



A systemic view of weight management services

A Virtual Advisory Board convened 28 February 2025

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Oviva is the leading provider of evidence-based weight management services for the NHS, including specialist multidisciplinary (Tier 3) weight management services. Oviva offers a fully remote service, active in all 42 ICBs, treats more than 8000 patients per month, and has demonstrated market-leading Tier 3 weight management outcomes.



Introduction

Oviva sponsored an advisory board on 28 February 2025, entitled 'A systemic view of weight management services'. It was attended by four UK GPs with a special interest in obesity. The objectives were to analyse the role of independent sector providers/the patients' Right to Choose in delivering specialist weight management services and gain insight into the implications of the 2024 NICE tirzepatide guidance for primary care.

The regulatory context

The 2023 NICE guidance on semaglutide for weight loss stipulated that it could only be prescribed for a maximum 2-year duration and could be accessed only through a specialist Tier 3 weight management service, of which there are very few, resulting in only a fraction of those qualifying for the treatment actually receiving it. The 2024 NICE tirzepatide guidance one year later removed the limitation on treatment duration and removed the stipulation that the medication should be prescribed in a specialist weight management service.

Right to Choose

Under the NHS Choice Framework (updated October 2024), patients treated in the NHS in England have the legal Right to Choose their provider for elective, consultant-led treatment. This provider can be anywhere in England, face-to-face or remote.

It was the consensus of the participants that Right to Choose offered many advantages:

- A decrease in patient waiting times
- Removal of geographical restrictions and variation, should the patient have no service provider locally, resulting in a narrowing of the inequality gap
- An increase in the quality of service, driven by competition among providers to offer optimal services to their 'customers'
- Increased patient engagement, satisfaction and autonomy

Perhaps most significantly, Right to Choose was seen as being disruptive, challenging the status quo and forcing providers to consider new models of weight management services.

But the number and range of **concerns, challenges and barriers** presented by Right to Choose was extensive, the

most significant relating to GP attitudes, services gaining GP trust (through awareness, education and positive communication), clear treatment pathways, funding models, societal elements and capacity/scalability.

A key factor is establishing **GP trust and confidence** in the providers to which they may refer patients; this is influenced by the nature of the service itself. Many (if not most) specialist weight management services have traditionally been established by bariatric surgical teams; patient education and support will be delivered by bariatric nurses with the aim of providing a gateway to surgery rather than medical management. Conversely, GPs need to know that they should not refer those patients who may indeed need to consider bariatric surgery to medically led services focused on injectable weight loss therapy. Unless GPs have that understanding of what is actually being provided by the providers (e.g. the specific treatments offered, screening for eating disorders, level of staff training for provision of weight management services), they will have concerns for the safety and medical wellbeing of their patients that will affect their referral decision.

It is the consensus of the Advisors that informed GP referral and **informed choice by patients** are key to impactful implementation of Right to Choose. GPs need to know the nature and quality of the services to which they are referring, and feel confident that this has been properly assessed. Ideally there would be provider maps showing GPs and patients the locations of top-performing providers, and exposing variation in obesity care.

There is widespread **lack of awareness** of patients' rights and clinician responsibilities embodied in Right to Care. Education is sorely needed.

Block funding of local ICB services does not incentivise patient access, innovation or efficiencies in clinical care and will result in the turning away of patients exercising their Right to Choose.

There is still a **retrograde perception** among some GPs who do not recognise obesity as a long-term condition, but rather as a lifestyle choice of the patient's making. A power dynamic between GP and patient undoubtedly exists, GPs

seeing themselves as the gateway to services. **Resistance and pushback** seen in these instances create one of the biggest barriers to Right to Choose, to be addressed by awareness and education initiatives.

A further pushback from GPs to patient choice originates in the absence of a clear patient treatment **pathway** – a need easily rectified.

Societal barriers abound, requiring input from the Department of Health, Public Health and NHS England in prioritising prevention (in the case of childhood obesity) and treatment – *how is clinical obesity addressed in schools? In the community? Is there any sharing of information with GPs?* However, care must be taken that prevention does not become a deflector from treatment – both are important but require different approaches.

Many GPs may not be confident in the use of the glucagon-like peptide-1 (GLP-1) class of treatments, and the new can be unsettling – an obvious target for trust-enhancing, evidence-based **education**.

One area of concern was that Right to Choose might detract from the **community** focus of primary care – will remote providers know the community well enough to provide optimal support, for example signposting to other local services?

Be mindful to avoid the **inverse care law**, in which those patients who are most knowledgeable about what is available and how to access it will receive care, to the exclusion of those with greater need.

Integrating tirzepatide NICE guidance into primary care

GP ability and willingness to take on

Primary care would be unwilling to take on obesity care under its core contract, but would be able to do so as an enhanced service, provided funding and support were made available. Perhaps the care provision could be stratified, such that patients could be triaged as either needing the expertise of a multidisciplinary team, or needing only a pared-down service, e.g. no dietitian, no psychologist.

Participants voiced the importance of building trust by



delivering the service in primary care. Funding for such a service in primary care would need to provide for trained clinicians who could screen patients for other issues, set appropriate goals and provide counselling services.

So, with appropriate funding, support and education of clinicians and patients, GPs could certainly provide this service. However, in light of the millions of people who qualify for care and the limited capacity of primary care, even if the structure is as simple as possible, is it a good idea to invest limited resources in a service that, on its own, cannot possibly satisfy demand? The participants thought not. It is not the role of GPs to get in the way of care – surely the smart option is to engage with a provider that can offer the capacity and scalability to sustain high-quality obesity care. It was agreed that the remote offering of Oviva meets that requirement.

The participants proceeded to consider the interoperability of a remote service with the clinical system. In the case of Oviva, patients are told that they are to contact Oviva and not their GP practice for all treatment-related concerns, such as common medication side effects, barring the occurrence of serious side effects. Participants advised that Oviva should communicate this practice broadly within primary care, lest they defer referral in anticipation of increased primary care workload.

New ways of thinking and new models are required. There remains the need to develop a model that can get care to those with the greatest need, including to the digitally excluded and to those with learning disabilities. A proactive patient pathway that involved them completing critical information before appearing for the GP consultation might expedite patient throughput.

Opportunities

Participants were quick to express enthusiasm for the opportunities commensurate with the development of the GLP-1 class of obesity treatments:

“ Now is the perfect time for people living with obesity – the challenges will be managing the opportunity”

“ It is important for the management of the health of an ageing public that people be able to age better – the challenge is to get treatment in the hands of those who need it most”

“ There is an exciting opportunity for primary care to move into commissioned services, creating a whole-system obesity service”

“ This is an awesome opportunity to tailor a service to a population’s individual needs”

It was the consensus of the participants of this Advisory Board that the development of the GLP-1 class of obesity treatments, combined with the NHS Choice Framework and remote obesity service providers, has set the scene for a major disruption of weight management services.

The opportunities are here. Now.

What might Oviva do to address concerns and build trust?

- Create an ICB-level heat map showing variations in care around the country, so that (1) patients can make informed choices and (2) clinicians can gain trust in their referred weight management services
- Engage with practices that already refer to Oviva to provide feedback and individual case studies
- Nurture the Patient Voice to act as champions of Oviva
- To allay concerns that a remote service may lack the community focus of primary care, Oviva to collate signposting to local support services, care co-ordinators and social prescribing
- ‘Be evangelical’
- Demonstrate Oviva’s capacity and scalability, building trust and confidence in seeing Oviva as a trusted partner in obesity care
- Create media campaigns and educational and training materials for GPs, and for GPs to signpost for patients
- Generate a Position Statement on what ought to be done to maximise the quality of obesity care
- Maximise communication of key messaging from the NICE recommendations
- Maximise communication with patients