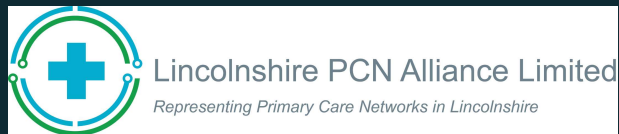


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Worth the weight?

Navigating the next wave of GLP-1 innovation, and where community pharmacy fits in



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WHO I AM

Dr Kevin Thomas

- GP partner and GP trainer in Lincoln since 2013; qualified Leicester 2008
- Clinical Director, East Lindsey PCN · Deputy CEO, Lincolnshire PCN Alliance
- Primary Care Partner Member, NHS Lincolnshire ICB · Chair, Lincolnshire Primary Care Collaborative
- Clinical lead for a recently awarded Innovate UK grant looking at innovative obesity treatment pathways
- Background in medical education: PG qualification 2017, Training Programme Director for the International GP Programme

BEFORE WE START

Three questions, hands up

1

Who has dispensed a GLP-1 this week?

2

Who has been asked “is this one safe?” about something bought online?

3

Who has had to say “I can’t help with that” and wished you could?

If your hand is up for the third one, this talk is for you.

PART ONE

The water we are swimming in

Why obesity is mostly about environment and biology, not willpower

THE OBESOGENIC ENVIRONMENT

An environment that makes gaining weight the path of least resistance

Food

Cheap, energy dense, engineered to be easy to eat, and sold on every forecourt and app

Movement

Designed out of work, travel and leisure, and rural Lincolnshire especially

Money and time

Two jobs, one microwave, no car. The cheapest calorie wins

Biology

A body that defends weight it has gained, and fights back when you lose it

The Government's own Foresight report mapped more than a hundred interacting drivers of obesity and concluded that weight gain is a normal response to an abnormal environment. That was 2007. Nearly twenty years on, the environment has only got worse.

ENGLAND, 54 MILLION ADULTS, 2019–25

Obesity has a postcode, and the gap is widening

**4% to
48%**

Prevalence from the most affluent part of central London to the north east of England

35%

More new cases in the most deprived areas than the least. For women the gap is 54%

94%

The widest gap of all: new cases in Asian women in the most deprived areas

+20%

Rise in new cases in people in their thirties. In the over-60s, rates fell

Lincolnshire sits on the wrong side of this: adult obesity here has run significantly above the England average for years, and Boston and South Holland further above again.

Lancet Diabetes & Endocrinology, 24 June 2026 (Cambridge/Lancet whole-population study, 54m adults) · Lincolnshire Health Intelligence Hub JSNA

Nobody in your pharmacy chose this. They were born into it.

Which is why, for a lot of people, a drug that works on appetite feels like the first fair chance they have had.

PART TWO

The drugs do work

For the first time we can see it at population level, not just in trials

UNITED STATES, 2022 TO 2025

The first sustained fall in adult obesity ever recorded

39.9% → 37.0%

Adult obesity, from the 2022 peak to 2025. Around 7.6 million fewer adults living with obesity

12.4%

of US adults now report taking a GLP-1 for weight loss, up from 5.8% in early 2024

The steepest falls are in the 40 to 64 age groups, which are also the groups with the highest GLP-1 use. It is survey data, but it is hard to explain any other way.

Gallup National Health and Well-Being Index, 2026

MEANWHILE, IN ENGLAND

Not here. Ours is still going up.

1 in 3

adults in England were living with obesity in 2025

+4%

new cases in 2025 compared with before the pandemic. No plateau, no decline

<1%

of the eligible population has an NHS prescription for these drugs

Same drugs, same evidence, very different access. The American curve bent because millions of people could get hold of the drug. Here, most of the people who can get hold of it are paying for it themselves.

WHO IS ALREADY TAKING THEM

1.6 million UK adults, and most of them are not getting it from the NHS

In the past year	Figure	What it means at your counter
Used a weight loss drug	1.6 million	2.9% of all UK adults
Interested in starting within a year	3.3 million	The queue forming behind them
Women vs men	4.0% vs 1.7%	Who is actually asking you
Adults aged 45 to 55	4.2%	Peak use, peak comorbidity risk
People with moderate or severe psychological distress	3.7%	The group that most needs a proper conversation

At roughly £200 a month, privately. The researchers’ own conclusion: large numbers are taking these drugs outside medical supervision, with wide potential for misuse.

**The market got there first. The NHS
NHS is now designing a service
service around a behaviour patients
patients have already started.**

That is unusual for us. It is also an opportunity, if we move quickly.

PART THREE

What NICE actually asks for

Including the part that rarely gets mentioned

A twelve-year queue, opened one cohort at a time

Phase	BMI	Weight-related conditions	Who that is
Year 1 from June 2025	40 and over	Four or more	The sickest first
Year 2 now	35 to 39.9	Four or more	Still very unwell
Year 3 from 2027	40 and over	Three or more	The queue starts to move
Everyone else	Per the licence	Per the licence	Up to twelve years away

Thresholds drop by **2.5 kg/m²** for South Asian, Chinese, other Asian, Middle Eastern, Black African and African-Caribbean backgrounds

220,000 people in the first three years, from an eligible population of **3.4 million**

THE PART THAT GETS FORGOTTEN

The drug on its own is not the treatment NICE described

Mandatory, not optional

Nutritional and dietetic advice as a **minimum**, plus access to behaviour change support, for everyone starting treatment

Nine months minimum

In primary care, dedicated wraparound support for at least nine months from the first prescription

Seen, not just supplied

Monthly face-to-face contact through titration and structured review for at least twelve months

Compare that with a website that posts a pen to your door on the strength of a short online form, with no follow-up. Both are legal, but only one of them is what NICE described.

WHAT HAPPENS WHEN THEY STOP

This is a treatment for a chronic condition, not a twelve-week course

82%

of people withdrawn from tirzepatide regained a quarter or more of the weight they had lost, within a year

Blood pressure, lipids and glucose drift back with the weight. The benefit lasts as long as the drug does.

And people stop for very ordinary reasons: the money runs out, the supply changes, the side effects bite, the prescription lapses.

You will often be the first to know when someone has stopped.

WHAT IS ACTUALLY COMING OFF

Mostly fat, but not only fat

75–85%

of the weight lost is fat mass. The worry that these drugs “eat your muscle” is overstated

The rest

is lean tissue, and that matters a great deal in a 72-year-old with knee arthritis

**Never
regained**

Weight that comes back after stopping comes back as fat. Muscle only comes back if you work for it

That is the real case for resistance training, and it has nothing to do with vanity or gyms. It is about losing 20 kilos and still being able to get up out of a chair at eighty.

THE ADVICE THAT RARELY GETS GIVEN

Two sessions a week and enough protein

What the guidance says

Muscle-strengthening activity on at least two days a week for every adult, alongside 150 minutes of moderate activity (UK Chief Medical Officers)

Resistance exercise is the most effective tool we have for holding on to muscle during weight loss

What it sounds like in plain English

“This will take your appetite away, so the protein has to be deliberate.”

“Twice a week, push something or carry something. Stairs, a resistance band, two shopping bags, standing up out of a chair ten times.”

“You are not training for anything. You are keeping what you have.”

This is what the support around the drug should sound like. At the moment, for most patients, nobody in the pathway is saying it.

BEHAVIOUR CHANGE

The drug opens a window. The habits decide what happens next.

What the drug does

Quietens the food noise. Makes a smaller plate feel like enough. Ends the nightly argument with the fridge

What it does not do

Teach anyone to cook, to shop, to sleep, to handle a bad week, or to eat when they are not hungry but still need the protein

Why it matters

Whatever habits are in place when the drug stops are what the person is left with. NICE asks for long-term, multicomponent support, and that is the hardest part to provide

A year or more of reduced appetite is probably the best opportunity for behaviour change in the whole of chronic disease. For most people at the moment, that window is being spent on a subscription and a courier.

PART FOUR

**Who gets left behind, and who is
is going to pick this up**

THE INVERSE CARE LAW, IN REAL TIME

The people most likely to benefit are least likely to be to be buying

Bought privately

Skews female, middle-aged, digitally confident and able to find £200 a month

Highest need

Most deprived communities, coastal Lincolnshire, people with severe mental illness, people with no car and no smartphone

Severe mental illness

Up to twenty years of life lost, much of it cardiometabolic, and the group least likely to reach a weight management service under their own steam

If access depends on who can pay and who can find their way round a website, these drugs will widen the gap the Lancet study has just shown us. A treatment this effective, reaching the wrong people, makes inequality worse.

UCL / BMC Medicine, January 2026 · Lancet Diabetes & Endocrinology, June 2026

THE ARITHMETIC OF THE ROLLOUT

3.4 million people need support. General practice cannot provide it alone.

3.4m

eligible in England
under TA1026

**9 months
months**

of wraparound support
each, minimum

12 years

to work through the queue
at the planned pace

11,000

community pharmacies,
open late, no
appointment, already
weighing people

This rollout does not work without community pharmacy. The question is how a pharmacy role gets commissioned and funded, and what it should look like.

AND IT IS ALREADY HAPPENING HERE

The Obesity Pathway Innovation Programme: £85m, thirteen sites, thirteen sites, one of them here

Lincolnshire

The first specialist weight management service the county has ever had, so people stop having to travel out of Lincolnshire for care. Face to face, by phone and through an app, with mental health expertise built in. First patients January 2027, running to March 2029.

Elsewhere in the programme

Leicester, Leicestershire and Rutland: six neighbourhood hubs sited in community pharmacies and gyms, aimed at the most deprived communities.

South London: obesity care delivered from a high street pharmacy alongside exercise groups and dietary advice.

Others in Birmingham, Dorset, Kent, Norfolk, Wales, Northern Ireland and Scotland.

Two of the thirteen national pilots have put the front door of obesity care inside a pharmacy. That is the direction of travel, and it is being tested with public money now.

GOV.UK / DSIT press release, June 2026 · up to £50m government and £35m Eli Lilly, to March 2029 · The Pharmaceutical Journal

WHERE COMMUNITY PHARMACY COULD FIT

Five jobs a funded service could cover

01

Finding people

The person who never books a GP appointment but collects a prescription every month

02

Safe supply

Verified weight and height, continuity through titration, spotting the person who has switched to a website

03

Side effects and red flags

Vomiting, dehydration, severe abdominal pain, gallstones, pregnancy and contraception, interactions

04

Follow-up

Checking in on protein, activity, sleep and alcohol, and linking people back into the structured behaviour support they have been given

05

Stopping well

Knowing who has stopped, why, and who needs catching before the weight and the blood pressure come back

None of this needs a new profession. It needs a properly commissioned and funded service, a shared record and someone willing to say yes.

WHAT THE REGULATOR FOUND

The GPhC has already looked closely at pharmacy weight management services

1,307

concerns about weight management medicines and services, January 2024 to December 2025

76%

of the 1,099 concerns raised in 2025 came from members of the public

27%

were about prescribing practice, the largest category, mostly BMI not being independently verified

5%

of 2,002 standards assessed across 77 inspections were not met or needed improvement

Most pharmacies met most standards. The problems clustered in a few places: verifying height, weight and BMI, keeping proper consultation records, risk assessment and governance, and follow-up after supply.

WHY THIS MATTERS FOR COMMISSIONING

What the GPhC is asking for is what any commissioner will ask for

Where the gaps were

Inconsistent independent verification of height, weight and BMI. Incomplete consultation records. Thin risk assessment and clinical governance. Limited follow-up and support after supply

What it now expects

Verify height, weight and BMI yourself, not from a questionnaire. Assess each person's suitability, with particular care around eating disorders. Document every consultation. Follow up properly, and check third-party prescribers are registered

Every commissioner thinking about putting NHS obesity care into pharmacies will read this review. The pharmacies that get verification, records and follow-up right now are the ones that will be trusted with that work.

FOUR THINGS TO TAKE HOME

If you remember nothing else

- 1 Obesity is mostly about environment and biology, not character. Nobody at your counter chose the environment they grew up in.
- 2 The drug is the easy part. Protein, resistance and habits decide whether the weight loss was worth having.
- 3 Right now access depends on who can pay and who is online. Left alone, that widens the gap these drugs could have closed.
- 4 Pharmacy is the obvious place to commission the support around the drug. Getting the basics right now is how the sector makes that case.

So, worth the weight?

The medicine is. The wait is not. And closing the gap between the two depends on who we commission to deliver the care.

Thank you. Questions, arguments and disagreement all welcome.

Dr Kevin Thomas · Clinical Lead, Obesity Pathway Innovation Programme,
Lincolnshire

