

October 2024



What does good look like? How to meet the needs of patients living with obesity

Prepared by

Newmarket Strategy

Reset Health

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Foreword

In common with every health system in the world, the NHS is determined to get serious about primary and secondary prevention. Tackling long term conditions is going to be vital not only to improve the health and wellbeing of the population but also to safeguard the NHS itself. We know that in too many cases, care of patients with chronic diseases is inadequate – a situation that is only going to worsen in years to come should demand continue to increase.

In no disease is this truer than with obesity. We know that obesity causes and exacerbates hundreds of serious comorbidities including heart disease, diabetes, renal failure and cancer. We also know that the proportion of the population that are living with obesity is rising. But despite this, there is real cause for optimism.

We now have treatments that we know can be highly effective, service models that we know can provide the care and support patients need, and the knowledge and data to evidence impact. With time, effort and investment we can make a real impact, not just on the levels of obesity but also on the wider burden of disease. Most importantly, we can positively impact the lives of millions of patients, their families and loved ones across the country.

It was in this context that we, supported by Reset Health, brought together a diverse group of stakeholders including patient representatives, leading clinicians, academics, providers, commissioners and pharmaceutical companies to think about how to meet the different needs of patients with obesity. I had the privilege to chair this series of roundtables as we worked through a range of different topics, including how to make services more equitable, how weight management services should be redesigned and the role that new pharmacotherapies can have. Rather than simply write-up our discussions to gather dust on a shelf, we have turned these into 'calls to action' – practical next steps that could be taken at all levels – from the clinic to the cabinet table at 10 Downing St.

I hope you find these thought-provoking, and would encourage you to continue on the journey with us.

David Reith

Senior Director, Newmarket Strategy

A handwritten signature in black ink that reads "David Reith." The signature is written in a cursive, flowing style.

Background

14 million (25.9%) adult Britons live with obesity – a figure that is forecast to rise to 20 million (37%) by 2030.¹

It is estimated that treatments for obesity-related comorbidities cost the NHS £6.5 billion per year – but the wider societal costs of this are thought to be nearer £98 billion per annum.² Professor Sir Stephen Powis, Medical Director of NHS England, has noted that without urgent action to tackle the issue there are likely to be ‘devastating consequences for the nation’s health’.³



To help patients living with obesity, the NHS created the tiered weight management service model. At the lower end of this, in Tiers 1 and 2, overweight patients can receive advice and access to community programmes. Tier 3 services are clinical services typically for individuals with obesity living with one or more comorbidity – this service may offer multidisciplinary (MDT) wraparound care, sometimes with the aid of pharmacotherapies, but this is not standardised across the country. For patients with severe

1 https://www.worldobesityday.org/assets/downloads/World_Obesity_Atlas_2022_WEB.pdf

2 <https://www.frontier-economics.com/uk/en/news-and-insights/news/news-article-i20358-the-rising-cost-of-obesity-in-the-uk/>

3 <https://www.gov.uk/government/news/new-drugs-pilot-to-tackle-obesity-and-cut-nhs-waiting-lists>

or complex obesity, bariatric surgery is provided in Tier 4. This model is intended to provide a stratified management service for all eligible patients.

Despite this, the NHS has a mixed record in the roll-out and delivery of weight management services. A recent FOI request sent to all ICBs showed that 12 (c.30%) have yet to commission a Tier 3 weight management service. Even where services are in place, they often lack the capacity to manage the volume of patient referrals – with half the Tier 3 services having average waits over 6 months and 1 in 6 having waits in excess of a year. At the top end, one Trust has an average wait of 3 years. Millions of patients are consequently left without any support and – even in cases where it would be highly beneficial to the patient – no access to clinical care involving weight management medications such as GLP-1s and necessary wraparound support.

The need for creative thinking

Given the scale of the problem, bold thinking is required in order to find effective strategies to meet the health needs of the population.

Therefore, we brought together a broad range of stakeholders – including clinicians, academics, commissioners, providers, pharmaceutical companies and patient groups – to explore what the future of weight management services could look like, and how we can collectively make the case for sustainable investment and reform. Part of this was looking at how clinicians across primary, community and secondary care can work together differently, and how digital and pharmacotherapy solutions can be used to improve access and outcomes. We ran a series of roundtables to explore a range of topics, which included:

- **How to meet the different needs of patients with obesity**
- **Supporting primary care in prescribing weight management medications**
- **Demonstrating the cost-effectiveness of obesity treatments**

Due to the wide range of stakeholders present, the roundtables allowed for a free-flowing discussion. Rather than look to push any agenda, product or service, they adopted a neutral and 'humble enquiry' approach. This ensured that all participants connected as equals, were open and honest, and allowed the group to explore practical steps. The sessions were chaired by David Reith, Director at a health and life sciences consultancy, Newmarket Strategy, who was formerly an NHS ICB Director of Commissioning Strategy.

In this document we have outlined the key themes which emerged through the roundtable series, as well as five calls to action which look to actively engage stakeholders across the system – including policymakers, clinicians, patients, industry and research bodies.

Key themes

Addressing stigma is the foundation for reform

Patients and clinical obesity specialists told us clearly that patient access and support is currently hampered by high levels of stigma, both within the medical profession and wider society. This leads to obesity not being seen as a chronic disease, but a behavioral concern, wherein the onus is on the patient to make lifestyle changes on their own. Evidence shows that stigma is harmful to patients and worsens outcomes. It makes patients less likely to seek healthcare and reduces their confidence to make changes. Stigma makes doctors less willing to prescribe clinical support, and means policymakers are less willing to see obesity as a serious condition, amenable to medical treatments. As well as this, weight-related stigma is more likely to be experienced by people from ethnic minorities and deprived communities. Together, these factors strip patients of the clinical, lifestyle and emotional support that would help them address excess weight and live a healthier life. It also diminishes the long-term risk of comorbidities, potentially leading to bigger strains on NHS services in the future and worse patient outcomes.

Consequently, attendees agreed it is vital there is a focus on destigmatising obesity within the medical community, through education and training, so patients can be signposted and access the right services in a timely and appropriate manner.

Primary care clinicians, in particular, would require targeted, robust education in order to destigmatise obesity and ensure that patient care is appropriate. This is because patients are likely to present in primary care first, and weight management services are expected to be increasingly integrated into these settings. Destigmatising obesity is also important for getting buy-in from the wider health system on necessary clinical reforms – such as those to clinical pathways and referrals.

Identifying and tackling stigma may also be necessary to ensure that policymakers and commissioners see obesity as an urgent medical issue requiring bold action. In this way, we will support faster reform and sustainable investment in weight management services.

“Nobody gets stigmatised having sleep apnoea, high cholesterol, hypertension or osteoporosis, all of which are comorbidities of obesity. We’re happy to spend billions on treating all these diseases, yet we’re not investing in treating the thing that is actually causing a lot of them - and which patients get stigmatised for.”

Specialist Weight Management Clinical Lead, Community Trust

Overcoming inequitable access to services

“The fact that we treat obesity in secondary care, for those in Tier 3 services, means we’re treating something in the most expensive part of our healthcare system that could be treated in the community. That makes it harder for commissioners to fund these services universally, increasing inequalities for eligible patients.”

Specialist Weight Management Clinical Lead, Community Trust

Some attendees expressed how we currently have “a complete postcode lottery” when it comes to services. Even where services do exist, 1-year waits are relatively common and the number of patients able to be onboarded is comparatively tiny to the number of eligible patients, at many providers.

A large part of this is due to the fact that commissioners are struggling to find the funding for Tier 3 weight management services in secondary care, with little flexibility to adjust commissioning practices year-on-year, even where large service gaps have been identified.

This issue also extends to funding new medicines. Whilst there is recognition that investment in these treatments could pay dividends in the long term, current financial pressures on ICBs mean that many are restricting access completely or prioritising only those of greatest need.

Tier 4 services are similarly restricted financially, but are also hard to scale up due to limited numbers of bariatric specialists and the additional support required pre- and post-surgery. A study by leading practitioners published this year concluded, “the expansion of BaS capacity in England beyond a small proportion of the eligible population will likely be challenging given the significant upfront economic investment and additional requirement of personnel and infrastructure.”⁴

For a medical condition that places such huge pressure on patients and society, having pockets of the country with no or limited access to services is a fundamental issue. The detrimental impacts of this are exacerbated by the fact that obesity rates are higher in population groups that have lower socioeconomic status, levels of education and employment.

Inequitable access widens health inequalities as patients who can afford to pay for these medications privately do so, whilst those in lower socio-economic groups are unable to.

4. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11293411/>

Despite pressures, opportunity abounds:

Whilst the current situation is bleak, we found there is real reason for optimism. There are now more options available for treatment than ever before, with more coming down the track as pharmaceutical companies vie to be market leader and providers increasingly offer digital health solutions. Some of the new pharmacotherapies are showing excellent patient outcomes – in relation to weight, diabetes and cardiovascular health – which will almost certainly improve their attractiveness to NHS commissioners.

These developments in the weight management space have meant the level of interest from the public, media and politicians is higher than ever. Not all attention has been positive though, with stories of black-market weight loss drugs being bought by the public, inappropriate use by those without serious weight issues and high prescription costs for the system. Nonetheless, the interest garnered means there is a huge opportunity for change and to mould the narrative to drive investment and reform.



Weight management services, including pharmacotherapies and wraparound support, need to be carefully integrated into primary care:

We explored the potential of primary care playing a greater role in managing obesity. Broadly this was welcomed as a way of improving timely access to care for more patients and meaning that expensive hospital-based services could be reserved for those complex cases that actually require them.

However, significant concerns were raised around primary care's capacity. Primary care is dealing with its own workload and workforce issues, and an additional service may add to mounting pressures, resulting in no actual benefit for patients with obesity.

It was also noted, whilst obesity would not be clinically "tricky" for primary care clinicians to manage, they may not know enough about the pharmacotherapies that are being developed to prescribe them, or have capacity to offer the wraparound support that is required.

“Obesity management should start in primary care settings as it’s prevalent and clinically manageable. We just need to ensure those clinicians have the necessary capacity and support to take on the additional workload.”

Professor and Consultant of Clinical Endocrinology

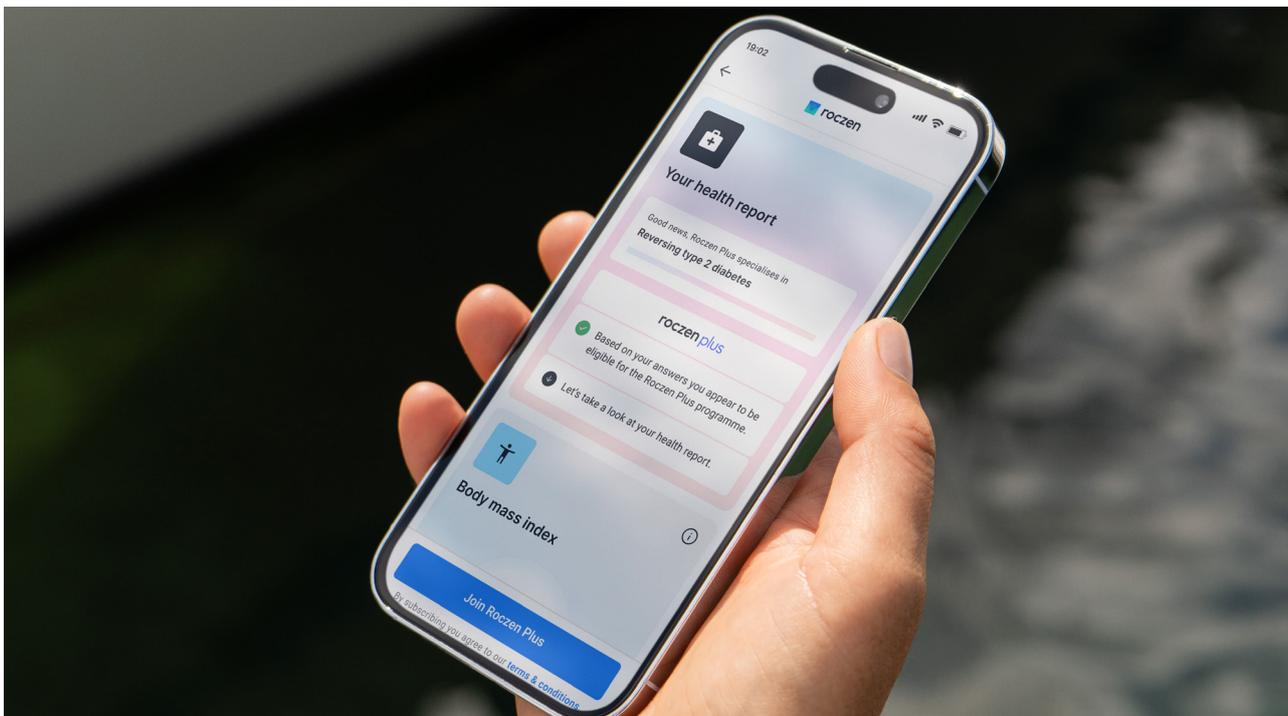


Despite these challenges, integrating weight management into primary care was deemed feasible with careful planning. Key considerations included providing clear guidelines, comprehensive training and education, and decision-support tools for triage, specialist referrals, and treatment pathways. The goal being to equip primary care clinicians with the knowledge and confidence to offer holistic weight management services, including prescribing new weight loss medications alongside wraparound support. Training and education, importantly, should be under constant review, ensuring that clinicians are kept informed and up to date on new treatments and guidelines.

One suggestion was to leverage an MDT approach – engaging community pharmacists, digital services, and secondary care clinicians where necessary, to ease the capacity pressures on primary care and provide essential wraparound support. New models of integration in this space could learn from successful models in other chronic disease areas, such as diabetes, in which primary care provides highly effective services.

“We need to make the point that piloting these drugs is so, so important for primary care. We need to be looking at the effect on primary practice, the training and education that may be required, and the full impact of using different models of care in that setting.”

GP & Tier 3 Weight Management Programme Lead



Digital health offers effective solutions for delivering services, particularly wraparound support:

“When we’re talking of wraparound services, there are hugely positive implications of digital health technologies. We can integrate and scale those monitoring services, even when they’re based out-of-area, and that would really relieve pressures on any future prescribing service.”

Consultant in Clinical Endocrinology

The role of digital health technologies in obesity management was discussed as a potential way to provide necessary lifestyle interventions and psychological support. Digital health services can theoretically be scaled across any population size, not being limited to acute hospital sites, massively widening access for patients with obesity. They reduce the need for travel and time off work – important factors for those in lower socioeconomic groups who may be less likely to get time off work or have the funds for transport.

Digital health services can also reduce pressures on existing Tier 3 services and their waiting lists, taking on referrals where appropriate, and enabling secondary care to focus on more complex cases as needed.

It was agreed that as uptake of GLP-1s increases there is a place for digital health in providing effective wraparound support to patients in Tier 3 services where required – driving cost-savings and efficiencies for the system and improved accessibility for patients.

We need to build a robust evidence base to make the case for long-term investment:

We need to make the case for long-term investment. A history of short-termism in funding decisions has led to limited benefit. We identified the need for robust data demonstrating the cost-effectiveness of obesity treatments, including their impact on obesity-related comorbidities, quality of life and wider societal benefits – such as workforce productivity and spend on social welfare.

A key focus has been on how we can, collectively, make that case and secure investment in weight management services, essentially arguing the case to the Government – including the Department for Health and Social Care (DHSC), the Treasury (HMT) and the Office for Budget Responsibility (OBR). Whilst many of the themes and points outlined in the roundtable series are well-known to specialist weight management clinicians and others, HMT and the OBR would need a solid economic case in order to put sustainable investment into obesity treatments going forward. Currently, data on this is lacking or fragmented, and uptake of GLP-1s has been slow meaning the opportunities to gather data are limited.

It was agreed that data could be gathered through both local pilot trials and large independent studies. Examining the real-world impacts of GLP-1s and digital health solutions, with a specific focus on how they impact the wider economy, actively save the system money and reduce the burden of comorbidities.



Calls to action

01

Redesign clinical pathways to be fit for purpose

Rationale for action:

There are many existing issues in NHS weight management services. We found these typically manifest through the tiered weight management service model. It is clear that eligible patients are missing out on effective, accessible, personalised care due to massive resource constraints and the fact that the tiered model may not currently be fit for purpose. Work is needed to determine how best to improve the service model, and a pathway redesign should then be configured off the back of this.

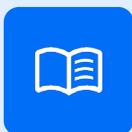
What this should look like:

NHSE, ICBs, clinicians, patients and other stakeholders, need to design new models that reflect the need for universal, timely, holistic weight management services.

The service redesigns should be clinically led and should factor in the following considerations to ensure they properly meets the needs of patients with obesity:



Where primary and community service integration should occur, with a focus on flexibility and reducing preventable costs in secondary care, allowing consultants to focus resources on the most complex cases



Clear guidelines supporting clinicians in the use and review of new pharmacotherapies, wraparound support, and MDT input implemented



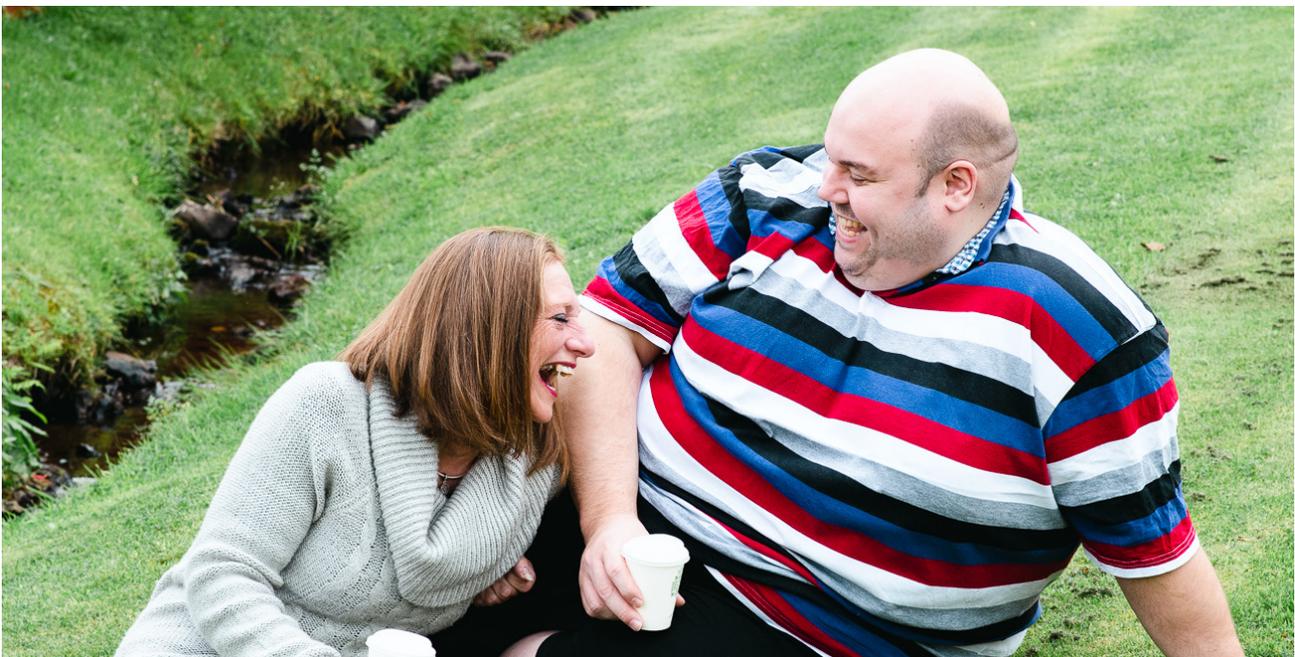
Guidance on where and when digital models of care should be implemented



Decision-tools to ensure movement between levels of care is seamless



Any new model needs to have efficiency and coherence at its core, enabling all systems to sustainably commission and support an accessible weight management service



This service redesign needs to be built into weight management guidelines and inform changes to workforce education on obesity and weight management services. The pathway redesigns should acknowledge where resource constraints exist in primary, community and secondary care, and also stipulate the need for frequent review, making sure they remain informed by emerging data.

There should be efforts to destigmatise obesity within any new models, so care can be delivered as effectively as possible to all eligible patients. This could include integrating measures to avoid stigmatising obesity into triaging and referral guidelines.

Who would need to take action:

This should be centrally led by NHSE, in collaboration with clinicians across primary, community and secondary care, and in consultation with patient groups.

02

Collaborations to build a robust evidence base for investment

Rationale for action:

The group agreed that the Government’s delayed £40 million pilot programme to trial GLP-1s alongside digital wraparound support needs to be carried out in order to test the real-world impact of GLP-1s on patients. This is vital so that we can make the case for investment in routine use of these clinically effective drugs and wraparound support. This evidence is hugely important as without it the Government and HMT are highly unlikely to commit funds to any new treatments or necessary service reforms. Evidence from these pilots can also further inform clinicians of the impacts of weight management services and support the design of a larger study into wider societal benefits.

What this should look like:

The pilots should be set up in collaboration with NHS Trusts and digital weight management providers with the primary purposes of trialling a GLP-1 service with wraparound support and collecting relevant real-world data. Data the pilot should attempt to collect includes:

-  A holistic overview of clinical outcomes
-  The effectiveness of digital health models at relieving secondary care pressures
-  Cost-effectiveness compared to other weight management services
-  The effectiveness of digital health models for wraparound support
-  The impacts on use of prescription medicines for comorbidities

A large independent study can be designed off the back of these pilots with the aim of collecting data on the wider societal benefits – e.g. looking into workforce productivity, welfare spend and the economy. This, together with the pilots, would provide a comprehensive and robust overview of the system-wide impacts of managing obesity effectively.

Results from both the pilots and the independent study can support existing data to inform policy and clinical guidelines, and ultimately drive the case for investment in weight management treatments.

Who would need to take action:

The pilots should be led by NHS Integrated Care Boards, across primary and secondary care, in collaboration with digital weight management providers, using the committed £40 million funding from the Government. The large independent study could be led by the NIHR in collaboration with NHSE, and sponsored by think tanks or industry with an interest in this space. These pilots have so far been put on hold, so they will need to be championed to the Government by stakeholders to ensure they go ahead.



03

Establish a clinical weight management data repository

Rationale for action:

Strengthening data collection processes so they are efficient, standardised and have better linkages would help to better inform service transformation. We heard that clinicians would like to improve their services, better understand the landscape, stay informed of new treatments or make the case for reform, but struggle to do so due to a limited evidence base.

There are existing data repositories for obesity and bariatric services. However, data submissions to these are not standardised so it can be hard to elicit value from the data. Clinicians are also required to make manual submissions which is highly onerous, leading to inevitable data gaps. Additionally, data sets lack proper linkage and interoperability across the system, therefore not reaching their full potential in informing service transformation. Existing data from local pilots into weight management services, the use of GLP-1s and digital health models, which can be used to support the reform agenda, also appears to be fragmented. Reforming data collection processes would ensure data repositories can better inform and support both clinicians and policymakers.

What this should look like:

Fortunately, through existing data repositories, such as the National Obesity Audit (NAO) and the National Bariatric Surgery Registry (NBSR), there are strong foundations we can build on. It is also important that data collections are not duplicated, to avoid waste, confusion and further fragmentation. A strengthening of data collection processes and management should consider:



How data collections can be automated, to release pressures on clinicians' time and ensure comprehensiveness



Where the data should be held and by who, so data collection processes and management are frequently monitored and sustainable



Which data metrics should be routinely aggregated, to add optimal value to service analysis and review



How existent and future data from pilots and trials can be integrated with NHS patient data, to facilitate better analysis of treatments and service pathways



How better linkages can be implemented between different clinical settings and existing data repositories, so data sets are holistic

All weight management services should be made aware of any changes to data collection processes and management, and encouraged to ensure their data is being submitted where appropriate.

Who would need to take action:

DHSC and NHSE should take the lead on this, in collaboration with the owners of existing data repositories (e.g. the NAO and NBSR), the Health Innovation Network (utilising their expertise and reach), NHS weight management service providers and clinicians.

04

Prioritise obesity in the 10-Year Health Plan

Rationale for action:

The group was encouraged by development of a new 10-Year Health Plan but strongly urged that it have a section on obesity given the urgency and detrimental impact on the nation's health and economy if not addressed. A clearly defined section on obesity would help ensure long-term investment in obesity care and ensure weight management services are sustainable, rather than affected by regular fluxes in political appetite. The 2025 Spending Review is expected to fund the new plan and so this would place obesity in a promising position for long-term funding.

What this should look like:

The section on obesity in the 10-Year Health Plan should include long-term provisions for:



Building and publishing robust national clinical evidence bases



Making sure effective care pathways are implemented where evidenced



Providing sufficient ring-fenced ICB funding for clinical- and cost-effective obesity treatments



And ensuring education of the healthcare workforce is up to date and fit for purpose

These provisions in a long-term plan would help to ensure that obesity services are sustainably supported and “future-proof”, with guidance on regularly reviewing weight management services to ensure they are fit for purpose.

Who would need to take action:

Sally Warren and her team (who are leading development of the 10-Year Health plan), the Government and NHSE, in consultation with a wide range of relevant stakeholders across the system – clinicians, patient groups, providers, pharma, commissioners, and academics.

05

Form an obesity action group to champion and drive clinical solutions

Rationale for action:

It was discussed how an obesity action group needs to be established to effectively champion the case for change. There are existing groups and think tanks that work in this area, but they typically focus on public health and public policy, rather than the clinical space.

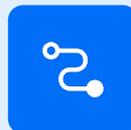
The calls for action in this document are all important, as is articulating solutions to the clinical issues being faced by NHS weight management services. However, without a purposeful, structured group to champion these solutions there is the risk they will go unheard of by policymakers. An action group focused on practical, clinical steps would ensure that positive change can be brought about and influence the way in which this happens. We have seen this happen in smoking cessation, with Action on Smoking and Health (ASH) taking a highly public, evidence-based approach to positively influencing policy – often using societal ROI tools to showcase benefit.

What this should look like:

The obesity action group should champion all other calls for action in this document, including:



Inclusion of obesity in the 10-Year Health Plan



A reform of service pathways to ensure they are fit for purpose



Long-term investment in obesity services to enable effective reform



The benefits of digital care models



The need for a more robust national evidence base on the clinical- and cost-effectiveness of pharmacotherapies with wraparound support



The need for improved and equitable patient access



The wider societal benefits of addressing obesity

A similar approach could be taken to this as ASH, using ROI tools to make cases for change and engaging frequently with policymakers, researchers and the public. It is important that this obesity action group is similarly transparent and collaborative.

Who would need to take action:

The group of individuals who attended the roundtable series - influential clinicians and academics in this space, alongside patient and industry representatives - could take the lead on forming an action group. It is vital that this group be led by a multidisciplinary collective with expertise across the various aspects of healthcare and obesity management.



Contact



David Reith
Senior Director

david.reith@newmarket-strategy.com
www.newmarket-strategy.com



Dr. Laura Falvey
Executive Clinical Director

laurafalvey@resethealth.clinic
www.resethealth.clinic