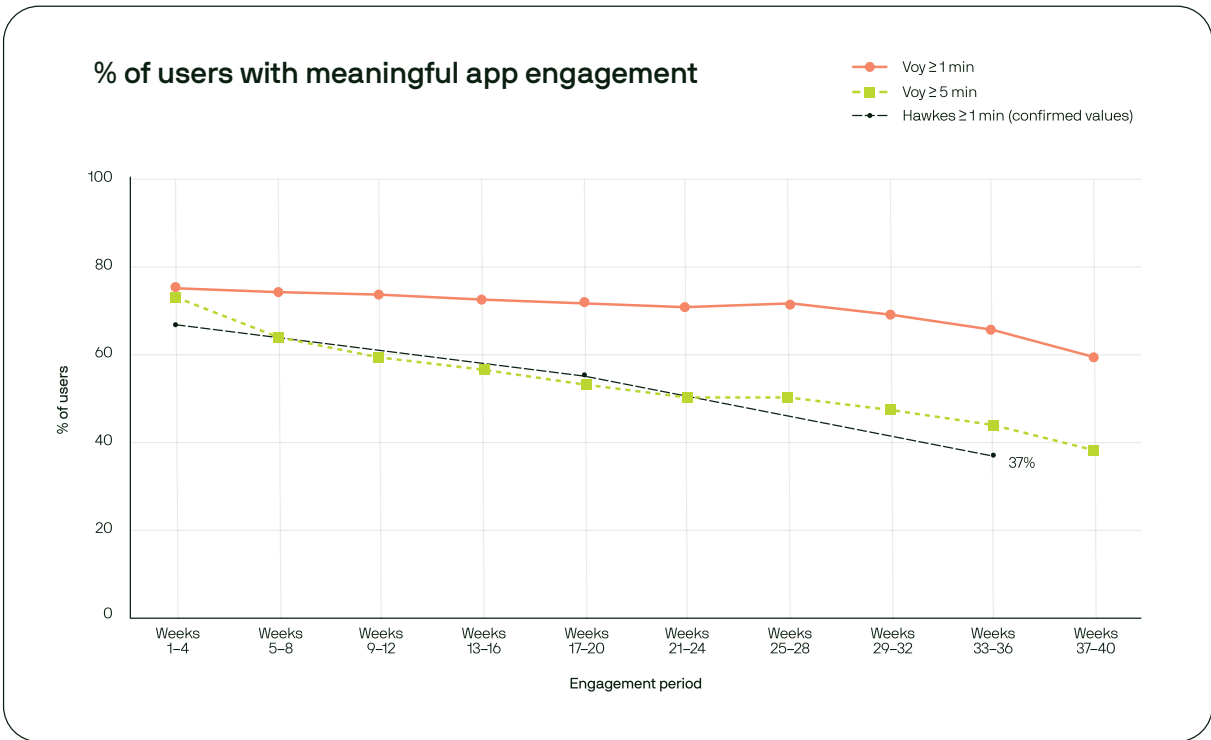
Voy pairs GLP-1 medications with a digitally managed medication experience, delivering outcomes that go beyond medication alone.

Voy's digital delivery channel can reach far beyond traditional hospital care pathways. Voy is accessible nationally, removes the requirement for travel to a hospital outpatient clinic, and enables safe titration, side-effect management and behavioural support remotely. The platform is regulated under CQC, GMC and GPhC standards for remote prescribing, with structured identity, BMI and contraindication verification at onboarding.<sup>56</sup>



Rather than being a collection of information and tools for a user to self-navigate, the Voy app is a behaviour change system that connects nutritional tracking, activity tracking, weight tracking, and educational content through integrating mechanisms:

- Structured check-ins that utilise tracking information as well as self-reflection to help the system understand what content will be most relevant to the user, and work with the user to set appropriate goals according to where they are in their journey
- A gamification layer of momentum points and streaks, experimentally proven to drive 10% greater engagement with app tools across nutritional, activity, and weight tracking, and sustain behaviour change
- Community engagement - 45% of community adopters meaningfully engage at least 3 times<sup>57</sup>



**The result is measurably superior retention - at week 36, 65% of Voy users remain meaningfully engaged with the app, compared to 37% in published NHS-DDPP comparators.<sup>58</sup>**

Patients have access to appointment and side effect helpline support seven days a week, and 85% of patients record reaching a clinician within ten minutes. A survey of 2,700 Voy members reported a 60% lower rate of side effects than external studies and internal data shows fewer than 1% of patients discontinue treatment due to side effects.

The Voy clinical team handles 4,000 appointments a week, 35,000 in bound patient queries and a 95% client satisfaction score.<sup>59</sup>

## Summary

By combining community anchored approaches and digital delivery at scale weight management services can reach the groups in greatest need that the current system is struggling to engage with.

Digital support is a critical component - alongside the medication - for delivering reductions in weight loss and improvements in health outcomes.

# 05 Policy recommendations: what commissioners should do now

# The new generation of GLP-1 and dual GIP/GLP-1 receptor agonists present a major opportunity to tackle one of the most important drivers of UK health inequality.

The policy architecture to prevent this is being built. NICE TA1026, the NHS England Interim Commissioning Guidance and the Healthier You 2026 specification already establish that wraparound care, equity of access and inclusion are mandatory.<sup>60</sup> The gap is not in policy intent.

It is in the specific operational mechanisms that determine whether intent translates into delivery — and in the absence of accountability that ensures delivery actually narrows the gap rather than widening it under the cover of national programmes.

The evidence set out in this paper identifies that gap as a set of identifiable, addressable failure mechanisms including:

- Obesity has not been seen as a health service priority with commensurate funding and recognition
- Current weight management services struggle to find and support the populations most affected<sup>61</sup>
- Early evidence on pharmacotherapy access shows inequalities in access for areas of higher deprivation<sup>62</sup>

- The current default site of delivery - through Trust-based hospital outpatient settings and traditional primary care embeds inequity
- Prescribing confidence and wraparound capacity are also inequity drivers<sup>63</sup>
- Equity data on access within the NHS is unpublished and there is a lack of transparency around accessing new treatments which could affect patient and clinical confidence<sup>64</sup>

**To tackle these issues and improve care for patients, there are two imperatives NHS weight management services must meet: delivering a more equitable service, that ensures that the wraparound works for the populations carrying greatest burden.**

# Imperative 1: Deliver a more equitable service

---

A modern obesity service should have equity as a central design feature. Currently a combination of low awareness of service offers, referral behaviour, the costs of participation, constrained capacity and the absence of public scrutiny of access disparities means that the population accessing NHS weight management services does not reflect the obesity burden.

---

## Recommendation 1

# NHS England should publish a national equity dashboard for GLP-1 commissioning, with a defined corrective mechanism where disparities widen.

ICB-level data collection on tirzepatide prescribing is already mandated under the Interim Commissioning Guidance, and providers under the Healthier You programme are required to report equity of access and outcomes at monthly contract review.<sup>65</sup>

Currently this data sits within NHS England-ICB relationships and provider contracts. It is not public, not comparable across ICBs, and not tied to a corrective mechanism. A national dashboard, drawing on existing reporting requirements, should publish uptake, completion and outcomes by deprivation decile, ethnicity, sex and disability - including the proportion of GLP-1 prescriptions originating from NHS versus private and digital out-of-pocket provision, to track whether the divide visible in current Health Foundation data is narrowing or widening.<sup>66</sup>

Accountability mechanisms could be introduced as part of this – where for example disparities widen for two consecutive quarters in an ICB, an automatic regional review and improvement plan should be triggered. This converts the existing equity reporting infrastructure into an accountability instrument and aligns directly with the Equality Act 2010 and NHS health inequalities duty.<sup>67</sup>

## Recommendation 2

# NHS England should go further than the new obesity incentives in the GP contract, rewarding practices specifically for reaching the patients least likely to come forward.

The 2026/27 GP contract takes an important step: for the first time, it pays practices to identify people living with obesity and refer them for treatment, backed by around £25m of funding. This matters, because referral rates have been stubbornly low with capacity constrained. The new indicators also sensibly adjust who qualifies to reflect the higher obesity risk in some ethnic groups.<sup>68</sup>

But the incentive rewards referral in general, not equitable referral. A practice can earn the full payment by referring the patients who are easiest to reach, while the people the rollout most needs to reach – those experiencing the greatest health inequalities, including people in the most deprived communities, ethnic minority groups, and people with disabilities - can fall outside the count without the practice losing out. In turn for practices serving more deprived and diverse populations there will be greater challenges in engaging communities and building trust. The risk is therefore an incentive that looks successful on paper while leaving the access gap untouched.

NHS England should go further: rewarding practices specifically for reaching the populations experiencing the greatest health inequalities, rather than patients in general, and ensuring the new workload is matched with capacity in the under-resourced practices that serve those communities – otherwise the incentive will be delivered where it is easiest, not where it is needed most and practices in areas of high deprivation will be further financially disadvantaged. Whether it is closing the gap or widening it should be visible through the equity dashboard set out in Recommendation 1.

### Recommendation 3

# NHS England and ICBs should push forward with wider reform and pilot a digitally enabled obesity prescription pathway.

---

GPs face a large range of service and demand pressures and people from marginalised communities often face additional hurdles to access care. Pharmacy First, the Community Pharmacy Independent Prescribing Pathfinder, NHS Talking Therapies and integrated sexual health services all demonstrate that specific services can prescribe medication safely with care continuity with GPs enabled by a shared care record and more co-ordinated working.<sup>69</sup>

NHS England should pilot a digitally enabled obesity prescription pathway in which approved digital providers can initiate GLP-1 prescribing following a GP referral. As with NHS Pharmacy First, clinical suitability would be assessed within the pathway against agreed criteria and care would be co-ordinated with GPs through the shared care record.<sup>70</sup> Evaluation of the pilot programme should compare the reach into underserved groups and clinical outcomes against the existing pathway.

# Imperative 2: Make the wraparound work for the populations carrying most burden

---

There remain gaps in obesity care, that mean delivering patient centred care is operationally challenging. Tailored, extended and wraparound models of support are needed to address health inequalities.

---

## Recommendation 4

# Establish an Obesity Transformation Fund to deliver integrated, equitable obesity care.

---

The DHSC and NHS England should establish an Obesity Transformation Fund to commission integrated obesity care — combining GLP-1 pharmacotherapy with the behavioural and digital wraparound support that evidence shows is necessary to make it work. The time-limited Transformation Fund would bring the support together as a single, coherent offer built around the patient pathway. The Transformation Fund would be distributed equitably across the country, with its reach and impact tracked against clear health-inequalities metrics.

## Recommendation 5

# Match intensity of support to barrier rather than to clinical complexity through piloting new triage models.

---

Current weight management commissioning maps patient complexity – comorbidity count, BMI severity, tier classification – onto required intensity of intervention. The assumption that complexity reliably predicts the support a patient needs is not well-evidenced. The variables that more often predict response – engagement appetite, the nature of the barrier holding a patient back, cultural and language fit, trust in services – are not captured in current triage tools and do not align neatly with clinical complexity.

For example a patient with moderate BMI but low trust, language barriers and limited digital confidence may need more intensive support than a clinically complex patient who is highly digitally engaged.

The consequence is systemic mismatch: clinically complex patients over-served on intensive pathways they do not need, and apparently simpler patients under-supported because their barriers are relational rather than clinical.

NHS England should work with ICBs to pilot need-based triage models within wraparound weight management services, matching intensity of support to barrier type rather than to clinical complexity alone, with evaluation of both cost per outcome and patient experience. The evidence and feedback from these pilots can then be used to adjust funding models for these services.

## Recommendation 6

# NHS England and ICBs should formally commission and fund a behavioural maintenance phase to support long-term outcomes after pharmacotherapy, with explicit equity reporting on who is supported.

NICE TA1026 recommends tirzepatide only alongside a reduced-calorie diet and increased physical activity, and directs prescribers to local pathways for that support – but it neither specifies nor funds the behavioural provision itself, and the NHS Healthier You Behavioural Support for Obesity Prescribing (BSOP) service is structured around the active treatment period.<sup>71, 72</sup>

The maintenance phase – after the structured programme ends but while the risk of weight regain continues – is where provision is least defined and least consistently funded, and the evidence base identifies it as decisive for sustained outcomes. Evidence shows a 14% weight regain within a year for patients switching from tirzepatide to placebo, with 89.5% of those remaining on treatment maintaining at least 80% of weight loss versus 16.6% for those where treatment has been withdrawn.<sup>73</sup> This gap falls hardest on those who could not fund continuation privately, so left unaddressed it widens the very inequalities the pathway is meant to close.

NHS England should commission and fund the maintenance phase as a defined part of the pathway, with engagement and outcomes reported at 12 and 24 months and stratified by deprivation, ethnicity, sex and disability.

# 06 Conclusion

# Obesity is one of the most significant and unequal public health challenges facing the UK.

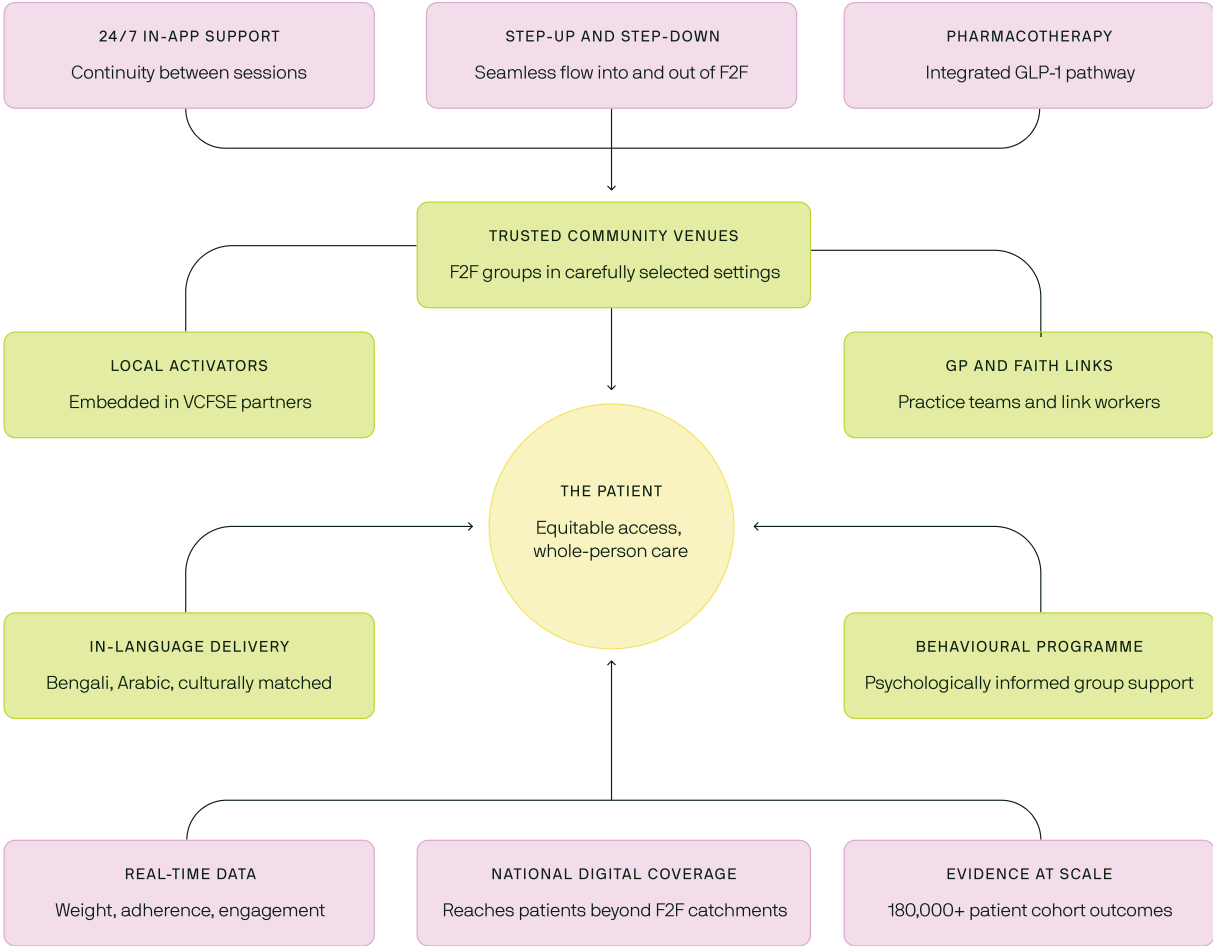
The harms - clinical, economic and human - fall hardest on the populations the existing system has historically been least able to serve. Adult obesity prevalence is higher in the most deprived communities and GLP-1 prescribing in the private market has been recorded as currently 32% lower in the most deprived areas.<sup>74,75</sup> Without deliberate intervention, the most significant clinical advance in obesity treatment in a generation will deepen these inequalities rather than close them.

This is also the first moment in UK obesity care when that outcome is avoidable. Pharmacotherapy that delivers weight loss at a magnitude previously achievable only through surgery has converged with digital behavioural infrastructure that has matured into a credible national delivery channel.<sup>76,77</sup> Together, they make it possible for the populations carrying the greatest burden - adults with complex multimorbidity, those from deprived and ethnic-minority communities, people with disabilities, and those with significant mental health need - to achieve weight management outcomes comparable to, or exceeding, those of the general population, when wraparound is structured around them.

What stands between the clinical possibility and the equitable outcome is implementation. Provider readiness, inclusive digital infrastructure, operational design, and the visibility of equity duties are all solvable problems with existing policy levers.<sup>78,79</sup> Acted on with urgency, they would make the GLP-1 rollout the moment Government policy begins to narrow obesity-related health inequalities.

# 07 Our Offer

# Our new combined Morelife and Voy offer can support the NHS to deliver real change at scale whilst ensuring equity of access for underserved communities.



● Morelife: community-anchored core    ● Voy: digital and F2F reach that amplifies

This white paper sets out the risks and opportunities that the rollout of GLP-1s presents for health inequalities in England. It also shows how these new medications when combined with digital wraparound support can play a significant role in addressing the current inequities patients face in the system.



**Morelife** brings more than 25 years of community-based reach into historically underserved populations - including deprived communities, minority ethnic groups and those with mental health needs.<sup>80</sup> **Voy** operates the largest published UK real-world GLP-1 weight management dataset, with peer-reviewed cohort outcomes anchoring its approach to digitally enabled care.<sup>81</sup>

Together, the two organisations offer a service that can reach across community, face-to-face and digital modalities, adapt intensity to individual need, and meet patients where they are at each stage of their journey - directly supporting the Ten Year Health Plan's three shifts of hospital to community, analogue to digital, and sickness to prevention.<sup>82</sup>



**Future Health** is a public policy research centre focused on creating healthier, wealthier people, communities and nations. Future Health publishes regular papers across its three policy research programmes of health prevention, health technology and the links between improvements in health and economic growth. You can find out more about our research here: <https://www.futurehealthresearch.com/>

# References

- <sup>1</sup>Frontier Economics for Nesta. *The economic and productivity costs of obesity and excess weight in the UK*. July 2025. <https://www.nesta.org.uk/report/the-economic-and-productivity-costs-of-obesity-and-overweight-in-the-uk/> ;
- <sup>2</sup>The Health Foundation. *GLP-1 drug prescriptions for obesity*. 2026. <https://www.health.org.uk/reports-and-analysis/analysis/glp-1-drug-prescriptions-for-obesity>
- <sup>3</sup>Department of Health and Social Care. *Fit for the Future: 10 Year Health Plan for England*. 2025. <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future>
- <sup>4</sup>NHS England. *Community pharmacy advanced service specification: NHS Pharmacy First Service*. 2025. <https://www.england.nhs.uk/publication/community-pharmacy-advanced-service-specification-nhs-pharmacy-first-service/>
- <sup>5</sup>Frontier Economics for Nesta. *The economic and productivity costs of obesity and excess weight in the UK*. 2025. <https://www.nesta.org.uk/report/the-economic-and-productivity-costs-of-obesity-and-overweight-in-the-uk/>
- <sup>6</sup>NHS England. *Health Survey for England 2024 — data tables, including adult and child overweight and obesity tables*. 2026. <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2024/health-survey-for-england-2024-data-tables>
- <sup>7</sup>NHS England. *Statistics on Public Health, England 2023 — Part 1: Hospital Admissions*. 2024. <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-public-health/2023/introduction>
- <sup>8</sup>NHS England Digital. *Health Survey for England 2024 — data tables, including adult and child overweight and obesity tables*. 2026. <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2024/health-survey-for-england-2024-data-tables>
- <sup>9</sup>Office for Health Improvement and Disparities. *Obesity profile: short statistical commentary*. 2025. <https://www.gov.uk/government/statistics/obesity-profile-may-2025-update/obesity-profile-short-statistical-commentary-may-2025>
- <sup>10</sup>Public Health England / OHID. *Obesity and weight management for people with learning disabilities: guidance*. 2020. <https://www.gov.uk/government/publications/obesity-weight-management-and-people-with-learning-disabilities/obesity-and-weight-management-for-people-with-learning-disabilities-guidance>
- <sup>11</sup>Frontier Economics for Nesta. *The economic and productivity costs of obesity and excess weight in the UK*. 2025. <https://www.nesta.org.uk/report/the-economic-and-productivity-costs-of-obesity-and-overweight-in-the-uk/>
- <sup>12</sup>Nesta. *Six things we learnt from the latest childhood obesity data for England*. 2025. <https://www.nesta.org.uk/data-visualisation-and-interactive/six-things-we-learnt-from-the-latest-childhood-obesity-data-for-england/>
- <sup>13</sup>The Health Foundation. *GLP-1 drug prescriptions for obesity*. 2026 <https://www.health.org.uk/reports-and-analysis/analysis/glp-1-drug-prescriptions-for-obesity>
- <sup>14</sup>All-Party Parliamentary Group on Obesity. *APPG on Obesity Publishes Policy Paper on Childhood Food Environment, Planning and School Food*. 2026. <https://obesityappg.com/inquiries>

- <sup>15</sup>Hazlehurst JM, et al. *Developing Integrated Clinical Pathways for the Management of Clinically Severe Adult Obesity: a Critique of NHS England Policy*. 2020. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7695647/>
- <sup>16</sup>Mahase E. *Specialist weight-loss services in England unable to keep up with spiralling demand*. 2024. <https://bmjgroup.com/specialist-weight-loss-services-in-england-unable-to-keep-up-with-spiralling-demand/>
- <sup>17</sup>British Dietetic Association and Royal College of Physicians workforce reports on dietetic, psychology and obesity medicine capacity. <https://www.bda.uk.com/>; <https://www.rcp.ac.uk/>
- <sup>18</sup>Future Health Research. *Building new health system action to reduce obesity: Audit findings of Integrated Care Board Forward Plans*. 2024. <https://futurehealth-research.com/report/building-new-health-system-action-to-reduce-obesity-audit-findings-of-integrated-care-board-forward-plans/>
- <sup>19</sup>Elhariry M et al. *Variation in the commissioning of specialist weight management services and bariatric surgery across England: results of a freedom of information-based mapping exercise across the 42 integrated care systems of England*. 2025. <https://pmc.ncbi.nlm.nih.gov/articles/PMC12096057/>
- <sup>20</sup>Finer N et al. *Commissioning of Tier 3 Obesity Services by Integrated Care Boards in England: An Analysis of Responses to Freedom of Information Requests*. 2025. <https://pubmed.ncbi.nlm.nih.gov/40810393/>
- <sup>21</sup>Coulman KD et al. *Access to publicly funded weight management services in England using routine data from primary and secondary care (2007–2020): An observational cohort study*. 2023. <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004282>
- <sup>22</sup>It is important to note that primary care data recording those living with overweight and obesity is very poor and patchy
- <sup>23</sup>National Institute for Health and Care Excellence. *Tirzepatide for managing overweight and obesity (TA1026)*. December 2024. <https://www.nice.org.uk/guidance/ta1026>
- <sup>24</sup>Dobbie et al. *Tirzepatide and the NHS: are we creating a two-tier obesity treatment system?* 2025. <https://bjgp.org/content/75/760/494>
- <sup>25</sup>National Institute for Health and Care Excellence. *Tirzepatide for managing overweight and obesity (TA1026)*. December 2024. <https://www.nice.org.uk/guidance/ta1026>;
- <sup>26</sup>Dobbie et al. *Tirzepatide and the NHS: are we creating a two-tier obesity treatment system?* 2025. <https://bjgp.org/content/75/760/494>
- <sup>27</sup>Dobbie et al. *Tirzepatide and the NHS: are we creating a two-tier obesity treatment system?* 2025. <https://bjgp.org/content/75/760/494>
- <sup>28</sup>Johnson H, Auerbach N, Clift AK, Huang DR. *Healthcare professionals' understanding, confidence and use of glucagon-like peptide-1 receptor agonists for obesity: a mixed-methods study*. 2025. UK Congress on Obesity
- <sup>29</sup>Johnson H, Auerbach N, Clift AK, Huang DR. *Healthcare professionals' understanding, confidence and use of glucagon-like peptide-1 receptor agonists for obesity: a mixed-methods study*. 2025. UK Congress on Obesity
- <sup>30</sup>Sanders GJ, Sirin Ayva AB, Gately P, Edwards S, et al. *Eligibility in Principle, Access in Practice: A Mixed-Methods Study of Clinical Prioritisation in Specialist Weight Management Services*. European Congress on Obesity. 2026

- <sup>31</sup>Sanders GJ, Sirin-Ayva AB, Gately P, Edwards S. *Expectation, Prioritisation and Access: A Qualitative Study of Patient Experiences within a Specialist Weight Management Programme during the Phased Implementation of GLP-1 Pharmacotherapy*. Morelife UK service evaluation. 2025.
- <sup>32</sup>Jastreboff AM, et al. *Tirzepatide Once Weekly for the Treatment of Obesity (SURMOUNT-1)*. 2022. <https://www.nejm.org/doi/full/10.1056/NEJMoa2206038>
- <sup>33</sup>National Institute for Health and Care Excellence. *Semaglutide for managing overweight and obesity (TA875)*. March 2023. <https://www.nice.org.uk/guidance/ta875>; National Institute for Health and Care Excellence. *Tirzepatide for managing overweight and obesity (TA1026)*. December 2024. <https://www.nice.org.uk/guidance/ta1026>
- <sup>34</sup>Johnson H, et al. *Impact of Digital Engagement on Weight Loss Outcomes in Obesity Management Among Individuals Using GLP-1 and Dual GLP-1/GIP Receptor Agonist Therapy: Retrospective Cohort Service Evaluation Study*. 2025. <https://www.jmir.org/2025/1/e69466>
- <sup>35</sup>Johnson H, Clift AK, Reisel D, Huang DR. *Digital Engagement Enhances Weight Loss Outcomes With Tirzepatide: Cohort Study Of 66,846 Adults*. Poster 446, ObesityWeek 2025 (The Obesity Society Annual Meeting), Atlanta, November 2025. (Conference abstract; data subsumed by larger 126,553 cohort in Johnson et al, JMIR, 2025)
- <sup>36</sup>Johnson H, Clift AK, Reisel D, Huang DR. *Digital Engagement Enhances Weight Loss Outcomes With Tirzepatide: Cohort Study Of 66,846 Adults*. Poster 446, ObesityWeek 2025 (The Obesity Society Annual Meeting), Atlanta, November 2025. (Conference abstract; data subsumed by larger 126,553 cohort in Johnson et al, JMIR, 2025)
- <sup>37</sup>Li S, Zhou Y, Tang Y, et al. *Behavior Change Resources Used in Mobile App-Based Interventions Addressing Weight, Behavioral, and Metabolic Outcomes in Adults With Overweight and Obesity: Systematic Review and Meta-Analysis of Randomized Controlled Trials*. 2025. <https://mhealth.jmir.org/2025/1/e63313>
- <sup>38</sup>Department of Health and Social Care. *Fit for the Future: 10 Year Health Plan for England*. 2025. <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future>
- <sup>39</sup>This includes new GP incentives up to £25m for BMI recording and “appropriate” weight-loss prescribing. NHS England. *2026/27 GP Contract*. 2026. <https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2026-27/>; NHS England. *Pharmacy First: NHS community pharmacy service*. 2024. <https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/pharmacy-first/>. NHS Business Services Authority. *NHS Community Pharmacy Independent Prescribing Pathfinder Programme*. <https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/dispensing-contractors-information/nhs-community-pharmacy-independent-prescribing-pathfinder-programme>; NHS England. *NHS Healthier You Programme 2026: Service Specification*: <https://www.find-tender.service.gov.uk/Notice/033470-2026>
- <sup>40</sup>Sirin Ayva AB et al. *Service Evaluation of a Community Weight Management Service in England (n=10,512)*. Morelife UK. (Project paper shared with Future Health Research)
- <sup>41</sup>Morelife study data on file shared with Future Health Research
- <sup>42</sup>Coulman KD et al. *Access to publicly funded weight management services in England using routine data from primary and secondary care (2007–2020): An observational cohort study*. 2023. <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004282>

<sup>43</sup>Sirin-Ayva AB et al. *Engaging with local communities – Morelife's Local Activator Model (Project paper shared with Future Health Research)*

<sup>44</sup>*Client Insights from Bengali-Speaking Weight Management Group*. Sirin-Ayva AB, Buckley M, Roast J, Edwards S, Gately P. Morelife UK (project document); summary also at <https://www.morelife.co.uk/research-and-studies/client-insights-bengali-speaking/>

<sup>45</sup>NCL ICB General Practice Website. *Weight Management Support for Adults: Morelife*. <https://gps.northcentrallondon.icb.nhs.uk/services/weight-management-support-for-adults-Morelife>

<sup>46</sup>Dr AB Sirin-Ayva, Dr Sophie Edwards, Victoria Simpson, Prof Paul Gately. Outcomes of 'My Life Plan' An Inclusive Digital Weight Loss Programme by Morelife (Project paper shared with Future Health Research)

<sup>47</sup>Bollyfit Active. *Home*. <https://www.bollyfitactive.co.uk/>

<sup>48</sup>Public Health England / Office for Health Improvement and Disparities. *Obesity and weight management for people with learning disabilities: guidance*. 2020. <https://www.gov.uk/government/publications/obesity-weight-management-and-people-with-learning-disabilities/obesity-and-weight-management-for-people-with-learning-disabilities-guidance>

<sup>49</sup>Sirin Ayva AB et al. *What we learned from a specific healthy lifestyle pilot for individuals living with learning disabilities (n=19)*. Association for the Study of Obesity (ASO) poster

<sup>50</sup>Voy data on file shared with Future Health Research

<sup>51</sup>Voy data on file shared with Future Health Research

<sup>52</sup>Voy data on file shared with Future Health Research

<sup>53</sup>Johnson et al. Presentation to European Congress on Obesity. May 2026

<sup>54</sup>Voy data on file shared with Future Health Research

<sup>55</sup>Voy data on file shared with Future Health Research

<sup>56</sup>Johnson H, Clift AK, Reisel D, Huang D. *Digital engagement significantly enhances weight loss outcomes in adults with obesity treated with tirzepatide: a retrospective cohort study of a digital weight loss service (n=126,553)*. JMIR, 2026. <https://www.jmir.org/2026/1/e83718>

<sup>57</sup>Voy data on file shared with Future Health Research

<sup>58</sup>Voy data on file shared with Future Health Research

<sup>59</sup>Voy data on file shared with Future Health Research

<sup>60</sup>National Institute for Health and Care Excellence. *Tirzepatide for managing overweight and obesity (TA1026)*. December 2024 (last updated 1 September 2025). <https://www.nice.org.uk/guidance/ta1026>; NHS England. *Interim Commissioning Guidance: Implementation of the NICE Technology Appraisal TA1026 and the NICE Funding Variation for Tirzepatide (Mounjaro®) for the Management of Obesity*. 27 March 2025. Publication reference PRN01879. <https://www.england.nhs.uk/publication/interim-commissioning-guidance-implementation-of-the-nice-technology-appraisal-ta1026-and-the-nice-funding-variation-for-tirzepatide-mounjaro-for-the-management-of-obesity/>; NHS England. NHS Healthier You Programme 2026

<sup>61</sup>Coulman KD et al. *Access to publicly funded weight management services in England using routine data from primary and secondary care (2007–2020): An observational cohort study*. PLOS Medicine, 2023. <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004282>

<sup>62</sup>The Health Foundation. *GLP-1 drug prescriptions for obesity*. 2026. <https://www.health.org.uk/reports-and-analysis/analysis/glp-1-drug-prescriptions-for-obesity>

<sup>63</sup>Johnson H, Auerbach N, Clift AK, Huang DR. *Healthcare professionals' understanding, confidence and use of glucagon-like peptide-1 receptor agonists for obesity: a mixed-methods study*. 2025. UK Congress on Obesity.

<sup>64</sup>Sanders GJ, Sirin Ayva AB, Gately P, Edwards S, et al. *Eligibility in Principle, Access in Practice: A Mixed-Methods Study of Clinical Prioritisation in Specialist Weight Management Services*. European Congress on Obesity. 2026

<sup>65</sup>NHS England. *Interim Commissioning Guidance (already cited as footnote 2 in opening paragraph); NHS Digital. Prescribing activity of Tirzepatide (Mounjaro®) in primary care settings for the purpose of weight management as per the NICE funding variation*. <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/tirzepatide-in-primary-care-data-collection/prescribing-activity-of-tirzepatide-mounjaro-in-primary-care-settings>; NHS England. *NHS Healthier You Programme 2026: Service Specification*: <https://www.find-tender.service.gov.uk/Notice/033470-2026>

<sup>66</sup>The Health Foundation. *GLP-1 drug prescriptions for obesity: Inequalities in access to private weight loss medications*. 2026. <https://www.health.org.uk/reports-and-analysis/analysis/glp-1-drug-prescriptions-for-obesity>

<sup>67</sup>National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022), sections 13G and 14Z35 (health inequalities duties on NHS England and Integrated Care Boards). <https://www.legislation.gov.uk/ukpga/2006/41/section/13G>; <https://www.legislation.gov.uk/ukpga/2006/41/section/14Z35>

<sup>68</sup>NHS England. *Quality and Outcomes Framework guidance for 2026/27*. 2026. <https://www.england.nhs.uk/wp-content/uploads/2026/03/PRN02356-quality-and-outcomes-framework-guidance-26-27.pdf>

<sup>69</sup>NHS England. *Pharmacy First: NHS community pharmacy service*. January 2024. <https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/pharmacy-first/>; NHS England. *Community Pharmacy Independent Prescribing Service Pathfinder Programme*. <https://www.england.nhs.uk/long-read/independent-prescribing-community-pharmacy-pathfinder-programme-transition-future-direction>; NHS England. *NHS Talking Therapies for anxiety and depression*. <https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/>

<sup>70</sup>NHS England. *Community pharmacy advanced service specification: NHS Pharmacy First Service*. 2025. <https://www.england.nhs.uk/publication/community-pharmacy-advanced-service-specification-nhs-pharmacy-first-service/>

<sup>71</sup>National Institute for Health and Care Excellence. *Tirzepatide for managing overweight and obesity (TA1026)*. December 2024. <https://www.nice.org.uk/guidance/ta1026>

<sup>72</sup>NHS England. *NHS Healthier You Programme 2026: Service Specification*: <https://www.find-tender.service.gov.uk/Notice/033470-2026>

<sup>73</sup>Aronne LJ, Sattar N, Horn DB, et al. *Continued Treatment With Tirzepatide for Maintenance of Weight Reduction in Adults With Obesity: The SURMOUNT-4 Randomized Clinical Trial*. 2024. <https://jamanetwork.com/journals/jama/fullarticle/2812936>

<sup>74</sup>NHS Digital. *Health Survey for England, 2024 — Adult overweight and obesity*. 2024. <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2024>

<sup>75</sup>The Health Foundation. *GLP-1 drug prescriptions for obesity*. 2026. <https://www.health.org.uk/reports-and-analysis/analysis/analysis/glp-1-drug-prescriptions-for-obesity>

<sup>76</sup>Jastreboff AM, Aronne LJ, Ahmad NN, et al. *Tirzepatide Once Weekly for the Treatment of Obesity (SURMOUNT-1)*. 2022. <https://www.nejm.org/doi/full/10.1056/NEJMoa2206038>

<sup>77</sup>Johnson H, Clift AK, Reisel D, Huang D. *Digital engagement significantly enhances weight loss outcomes in adults with obesity treated with tirzepatide: a retrospective cohort study of a digital weight loss service*. 2026. <https://www.jmir.org/2026/1/e83718>

<sup>78</sup>National Institute for Health and Care Excellence. *Tirzepatide for managing overweight and obesity (TA1026)*, December 2024. <https://www.nice.org.uk/guidance/ta1026>

<sup>79</sup>Department of Health and Social Care. *Fit for the Future: 10 Year Health Plan for England*. 2025. <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future>

<sup>80</sup>Morelife UK. *Supporting Inclusion Health*. <https://www.more-life.co.uk/supporting-inclusion-health/> ; Morelife UK. *Places We Work – Greater Manchester – "We have been delivering weight management and healthy lifestyle interventions for over 25 years."* <https://www.more-life.co.uk/places-we-work/greater-manchester/>

<sup>81</sup>Johnson H, et al. *Impact of Digital Engagement on Weight Loss Outcomes in Obesity Management Among Individuals Using GLP-1 and Dual GLP-1/GIP Receptor Agonist Therapy: Retrospective Cohort Service Evaluation Study*. 2025. <https://www.jmir.org/2025/1/e69466>

<sup>82</sup>Department of Health and Social Care. *Fit for the Future: 10 Year Health Plan for England*. 2025. <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future>