Introduction to Obesity: A Clinical Re-Evaluation

Understanding the architecture of a complex, multifactorial chronic disease.

Speaker: Hannah Beba, Consultant Pharmacist for Diabetes, Leeds Health and Care Partnership.

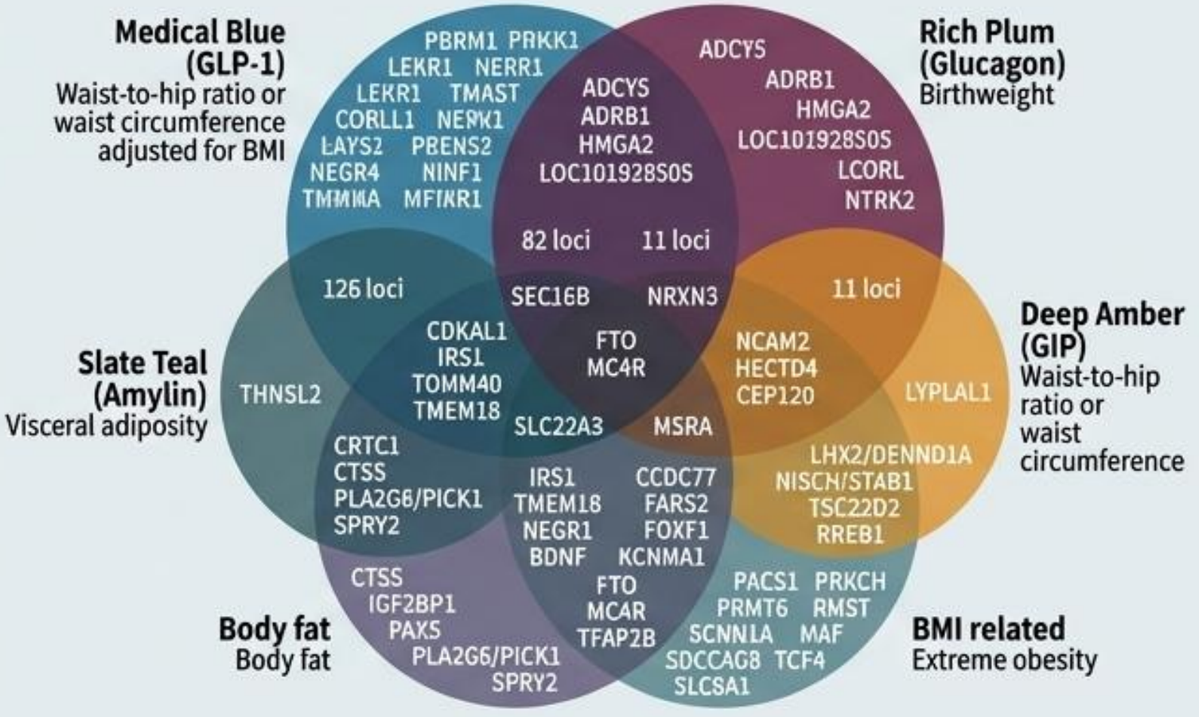
Reframing Obesity: From Thermodynamics to Biology

The Outdated Paradigm

The 1st Law of Thermodynamics (calories in vs. out) is insufficient. The brain's hypothalamus controls food intake via complex hormonal and nutritional cues, not just willpower.

Genetic Drivers: The MC4R Mutation

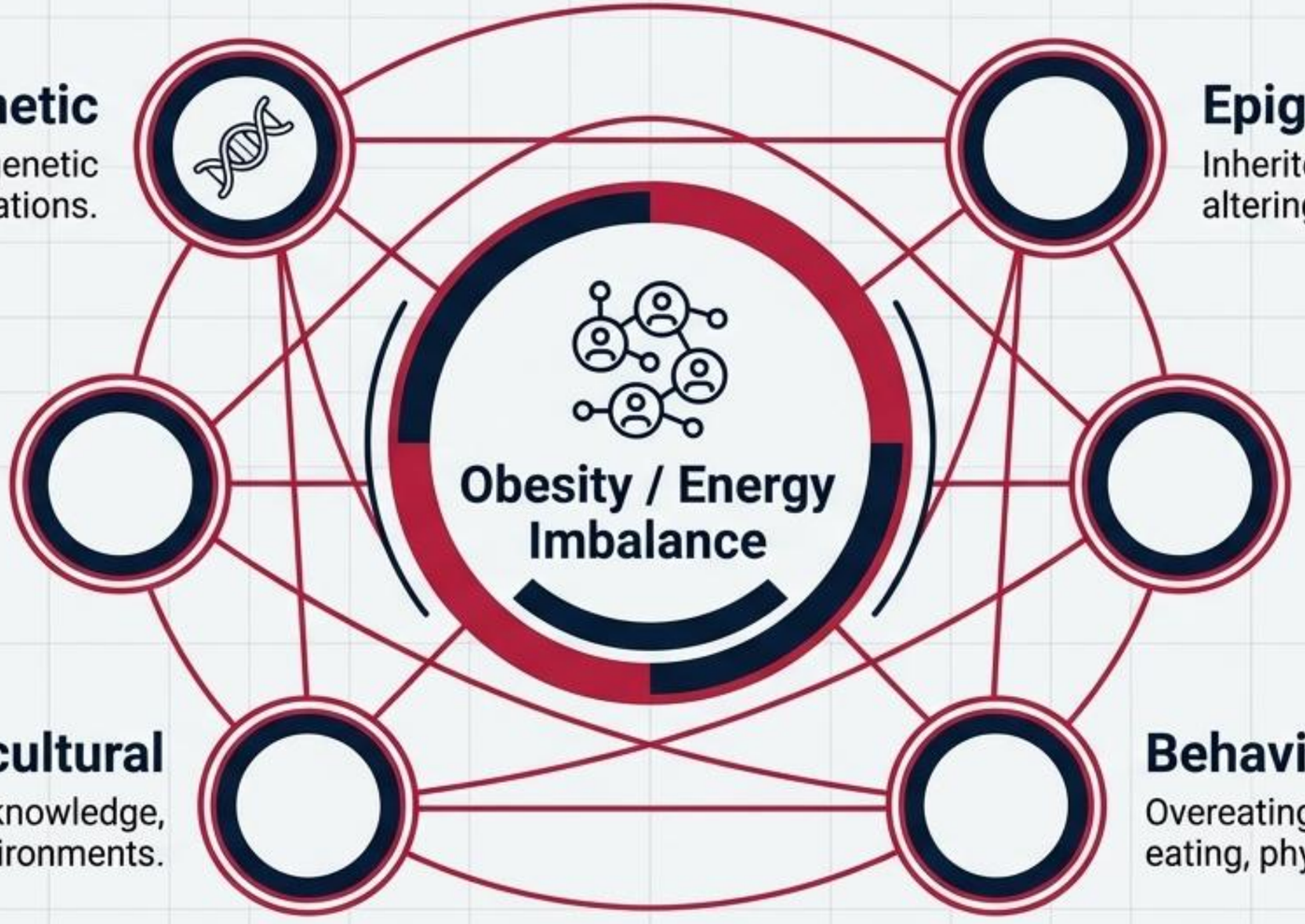
- Leptin/POMC pathways are critical regulators of energy.
- MC4R mutations are present in 0.3% of the population across all ethnicities.
- Causes individuals to be ~18kg heavier by age 18 (representing 10% of the top 1% obese population).
- Evolutionary note: Evolved in cave fish to maintain food motivation.



	Preclinical obesity	Clinical obesity
Excess adiposity	✓ BMI ✓ Waist circumference, etc.	✓ BMI ✓ Waist circumference, etc.
Mechanisms and pathophysiology	Alterations of cells and tissue → Alterations of organ structure	Alterations of organ function → End-organ damage
Clinical manifestations	Minor or absent; substantially preserved organ function	Signs and symptoms; Limitations of dally activities; Complications
Detection and diagnosis	Anthropometrics, medical history, review of organ systems, and further diagnostic assessment as needed	Anthropometrics, medical history, review of organ systems, and further diagnostic assessment as needed

The Architecture of Adiposity: A Multifactorial Ecosystem

Our body weight is driven by an energy balance (food intake vs. metabolism/expenditure), but this balance is disrupted by a complex web of six interconnected drivers.



Genetic

Modest to high genetic contributions, rare mutations.

Epigenetic

Inherited expressions altering metabolism.

Environmental

Physical challenges, chronic fatigue, technological changes.

Physiological

Ageing, sex, neuroendocrine factors, sarcopenia, microbiota, medications.

Sociocultural

Peer pressure, lack of knowledge, workplace environments.

Behavioural

Overeating, lack of sleep, emotional eating, physical inactivity.

The System Strain

30%

of adults in West Yorkshire live with obesity

£2.46 billion

annual cost (NHS treatment, social care, productivity)

>20%

Referrals up in two years as demand outstrips capacity

The Human Reality

78%

have mental health conditions

Over 70% experience social isolation

“The reason I’m fat is because I ate instead of self-harming... this body saved my life.” ~

The current traditional model is financially unsustainable and psychologically damaging. A new paradigm is required.

The West Yorkshire 'Multiplier Effect': Quantifying Long-Term Impact

~50,000 QALYs Generated

Achieved if just 5% of the regional population with a BMI >35kg/m2 reduces to 25kg/m2.

£1.25 Billion in improved health value (extended and better quality of life).

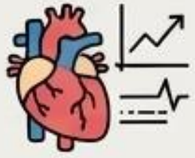
£3.1 Billion/Year Freed

Potential annual savings in future health, social care, and productivity costs by lowering current disease trajectories (combating the projected £9.2bn cost by 2040).

A clinically and cost-effective prototype in West Yorkshire designed explicitly as a scalable national template.

The Systemic Blast Radius of Clinical Obesity

Documented positive causal relationships linking obesity to multi-organ disease progression



Cardiometabolic

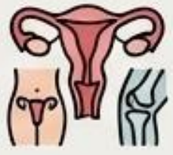
- Type 2 Diabetes
- Coronary Artery Disease (early onset)
- Heart Failure
- Fasting Insulin
- Blood Pressure

Neuro-Psychiatric

- Multiple Sclerosis
- Alzheimer's
- Bipolar Disorder
- Schizophrenia
- Psychological Distress

Cancer

- Squamous / Small cell lung cancer
- Colorectal
- Endometrial
- Pancreatic
- Breast
- Prostate



Reproductive & Misc

- Polycystic Ovary Syndrome (PCOS)
- Deep Vein Thrombosis (DVT) without PE
- Knee / Hip Osteoarthritis

The Demographics of Risk: Socioeconomic Intersections.

Deprivation

Individuals living in the most deprived areas have a **significantly higher prevalence** of excess weight compared to those in the least deprived areas.

Disability

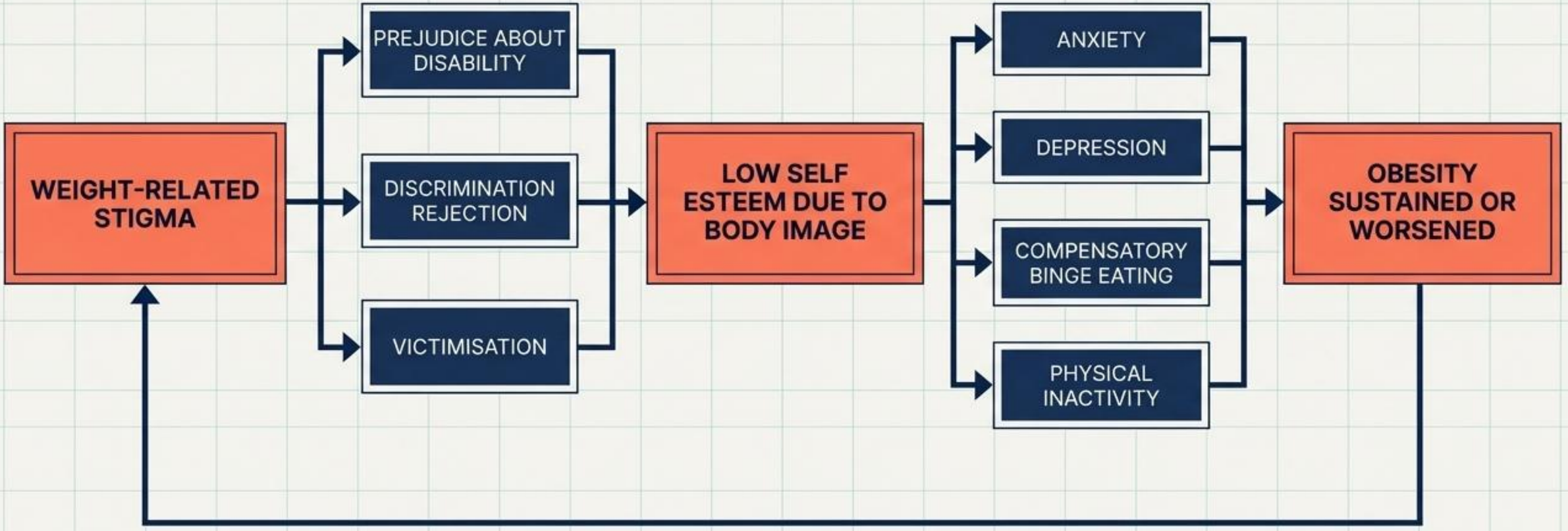
Excess weight is **notably more prevalent** among adults living with disabilities.

Ethnicity

Prevalence **varies significantly** across different ethnic groups, requiring culturally nuanced clinical approaches.

The Hidden Barrier: The Cycle of Weight-Related Stigma

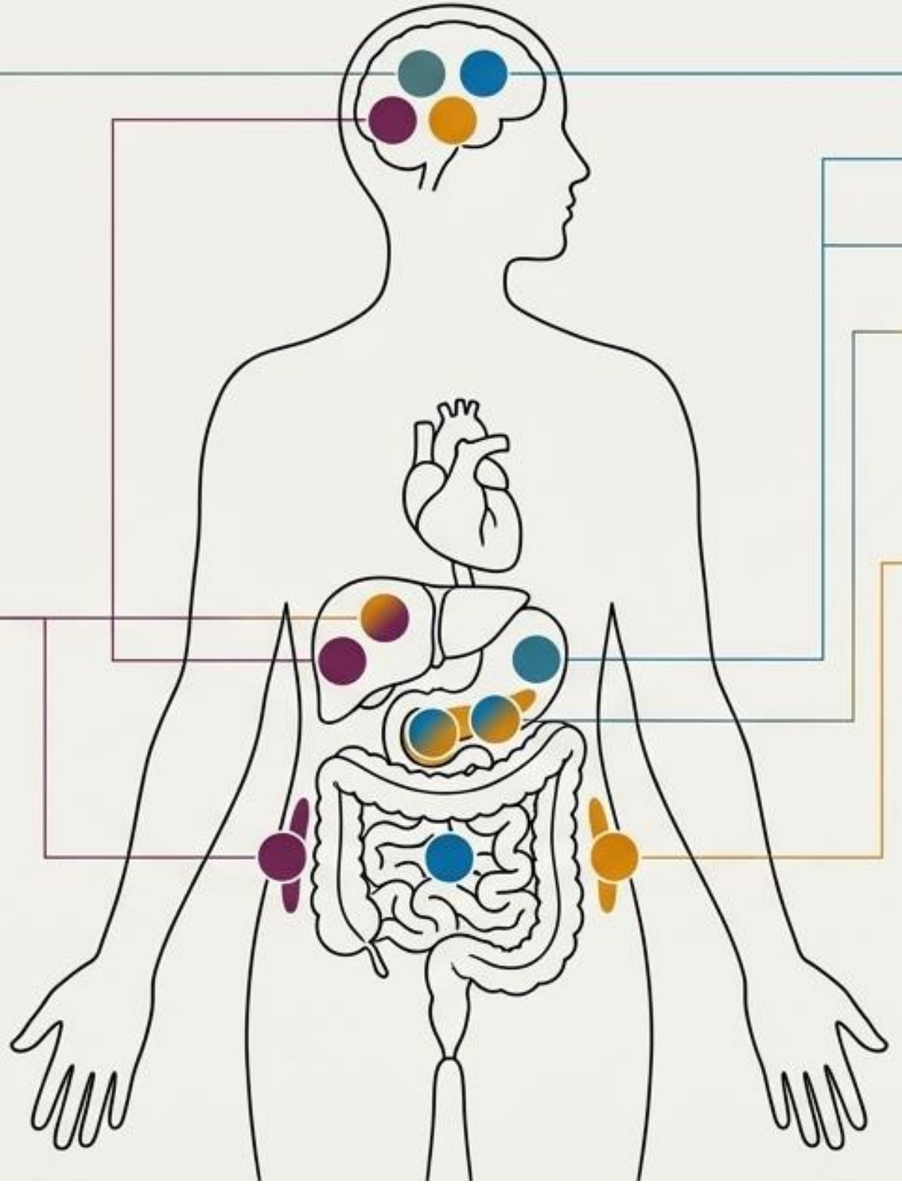
"Language matters. Stigma is an active contributor to the pathophysiology of obesity."



The Incretin Engine: Multi-Organ Targeting

Amylin
Brain: Satiety ↑
Stomach: Gastric emptying ↓
Note: Modulated by nutrients in GI tract, independent of potentiated insulin release.

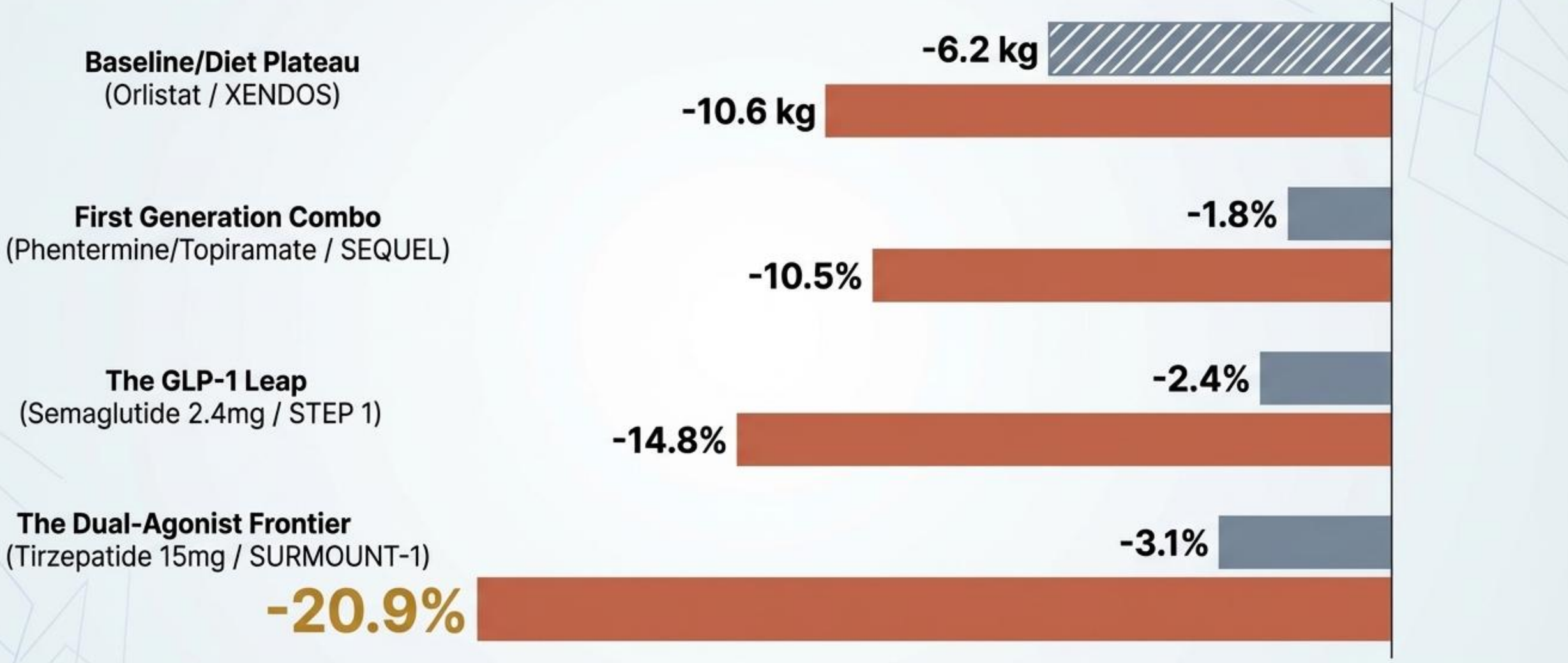
Glucagon
Liver: Glucose production ↑
Brain Adipose: Thermogenesis ↑
Adipose: Lipolysis ↑



GLP-1
Brain: Satiety ↑
Stomach: Gastric emptying ↓
Pancreas: Insulin ↑, Glucagon ↓

GIP
Adipose: Decreased insulin sensitivity, increased lipid buffering/storage
Brain: Reduced food intake
Pancreas: Insulin ↑, Glucagon ↑

The Step-Function Leap in Clinical Efficacy



Conclusion: Crossing the threshold from modest **clinical benefit (~5%)** to transformative, bariatric-level weight loss **(15-20%+)**.

Generation 1 Mono-Agonist: The Liraglutide Universe

Type 2 Diabetes (LEAD 1-6)	Obesity (SCALE)	Cardiovascular (LEADER)	NASH (LEAN)
• 0.8–1.5% HbA1c reduction.	• 5.4% to 9.1% weight loss at 56 weeks.	• 9,340 high-risk adults.	• 39% achieved NASH resolution vs 9% placebo.
• Modest weight loss (-1.8kg to -3.2kg).	• 63.2% achieved ≥5% weight loss.	• 13.0% MACE vs 14.9% placebo (HR 0.87).	• Reduced fibrosis progression (9% vs 36%).
• Improved β-cell function; lower hypoglycemia risk.	• Delayed T2DM onset.	• CV death reduced (4.7% vs 6.0%).	

Generation 2 Mono-Agonist: The Semaglutide Universe

Type 2 Diabetes (SUSTAIN & PIONEER)	Obesity (STEP 1-8)	NASH (Phase 2)	Renal (FLOW)
• HbA1c reductions up to -2.2% (SUSTAIN FORTE). • Superior to exenatide, insulin glargine, dulaglutide, and canagliflozin. • Oral formulation (PIONEER) non-inferior to liraglutide.	• The 15% Threshold. • STEP 1: -14.9%. • STEP 3 (w/ therapy): -16.0%. • STEP 4 (sustained): -17.4%. • STEP UP (7.2mg high dose): -20.7%.	• 59% resolution at 0.4mg daily vs 17% placebo. • No significant fibrosis improvement in F4 cirrhosis.	• Trial stopped early for efficacy. • Significant reduction in kidney disease progression, CV events, and death in T2D with CKD (eGFR 25-75).

The Dual-Agonist Era: Tirzepatide

Mechanism: GLP-1 + GIP

Suppresses appetite centers in the brain and slows GI transit.

Efficacy

Up to 20% starting body weight loss (dependent on dose/lifestyle).

Current Status

Prescribed widely for T2D; now officially NICE-approved for weight loss in the UK.

Wraparound Care Requirement

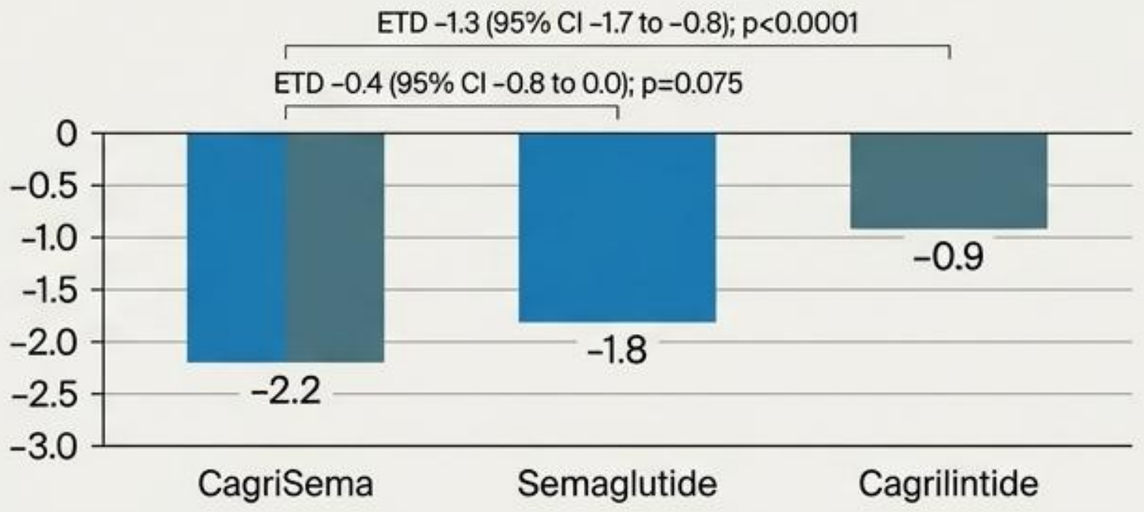
Mandatory participation in diet, nutrition, and physical activity support programs per NICE guidance.

The Pipeline: Amylin Co-Agonism

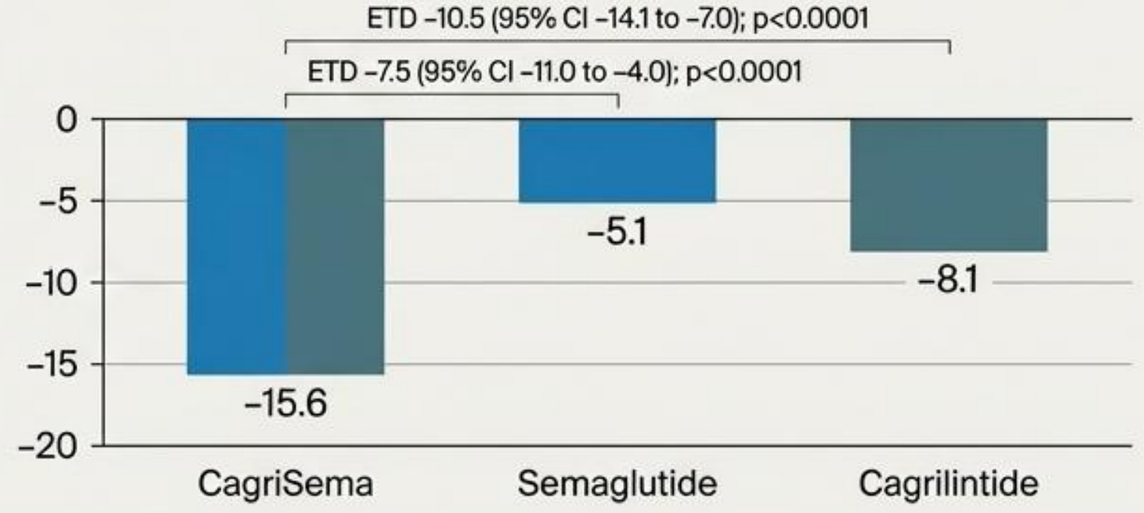
The Amylin Pathway

- A 37 amino acid peptide co-secreted with insulin.
- Modulates blood glucose by delaying gastric emptying and suppressing food intake.
- CagriSema (GLP-1 + Amylin): Phase 2 Trial data at 32 weeks.

Change from baseline in HbA1c (percentage points)



Change from baseline in bodyweight (%)



The Pipeline: Glucagon Activation & Energy Expenditure

Glucagon Receptor Activation*

Adipose tissue
Lipolysis; visceral fat ↓

Heart
Fibrosis; epicardial fat ↓

Kidneys
Fluid and electrolyte homeostasis

Liver
Energy expenditure; fibrosis ↓

+

GLP-1 Receptor Activation*

Brain
Food intake/appetite ↓

GI tract
Gastric emptying ↓

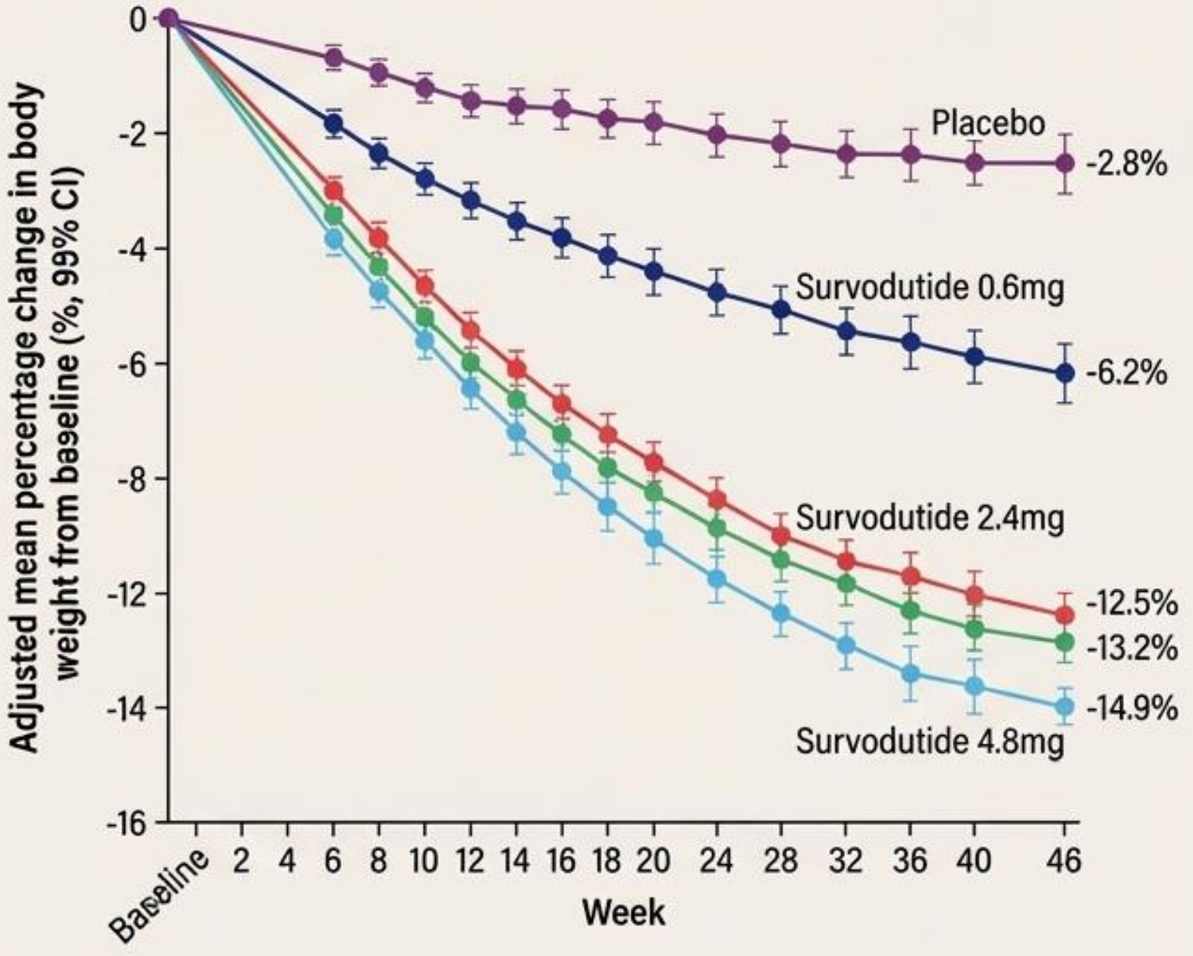
Heart
Plasma volume, intracardiac and pulmonary pressures ↓

Inflammation/other
CRP; vascular protection ↑

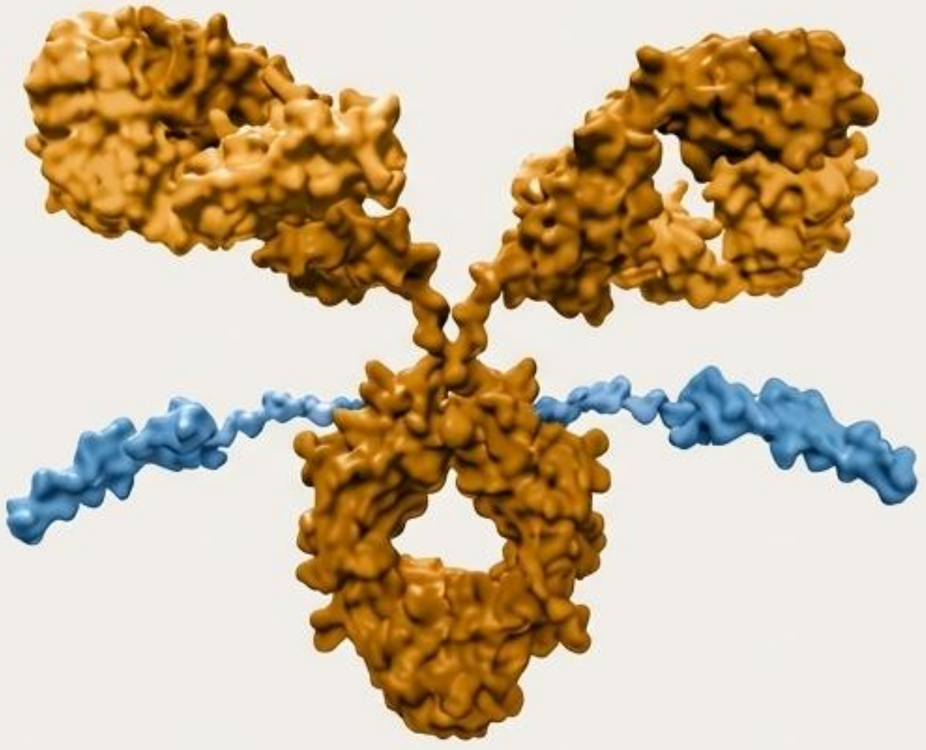
Additional mechanisms | Weight loss related | Additional mechanisms

Glucagon Activation: Opposes insulin action, stimulates gluconeogenesis, glycogenolysis, and lipolysis.

The Differentiator: Improved efficacy attributed directly to increased energy expenditure in liver and adipose tissue, complementing GLP-1 appetite suppression.



The Pipeline: Bispecific Engineered Molecules



Mari-Tide (AMG 133)

Fully human monoclonal anti-human GIPR antagonist antibody conjugated to two GLP-1 analogue agonist peptides.

Average 20% weight loss

Achieved at 52 weeks in Phase 2 trials.

No Plateau Evident

Weight loss plateau not yet seen at 52 weeks; further loss likely with longer duration.

Reduced Dosing Frequency

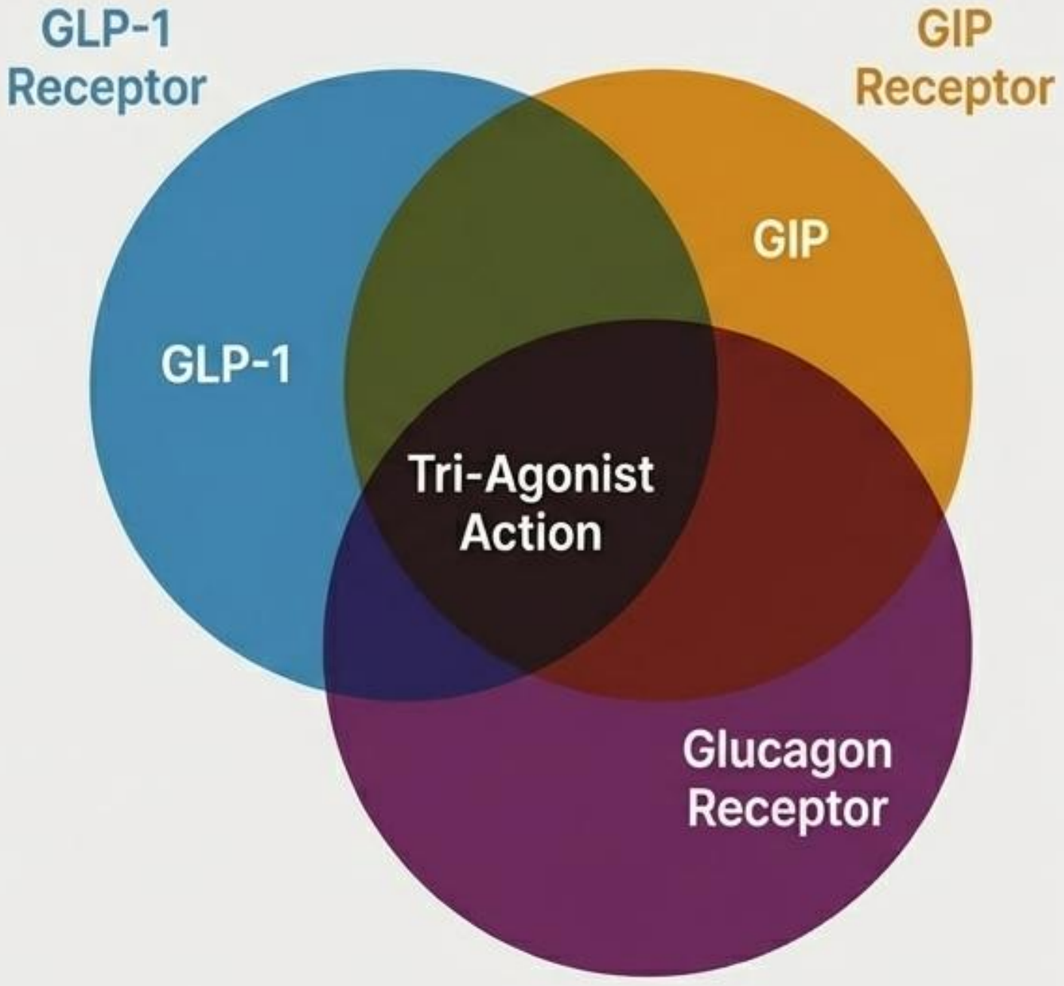
Allows for monthly (or less frequent) subcutaneous administration.

The Pipeline: Tri-Agonists & Breaking Barriers

The Tri-Incretin Hypothesis

GLP-1, GIP, and glucagon have similar peptide sequences, allowing for the engineering of single-sequence multi-receptor agonists.

Is three a crowd, or a cure?

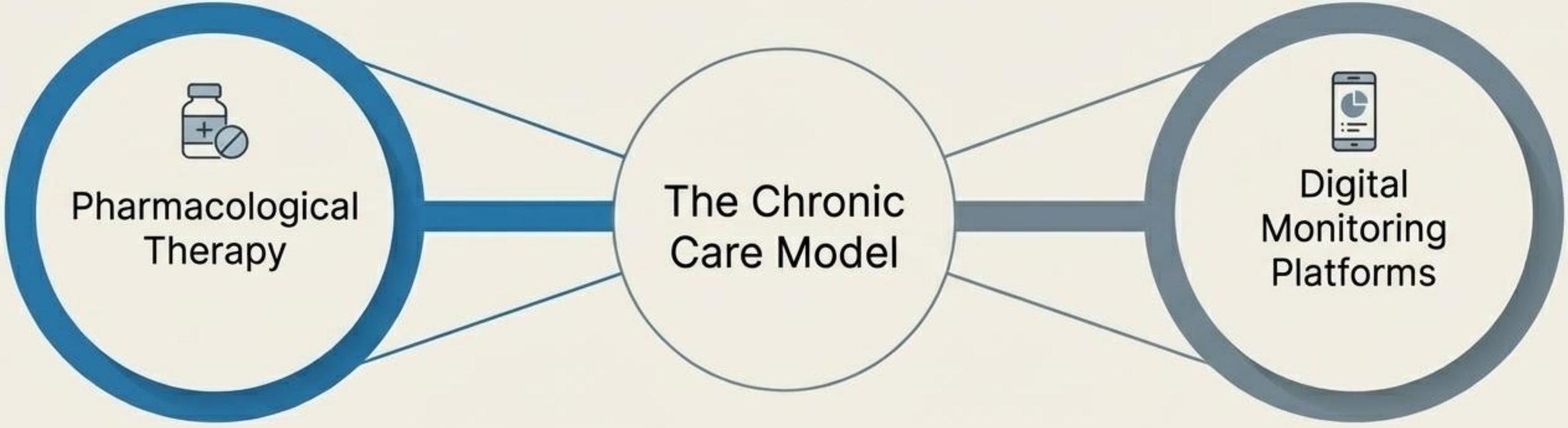


Retatrutide (Phase 2)

- Double-blind RCT (48 weeks).
- Dosing tiers from 1mg to 12mg.
- Outcomes: Breaking the >20% barrier.

Multi-receptor agonists prove definitively more effective than mono-agonists for reducing body weight and correcting systemic metabolic dysfunction.

The Ecosystem: Digital Wraparound Care



Clinical Reality	**NICE Early Value Assessment** (Approved Digital Platforms)			
Obesity is a chronic condition requiring long-term management. Crucially, there are no long-term stopping rules for these therapies.	• CheqUp	• Gro Health • W8Buddy	• Juniper	• Liva
		• Oviva	• Roczen	• Second Nature

The New Standard of Metabolic Care

1

Biological Reframing

Obesity is decisively a complex genetic and neuro-hormonal disease, not a failure of thermodynamics or willpower.

2

Combinatorial Scaling

Combinatorial incretin therapy (**GLP-1** (Medical Blue), **GIP** (Deep Amber), **Glucagon** (Rich Plum), **Amylin** (Slate Teal)) fundamentally alters the clinical trajectory of multi-organ metabolic dysfunction, compounding efficacy.

3

Infrastructure Reality

Realizing these systemic benefits requires navigating complex phased rollouts and integrating scalable, digital wraparound care for chronic disease management.

The Precision Obesity Playbook

10 Clinical Vignettes Translating the Pharmacotherapy Frontier

[GLP-1] [Dual Agonists] [Triple Agonists] [Multimorbidity]

The Incretin Landscape: Current Standards & Future Frontiers

Therapeutic Agent	Receptor Targets	Delivery & Route	Weight Loss Tier & Primary Niche
Semaglutide	 GLP-1	Injectable / Oral (Peptide)	Standard Tier. First-line foundation.
Tirzepatide	 GLP-1 + GIP	Injectable	High Tier. Severe metabolic dysfunction / T2DM.
Orforglipron	 GLP-1	Oral (Non-Peptide)	Standard to High Tier. Needle phobia / Maintenance.
Retratrutide	 GLP-1 + GIP + Glucagon	Injectable	Extreme Tier (~23-24%). Refractory risk / MASLD.

Patient Profile 01

41-year-old Woman

BMI: 42 | HbA1c: 39 mmol/mol | BP: 132/82

Comorbidities: PCOS, Obstructive Sleep Apnoea (on CPAP), Depression (well-controlled on sertraline).

History: Multiple commercial weight-loss programs with only transient benefit.

First-Line GLP-1 Foundation

Action Plan: Initiate once-weekly injectable semaglutide alongside a structured lifestyle program.

1. Screening

Rule out pancreatitis history, medullary thyroid carcinoma, pregnancy, severe GI disease.

2. Escalation

Slow dose titration of once-weekly injectable semaglutide to manage GI adverse effects.

3. Expectation Setting

Define realistic timelines and targets for weight loss beyond commercial program transients.

The Metabolic Maximizer: Tirzepatide vs. Semaglutide

Patient Profile 02

56-year-old Man

BMI: 38

HbA1c: 70 mmol/mol

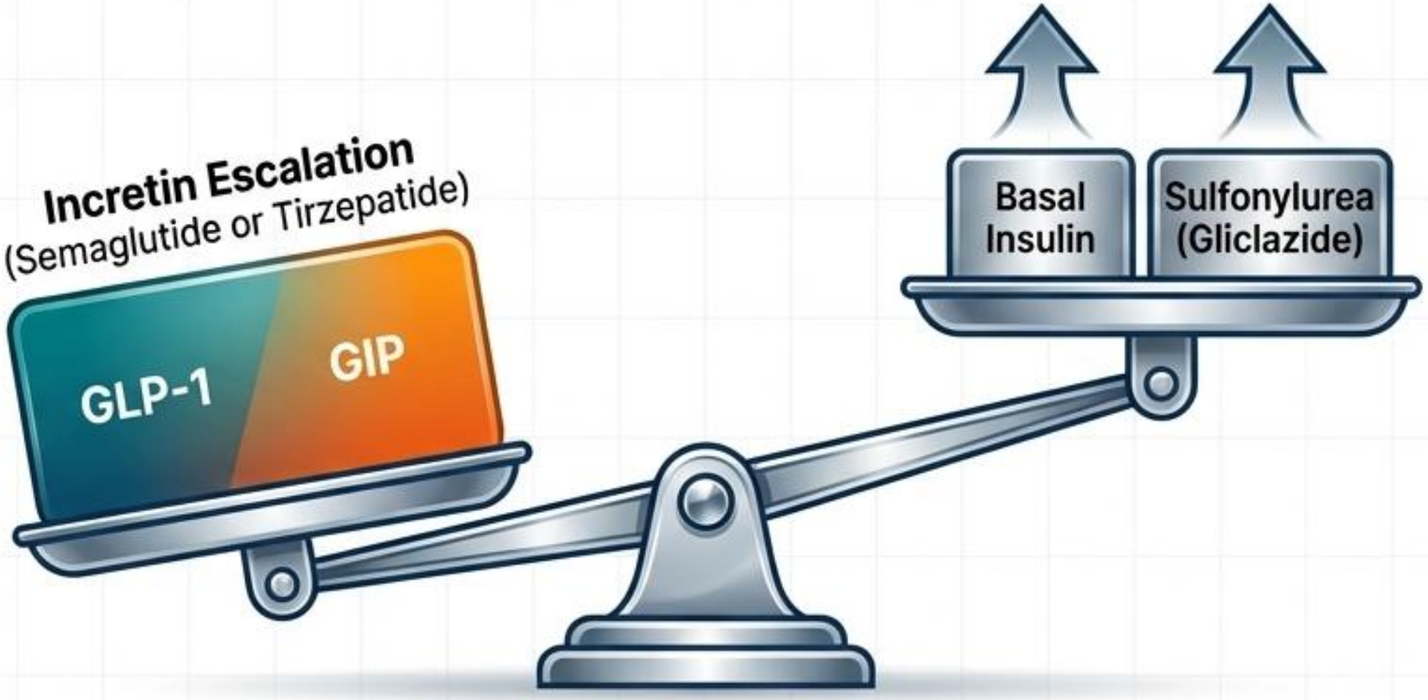
eGFR: 65 mL/min

Comorbidities: T2DM (10 years), Mild Retinopathy, ASCVD (prior NSTEMI).

Current Meds: Metformin, Gliclazide, Basal Insulin.

Patient Goal:
"Get off insulin".

The Deprescribing Teeter-Totter



Decision Focus: Choosing between semaglutide and the dual GIP/GLP-1 agonist tirzepatide for maximal HbA1c and weight reduction.

Deprescribing Pearl: Proactive down-titration of insulin and sulfonylureas is mandatory to prevent hypoglycemia as weight drops and insulin sensitivity rebounds.

Watch-out: Balance CV risk reduction against the need to monitor background retinopathy during rapid glycemic improvement.

The Oral Non-Peptide Frontier: Orforglipron

Patient Profile 04

59-year-old Woman

BMI: 39 | HbA1c: 76 mmol/mol

Meds: Maximized Metformin, SGLT2i, DPP-4i.

Challenge: Needle-phobic. Refuses injectables.

Patient Profile 05

52-year-old Man

Current BMI: 36 (Down from 44)

History: Lost 18% body weight over 18 months on injectable semaglutide.

Challenge: Injection fatigue. Wants maintenance.

Mechanism: **A once-daily oral GLP-1 receptor agonist with NO food or water timing restrictions.**

- **Strategy 1:** Switch DPP-4i to Orforglipron to drive clinically meaningful body weight and HbA1c reductions without needles.
- **Strategy 2:** Transition to Orforglipron as chronic weight-loss maintenance to prevent post-injection weight regain.

⚠ **Clinical Pearl:** Close post-marketing surveillance required due to different metabolic pathways compared to peptide injectables.

The Triple Agonist Frontier: Retratrutide in Severe Disease

GLP-1 + GIP + Glucagon = Maximum Metabolic Burn

Case 6

48-year-old Woman

[BMI: 45] **[HbA1c: 64 mmol/mol]**

History: Raised ALT, severe MASLD. Prior semaglutide failure (nausea/vomiting).

Strategy

MASLD Focus

Action: Refer to specialist clinic. Consider retratrutide.

Data: Phase 2 data shows ~23-24% weight reduction and profound improvements in liver fat and metabolic markers.

Pearl: GLP-1-like GI profile requires careful re-titration.

Case 7

63-year-old Man

[BMI: 41] **[HbA1c: 74 mmol/mol]**

History: ASCVD, CKD 3. Refractory to SGLT2i + maximal GLP-1 RA. On high-dose basal-bolus insulin.

Strategy

Refractory CV Risk Focus

Action: Switch from GLP-1 to retratrutide under tight supervision.

Data: Aggressively manage insulin dose reductions as insulin sensitivity rapidly improves.

Pearl: Monitor heart rate and hepatic parameters linked to glucagon activation.

Patient Profile 08

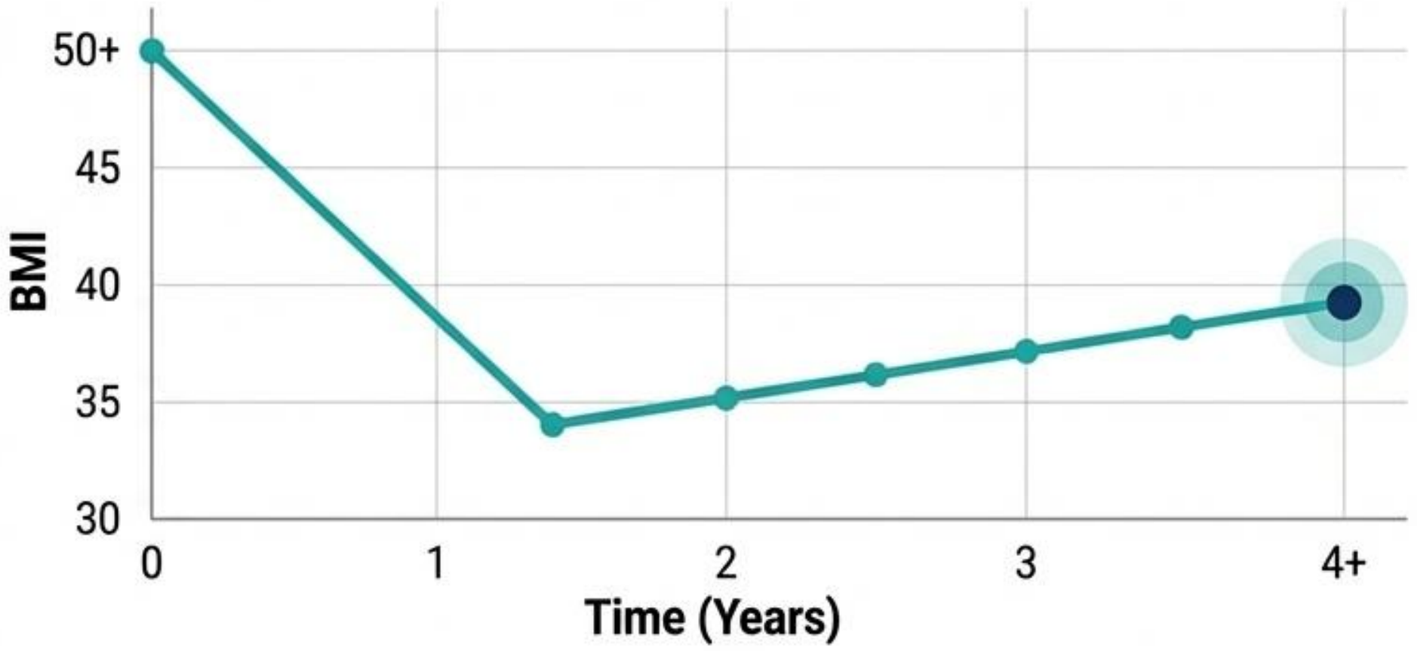
45-year-old Woman

Current BMI: 39 | Pre-op BMI: 50

History: Sleeve gastrectomy 4 years ago.

Comorbidities: T2DM in partial remission (HbA1c 45 mmol/mol on metformin), significant joint pain.

Complex Profiles: Overcoming the Bariatric Plateau



Action

Integrate incretin pharmacotherapy (GLP-1 RA now; future potential for orforglipron/retratrutide) via a multidisciplinary bariatric service.

Safety Pearls

Post-surgical altered anatomy requires strict monitoring of hydration and nutritional status when introducing GI-altering medications.

Holistic Care

Combine molecular tools with behavioral support to identify and address environmental drivers of weight regain.

Patient Profile 09

28-year-old Man

[BMI: 44]

[ALT: Mildly raised / MASLD]

Comorbidity: Active Binge Eating Disorder, low mood.

Patient Demand: "I want the strongest weight-loss injection."

Complex Profiles: The Active Eating Disorder Boundary

The Treatment Hierarchy

The Action: Involve psychology and dietetics immediately. Withhold powerful agents until behavioral stability is achieved.

The Risk: Chemically forcing rapid weight loss without addressing the underlying disorder can severely worsen body image and psychological distress.

Teaching Pearl: A shared, staged plan is non-negotiable. Psychological therapy first. Reconsider pharmacotherapy second.

Patient Profile 10

72-year-old Woman

BMI: 35 | HbA1c: 60 mmol/mol

Comorbidities: HFpEF, AF (anticoagulated), CKD 3b, Osteoarthritis, Mild cognitive impairment.

Polypharmacy Alert: 12 regular medicines.

Complex Profiles: Frailty & Polypharmacy

Primary Metric: Functional Mobility

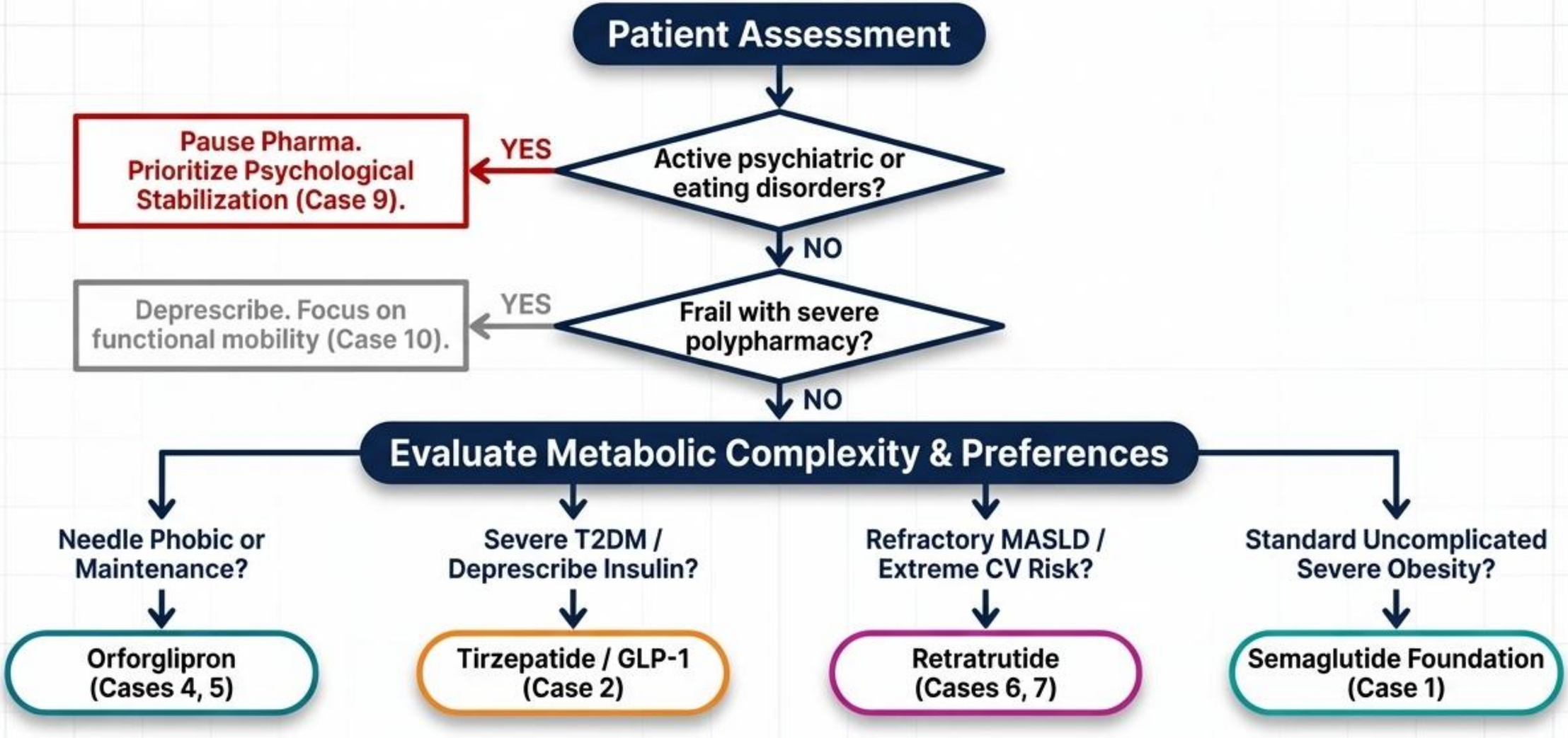
The Shift

Pivot goals from % body weight reduction to improving functional mobility and quality of life. Consider low-dose, ultra-slow titration of a GLP-1 RA only after simplifying her current 12-drug regimen.

Risks to Weigh

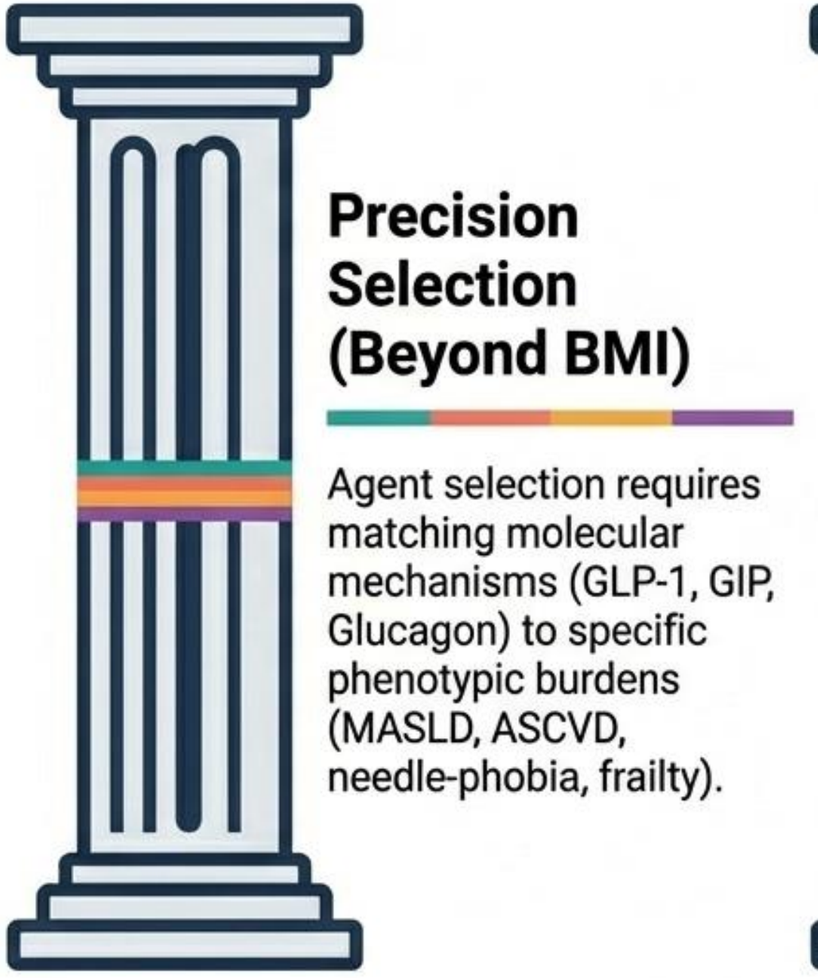
GI issues and dehydration can lead to acute kidney injury, sarcopenia, and catastrophic falls in frail adults. Future oral options (Orforglipron) remove needles but still add to overall pill burden.

Synthesis: The Precision Obesity Decision Framework



Obesity is not a monolith. The future of metabolic health requires matching the molecular precision of our tools to the clinical reality of the patient.

Core Tenets of Obesity Pharmacotherapy



Precision Selection (Beyond BMI)

Agent selection requires matching molecular mechanisms (GLP-1, GIP, Glucagon) to specific phenotypic burdens (MASLD, ASCVD, needle-phobia, frailty).

Proactive Deprescribing

Initiating powerful incretins mandates the active dismantling of previous regimens. Deprescribing insulin, sulfonylureas, and assessing psychotropics is critical.

Chronic Maintenance Mindset

Obesity is a relapsing disease. Pharmacotherapy must be viewed through a lifelong lens—a lens—transitioning to orals or rescuing post-bariatric regain.

From acute weight loss to lifelong metabolic modulation.

The Power of Comprehensive Obesity Management: Beyond Single-Method Care

Evidence shows that obesity management is most effective when it combines intensive behavioral programs with pharmacotherapy and ongoing clinical supervision. This "comprehensive care" model significantly improves weight loss maintenance and cardiometabolic health while mitigating the risks associated with potent new medications.

SUPERIOR CLINICAL OUTCOMES

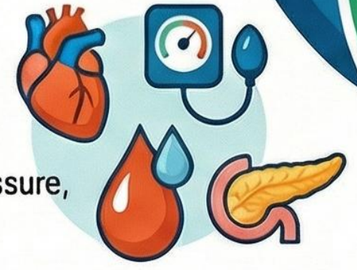
Synergy of Behavior & Medication

Combining pharmacotherapy with structured behavioral programs yields larger weight loss than either method alone.

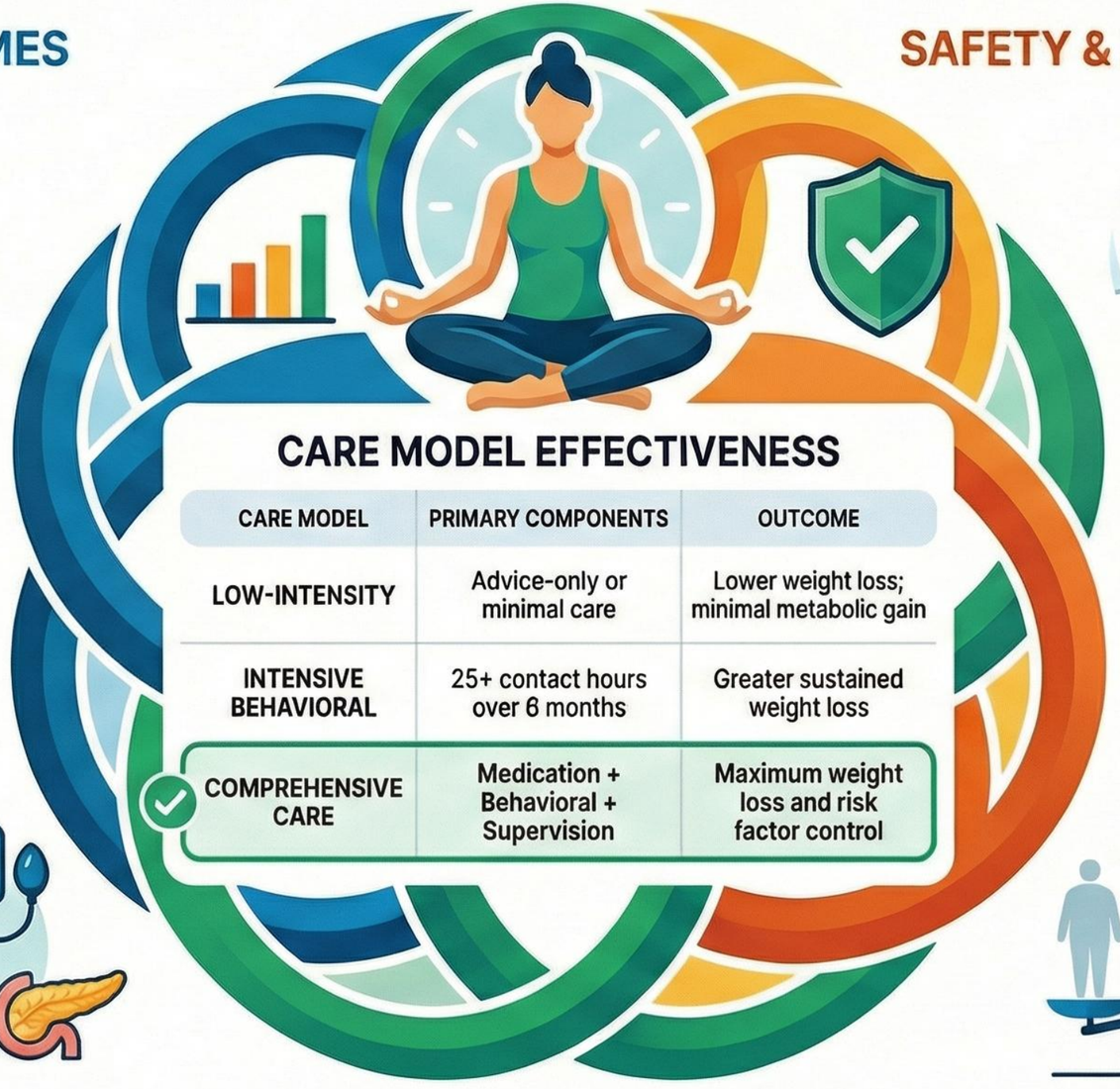
12–14 SESSIONS
FOR MAXIMUM IMPACT

Intensive behavioral programs with at least 25 contact hours consistently outperform low-intensity or advice-only approaches.

Cardiometabolic Risk Factor Control



Multicomponent care significantly improves blood pressure, HbA1c profiles, and lipid levels compared to minimal-care.



CARE MODEL EFFECTIVENESS

CARE MODEL	PRIMARY COMPONENTS	OUTCOME
LOW-INTENSITY	Advice-only or minimal care	Lower weight loss; minimal metabolic gain
INTENSIVE BEHAVIORAL	25+ contact hours over 6 months	Greater sustained weight loss
COMPREHENSIVE CARE	Medication + Behavioral + Supervision	Maximum weight loss and risk factor control

SAFETY & LONG-TERM SUSTAINABILITY

The Necessity of Clinical Supervision

Ongoing monitoring is required for dose titration and managing GI side effects or rare events.

Protecting Lean Mass & Nutrition

Team-based support prevents nutritional deficiencies and loss of lean mass during potent pharmacotherapy.

Risk of Weight Regain

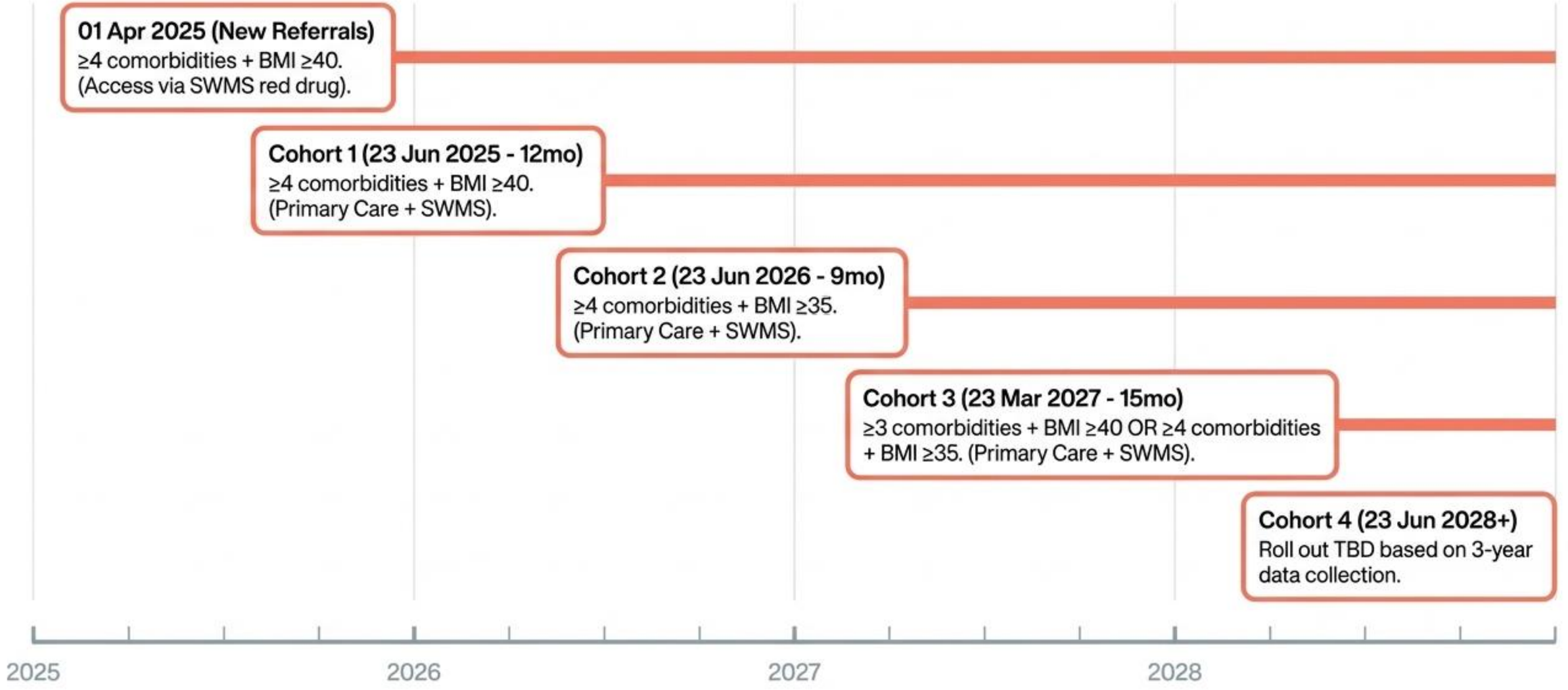
Stopping medication without continued behavioral support and monitoring is associated with substantial weight regain.

Demographic Adjustments: The BMI Sliding Scale

Use lower BMI thresholds for people from specific ethnic backgrounds.

- South Asian
- Chinese
- Other Asian
- Black African
- Middle Eastern
- African-Caribbean

Obesity Cohort Rollout Timeline (2025–2028)



The Diagnostic Matrix: Qualifying Comorbidities

Condition	Clinical Threshold
Atherosclerotic Cardiovascular Disease (ASCVD)	Cerebrovascular disease, ischaemic heart disease, peripheral vascular disease, heart failure. (Note: Wegovy is not approved in WY for ASCVD risk reduction alone).
Hypertension	Established diagnosis AND requiring blood pressure lowering therapy.
Dyslipidaemia	Treated with lipid lowering therapy OR LDL-C ≥4.1mmol/L OR HDL-C <1mmol/L (men) / <1.3mmol/L (women) OR fasting Triglycerides ≥1.7mmol/L.
Obstructive Sleep Apnoea (OSA)	Diagnosis via sleep study AND meets criteria for CPAP or equivalent.
Type 2 Diabetes	Diagnosis of T2D.

West Yorkshire Weight Management: 6-Month Mobilization Roadmap

Phase 1: Operational Readiness & Demand Control

Safe Service Mobilization
Launching commissioned services using BAG-rated templates and risk-stratification tools for consistent clinical access.

Predictive Capacity Modeling
Utilizing month-by-month cohort estimates to align workforce capacity with expected patient volume and complexity.

Equitable Activity Caps
Establishing spend controls that include inequality weighting to protect access for high-deprivation arees.

Core 90-Day Delivery Metrics

Priority Metric	Tracking Method

Activity Funnel
Referrals → Starts → Completions

Inequality Gap
IMD and ethnicity breakdown

Financial Grip
Activity vs. tariff claims and medication spend

Phase 2: Governance & Performance Oversight

The 'Single Source of Truth' Dashboard
Implementing an MVP dashboard to track the referral funnel, spend, and health inequality metrics.

Competent Workforce Training
Deploying a trauma-informed, culturally competent training pathway for all clinical and administrative roles.

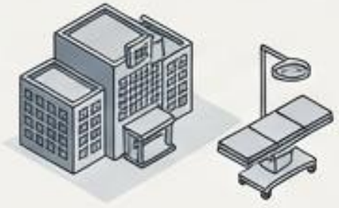
The WY Governance Spine
Unifying communications, contresting, and clinical safety monitoring under a single accountability framework.

Reimagining the obesity care pathway from reactive to proactive

	The Old System	The Neighbourhood Vision
Focus	Reactive treatment of severe comorbidities.	Proactive risk stratification and early intervention.
Setting	Hospital-based specialized weight management and bariatrics.	Neighbourhood Health Centres (NHCs) and high street touchpoints.
Workforce	Siloed GPs and acute specialists working independently.	Integrated Neighbourhood Teams (INTs) and empowered Pharmacy Prescribers.
Flow	Fragmented referrals; patients passed 'from pillar to post.'	Single Point of Access (SpoA) routing to specialized community streams.










Three pillars drive the delivery of neighbourhood reform

Pillar 1: Upgrading Routine Care

Digital triage, pharmacy-first expansion, and empowering GPs through reduced bureaucracy.

Pillar 2: Proactive Care

Integrated Neighbourhood Teams (INTs) and shifting traditional outpatient care into the community.

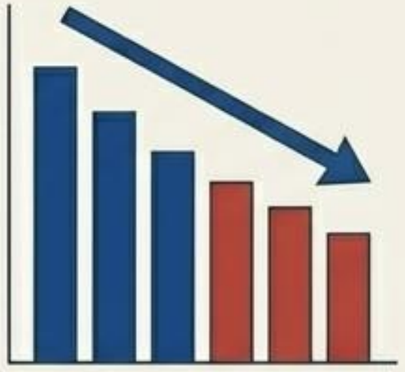
Pillar 3: Hospital Alternatives

Virtual wards and urgent community response designed to intercept crises and prevent acute admissions.

Defining and measuring success through mandated national metrics

Metabolic Outcomes

Achieve a 10% improvement in evidence-based QOF outcomes for diabetes and CVD by March 2029.



Paediatric Care

Deliver a 10% reduction in acute outpatient appointments for children under 16 by March 2029.

System Flow

Achieve a 25% diversion rate from outpatients via Single Point of Access by March 2027.

Local Alignment

Track improved overall satisfaction with care and address specific inequalities identified in the local JSNA.

PLAN VIEW

The Scottish Approach to Change

A unified, evidence-based framework for health and care renewal.

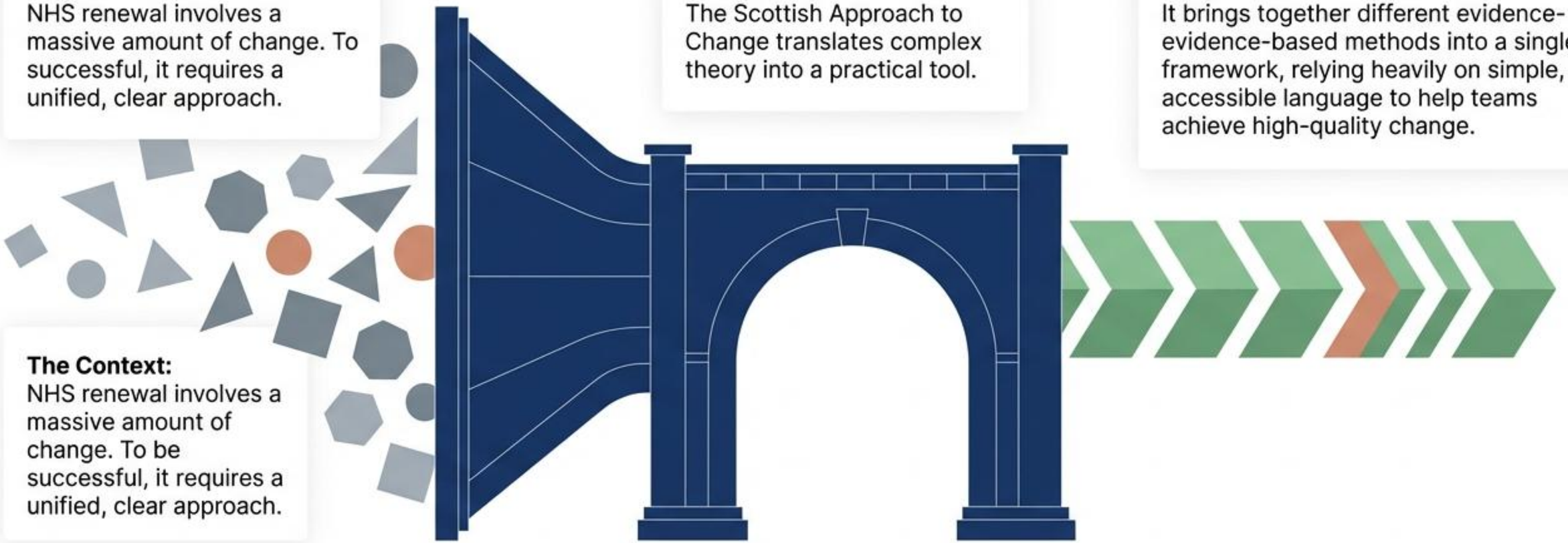
Healthcare Improvement Scotland

Doing change well across the health and care system

The Context:
NHS renewal involves a massive amount of change. To successful, it requires a unified, clear approach.

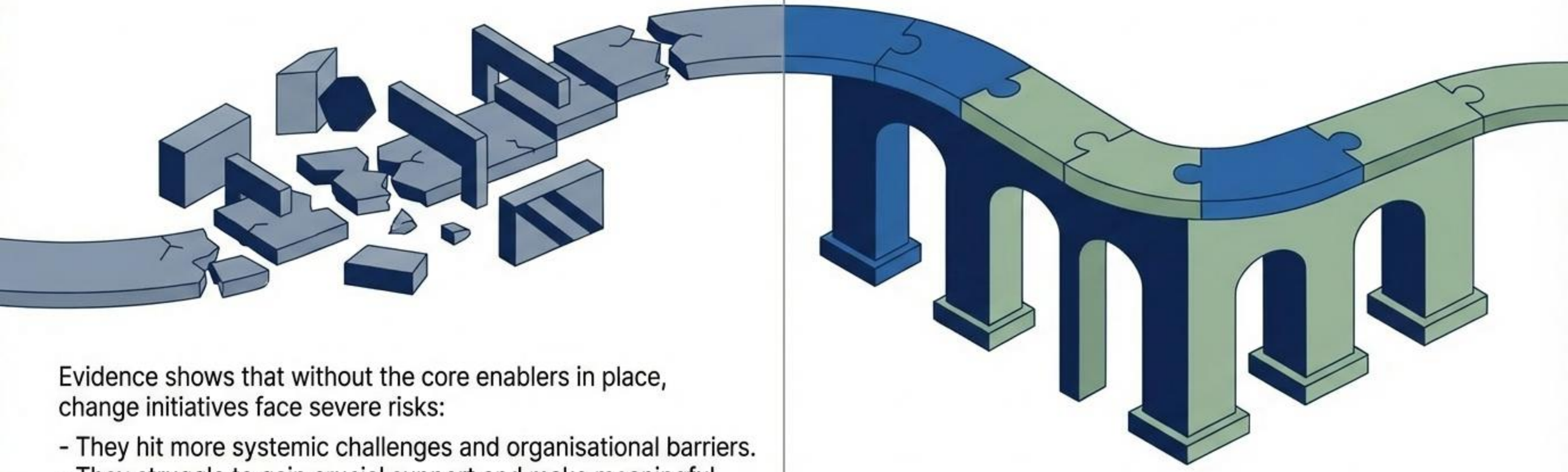
The Solution:
The Scottish Approach to Change translates complex theory into a practical tool.

The Mechanism:
It brings together different evidence-evidence-based methods into a single framework, relying heavily on simple, accessible language to help teams achieve high-quality change.



The Context:
NHS renewal involves a massive amount of change. To be successful, it requires a unified, clear approach.

The evidence against unguided change



Evidence shows that without the core enablers in place, change initiatives face severe risks:

- They hit more systemic challenges and organisational barriers.
- They struggle to gain crucial support and make meaningful progress.
- They are significantly more challenging to sustain over time.

The Takeaway: Successful change fundamentally relies on having five specific enablers in place.

Aligning people, processes, and leadership around a shared purpose

The five enablers of quality and change create the exact conditions that support successful improvement.

Defining purpose and establishing systematic rigour

Enabler 1: Clear vision and purpose

- Define a clear vision and purpose that drives your change.
- You must explicitly outline what you are trying to do and exactly how you will get there.

Enabler 2: Process rigour

- Outline a highly rigorous approach in how you operate.
- Undertake change systematically across your entire organisation, leaving nothing to ad-hoc processes.

Empowering people and shaping the right environment

Enabler 3: Leadership and culture

- Change cannot survive in a hostile environment.
- Create the exact conditions for change to thrive by actively setting the right culture and demonstrating effective leadership.

Enabler 4: People-led

- Take a fundamentally people-led approach.
- Actively invite people to co-design and deliver change together, rather than imposing it from the top down.

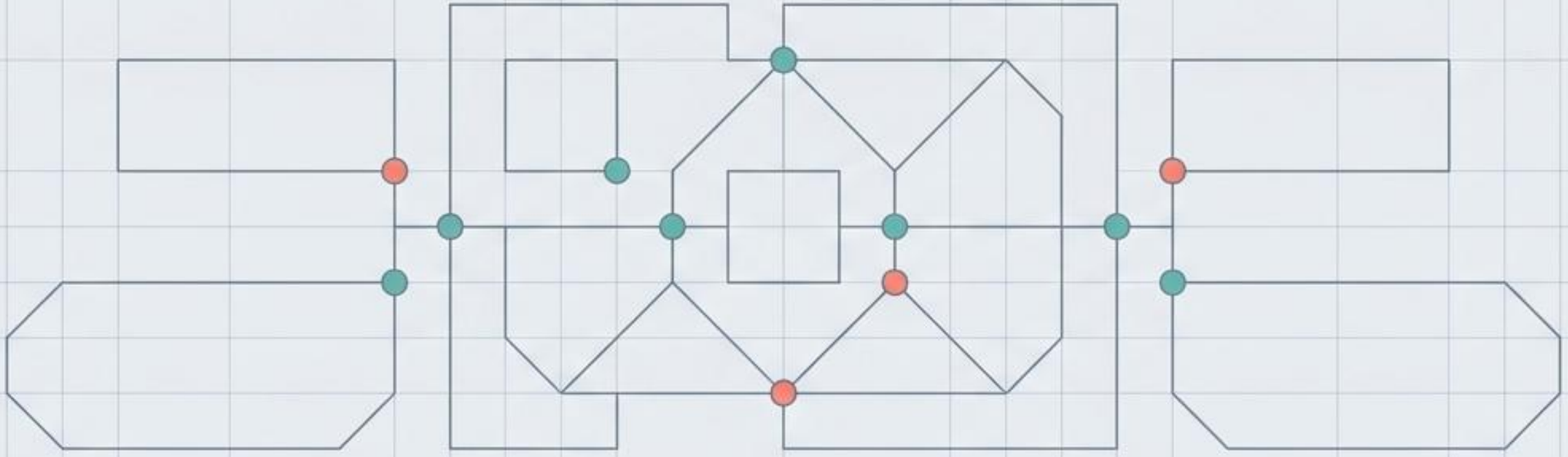
Embedding a sustainable learning culture

Enabler 5: Learning system

- A static approach will eventually fail.
- You must embed a continuous learning culture to support and adapt your change programme sustainably over the long term.

Architecting the Primary Care Obesity Audit

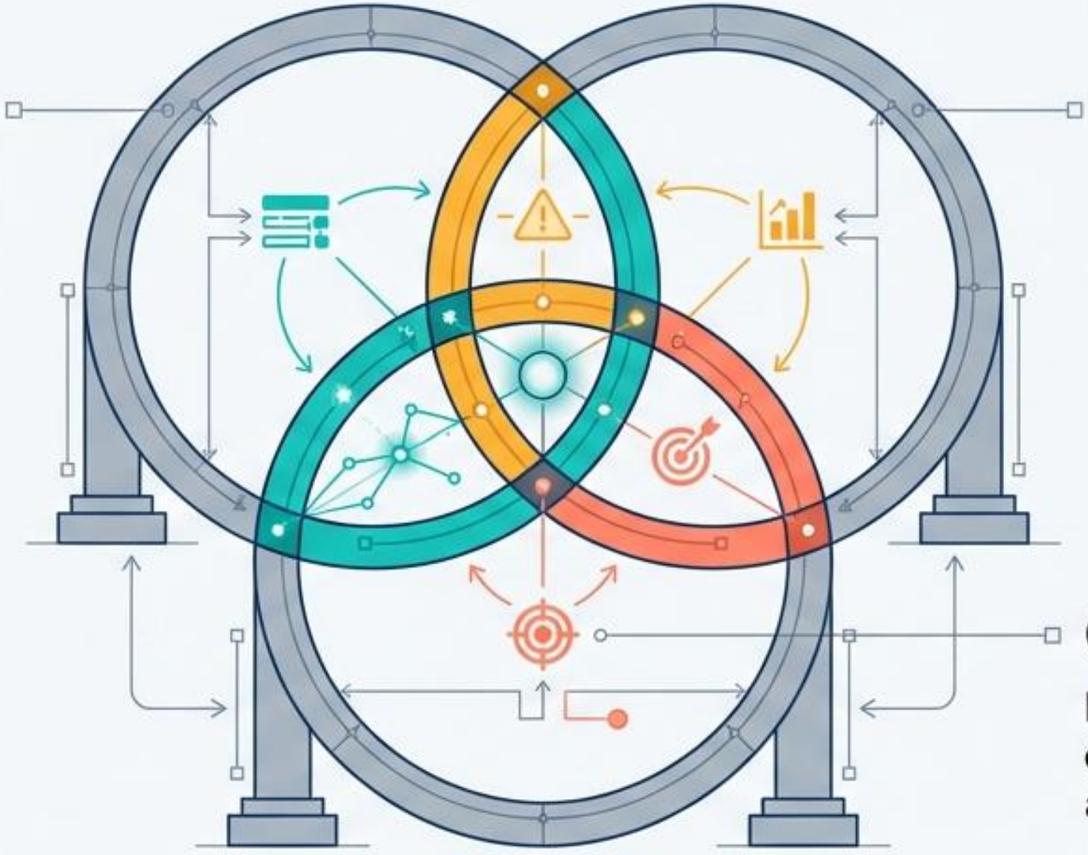
A blueprint for embedding quality improvement, structured data, and automated reporting into local weight-management services.



The Strategic Foundation: The Alignment Triad

Local Pathways

Your specific local clinical routes, commissioned services, and referral networks.



National Data Flows

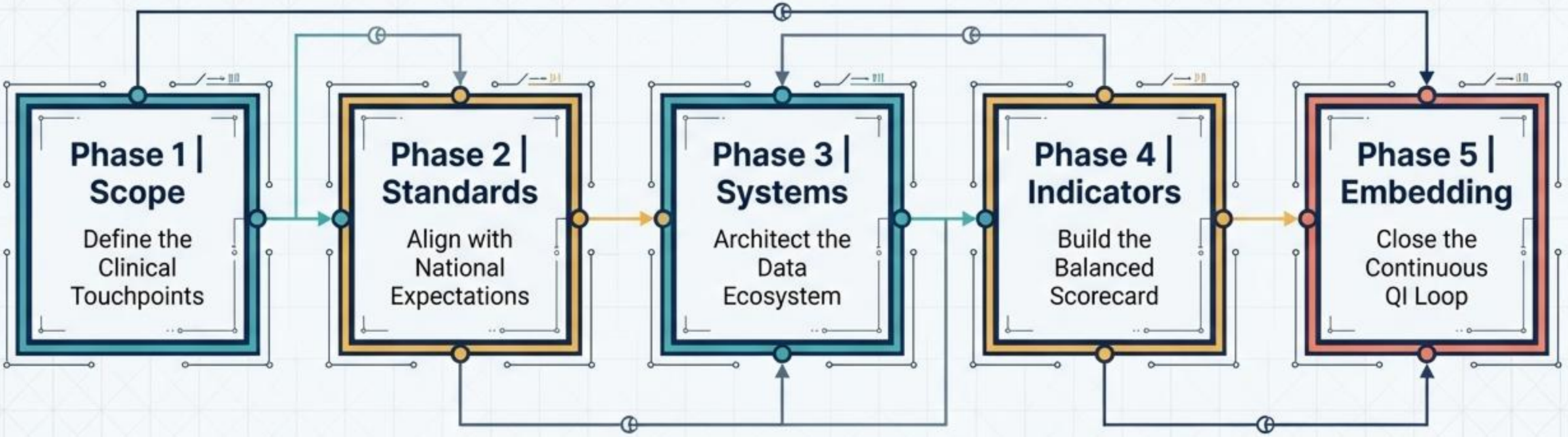
The National Obesity Audit (NOA) infrastructure and broad CVD prevention datasets.

GP/PCN Services

Existing weight-management enhanced service frameworks and financial levers.

Frame your audit as local implementation of national guidance, not a scratch-built standard.

The 5-Phase Implementation Blueprint



Phase 1: Define the Scope Across the Patient Journey

Identification & Coding

Register completeness, annual BMI recording, and opportunistic case-finding.

Assessment Quality

Documentation of comorbidities, complications, clinical risk, and patient readiness to change.

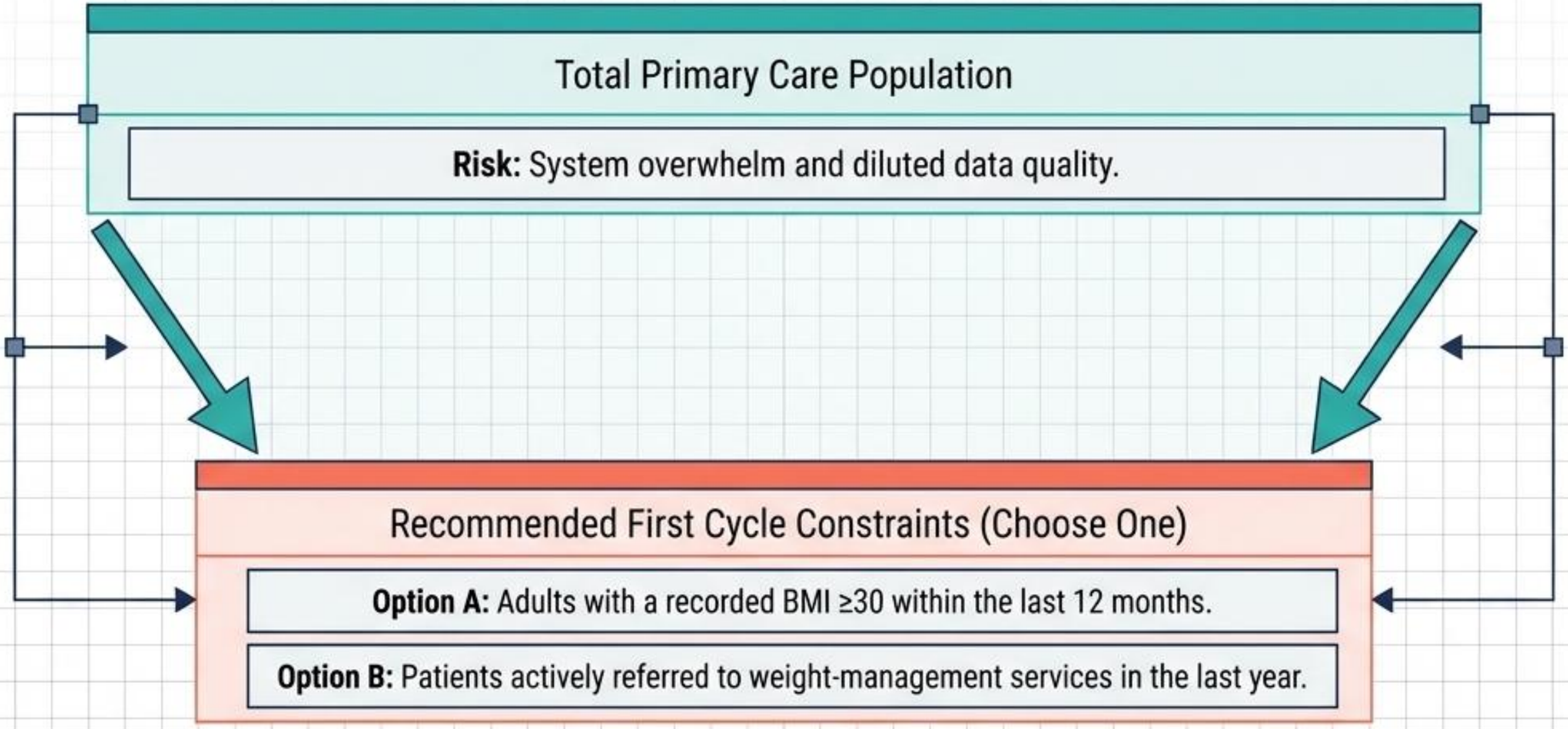
Intervention & Referral

Provision of brief advice, referrals to tier 2/3 services, use of Anti-Obesity Medications (AOMs), and self-management support.

Follow-up & Outcomes

Tracking BMI change, cardiometabolic risk factors, patient-reported outcomes (PROMs), and service retention.

Phase 1: Constrain the First Cycle to a High-Impact Cohort

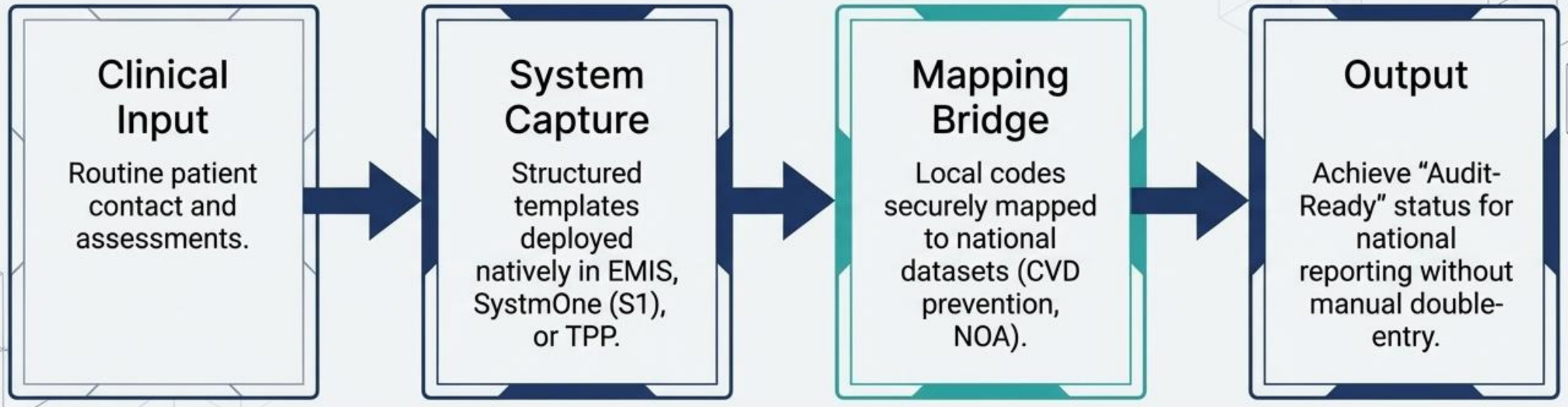


Keep the initial data capture tight. Establish the system architecture on a defined cohort before scaling outward.

Phase 2: Map Local Indicators Directly to National Expectations

Implicit National Levers	Local Audit Actions
Maintain an obesity register & annual BMI records.	Audit BMI ≥30 (and ≥27.5 in high-risk ethnic groups).
Structured care pathways.	Audit proportion of eligible patients with appropriate weight-management referral documented.
Commissioned pharmacotherapy/surgery guidelines.	Audit adherence to local NICE-aligned thresholds for intervention.
Patient-centered care standards.	Audit recording of lifestyle advice, shared decision-making, and signposting.

Phase 3: Architect a Seamless Data Ecosystem with BI Teams

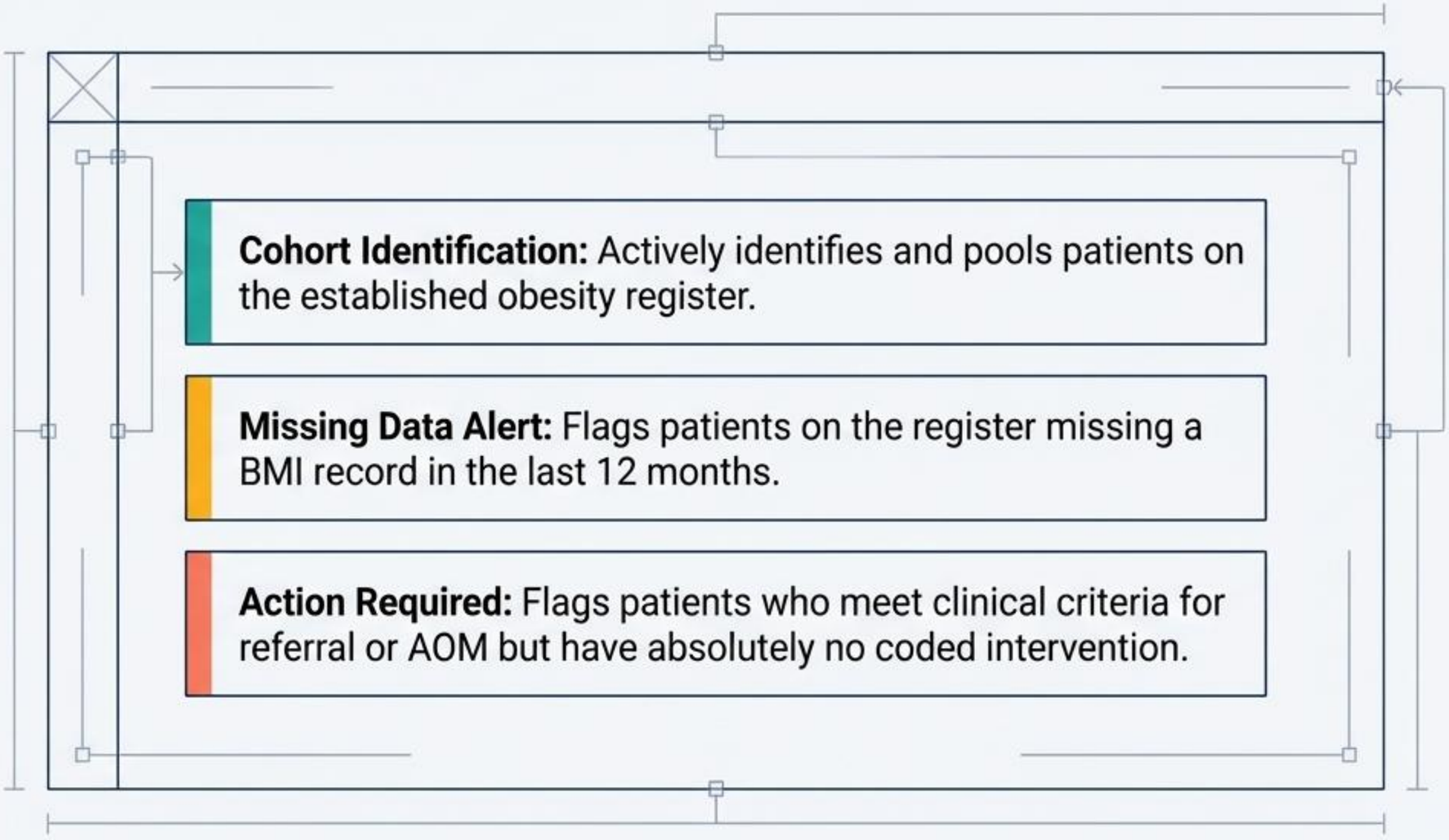


Strategic Imperative: Work directly with digital/BI teams to map local codes to the upcoming National Obesity Audit (NOA) dataset from day one.

Phase 3: Required Clinical Template Architecture

Clinical Action	Required Data Fields
Obesity Review	Required Data Fields: BMI, specific comorbidities, medications affecting weight, psychosocial factors, patient goals.
Weight-Management Referral	Required Data Fields: Target service identified, eligibility criteria verified as met, shared decision-making documented.
AOM Initiation / Review	Required Data Fields: Clinical indication, specific agent, baseline measures, review points, agreed stop rules.

Phase 3: Deploy Smart Flags for Proactive Case Management



Phase 4: The Balanced Indicator Scorecard

Structure & Process

Adults with any BMI recorded in last 5 years.
Adults on register with BMI re-recorded in last 12 months.
Eligible patients with coded brief advice, tier 2/3 referral, or consideration of AOM.

Quality & Safety

AOM patients with documented eligibility (BMI/comorbidity).
Baseline renal/liver function and contraindications checked.
Agreed stop rule and review date documented.

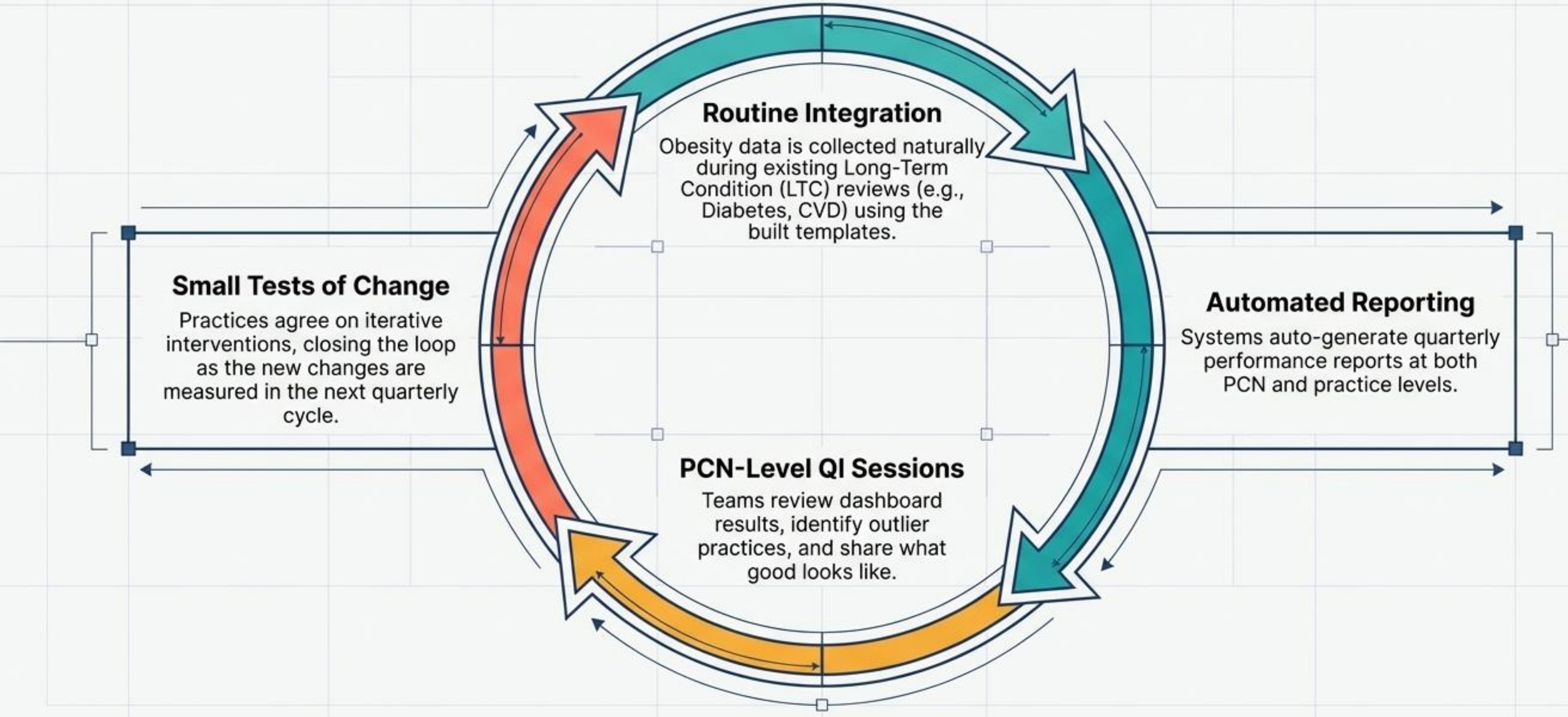
Outcomes

Mean weight/BMI change at 3, 6, and 12 months for referred/AOM patients.
Proportion achieving ≥5% and ≥10% weight loss at 12 months.

Equity

Distribution of referrals and AOM prescribing analyzed by sex, age band, deprivation quintile, and ethnicity—directly compared against baseline practice population.

Phase 5: The Continuous Obesity Quality Improvement Loop



Next Steps: Structuring Your Governance Proposal

Action 1: Define your exact ICB and PCN setup.

Action 2: Identify if your practice is already utilizing the weight-management enhanced service.

Action 3: Clarify your local obesity medication pathway and commissioned services.

One-Page Standards-Based Proposal

Finalized document, ready for submission, adhering to all defined standards.

Final Deliverable

Combine these three local truths with the 5-phase blueprint to draft a **standards-based audit proposal** ready for your QI or governance committee.