The GLP-1 Population Health Project

Evaluating the role of local government in provision of GLP-1 agonists in England

August 2026

Dr Olly Scargill

With a foreword by Steve Brine

Acknowledgements

The author is grateful to the research participants, including the three interviewees, for the valuable insights about their local populations. Particular thanks go to Steve Brine for his considered foreword.

About the Author

Dr Olly Scargill is a GP registrar working in Royal Free London NHS Foundation Trust. He was previously a Foundation Doctor in the Northumbria Healthcare NHS Foundation Trust, having studied at Newcastle University. In addition to medical practice, Olly is experienced in health policy and scrutiny, including in local government.

Foreword

Steve Brine was Member of Parliament for Winchester from 2010 to 2024. He served as Public Health Minister under Theresa May, and subsequently as Chair of the Health and Social Care Select Committee. He is now the co-host, with Lord Bethell, of the Prevention is the New Cure podcast.

Obesity has been rising in England for thirty years. GLP-1 agonists could be a valuable tool for tackling this challenge - but a tool is only as good as the system built around it.

As Public Health Minister in 2018, I launched the Trailblazer programme - inviting local authorities to design their own solutions to tackling childhood obesity, rather than dictating one from Whitehall. As I said at the time, local leaders are the real experts on their communities. That instinct hasn't changed, whether in chairing the Health and Social Care Select Committee since, or in conversations on my podcast now. If we are to forge successful, local preventative interventions, we must listen to those who know their communities and understand the multifactorial causes of a challenge as difficult as obesity. This couldn't be more in line with the stated direction of the new Prime Minister.

This report is a timely contribution to that conversation, arriving at a moment when the approach to obesity has been significantly altered by recent advances in medication. Collating the experiences of public health teams across local authorities in England, it offers a grounded account of how GLP-1 agonists are actually landing in communities up and down the country.

Its starting point is an important one: GLP-1s can be transformative for many individuals, but they are not, by themselves, a strategy for obesity. Without addressing the wider, structural drivers of the condition, and by expanding the use of GLP-1s blindly, we risk encountering further challenges down the line.

There has been significant movement in who can prescribe GLP-1s, in where the funding for this lies, and in the expansion of private provision. Reports such as this, as I did when chairing the Health Select Committee, build on the evidence of professionals who see the impact of these medications in their own communities, will help government adapt quickly as the situation continues to change.

The clinical case for these medicines is a question for clinicians, not for local government. But local government does have a role identifying where the system around the medicine still needs to catch up. As rollout continues, its findings should be tested against a wider base of evidence.

A whole-system obesity strategy will encompass medical, psychological and structural interventions. To place GLP-1s entirely outside of that system would be doing them a disservice. To place them within it effectively will require the input of people who know their local communities. This report provides a starting point for doing just that.

Steve Brine

1 Introduction

The licensing of GLP-1 agonists has fundamentally changed our approach to weight management. Access to these medications already varies, not just due to clinical eligibility, but due to geography and an individual's ability to access private treatment. Whilst GLP-1s represent a significant breakthrough in the medical management of obesity, we should consider the potential of inequitable availability to exacerbate existing health inequalities. Although prescribing sits within the NHS, tier 1 prevention and tier 2 weight management services (discussed later) fall within the remit of local authorities - making their perspective particularly important as access expands.

Obesity prevalence has doubled over the last thirty years in England, highlighting the growing scale of this challenge. According to figures published by the NHS in January 2026, 30% of people over 16 in England are living with obesity - with a further 36% being overweight.[1]

Obesity contributes substantially to morbidity, reduced quality of life and increasing demand on health and care services, making it one of the most significant public health challenges in England. As obesity becomes more prevalent, public policy will have to expand to meet this challenge.

This report presents recommendations to the Department of Health and Social Care (DHSC) examining the key public health challenges presented by the rollout of GLP-1s, based on the results of surveys and interviews conducted with local authority public health officials across England.

It does not seek to assess the clinical efficacy of GLP-1s. It considers the wider population health implications of their rollout and the views of local authority public health officials to how such implications should be addressed.

The aims of this report are:

- To identify the public health challenges associated with the provision of GLP-1s in England
- To represent the views and concerns of local authority public health officials across England about the provision of GLP-1s
- To identify opportunities to strengthen collaboration between local authorities and NHS organisations in the provision of GLP-1s.

These objectives were addressed using a mixed-methods questionnaire distributed to all local authorities with public health responsibilities in England. Survey respondents included registrars, consultants and directors of public health.

In addition, three in-depth interviews with public health directors in geographically diverse areas were drawn upon for a more comprehensive understanding of the challenges they had experienced in the rollout. The recommendations in this report derive from a thematic analysis of these responses. All responses have been anonymised - no direct quotes or identifying details are used.

1 NHS England (2026). "Health Survey for England, 2024". Available at: **https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2024/adults-overweight-and-obesity**

Tirzepatide (Mounjaro®)

Tirzepatide is currently the only GLP-1 agonist which can be prescribed from primary care, and accounts for 80% of GLP-1 use for weight loss alone.[2]

In December 2024, the National Institute for Health and Care Excellence (NICE) published guidance for the provision of Tirzepatide. Over a period of 3 years, NHS England will prioritise a cohort of 220,000 patients based on clinical need which will then form an evidence base for future provision.

The current NICE guidance for Tirzepatide states it can be prescribed for adults who have an initial BMI of at least 35 kg/m^2 (or lower for those of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic background) plus at least 1 weight-related comorbidity.[3]

The initial rollout limited Tirzepatide provision through primary care to those with a BMI of 40 kg/m^2 or more (adjusted for ethnicity as discussed) and 4 weight-related comorbidities. There is a planned expansion of the number of people eligible to access the drug over the coming months.

NICE identifies the following common weight-related comorbidities:

- Hypertension
- Dyslipidaemia
- Obstructive sleep apnoea
- Cardiovascular disease
- Prediabetes
- Type 2 diabetes mellitus

Prescription of Tirzepatide

Tirzepatide is administered as a weekly subcutaneous injection and can be prescribed in the NHS through primary care or in specialist overweight and obesity management services.

Since April 2026, prescribing of Tirzepatide has been included in the NHS GP contract. This has shifted funding responsibility away from specialist services to primary care. It is not mandatory for practices to participate and meeting eligibility criteria does not guarantee access to the treatment. This funding shift has reduced reliance on specialist services and positioned primary care as the default route for the treatment.

Specialist overweight and obesity management services, which can be based in the community or in secondary care, are still able to prescribe Tirzepatide and can also provide nutritional, psychological and surgical interventions.

As of January 2026, of the 1.5 million people who use GLP-1s in the UK, 95% of them are prescribed it privately. Whereas NHS provision of the drug includes behaviour support provided by a structured local or national programme, there is variety in the service a patient receives when accessing the medication privately.[4]

Together, these arrangements create a complex system in which prescribing, behavioural support and prevention are commissioned by different organisations. Understanding the role local authorities should adopt within this system is vital to ensure that GLP-1s deliver both sustainable and equitable results.

2 Jackson SE, Brown J, Llewellyn C, Mytton O, Shahab L (2026). "Prevalence of use and interest in using glucagon-like peptide-1 receptor agonists for weight loss: a population study in Great Britain". Available at: **https://pmc.ncbi.nlm.nih.gov/articles/PMC12781702**
3 National Institute for Health and Care Excellence (2026). "Overweight and obesity management". Available at: **https://www.nice.org.uk/guidance/ng246/chapter/Medicines-and-surgery**
4 University of Cambridge (2026). "Lack of support for people on weight loss drugs leaves them vulnerable to nutritional deficiencies, say experts". Available at: **https://www.cam.ac.uk/research/news/lack-of-support-for-people-on-weight-loss-drugs-leaves-them-vulnerable-to-nutritional-deficiencies**

2 Obesity as a local population health challenge

Key points for this section:

- There was a broad consensus that obesity is a major public health challenge across local authorities. Public health leaders rated its significance very highly, showing widespread recognition of the scale and urgency of the issue
- When asked about which groups suffer the worst obesity-related health inequalities, deprivation was by far the most significant determinant
- There is a clear gap between population need and the adequacy of current obesity services. Respondents described a wide variation across areas in terms of how well their obesity services were meeting local need - indicating that many services are under-resourced relative to the scale of the challenge.

Obesity as a local public health challenge

Survey responses show that obesity is widely regarded as a major public health challenge across England. When asked to rate the significance of obesity in their area, public health professionals gave an average score of 8.58/10.

Most responses clustered tightly between 8 and 10, indicating a consensus across local authorities regardless of local variation in demographics, geography and service pressures.

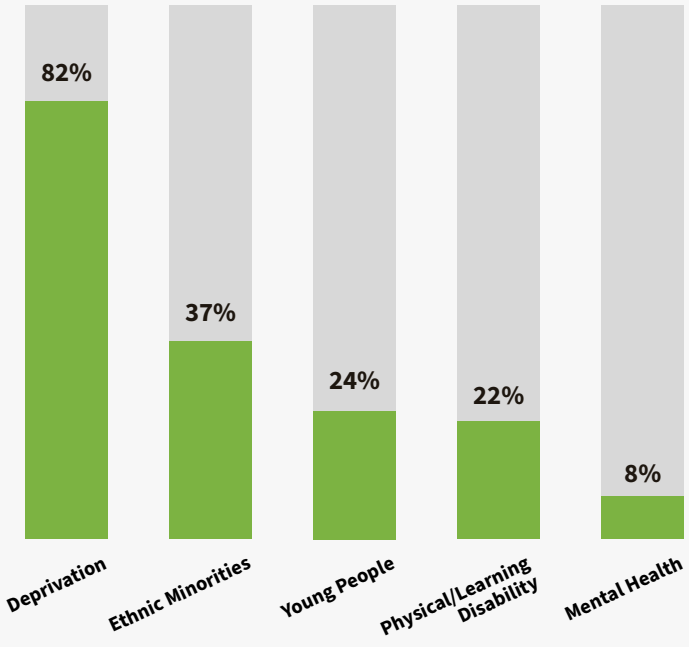
Population groups experiencing the greatest obesity-related inequalities

When asked which groups experience the greatest obesity-related health inequalities, survey participants overwhelmingly identified people living in deprivation.

These findings are particularly relevant in the context of GLP-1s. A 2025 Ipsos poll found that 30% of the general public would use GLP-1s if provided by the NHS, but only 11% would use them if they had to purchase them privately. This gap, along with the current limitations in NHS provision, reinforces the concerns of public health professionals about inequitable access for those living in deprivation.[5]

Respondents consistently framed obesity as a problem due to structural drivers such as deprivation and the wider food environment. This represents a common theme throughout the report - public health professionals see GLP-1s as only one component of a much broader response to the challenge of obesity.

Figure 1: Population groups experiencing the greatest obesity-related inequalities, responses grouped by theme
(Respondents could raise multiple themes; totals exceed 100%)



5 Ipsos (2026). "Proportion of Britons who have taken or know someone who is using weight loss injections doubles in the past year". Available at: **https://www.ipsos.com/en-uk/proportion-britons-who-have-taken-or-know-someone-who-using-weight-loss-injections-doubles-past**

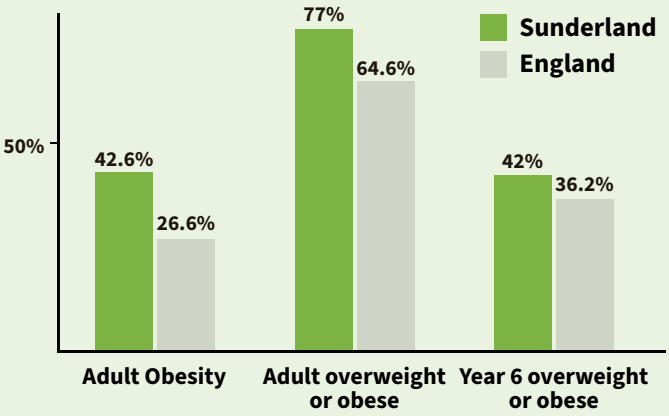
Case study: Sunderland

How well current obesity services meet population needs

Despite the significance placed on obesity, those surveyed rated how well their current services meet population needs at an average of 4/10, highlighting a substantial mismatch between need and current service provision.

Whilst agreeing on the mismatch, the extent of this agreement varied. 39% of respondents rated services 0-3/10, 51% rated 4-6 and only 10% rated 7 or above. In this context, it is likely that the impact of future GLP-1 expansion will vary depending on the strength of local services.

Figure 2: Sunderland v England obesity rates
Source: Public Health England



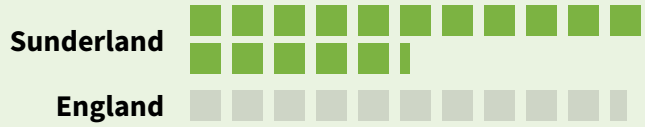
Sunderland: deprivation-driven obesity

According to Public Health England's Fingertips profile, Sunderland has the highest adult obesity prevalence in England, with consistently elevated rates across the life course.[6]

Deprivation levels are also high, with Sunderland ranked among the top 15% most deprived local authorities.[7] Structurally, the city has a higher than average fast-food outlet density and a greater number of people are classed as "inactive" (performing less than 30 minutes of exercise a week).[8]

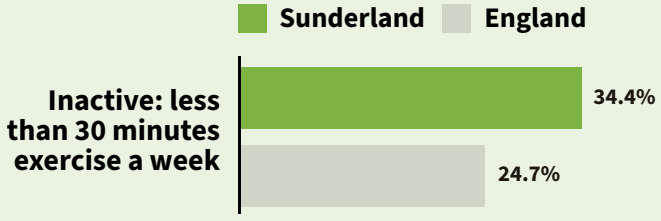
Sunderland demonstrates how a combination of socioeconomic disadvantage, the local food environment and opportunities for physical activity can drive obesity. In these circumstances, pharmacological treatment alone is unlikely to address the wider conditions contributing to the challenge.

Figure 3: Sunderland v England fast-food outlet density
Source: Public Health England



(1 square equals 10 fast-food outlets per 100,000 population)

Figure 4: Sunderland v England inactivity
Source: Active Lives, Sport England



6 Department of Health & Social Care. "Fingertips, Public health profiles". Available at: **https://fingertips.phe.org.uk/profile/obesity-physical-activity-nutrition/data**
7 Sport England. "Active Lives". Available at: **https://activelives.sportengland.org**
8 Ministry of Housing, Communities and Local Government (2025). "English indices of deprivation 2025: statistical release". Available at: **https://www.gov.uk/government/statistics/english-indices-of-deprivation-2025/english-indices-of-deprivation-2025-statistical-release**

3 Obesity-related health inequalities and the risks posed by GLP-1 agonists

Key points for this section:

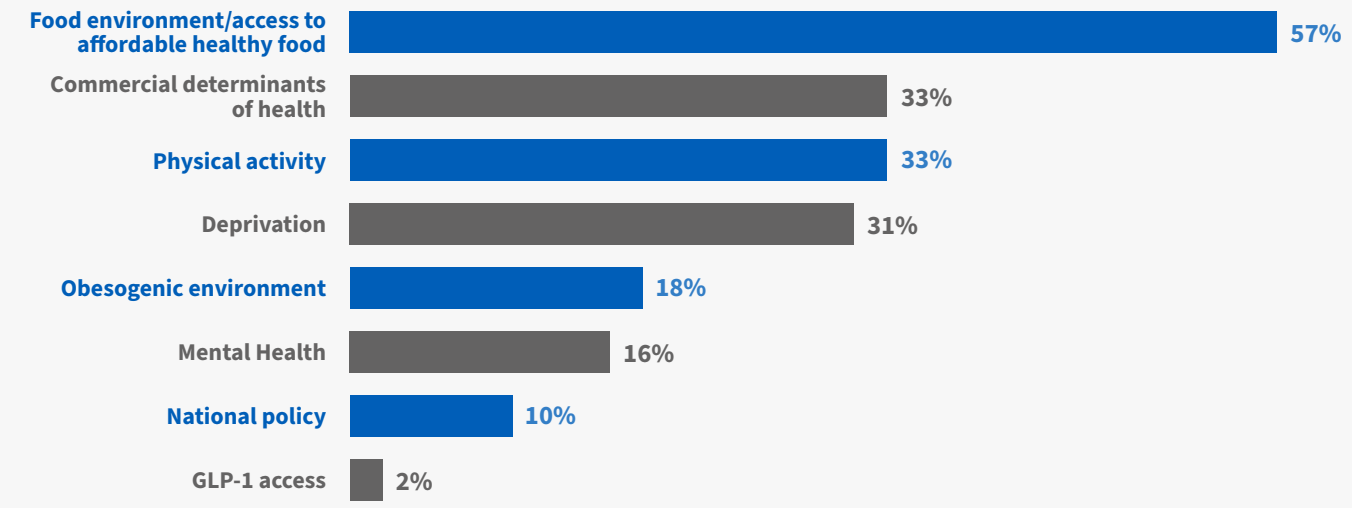
- Commercial determinants of health and the wider obesogenic environment overwhelmingly dominated responses about the barriers to achieving a healthy weight - not access to GLP-1s themselves
- Public health professionals are far more confident that GLP-1s could widen inequalities than reduce them. Nearly all respondents rated the risk of widening inequalities as high, while views on their potential to reduce inequalities were far more mixed
- The West Yorkshire case study illustrates how these risks materialise concretely, where deprivation, trauma and differences in primary care capacity intersect to shape the impact of pharmacological treatment.

Survey respondents identified the greatest barriers to achieving a healthy weight in their local area. Responses were dominated by structural and environmental factors rather than individual behaviour or medical access.

These findings align closely with the definition of the commercial determinants of health, which is **the activities of some corporations which impact negatively on the health of both individuals and the planet**. As discussed in a 2023 paper by the Faculty of Public Health, the problem is illustrated by four industries (tobacco, ultra-processed food, fossil fuel and alcohol) accounting for at least a third of global deaths.[9]

Despite the survey being framed around GLP-1s, respondents rarely identified access to medication as a barrier. Instead, they consistently highlighted structural determinants. This suggests that public health professionals continue to view obesity as a population health challenge of which expansion of GLP-1s alone will do little to change the underlying drivers.

Figure 5: Barriers to achieving a healthy weight, responses grouped by theme
(Respondents could raise multiple themes; totals exceed 100%)



9 Gilmore, AB et al. (2025). "Defining and conceptualising the commercial determinants of health". Available at: **https://www.fph.org.uk/media/3832/gilmore-2023-defining-and-conceptualising-the-commercial-determinants-of-health.pdf**

Case study: West Yorkshire

Do GLP-1s reduce or widen inequalities?

When asked to what extent GLP-1s could reduce these inequalities in their local area, participants gave an average score of 4.69 out of 10. There was a wide spread in responses, with no clear consensus.

By contrast, when asked to what extent GLP-1s could widen inequalities if not implemented carefully, the average score was 8.49 out of 10, and 94% of respondents rated this risk 7 or higher.

While respondents expressed mixed views about whether GLP-1s would reduce inequalities, there was near consensus that expansion could risk widening them.

An article published in Nature Medicine in June 2026 by researchers at UCL and Cambridge makes a related point, stating that whilst GLP-1s can help, long-term benefit depends on affordable, healthy food and appropriate support. The authors warn that assuming patients can easily access and afford these things is unrealistic for many and could widen inequalities.[10]

West Yorkshire: obesity-related health inequalities

More Than Weight, a report commissioned by West Yorkshire Integrated Care Board, demonstrates how obesity-related health inequalities are shaped by the concerns identified by our survey participants - particularly deprivation, trauma, mental health and service access.[11]

Around 27% of adults in West Yorkshire live with obesity, with prevalence highest in the most deprived communities. The More Than Weight report highlights the complex experiences behind the statistics.

Among participants, 66% reported frequent emotional eating and 78% reported at least one mental health or neurodevelopmental condition. This illustrates the close relationship between obesity and wider psychological and social challenges, and how a pharmacological approach is likely to be inadequate in isolation.

The report identifies several priorities for reducing obesity-related health inequalities, including recognising trauma and inequality as drivers of obesity, involving lived experience in service design, ensuring professionals have the capacity to provide psychological support and improving equitable access to care. These priorities correspond closely with the themes from survey respondents.

Although the More Than Weight report was not focused on medication, it highlights the wider system factors that will influence whether GLP-1s reduce or widen inequalities. The report identifies inequality, access to appropriate support and workforce capacity as important challenges within obesity care, all factors which are relevant in the GLP-1 rollout.

The findings from West Yorkshire demonstrate that the impact of GLP-1s will depend heavily on how they are embedded within the wider obesity system.

10 UCL (2026). "Weight loss drugs risk widening health inequalities". Available at: **https://www.ucl.ac.uk/news/2026/jun/weight-loss-drugs-risk-widening-health-inequalities**
11 Humber and North Yorkshire Centre for Excellence and West Yorkshire Health and Care Partnership (2025). "More Than Weight: Exploring the human, social and economic cost of obesity". Available at: **https://www.wypartnership.co.uk/application/files/7917/5915/1311/More_Than_Weight_report_2025.pdf**

4 The role of local authority public health teams

Key points for this section:

- Whilst local authorities commission much of the obesity service, they don't provide obesity medication. This creates a disconnect between prevention and treatment
- There is a stark gap between appetite and reality. A clear majority of respondents want local authorities involved in evaluating population-level outcomes of GLP-1 provision, yet current collaboration between the NHS and local authorities on tackling obesity is rated poorly
- The barriers to better partnership working are overwhelmingly structural - in particular capacity, funding and frequent NHS reorganisation. New national initiatives are beginning to target this gap directly, though it is unclear how far they reach into local authority-led prevention work.

Current weight management services provision

Weight management services in England are provided in a 'tiered' approach. Responsibility for providing these services shifted significantly with the Health and Social Care Act 2012, when the commissioning of tiers 1 and 2 was transferred to local authorities and funded by a ringfenced public health grant. Yet, there is no statutory duty for local authorities to provide these services and access to such services varies nationally.

- Tier 1 is focussed on population-level prevention and community-wide lifestyle changes. Commissioned by: local authorities
- Tier 2 involves structured programmes (which can be either community-based or conducted digitally) which are designed to achieve behaviour change with nutritional advice and physical activity. These programmes are over several weeks and many do not require a GP referral. Commissioned by: local authorities
- Tier 3 is a specialist service operated by medical professionals, offering a multidisciplinary approach combining dietetics, psychology and physical activity specialists. Tier 3 services also provide weight loss medications including Tirzepatide. This requires a GP referral and, although the waiting time varies across the country, it is not uncommon for patients to wait many months to be seen. Commissioned by: integrated care boards
- Tier 4 is the specialist surgical or complex medical interventions involving bariatric surgery. Access to this service generally requires completion of the tier 3 service. Commissioned by: integrated care boards.

Funding pressures have resulted in substantial variation between the obesity services local authorities can provide. In interviews conducted for this report, one participant described how some local authorities have decommissioned community-based tier 2 programmes, such as weight-loss groups, on cost grounds. This has significant implications for those receiving GLP-1s, as their care depends not only on prescribing arrangements but also on the availability of support services.

Local authority role in GLP-1 rollout: the current position

Despite their long-standing role in commissioning tiers 1 and 2, local authorities currently have no formal role in GLP-1 prescribing. This is despite local authorities being able to commission prescribing services, for example in drug and alcohol or sexual health services. This creates a disconnect between the responsibilities for prevention and for clinical treatment.

Wraparound care for those prescribed Tirzepatide consists of clinical support and behavioural support.[12]

- Clinical support includes assessment, dose titration and monitoring of treatment response and side effects. This is funded by the GP contract if prescribed in primary care, or by the ICB if prescribed by a specialist service.

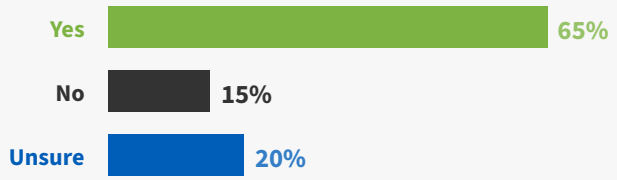
- Behavioural support includes improving health literacy, promoting nutrition and equipping patients with the tools they need to develop sustainable habits. This is delivered through either a nationally funded service ("The Healthier You: NHS Behavioural Support for Obesity Prescribing") or by a locally commissioned equivalent service depending on local ICB commissioning. NICE guidance requires that patients taking Tirzepatide receive this support alongside clinical support.

Whilst respondents recognised that local authorities do not have a statutory role to address, fund or resource programmes associated with GLP-1s, they wanted a role in evaluating what interventions achieve and consistently distinguished between prescribing GLP-1s and evaluating their population impact. The findings suggest that many public health professionals perceive this as a missed opportunity, given that they are commissioners of prevention and have established responsibilities for the wider determinants of health.

Should local authority public health teams evaluate GLP-1 outcomes?

A clear majority of survey participants supported greater local authority involvement in evaluation.

Figure 6: Should local authority public health teams be involved in evaluating population-level outcomes of GLP-1 programmes?



How effectively is the NHS working with local authorities?

Despite this appetite for involvement, respondents rated current collaboration between the NHS and local authorities on tackling obesity poorly, giving an average score of 4.44 out of 10.

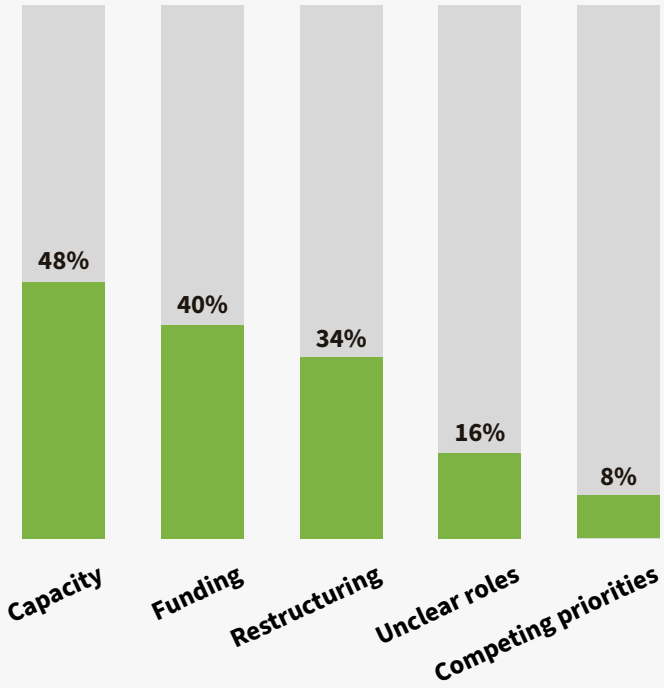
One public health director interviewed described the roles as having been muddied by Covid-era local authority obesity funding, and reflects other respondents' concerns about short-term funding failing to produce sustained collaboration. A £30 million grant introduced in 2020 (as part of the government's obesity strategy prompted by links between obesity and worse COVID-19 outcomes) funded local authorities to deliver an expanded weight management service. Despite evidence suggesting the grant was effective, particularly in more deprived areas, it was withdrawn after only a year.[13]

12 NHS England (2026). "Tirzepatide (Mounjaro®) in primary care for weight management: information on wraparound care". Available at: **https://www.england.nhs.uk/long-read/tirzepatide-in-primary-care-for-weight-management-information-on-wraparound-care**
13 Jonathon Holmes (2022). "Obesity, deprivation and Covid-19: why rowing back on the obesity strategy could prove to be a costly error". Available at: **https://www.kingsfund.org.uk/insight-and-analysis/blogs/obesity-deprivation-covid-19**

Barriers to collaboration

When asked about the barriers to collaboration between the NHS and local authorities in tackling obesity, the main causes raised by respondents were capacity and staff time, funding, and organisational instability due to ongoing NHS and ICB restructuring. Notably, all barriers were organisational rather than clinical.

Figure 7: Barriers to NHS-local authority collaboration on tackling obesity, responses grouped by theme
(Respondents could raise multiple themes; totals exceed 100%)



What would improve partnership working?

Funding and dedicated resources were the most common answer, followed by calls for a whole-system approach joint between NHS and local authorities with shared budgets and incentives (rather than the current fragmented system).

Clearer, more empowered leadership, such as a named lead across the ICB, was also a recurring theme, alongside structural and staffing stability after a prolonged period of reorganisation.

One interview participant offered a novel approach: that patients prescribed GLP-1s could be routinely referred into a single integrated lifestyle service covering not just diet and activity but other related behaviours, such as alcohol and smoking. This would replace the current pathway of being signposted to multiple single-issue services.

The Obesity Pathway Innovation Programme (OPIP) is an £85 million initiative launched in 2025 that join up NHS services, local authorities and community partners with an explicit aim of reducing inequalities and reaching underserved communities. Around £35 million of the total funding comes from Eli Lilly, the manufacturer of Tirzepatide. Several pilots involve local authorities as delivery partners - one example is the Leicester, Leicestershire & Rutland pilot, which has opened six new neighbourhood hubs and expands local pharmacies to take weight loss support and medications to community settings. This model reflects the improvements several respondents identified.[14]

One limitation of OPIP is the short pilot timelines. These brief interventions fail to capture long-term weight maintenance or what happens after people stop medication, and therefore cannot reflect sustained behaviour change or multi-year cost-effectiveness. Longer follow up will allow these pilots to demonstrate lasting benefit.

Interview participants also raised a related concern about capacity: as GLP-1 prescribing increasingly moves into general practice, this places additional strain on already stretched primary care services. One participant suggested this is one area public health teams could add value - supporting general practice with behavioural and preventative support.

There was a strong consensus from the responses that bridging the disconnect between treatment and prevention, through stronger partnership working, shared evaluation and integrated behavioural support, will offer greater benefit than further organisational change.

14 NHS Leicester, Leicestershire and Rutland (2026). "New NHS Weight Loss Service For People In Leicestershire, Rutland And Northamptonshire". Available at: **https://leicesterleicestershireandrutland.icb.nhs.uk/new-nhs-weight-loss-service-for-people-in-leicestershire-rutland-and-northamptonshire**

5 Safeguards before expansion of access to GLP-1 agonists

Key points for this section:

- Inequitable access and a reduced emphasis on prevention dominate concerns about expanding GLP-1 access, each cited by around 9 in 10 respondents
- Recommended safeguards focus on making wraparound support genuinely mandatory and enforced, rather than guidance alone, alongside sustained investment in prevention so medication does not substitute addressing the root causes of obesity
- A recurring theme was to encourage eating disorder screening before prescription as well as efforts to prevent nutrient deficiencies, muscle and bone loss.

Which risks concern professionals most?

Two concerns dominated responses: inequitable access and the possibility that increased investment in GLP-1s could reduce emphasis on prevention, which would have a significant impact on a population level.

There was also a specific cluster of concerns mentioned repeatedly in free-text responses: nutrient deficiencies, loss of muscle mass and reduced bone density (particularly in women and older adults, where the risk of osteoporosis is higher).

Several respondents mentioned wider concerns about emotional wellbeing, body image and a person's relationship with food, especially given the frequency of treatment discontinuation and subsequent weight regain.

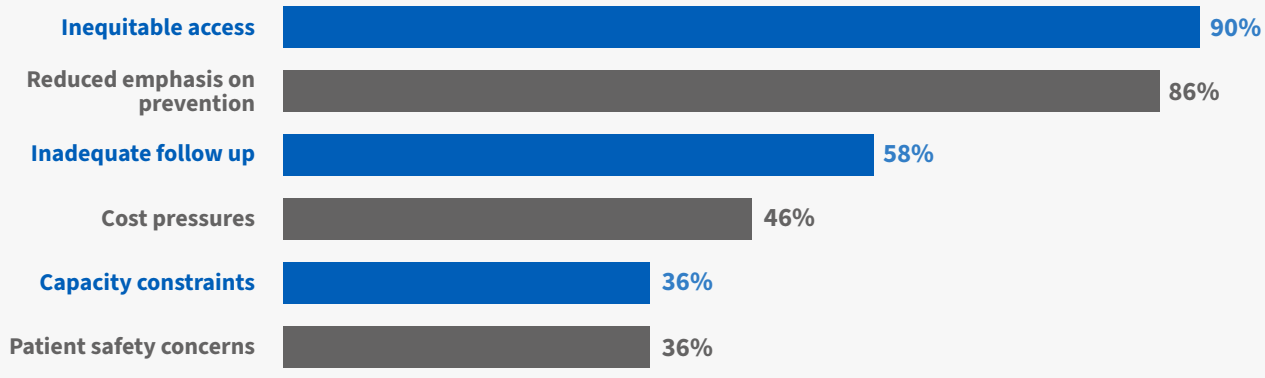
A smaller number of respondents also raised the growth of unregulated or counterfeit "fake" weight-loss products.

Respondents rarely focused on the safety profile of GLP-1s themselves. Instead, concerns focused on the system of delivery.

What safeguards should be in place?

Participants were asked what safeguards should be in place before further expansion of GLP-1s. Five broad themes emerged: enhanced wraparound care, enhanced clinical safety, more equitable access, continued investment in prevention and improved outcome monitoring.

Figure 8: Risks in the expansion of GLP-1 access, responses grouped by theme
(Respondents could raise multiple themes; totals exceed 100%)



Enhanced wraparound care

The most common theme was the need for good wraparound care and long-term behavioural support. Nearly half of respondents felt that GLP-1s should only be prescribed as part of a comprehensive obesity management programme, incorporating behavioural support, dietetic input, physical activity and regular follow-up. Several respondents expressed concern that while national guidance recommends wraparound support, this is not always consistently delivered or monitored in practice.

In one interview, a public health director raised concerns about whether the national wraparound support service is suitable for patients with more complex needs. This included adults with learning disabilities, who were identified as one of the population groups most at risk of obesity-related health inequalities earlier in this report. This suggests there is a gap between who the support model was designed for and the needs of some of the population groups who may benefit from it most.

Enhanced clinical safety

Many respondents emphasised the importance of enhancing patient safety, calling for greater investment in training for healthcare professionals - particularly around improving confidence in discussing obesity and weight management. A small number of respondents also recommended routine screening for eating disorders and other psychological risk factors before treatment can be initiated.

More equitable access

A similar proportion of respondents brought up equity, eligibility and appropriate access. Around a third of respondents believed that eligibility should be designed to reduce health inequalities, rather than relying solely on clinical criteria. Some respondents also highlighted the need for robust referral pathways and clear eligibility criteria, one example being requiring completion of a tier 2 weight management programme before pharmacological treatment is considered.

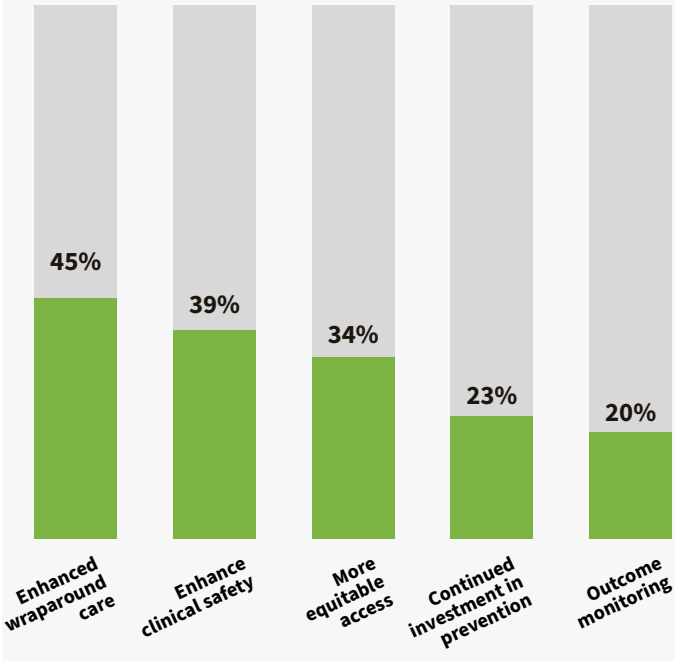
Continued investment in prevention

Several respondents also commented on the importance of national communication around these medications. They argued that this could unintentionally give the idea that GLP-1s can replace lifestyle support, and that messaging neglects to position them as one component of a wider obesity strategy that continues to prioritise prevention. There was concern that increased investment in GLP-1s should not come at the expense of wider public health initiatives. A small number of respondents went further, suggesting that expansion of access should not proceed without wider public and professional debate.

Effective long-term outcome monitoring

Finally, respondents highlighted the importance of effective, long-term outcome monitoring. This would include assessing equity of access and population-level impact, aligning with significant support, as previously discussed, for a stronger local authority role in evaluation.

Figure 9: Safeguards before expansion of GLP-1 access, responses grouped by theme
(Respondents could raise multiple themes; totals exceed 100%)



Support for people accessing GLP-1s privately

The potential lack of wraparound support for those who access the treatment privately emerged as a key safeguarding concern. As discussed earlier, the majority of current GLP-1 users in the UK access the medication privately rather than through the NHS. One interviewee argued that safeguards cannot only be designed around those who access the treatment through the NHS, and this approach risks overlooking the vast majority of individuals receiving these medications.

The support in private provision varies enormously, from services offering little more than an online questionnaire before dispensing medication, to others providing genuine structured coaching and support. The interviewee noted that better-resourced private packages, which may include dietitian coaching and regular check-ins, are likely to cost more, while cheaper packages typically offer less. Consequently, inequalities may arise not only in access to the medication itself but also in access to the behavioural support most likely to improve long-term outcomes.

A potential mechanism to address this gap would be for a route back into NHS wraparound care for people accessing GLP-1s privately, rather than private access existing beyond public health's remit.

Support for people after stopping GLP-1s

Another interviewee raised the lack of support offered after stopping the treatment as a significant concern.

This was echoed in a 2025 article in ScienceDirect which found that, despite weight regain being marked following cessation of treatment, there is little support offered.[15] If long-term behavioural support remains limited, the population health benefits of GLP-1s may be substantially reduced - despite successful short-term weight loss.

There was support among interviewees for continued coaching and lifestyle guidance beyond the period in which the medicine is prescribed. This would also help tackle concerns about unhealthy relationships with food and body image.

15 Scragg, J et al. (2025). "The societal implications of using glucagon-like peptide-1 receptor agonists for the treatment of obesity". Available at: **https://www.sciencedirect.com/science/article/pii/S2666634025002326**

6 Recommendations

The expansion of GLP-1 agonists can strengthen weight management services and should not operate separately from them. This report makes twelve recommendations to achieve this, falling into three distinct categories: improve the implementation of GLP-1s, the partnership between NHS and local authorities, and population health more generally.

Improve the implementation of GLP-1s

1. Introduce national minimum standards for wraparound behavioural support.

The strongest safeguard identified by respondents was the need for more comprehensive behavioural support. Respondents questioned how consistently wraparound care is being delivered, especially among those receiving the medication privately.

Government should establish minimum standards for behavioural support including, but not limited to, nutritional advice, physical activity support, psychological support and routine follow-up with reasonable adjustments for those with complex needs.

2. Improve long-term outcome monitoring and guidance for patients discontinuing GLP-1s.

Current services focus primarily on treatment initiation. Several respondents highlighted concerns about weight regain and loss of behavioural support on treatment cessation.

Evaluation should extend beyond initial weight loss, and include monitoring of weight maintenance and long-term health outcomes rather than relying solely on short-term weight reduction.

National guidance should include structured support following discontinuation, including:

- Dietary support
- Physical activity
- Weight regain prevention
- Psychological support
- Ongoing outcome monitoring.

3. Ensure behavioural support is available to people accessing GLP-1s privately.

Around 95% of those currently using GLP-1s obtain the medication privately, yet existing safeguards focus on patients who access the medication through the NHS.

DHSC should establish a mechanism to allow people accessing GLP-1s privately to receive NHS-approved behavioural support where clinically appropriate. This would reduce inequalities created by variation in private providers.

4. Strengthen obesity training across the wider workforce.

Training for the wider workforce should reach beyond clinical support for those living with obesity. It should include addressing weight stigma, trauma-informed care, behavioural change and awareness of health inequalities.

5. Ensure screening for eating disorders before initiation of GLP-1s.

Government should mandate screening for eating disorders, nutrient deficiencies and reduced bone and muscle density prior to prescription of GLP-1s.

Improving the partnership between NHS and local authorities

6. Develop an integrated obesity pathway spanning NHS and local authority services.

Rather than creating parallel systems, survey respondents supported integrated approaches. DHSC should promote a joint obesity pathway linking prescribing, behavioural support, community weight management services and lifestyle support such as smoking cessation, alcohol and drug services, and social prescribing.

7. Include local authority public health teams in future NICE implementation planning.

Local authorities are responsible for much of the behavioural support infrastructure. Whilst they don't produce NICE guidance, they should be formal consultees during implementation planning.

8. Strengthen partnership working through shared governance arrangements.

Each Integrated Care Board should establish:

- A named obesity lead
- Joint governance meetings
- Shared performance indicators
- Regular strategic planning with local authority public health teams.

This would create clear and accountable links between the organisations to ensure a joint approach.

Improving population health

9. Establish a formal role for local authority public health teams in evaluating population-level GLP-1 outcomes.

Survey respondents supported local authority involvement in evaluating population-level outcomes.

Local authorities already possess expertise in population health intelligence, inequalities and prevention. DHSC should require Integrated Care Boards to involve local authority public health teams in the evaluation of GLP-1 implementation, including monitoring:

- Uptake
- Inequalities in access
- Long-term outcomes
- Impact on wider obesity services.

10. Protect investment in tier 1 and tier 2 prevention services.

Expansion of GLP-1s must not occur at the expense of existing public health interventions.

Government should maintain investment in local authority obesity prevention, protecting tier 2 behavioural programmes and ensuring public health grants are not reduced as the use of pharmacological treatment increases.

11. Require 'Health Equity Impact Assessments' before significant expansion of GLP-1 eligibility.

Respondents consistently identified deprivation as the greatest driver of obesity-related inequalities and expressed significant concern that expansion could widen inequalities.

Before future expansion phases, Integrated Care Boards should complete impact assessments with findings reviewed jointly with local authorities.

12. Position GLP-1s explicitly within a whole-system obesity strategy.

Throughout the report, respondents consistently viewed GLP-1s as one component of obesity care rather than a replacement for prevention.

Future national policy should explicitly frame GLP-1s as one element of a comprehensive obesity strategy which encompasses prevention, behavioural support and structural drivers including healthy environments, deprivation and commercial determinants of health.

7 Conclusion

The introduction of GLP-1 agonists represents a significant development in obesity treatment. However, the findings of this report suggest that a pharmacological approach alone will not address the underlying drivers of obesity or the health inequalities associated with it.

Public health professionals expressed broad agreement that obesity remains one of the most significant public health challenges facing England, with deprivation, the food environment and wider social determinants continuing to impact upon an individual's likelihood to live with obesity.

While there was optimism about the benefits GLP-1s could bring for many individuals, there was also widespread concern that their expansion could reinforce and widen existing health inequalities. These concerns centred less on the medicines themselves, and more on the systems through which they are delivered.

Survey respondents consistently viewed GLP-1s as one component of a broader obesity strategy rather than a replacement for prevention, behavioural support or action on the wider determinants of health.

A consistent theme across the survey responses and interviews was the disconnect between prevention and treatment. Local authorities commission some of the services that support healthy weight and behaviour change, yet have no formal role in the evaluation of GLP-1s.

Respondents suggested they could contribute to the provision of GLP-1s through evaluation, addressing health inequalities and strengthening links to the wider prevention programmes they commission. This would complement prescribing done by clinicians.

If implemented appropriately, GLP-1s have the potential to improve health and reduce inequalities. If implemented in isolation, we risk the benefits of this treatment being distributed unevenly.

Ultimately, the question is not about whether GLP-1s should form part of obesity care. The debate is around how they should be integrated to deliver equitable, sustainable and population-level improvements in health. The insights of local authority public health professionals presented in this report provide a strong foundation for future progress in this area.