LONDONASSEMBLY

September 2025

Health Committee

This document contains the written evidence received by the Committee in response to its Call for Evidence, which formed part of its investigation into weight loss medication in London.

Calls for Evidence are open to anyone to respond to. In August 2025 the Committee published a number of questions related to its investigation, which can be found on page 2. The Call for Evidence was open from 6 August to 19 September 2025.

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BOMSS GUIDELINES FOR NHS PATHWAY FOR PATIENTS LIVING WITH COMPLEX AND SEVERE OBESITY

Background

For decades "weight loss" or metabolic bariatric surgery (MBS) has been the only effective treatment for severe and complex obesity (NICE NG246).

Over the last five years obesity management medications (OMMs) in the form of GLP-1 agonists have been approved by NICE for the treatment of this condition (NICE NG246).

For the cohort of patients with severe and complex obesity who fulfil the NICE criteria for both medication and surgery there is no guidance as to which treatment options should be recommended for which sub-group of patients.

Although there is an argument that all patients should receive medication as initial first line therapy, the latest NHS England interim commissioning guidance for Tirzepatide (NICE TA1026) acknowledges that there are both logistical and financial constraints which means this approach will not be offered by the NHS at present.

There is therefore a need to develop pathways to ensure the maximal number of patients with severe and complex obesity can access the most efficacious treatment safely and at the appropriate time within the financial constraints of a publically funded service.

The purpose of this document is to propose a pathway for patients referred through primary care for management of severe and complex obesity.

Key considerations for proposed pathway

1. The patient is at the centre of all decision making. Patients should be informed of all treatment options available to them including their risks, benefits, effectiveness, cautions, and any recommended support and follow-up; and have the opportunity to ask questions in a shared decision making consultation.
2. It is recognised that within the NHS financial and logistical considerations may limit the choice of treatments offered to patients.
3. There are limited data on comparative outcomes between medical and surgical treatment, however current evidence suggest that surgery offers greater and more durable outcomes both in terms of weight loss and improvements in obesity-associated conditions.
4. Patients with severe and complex obesity should initially be assessed and managed by a multimodal non-medical and non-surgical Specialist Weight Management Service (though it is recognised that this provision is patchy across the United Kingdom)
5. Decisions on definitive treatment should be made by a multidisciplinary team (MDT) with expertise in both medical and surgical management.
6. Discussion of medical options should include all GLP-1 medications including Semaglutide and Tirzepatide; and emphasise the importance of wraparound care and longer-term follow-up. It should be acknowledged that evidence on long term outcomes with these is scarce; and it does appear that cessation of these medications leads to weight regain and recurrence of obesity- related complications in the majority of patients.
7. Discussion of surgery options should include all bariatric surgical procedures (including, where appropriate, endoscopic options) and the importance of long-term follow-up.

Proposed pathway

Based on current clinical evidence and cost effectiveness assessments, we propose the following three referral streams:

Referral to Bariatric Surgical service

- Patients with a BMI ≧ 50 kg/m^2 should be considered for surgery as definitive treatment. **(see note 1)**

- Patients with BMI 40-50 kg/m^2 with one or more qualifying obesity-related metabolic co-morbidities (**see note 2)** should be considered for surgery as definitive treatment.

- Patients with severe and complex obesity who have:
    i. a contra-indication to OMMs.
    ii. are unable to tolerate OMMs due to side-effects
    iii. where OMMs have been ineffective after a trial period of at least 3 months

Referral for Surgical or Medication treatment

Patients in the following categories should be consider for either:

a. Referral to a bariatric surgical service for consideration for surgery; or

b. OMM prescribed within an appropriate Specialist Weight Management Service

- Patients with BMI 40-50 kg/m^2 with no qualifying obesity-related metabolic co-morbidities should undergo MDT assessment and then be considered either for treatment with medication or surgery.

- Patients with BMI of 35-40 kg/m^2 with one or more qualifying obesity-related metabolic co-morbidities should undergo MDT assessment and then be considered either for treatment with medication or surgery (**see note 2).**

Referral for Medication Treatment

Patients in the following category should be consider for referral for medication prescribed within in an appropriate Specialist Weight Management Service

- Patients with a BMI of 30-35 kg/m^2 with or without qualifying obesity-related metabolic co-morbidities should be considered for treatment with OMM as first-line therapy.

Notes

1. For patients with very high BMI (over 60 kg/m^2) or those with multiple medical co-morbidities, OMM may be utilised pre-operatively as a bridge to surgery to reduce the incidence of peri-operative complications following surgery.

2. Qualifying obesity-related metabolic co-morbidities are based on the NICE England Tirzepatide funding variation and are:
    - Type 2 diabetes
    - Established atherosclerotic disease
    - Obstructive sleep apnoea requiring CPAP treatment
    - Dyslipidaemia requiring medical therapy
    - Hypertension requiring medical therapy

3. For patients from certain ethnic backgrounds, the above BMI thresholds should be reduced by 2.5kg/m^2 as per NICE guidance.

It is acknowledged that this is a rapidly developing field and these criteria may be subject to revision depending on future publications. In addition we note that at present funding may be limited for some parts of the medication pathway as per latest NHS England interim commissioning guidance for Tirzepatide (NICE TA1026)

London Assembly's Health Committee inquiry into weight loss medication in London

Written evidence from the Company Chemists' Association (CCA)

Company Chemists' Association
Established in 1898, the Company Chemists' Association (CCA) is the trade association for multiple pharmacies across England, Scotland and Wales. The CCA membership includes ASDA, Boots, the Lincolnshire Co-op, Morrisons, Pharmacy2U, Rowlands Pharmacy, Superdrug, Tesco, and Well, who between them own and operate around 4,000 pharmacies across Great Britain. Our vision is that everyone, everywhere, can benefit from world class healthcare and wellbeing services provided by their community pharmacy.

Background
Whilst the NHS rollout of access to GLP-1 weight loss drugs remains limited in nature[1], CCA members already have considerable experience in providing comprehensive weight loss services privately. The recently published *10 Year Plan for the NHS* reiterated the Government's commitment to expanding the role of community pharmacies in delivering clinical care and the management of long-term health conditions. With roughly 95% of all patients accessing new GLP-1 weight loss medications privately[2], pharmacies are well placed to use their experience to rapidly improve access to any future NHS pathways.

The CCA's written evidence
The CCA welcomes the opportunity to take part in this timely inquiry. Our response comes from a community pharmacy perspective with our members already providing access to weight loss services privately in London and across the UK. As such, we have only responded to Q1 and provided further information about the current state of NHS and private provision, which we believe will be of benefit to the Committee.

1. What are the benefits and risks of weight loss medicines?
There are a wide range of significant socio-economic benefits that weight loss medications provide, including both improved wellness and health, and through savings to public finances by preventing future health problems associated with obesity.

Benefits to individuals
GLP-1 receptor agonists (weight loss medications) have been clinically shown to result in significant weight loss, often exceeding 15–20% of body weight[3]. Beyond the immediate improvements from being physically fitter and healthier, with musculoskeletal benefits, these medications have multiple recognised or emerging benefits. These include reduced risk of developing comorbidities including Type 2 Diabetes[4,5], cancer[6] and cardiovascular disease or

[1] Thousands of patients miss out on weight loss jab due to NHS 'postcode lottery' | The Independent
[2] Are weight loss drugs making only the wealthy healthy? | UK News | Sky News
[3] BBC News - Weight-loss drugs tested in head-to-head trial: www.bbc.co.uk/news/articles/cy75dk8kjr1o
[4] Harvard Medical School: www.health.harvard.edu/staying-healthy/glp-1-diabetes-and-weight-loss-drug-side-effects-ozempic-face-and-more
[5] Association of British Dieters - joint statement regarding GLP-1/GIP Receptor Agonists for people living with obesity and/or type 2 diabetes released: www.bda.uk.com/resource/new-joint-statement-regarding-glp-1-gip-recepto-agonists-for-people-living-with-obesity-and-or-type-2-diabetes-released.html.
[6] Sky News: Weight loss jabs could almost halve risk of obesity-related cancers beyond slimming down, study suggests | Science, Climate & Tech News | Sky News

experiencing a cardiac event[7]. The loss of excess weight also reduces the complications of musculoskeletal problems such as chronic back ache and hip or knee pain. With weight loss comes an improved quality of life, better management of existing comorbidities, and enhanced energy levels and mobility. In addition, there are improvements to mental health and added fulfilment from a greater chance of returning to the workplace and contributing to economic growth[8].

Benefits for the health and social care sector

The NHS would benefit hugely from reduced pressures with lower volumes of obesity related chronic health conditions in the future. For example, obesity accounts for 90% of newly diagnosed Type 2 diabetes cases, 31,000 deaths annually from heart and circulatory diseases, and more than 1 in 20 cancers in the UK[9]. Reducing the population's risk of developing these conditions from obesity is crucial to alleviating current and future pressures on NHS services, in addition to the fiscal and cost saving benefits this presents to the NHS and the wider economy[10].

Further research is required but studies suggest weight loss medications are both more effective for patient outcomes and more cost effective compared to other treatments[11]. At the lower end of interventions, the NHS can prescribe behavioural change programmes (Tier 2) which are cheaper but have been shown to be less effective[12]. At the higher end, the NHS offers bariatric (weight loss) surgery (Tier 4) but this is costly, invasive and requires the patient to commit to making lifestyle changes upfront[13]. Reports have also highlighted the significant cost to the NHS from people going abroad for bariatric surgery then later requiring urgent medical care at home following complications[14].

GLP-1 drugs (weight loss medications) provide a more balanced approach, offering more meaningful results compared to behaviour change programmes but with lower risks than surgery. Weight loss medications can be seen as a more desirable option as demands on the patient are minimal, resulting in higher compliance with only once weekly injections.

It is important that any conversation on the cost effectiveness of weight loss medications considers the wider costs to society and the economy from obesity. A recent, and the most comprehensive, estimate of the economic cost of obesity in the UK, put the annual figure at £58 billion, in 2020, equivalent to about 3 per cent of GDP[15].

A report from The Tony Blair Institute (TBI) has suggested that by extending the eligibility of weight loss medications, greater payback to the economy and cost-benefit neutrality could be achieved sooner than the NHS's existing timetable. Currently, the NHS's rollout programme would suggest that cost-benefit neutrality will be achieved by 2053. However, the TBI argued that increasing

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[7] British Heart Foundation: www.bhf.org.uk/what-we-do/news-from-the-bhf/news-archive/2024/may/weight-loss-drugs-could-have-cardiovascular-benefits-new-research-shows.
[8] Obesity Evidence Hub: Health benefits of weight loss | Obesity Evidence Hub
[9] Frontier Economics – the rising cost of obesity in the UK: www.frontier-economics.com/uk/en/news-and-insights/news/news-article-i20358-the-rising-cost-of-obesity-in-the-uk.
[10] The Tony Blair Institute: Wider access to obesity drugs could save UK £52 billion by 2050.
[11] BMJ medicine: www.bmj.com/content/384/bmj-2022-072686
[12] BMJ medicine: https://bmjmedicine.bmj.com/content/1/1/e000130
[13] NHS Royal Berkshire - Weight loss (bariatric) surgery: www.royalberkshire.nhs.uk/media/nbrbjc13/weight-loss-bariatric-surgery-key-facts_aug24.pdf
[14] BBC News - Bariatric tourism care costs NHS more than actual surgery: www.bbc.co.uk/news/uk-england-london-67946049
[15] Frontier Economics - the rising cost of obesity in the UK: www.frontier-economics.com/uk/en/news-and-insights/news/news-article-i20358-the-rising-cost-of-obesity-in-the-uk/

access to weight management medications to 14.7 million people would deliver cost-benefit neutrality by 2035 (18 years earlier) and net gains year on year afterwards, with "cumulative fiscal benefits estimated at £52 billion by 2050"[16].

The cost effectiveness to the NHS of weight loss medications must also consider the wider benefits to the economy and the future benefits, including financial, that these would have on NHS beyond the immediate term.

Challenges for individuals

Studies show many patients who take weight loss medication regain much of the lost weight within one year after stopping therapy[17]. Therefore, any NHS pathway needs to include wraparound support (i.e. dietary/lifestyle modifications) rather than just medication supply. This will help educate and guide people to make long-term behavioural change, ensuring they keep the weight off. Community pharmacy is ideally placed to provide this.

Some existing NHS treatments for obesity require patients to achieve lifestyle changes as a means of access. Although important and key to success, a balance needs to be found with weight loss medications to ensure that access is not limited or treatment withdrawn if requirements such as dietary modifications are not met.

Current GLP-1 agonist are routinely available via injections. This may not be favourable to all patients and will require additional support. Pharmacists' core skills with medicines are ideally placed to support with adherence. Whilst there are solid dosage forms, these are not as commonly available as injections[18].

Challenges for the health and social care sector

Current treatment volumes are limited and usually initiated in secondary care. The lack of a national population level pathway to access these new medications places a cap on the true benefits of these drugs.

To realise population scale benefits, treatment needs to be initiated and managed in primary care. Secondary care services can then focus on patients with more complicated needs. Primary care capacity, particularly in general practice is stretched and is unlikely to be able to manage additional demand. With an appropriately funded NHS service community pharmacy can quickly scale to meet demand. This was seen previously with covid vaccinations, and more recently with Pharmacy First.

Weight loss medicines are not immune to the current challenges faced by the medicine supply chains. There has already been reported shortages which may impact patients that use GLP-1 for treatment of diabetes[19]. Whilst there is evidence to suggest that this specific issue has now been resolved, future supply chain resilience will continue to be a challenge as global demand and competition increase.

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[16] The Tony Blair Institute - Anti-Obesity Medications: Faster, Broader Access Can Drive Health and Wealth in the UK.

[17] University of Chicago: Research shows GLP-1 drugs are effective but complex - UChicago Medicine.

[18] The General Pharmaceutical Council: Weight loss medications- FAQ | General Pharmaceutical Council.

[19] Diabetes UK- GLP1 RA shortages: https://www.diabetes.org.uk/guide-to-diabetes/managing-your-diabetes/treating-your-diabetes/tablets-and-medication/incretin-mimetics/shortage-FAQs.

The current state of weight loss medications

Weight loss medicines have been authorised by the National Institute for Health and Care Excellence (NICE) for 220,000 NHS patients in England (based on clinical need) over the first three years of a twelve-year rollout[20]. However, whilst 4.1 million people in England are currently eligible, the NHS estimate that fewer than 50,000 people a year will receive treatment by 2028, despite additional funding[21].

The NHS' rollout of GLP-1s is impeded by access, geography and limited NHS provision. GLP-1 medicines are only available via Tier 3/4 services and require patients to either have a BMI greater than 35 or between 30–34.9 with weight-related co-morbidities[22]. Demand is much greater than this and it is estimated that 95% of those using GLP-1s access them privately. It is unknown to what degree price acts as a barrier to access, which may exacerbate health inequalities[23].

Compounding this, NHS waiting times for specialist weight management support can be up to five years, with some areas closed to referrals entirely[24]. Furthermore, a wider health inequality gap is developing with the NHS rollout remaining slow[25] and economically deprived communities experiencing higher obesity rates[26].

Issues around waiting times and access are pushing people to take risks and unknowingly obtain unlicensed products from irreputable sources, in some cases with harmful consequences[27].

What role could community pharmacy play in the future?

Most pharmacy-delivered GLP-1 services are privately funded, and their role in NHS-funded weight management treatments remains small and underutilised. Having already demonstrated the benefit to those paying privately, increasing the role of community pharmacies within the mix of public/private service provision is vital to ensuring the broadest possible access, especially to those patients who may be unwilling or unable to pay for private treatment. For others, private access remains a viable option, offering benefits to the population as a whole. Some people may choose the convenience of private healthcare even if they are eligible for NHS care. This would free up further NHS capacity.

Crucially, 98.3% of people in urban areas of England live within a 20-minute walk of a pharmacy[28]. Many of the patients who would benefit from weight loss medicines are of working age. Community pharmacies are often open during evenings and at weekends allowing services to be accessed outside of work commitments.

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[20] Medicines for obesity: www.england.nhs.uk/ourwork/prevention/obesity/medicines-for-obesity

[21] New Position Statement: A Way Forward for the Treatment of Obesity - Obesity Health Alliance

[22] GLP-1 agonists: www.guysandstthomas.nhs.uk/health-information/diabetes-medicines-glp-1-agonists.

[23] Beyond GLP-1s: Rethinking Obesity Treatment for the Long Term: www.technologynetworks.com/drug-discovery/articles/beyond-glp-1s-rethinking-obesity-treatment-for-the-long-term-401550.

[24] Obesity Health Alliance: https://obesityhealthalliance.org.uk/wp-content/uploads/2024/10/OHA_Treatment_2024.pdf

[25] Sky News: www.news.sky.com/story/are-weight-loss-drugs-making-only-the-wealthy-healthy-13285998

[26] The King's Fund: New analysis reveals stark inequalities in obesity rates across England | The King's Fund

[27] BBC - Weight loss injection hype fuels online black market: www.bbc.co.uk/news/health-67414203

[28] The Pharmaceutical Journal: https://pharmaceutical-journal.com/article/news/more-people-live-within-a-20-minute-walk-of-a-pharmacy-than-a-gp-surgery.

Tackling health inequalities is a key objective in the Government's *10 Year Plan*. Community pharmacies are ideally placed to provide access to publicly funded weight loss medications, in the most deprived communities. It is recognised that access to much of healthcare is reduced in deprived communities – where demand is often greater. Community pharmacy bucks this trend with more pharmacies in more deprived communities ('positive pharmacy care law')[29].

[29] The Pharmaceutical Journal – Pharmacies in England's most deprived areas provide 50% more NHS services to their local populations: https://pharmaceutical-journal.com/article/news/pharmacies-in-englands-most-deprived-areas-provide-50-more-nhs-services-to-their-local-populations.

General Pharmaceutical Council

Weight loss medication - Call for Evidence

London Assembly Health Committee -

Date of consultation – 6 August – 19 September 2025

Introduction

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacy premises in Great Britain. Our role is to protect, promote and maintain the health, safety and wellbeing of patients and the public who use pharmacy services in England, Scotland and Wales.

We have a statutory role in relation to 'system' regulation (as we regulate registered pharmacies) as well as 'professional' regulation of individual pharmacists and pharmacy technicians. Our main work includes:

- setting standards for the education and training of pharmacists, pharmacy technicians and pharmacy support staff, and approving and accrediting their qualifications and training
- maintaining a register of pharmacists, pharmacy technicians and pharmacies
- setting the standards that pharmacy professionals have to meet throughout their careers
- investigating concerns that pharmacy professionals are not meeting our standards, and taking action to restrict their ability to practise when this is necessary to protect patients and the public or to uphold public confidence in pharmacy
- setting standards for registered pharmacies which require them to provide a safe and effective service to patients
- inspecting registered pharmacies to check if they are meeting our standards.

GPhC Response

Whilst we have a regulatory role regarding pharmacists, pharmacy technicians and pharmacy premises, the evidence required by the London Assembly Health Committee regarding weight loss medication is not something we hold as an organisation.

However, we would like to bring two of our guidance documents to your attention. These documents demonstrate the standards we expect pharmacist prescribers and registered pharmacies providing pharmacy services at a distance, including on the internet to follow when undertaking the prescribing of medicines in person or online, which could include weight loss medication.

Both documents include reference to regulatory guidance, framework and expectations for pharmacists prescribing medicines.

The documents indicate good practice for pharmacists undertaking prescribing and the sales of medicines. They set out clear expectations regarding suitable safeguards for both the prescriber and the patient, with our pharmacy services at a distance guidance referring to the provision of weight loss medications.

Both documents are linked to our standards for pharmacy professionals and standards for registered pharmacies , which set out the standards that pharmacy technicians, pharmacists and pharmacy premises must meet. Both sets of standards are statutory and underpinned in legislation under the Pharmacy Order 2010.

We advise London Assembly Health Committee to read through the above-mentioned documents to help understand the regulatory position regarding the prescribing and selling of weight loss medicines by pharmacy premises.

If you would like to discuss the points raised in this response, or any other aspect of the GPhC's work, please do not hesitate to **contact us**.

GPhC Policy & Standards Team

28/08/2025

National Pharmacy Association

Evidence Submission on Weight Loss Medication in London

Authored by: Sygy Collins, Public Affairs and Policy Officer

Introduction:

- *At the time of writing, and before the government and Eli Lilly agree on price changes for Mounjaro, weight loss injections are more expensive than diet and lifestyle interventions such as community weight loss groups or calorie-counting apps.*
- *DHSC and Eli Lilly announced £85m in joint funding to roll out weight loss injection pilots during this summer's parliamentary recess, and the NPA believes that local ICBs will apply for the funding needed to take part.*
- *As of August 2025, weight loss injections cost the NHS an average of £3000 per patient annually. This contrasts with a gastric bypass operation costing £16,000 per patient. Weight loss injections are more effective for achieving meaningful weight loss in patients who have struggled to adhere to traditional methods.*
- *As of August 27, 2025, Eli Lily has temporarily halted orders of Mounjaro to the UK, with the manufacturing company stating that they will prioritise providing orders to existing Superdrug patients*[1].

Recommendations

- The London Assembly should work with London's ICBs and Community Pharmacy to secure funding for weight loss injection pilots in London.
- The London Assembly should engage with the MHRA and DHSC to ensure regulation of unregulated online suppliers distributing packages to London and work with the Metropolitan Police to take stronger action against those selling weight loss injections (real or counterfeit) on London's black market.

What are the benefits and risks of weight loss medicines?

The benefits of weight loss medication intersect across numerous factors: preventive health, reduction of pressures on secondary care, improved mental health, and ensuring that the country has a healthy workforce and reduced economic pressures due to staff sickness. Currently, complications from obesity are estimated to cost the NHS more than £11bn a year[2].

Weight loss injections can help patients lose 15-20% of their body weight. Weight loss to this extent can significantly reduce the risk of developing conditions such as cancer, joint problems,

[1] The Independent: Sales of Mounjaro weight loss jab to UK suspended as pharmacies hit by shortage ahead of price hike (August 2025) – Access here

[2] BBC News: I feel blessed to get weight-loss jab – but can the NHS afford it for all? (January 2025) – Access here

and heart disease and reverse other conditions such as prediabetes and hypertension. Across the piste health improvements have been noted in a patient treated with weight loss injections by a NPA member pharmacist.

Case Study 'S': *'S' is an online pharmacist who provides telephone support and consultations for patients seeking weight management through weight loss injections such as Mounjaro.*

'S' has provided ongoing care for male patient 'A'. At the time of first consultation, 'A' was 60kg overweight, with hypertension managed by two medications, and type two diabetes. His weight, inflammation, and the impacts on his immune system from diabetes placed him at a very high risk of developing cancer.

Under 'S's' guidance, 'A' received monthly 20-minute telephone check-ins to review his next dosage of Mounjaro. In these telephone consultations, the pharmacist and patient discussed side effects, dietary habits, physical activity, and proper hydration. Over the last six months, 'A' has lost a substantial amount of weight, his blood pressure returned to a normal range (allowing him to discontinue blood pressure medication), his blood tests show that he is now non-diabetic, and his quality of life has improved.

Case Study 'SB': 'SB' is a prescribing community pharmacist located next door to a GP surgery. 'SB' has recently worked with a patient 'K' who gained a lot of weight due to the mental health medication Olanzapine (a second-generation antipsychotic used to treat schizophrenia and bipolar disorder known to cause rapid weight gain and appetite changes).

'K' self-reported that she previously had an incident where she was 'tormented for her weight when catching the bus'. Since starting Mounjaro and receiving wrap around support from 'SB', including help with knee exercises, she has lost 24kg. 'K' now feels comfortable riding the bus, went swimming in a public pool for the first time in 26 years and feels that her 'day-to-day' mental health has improved.

'SB' has also self-reported other case studies where her patients have had their fatty liver disease and pre-diabetes reversed after losing weight via the injections.

In terms of clinical risks, there have been reports that some weight loss injections (Mounjaro, Wegovy and Ozempic) may be associated with inflammation of the pancreas, with data from the MHRA showing that ten people in the UK have died after suffering from pancreatitis linked to weight loss injections[3].

The MHRA's Yellow Card Biobank will now start investigating where an individual's genes may influence the risk of acute pancreatitis from the injections[4].

Outside the clinical sphere, there are economic risks and benefits associated with weight loss medication. The first is the growing demand and associated cost (which will be elaborated on later in our submission). London's Guy's Hospital estimated that 130,000 patients are eligible for weight loss medication in South-East London, however, the hospital's weight loss clinic states that they can only see around 3,000 patients[5].

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[3] Chemist and Druggist: *MHRA investigates after 10 weight loss jab linked pancreatitis deaths* (June 2025) – Access here

[4] MHRA Press Release: If you take a GLP-1 medicine and have been hospitalised by acute pancreatitis, the Yellow Card Biobank wants to hear from you (June 2025) – Access here

[5] BBC News: I feel blessed to get weight-loss jab – but can the NHS afford it for all? (January 2025) – Access here

The BBC reported that the NHS is set to roll out Mounjaro over the next twelve years due to concerns it could overwhelm services. Over the next three years, the BBC estimates that only 220,000 people in England will benefit from the drug on the NHS out of the 3.4 million who are eligible[6]. Professor Sattar (Glasgow University) said: "The cost of the drugs is still at a level where we cannot afford to treat several million people within the UK with these drugs. It would simply bankrupt the NHS."[7]

What plans do the NHS in London have to roll out weight loss medicines in the coming years, and will this be enough to meet demand?

As stated in this submission's introduction, the Department of Health and Social Care and Eli Lilly have announced £85m in joint funding for weight loss pilots nationwide via a new health innovation programme (£10m has been earmarked for the devolved nations) and will be open to proposals and bids from NHS healthcare stakeholders[8].

The programme will test ways to support patients living with obesity and will include access to holistic care, wrap around services, and obesity treatments through new routes such as pharmacies[9] and will build on 23 projects within the Weight Management Pathway Design Acceleration programme run by Innovate UK[10].

There is a key opportunity for London stakeholders to work in partnership with London NHS stakeholders to produce and co-design bids for their relevant areas in London, reflecting each area's health needs and demographics.

In terms of demand, our member pharmacists have provided feedback flagging the following concerns:-

- There is significant public awareness of weight loss injections due to both traditional media and social media. The rise in awareness of weight loss injections means there is a risk that demand for the injections via the NHS in London will not be met.
- Rising demand against strains on stock and Mounjaro's September 2025 price increase mean that, even with private procurement/online pharmacies, the market for weight loss injections is big but still limited.
- For a rough estimate, IQVIA found that 1.5 million British weight loss treatment users were using it in March this year, showing a 56% growth in the amount that people in the UK spend on private access to medicines[11].

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[6] BBC News: I feel blessed to get weight-loss jab – but can the NHS afford it for all? (January 2025) – Access here
[7] BBC News: I feel blessed to get weight-loss jab – but can the NHS afford it for all? (January 2025) – Access here
[8] DSIT, DHSC, NHSE, Innovate UK Joint Press Release: New help for patients battling obesity through pharmacies and community access (August 2025) – Access here
[9] DSIT, DHSC, NHSE, Innovate UK Joint Press Release: New help for patients battling obesity through pharmacies and community access (August 2025) – Access here
[10] DSIT, DHSC, NHSE, Innovate UK Joint Press Release: New help for patients battling obesity through pharmacies and community access (August 2025) – Access here
[11] Chemist4: UK Weight Loss Statistics Portal – Access here

- In March 2025, 1,527,000 packs of weight loss medication were supplied, with 80% of these packs then sold by private providers[12].

On what scale are Londoners accessing weight loss medicines through private suppliers?

While the NPA cannot provide a quantitative figure we can provide an educated estimate that a quarter of a million people in London are currently using weight lost medication. This estimate is based on an estimate that one-in-35 people in the UK are on weight loss medication divided with London's population.

This section will look at the recent uptick our member pharmacists have reported in the general public attempting to access the medication. This section will also focus on members of the public accessing the drugs through unregulated online pharmacies or via the 'black market' (e.g. through gyms, Facebook, or beauty salons).

Case Study *'P': A London-based member pharmacist ('P') has self-reported that he feels that a lot of the general population is trying to access weight loss medication or is thinking of taking the medication due to the vast increase in enquiries his pharmacy has received in the past few months.*

Our member pharmacists have also expressed concerns about patients who are not eligible trying to access the medication via the black market after being rejected for the medication by a community pharmacist.

A London-based community pharmacist (*'B'*) told us that many of their community pharmacy colleagues are already hypervigilant to patients with suspected eating disorders trying to access the medication due to education around laxative abuse. Furthermore, 'B' self-reported a case where a breastfeeding mother tried to access the medication to lose her baby weight and was subsequently turned down and told to return when she had finished breastfeeding.

The rise in the price of Mounjaro and the current reporting that Eli Lily has temporarily halted Mounjaro orders to British wholesalers raises concerns among our membership that the public may rely more on Facebook, salons, and other unregulated sellers[13].

There have already been alarming cases reported in the media around the misuse of weight loss injections. The BBC has reported that beauty salons are selling unlicensed versions of Semaglutide (the active ingredient in Ozempic)[14]. In one extreme case, a member of the public purchased Semaglutide via Instagram, resulting in the patient being admitted to the hospital after an extreme bout of vomiting. There have also been reports of people who are not overweight or with an eating disorder accessing the medication as a '*quick fix'*.

Case Study 'A': One of our pharmacists reported a case where a client called 'A' came into his premises after being unwell after taking a previous weight loss jab from an online pharmacy.

[12] The Pharmacist: Around 1.5 million UK citizens used weight-loss jabs in March 2025 (May 2025) – Access here
[13] Independent: Sales of Mounjaro weight loss jab to the UK suspended as pharmacies hit by shortage ahead of price hike (August 2025) – Access here
[14] BBC News: Weight loss injection hype fuels online black market (November 2023) – Access here

However, the unregulated online pharmacy was offering doses via vial size. This meant that 'A' had previously self-administered a 30mg dose of Mounjaro, which is[15]The maximum clinical dose of Mounjaro is 15mg, and it is only prescribed to a small number of patients for reasons such as a patient's failure to suppress appetite in incremental doses over a minimum of one month (the quickest someone should reach this dose is six months minimum), patients with Endocrine Disease, Hashimoto's Disease, diabetes, or cardiovascular disease that is poorly managed or drug-induced.

Are Londoners who are not medically eligible acquiring weight loss medicines, and if so, what are the risks of them doing this?

When clinically prescribed through a community pharmacist, weight loss medication offers excellent opportunities to alleviate pressures on the health system due to the link between obesity and conditions such as CVD, stroke, and obesity being a determinant for various cancers, which in turn can place pressures on the national workforce due to people having to go on sick leave.

However, our member pharmacists have encountered many patients who have used unregulated online suppliers to purchase weight loss medication, with the patients admitting that they have lied about their weight on the online form. In extreme cases, this has caused patients to be shipped the highest maximum dose of Mounjaro, which should only be used in rare cases or patients with endocrine disorders.

This question also touches on the issue of the lack of regulation of online sellers. One of our member pharmacists reported that there are issues of patients going to multiple private internet websites, buying the injections, and selling them on. This is due to a lack of regulation and data sharing between these unregulated sellers and primary care, meaning there is no way to monitor how many orders and collections one has made.

There are well-documented cases of people acquiring weight loss medicines who are not medically eligible, as shown in the section above. However, there are concerns about fake Mounjaro.

If you have taken them, what are your experiences of taking weight loss medication?

Case Study: NS's Experience with Mounjaro**:** NS, a Commercial Manager at the NPA, started taking Mounjaro under the direction of an NPA Community Pharmacy three months ago.

He describes the medication as a "tool" rather than a cure, aiming to use it as a complement to healthier lifestyle changes rather than relying on it alone.

When NS began treatment, his BMI was over 40 and he was living with hypertension, pre-diabetes, and sleep apnoea. He has long struggled with weight management; while able to lose weight in the past, he repeatedly regained more than his original starting weight after dieting. NS initially approached his GP about Mounjaro but was faced with a year-long waiting list to see a

[15] Healthline: Dosage for Mounjaro: What you need to Know – Access here

dietitian. Unwilling to wait, he turned to a community pharmacy to support his weight loss journey.

NS obtained Mounjaro via an NPA member pharmacist running a fully registered online service. The process included a detailed consultation where NS provided waist measurements, height, weight, and a dated photo. Subsequent pharmacist-led teleconsultations were required before each prescription was dispensed, covering progress, calorie intake, water consumption (target of three litres daily), and activity (10,000 steps per day).

Progress to Date

- Starting weight: 21st 10lbs on the 3rd June 2025
- Current weight: 18st 4lbs (over 20kg lost in three months)
- Goal weight: 16st 7lbs by year-end
- Medication: Started on 2.5mg in June, moving to 5mg in August and 7.5mg from October, though rising costs remain a challenge

Alongside medication, NS plans to begin intermittent fasting to further support blood sugar control. He reports that Mounjaro has suppressed his appetite and reduced his stomach capacity, making it easier to sustain a calorie deficit. His lighter frame has also enabled him to resume cycling for the first time in five years, and he notes that his sleep has significantly improved after an initial adjustment period, as tracked via his Apple Watch.

NS has set 7th January as his unofficial 'end date' with Mounjaro**,** aiming to maintain his progress through lifestyle changes, intermittent fasting, and increased physical activity once he tapers off the medication.

Supplementary Questions

1. <u>What support and information are the manufacturers of weight loss medicines providing to suppliers?</u>

Manufacturers provide support and information to community pharmacists, independent prescribers, and suppliers. Manufacturers such Eli Lilly and Novartis each have dedicated obesity clinical teams. Eli Lilly runs regular educational webinars and talks featuring speakers such as bariatric clinicians and endocrinologists, which Ms Basra routinely attends. These sessions are aimed at prescribers or those considering prescribing and include opportunities for participants to ask questions.

In addition, Eli Lilly offers a free training course for any prescriber, which is particularly valuable for community pharmacists who want to serve their patients effectively. Eli Lilly has even invited individual community pharmacists to deliver training. Eli Lilly plans to expand their webinars to combat weight loss injection misinformation.

2. <u>What further action would you like to see to increase access to weight loss medicines and address any risks associated with them?</u>

There is a strong case for moving the provision of weight loss injections into community pharmacy through a funded, nationally commissioned programme as localised commissioning risks creating competition between services. However, robustly funded national approach would ensure consistency and equity for patients. A national programme would not require additional training or extra input from staff, as community pharmacists are already familiar with the pathway.

This urgency is crucial: the sooner the programme is rolled out, the sooner we will see both public health benefits and preventative impacts. A community pharmacy model, similar to the COVID-19 vaccination programme, would also allow for immediate data collection to monitor outcomes.

Collaboration between City Hall's public health team, the Metropolitan Police, and local London ICBs will be essential to monitor and address the risk of a black market emerging in the capital.

City Hall can work to complement any national rollout through a strong public health campaign developed to raise awareness of the dangers of obtaining weight loss injections from unregulated sources (the gym, salons, Facebook). This campaign could take the form of bus stop digital posters or advertisements on buses (similar in style to TfL's anti–sexual harassment campaign), using subliminal messaging to contrast safe and unsafe routes of access.

Such a campaign would benefit from joint leadership between the Mayor's Office, NHS London, and community pharmacy bodies such as the NPA.

NHS England London

To:

- scrutiny@london.gov.uk

cc.

- Matthew Honeyman
- Tim Gallagher

NHS England
10 South Colonnade
London
E14 4PU

17 September 2025

Dear whom it may concern,

Re: Health Committee call for evidence: London Assembly Investigation - *Weight loss jabs in London*

Thank you for your request for evidence in relation to your investigation into the use of the newer treatments for obesity in London. This response will address your stated questions and will also set out some context to the issues from the perspective of the NHS.

As you have highlighted, there is a very active independent sector market for these medicines and significant numbers of patients are accessing them privately (i.e. not via the NHS). The NHS has no remit in relation to private services that are not commissioned by the NHS. This response focuses primarily on provision of medications by the NHS.

There are many NHS organisations in London, some of which commission or regulate healthcare services, and some of which provide them. This response has been co-ordinated by NHS England (London), noting that publicly funded specialist weight management services (SWMS) are commissioned by integrated care boards (ICBs), and local authorities. Additionally, the commissioning of primary care services such as general practice is currently delegated to ICBs by NHS England

The NHS in England is subject to significant reform at the current time, as mandated by the government. NHS England and the ICBs are working to reduce their running costs (i.e. staffing) by roughly 50%. NHS England will be integrated into the Department of Health and Social Care by April 2027. ICBs are therefore planning and implementing the rollout of the newer obesity treatments in a very challenging environment. We are grateful to our colleagues in London ICBs that have contributed to the content of this response.

Summary response to questions

- *What plans does the NHS in London have to roll out weight loss medicines in the coming years, and will this be enough to meet demand?*

All of London's ICBs are working towards providing access to the newer treatments for obesity to those patients that will benefit most, in line with the Technology Appraisals from the National Institute for Health and Care Excellence (NICE) that recommend their use for specific cohorts of patients and require ICBs to fund this. These require ICBs to make all these treatments available via their commissioned specialist weight managements services, and in the case of tirzepatide (Mounjaro®), also via primary care settings to a specific cohort of patients – those with a BMI of equal to, or greater than 40kg/m^2 and any four of the five 'qualifying' co-morbidities being included in the first cohort and prioritised for 2025/26.

Four of the five ICBs in London have commissioned specialist weight management services appropriate for the provision of the newer therapies, and the newer treatments are available via these services. All patients in London additionally have access to treatment from national independent sector providers under NHS Right to Choose that have contracts with ICBs elsewhere in England. Where an ICB has a policy which sets out eligibility for access to weight management medicines, the national independent sector providers must follow this policy for patients who are registered with a GP in that ICB.

In relation to primary care provision, all the ICBs in London are in the process of implementing a process by which patients in the current eligible cohort will be identified by their registered medical practice (their GP) and contacted to invite them to make an appointment. Our ICBs are at different stages in their implementation of this, but this will be implemented in the Autumn of 2025.

'Wraparound' care is an essential adjunct for the newer treatments for the management of obesity, which must be prescribed alongside a reduced calorie diet and increased physical activity (GLP-1 medicines for weight loss and diabetes: what you need to know - GOV.UK). NHS England has retained funding to deliver the wraparound care required in primary care efficiently and quickly across all ICBs in 2025/26.

ICBs are expected to meet demand for those patients that are eligible at each stage of the rollout. As the implementation programme progresses, new cohorts of patients will become eligible for treatment. At each stage our ICBs will be committed to prioritising treatment for those that will benefit them most. There will be demand from patients that are not eligible, and until they become eligible these patients have access to other treatment options and support from the NHS to lose weight.

- *Why do London's ICBs appear to be prescribing weight loss drugs at higher levels than ICBs in other parts of the country?*

Our own analysis of the available data provides assurance that London ICBs are not an outlier in relation to prescribing of the newer weight loss treatments. There are several confounding factors in the data available in the public domain that can result in incorrect conclusions being drawn, and these are explained in greater detail below.

The newer treatments for obesity are also used for the treatment of type 2 diabetes, and currently most patients using them, are doing so to treat their diabetes. To truly differentiate between the prescribing for the uses would require access to individual patient records. Whilst London ICBs largely have access to anonymised data from GP clinical systems that would enable us to quantify their use for obesity in London, we would not have access to this data for the rest of England and as a result, we are unable to conduct a meaningful comparison using that data. We do however have access to a range of data sources that allow us to benchmark London against other regions.

The London Assembly team has accessed information from the NHS Business Services Authority that was thought to suggest that services in London are prescribing one specific treatment (Wegovy®) in greater quantities than other regions, and with a greater rate of increase: we can replicate this here (Analyse | OpenPrescribing). Note that Wegovy® is a brand of semaglutide that is licensed for obesity and not diabetes and it is reasonable to assume that it is being used for obesity.

This data relates to prescriptions dispensed by community pharmacies, which represents a minority of supply of this medication; most prescriptions for Wegovy® are supplied by hospital-based specialist weight management services with medication issued by the hospital, although sometimes prescribing responsibility might pass to GPs when patients are stabilised on treatment. This data is therefore incomplete. When all prescribing of Wegovy® in London is viewed together (both primary and secondary care supply), we can see that the NHS in London accounts for the second largest spend on Wegovy® of the seven regions in England. It may well be the case that London services are providing Wegovy to patients resident outside of London, as many such patients access healthcare in London.

We would pay tribute to our ICBs and their commissioned specialist weight management services for providing such good access to this treatment despite these restrictions on its use.

- *How are Londoners who are not medically eligible acquiring weight loss jabs, and what are the risks of them doing this?*

All the newer therapies for obesity are prescription only medicines in the UK, which means they must only be supplied with the authority of a healthcare professional (on a prescription or using a similar legal mechanism). Any other supply would be in breach of regulation, although it does occur in the illicit market.

Whilst treatments are available on the NHS to those patients that are eligible, these medicines can also be obtained via private (non-NHS) services. Such services are provided by a wide range of providers, such as private online weight loss services. The quality of these services will naturally vary, but all *bona fide* services are registered and regulated, usually either by the Care Quality Commission (where they are medically led), or by the General Pharmaceutical Council (where they are provided by pharmacies) who set clear guidelines on safe and effective services.

Medicines should not be bought from unregulated sellers such as beauty salons or via social media, or from anywhere without a prior consultation with a healthcare professional. The MHRA have had reports of people experiencing severe side effects from fake GLP-1 medicines. The only way for patients to guarantee that they receive a genuine medicine is to ensure it is being supplied by a legitimate pharmacy, including those trading online, from a prescription or similar legal mechanism issued by a healthcare professional.

Like all medicines, the newer obesity treatments can cause side effects. Some of the most common side effects are gastrointestinal effects such as nausea, vomiting, and diarrhoea. These side effects were observed in clinical trials for these products and are usually mild to moderate in severity or short in duration. However, some (such as nausea, vomiting and diarrhoea) sometimes lead to more serious complications such as severe dehydration, resulting in a need for hospital treatment.

Although infrequent, inflammation of the pancreas (known as acute pancreatitis) has been reported with GLP-1 medicines, and this is a serious complication. The main symptom of this condition is severe pain in the stomach that radiates to the back and does not go away. Anyone who experiences this should seek immediate medical help. There are other serious side effects, and a full list can be found in the product information for the individual medicines:

- Liraglutide (Saxenda®)
- Semaglutide (Wegovy®)
- Tirzepatide (Mounjaro®)

It remains the case that many patients access these treatments privately without an in-person consultation with a healthcare professional, with such services often being provided remotely. Patients are usually required to provide information about themselves (including height and weight, pre-existing health conditions, other medications used and reasons for wanting to lose weight) and will be asked to agree that the service can exchange information with their GP. The service should independently verify the person's weight, height and/or body mass index before a consultation that takes place online or over the telephone (Providing services online | General Pharmaceutical Council). These safeguards are not perfect and of course any patient who chooses to provide false information might do so and might be able to access medicines inappropriately. In the case of private (non-NHS) services it is a matter for the regulators to enforce the regulations that are already in place, and to work with government to strengthen those regulations where necessary. All healthcare professionals should continue to do their best to provide care that is safe and effective.

- *Are private providers of weight loss medicines communicating the risks to Londoners who purchase them?*

All healthcare professionals that are providing the newer treatments for obesity, whether in the NHS or not, are expected to be familiar with guidance on running safe and effective services, and to be familiar with the risks and benefits of medicines that they recommend or prescribe. The number of independent sector providers of such treatments is significant, and the NHS does not routinely have access to information on the quality of care that non-commissioned services provide.

The Care Quality Commission, and the General Pharmaceutical Council undertake actions such as pro-active inspection of services and respond to concerns to ensure that patients accessing those services are safe. In response to concerns about poor practice, and more rarely, patient harm, regulators have issued specific guidance and warnings relating to the supply of these medicines by weight management services. Some of these messages have been amplified to patients by the press (Weight-loss jab patients to face stricter checks in crackdown on pharmacies - BBC News).

Context

Obesity is a growing public health concern in England, with 29% of adults living with obesity (BMI ≥30 kg/m²), and 64% living with overweight or obesity. The standardised figures for London (allowing for comparison between regions) are much lower at 19%, and 62% respectively (Health Survey for England, 2022 Part 2 - NHS England Digital). The prevalence of obesity continues to rise, driven by multiple factors such as diet, sedentary lifestyles, socioeconomic inequalities, and genetic predispositions. Obesity significantly increases the risk of developing several chronic conditions, including type 2 diabetes, cardiovascular disease, certain cancers, and musculoskeletal disorders, as well as being associated with reduced quality of life and increased mortality rates.

The rising prevalence of obesity imposes a significant economic burden on the NHS and the wider economy, costing the NHS approximately £11.4 billion annually with this figure projected to increase with rising obesity rates and related comorbidities. Further, the wider societal impact of obesity-related ill health costs such as lost productivity, unemployment, and social care amounts to an estimated £74.3 billion per year (Obesity Healthcare Goals - GOV.UK).

Obesity is associated with reduced workforce participation and social mobility, lower earnings and barriers to career progression thus compounding socioeconomic inequalities. The increasing strain on NHS primary care, specialist services, and hospital admissions underscores the need for more cost effective, scalable and innovative treatments and management approaches. These interventions aim to improve health outcomes, reduce long-term costs to both the NHS and society, ultimately striving to improve both individual well-being and economic sustainability (Statistics on Obesity, Physical Activity and Diet, England 2021 - NHS England Digital).

Despite public health initiatives and lifestyle interventions to address the rising prevalence of obesity and associated comorbidities, progress has been slow. For many adults, obesity is a chronic, relapsing condition, and while dietary changes, physical activity, and behavioural therapy play a role, achieving and maintaining substantial long-term weight loss can be a significant challenge.

However, any period of weight reduction, for people living with overweight or obesity brings meaningful health benefits, including improved metabolic health, reduced cardiovascular risk, and enhanced quality of life. This underscores the importance of adjunctive therapies that complement lifestyle changes, offering individuals greater support to achieve sustained weight loss and long-term health improvements.

Medicines used for weight management

New pharmacotherapies represent a transformative addition to the obesity management landscape and offer a promising option for individuals who have not achieved clinically significant weight loss or sustained weight management with lifestyle and behavioural interventions alone.

While the efficacy of glucagon-like peptide-1 (GLP-1) receptor agonists such as liraglutide (Saxenda®) and semaglutide (Wegovy®), and the novel gastric inhibitory polypeptide/glucagon-like peptide-1 (GIP/GLP-1) receptor agonist, tirzepatide (Mounjaro®), for weight management are well documented in clinical trials and form the basis for current NICE recommendations, there are important considerations which need to be taken into account in real world implementation in the NHS in England. It is crucial to explore their practical application beyond controlled trial settings, ensuring that outcomes align with real-world patient experiences.

Wraparound care is an essential adjunct for the newer treatments for the management of obesity, which must be prescribed alongside a reduced calorie diet and increased physical activity (GLP-1 medicines for weight loss and diabetes: what you need to know - GOV.UK). NHS England has retained funding to deliver the wraparound care required in primary care efficiently and quickly across all ICBs in 2025/26.

The modes of availability of newer therapies in England

We should note that the newer therapies listed above are products marketed by multi-national pharmaceutical companies that have invested a significant amount into research and development. The activities of manufacturers themselves are highly regulated in the UK and the Medicines and Healthcare products Regulatory Agency (MHRA) must approve the medicines based on safety and efficacy data from clinical trials before they can be marketed. The drugs are marketed to both public and private healthcare systems, and in some cases (such as with the NHS) pricing agreements are reached to facilitate patient access to the treatments. Some treatments have been available for many years, such as liraglutide (Saxenda®), whilst others are relatively new, such as semaglutide (Wegovy®), and tirzepatide (Mounjaro®).

Patients in England access these medicines in three broad ways:

- Via a publicly funded (NHS commissioned) and regulated service, free at the point of use

  This could be a locally commissioned service, or an independent sector provider which has been commissioned by another ICB in England to provide services which would then be available to people registered with GPs in other ICBs under NHS Right to Choose
- Via a private (non-NHS) regulated service where they pay for the full cost of their treatment
- Via illicit means (purchased from unregulated sources)

Patients should be made aware of safe options for accessing these drugs. Where they are not accessing these via an NHS service, they should be directed towards services that are regulated (for example, by the Care Quality Commission, or General Pharmaceutical Council) or provided by a healthcare professional whose activities are regulated by their profession's own regulator (for example by the General Medical Council). All *bona-fide* services should make information about how they are regulated available to their service users.

The independent sector market for these therapies in England is significant. From the very limited data available to the NHS, it is likely that hundreds of thousands of patients in England are currently using these treatments (data shared as commercial in confidence and on file at NHS England).

Despite the very good access to these newer therapies from regulated providers and professionals there will always be an illicit market. Patients should be aware that this alternative cannot be considered safe, and that there are real risks of harm by using medicines that are not suitable for them, or medicines that are counterfeit, or not of the quality they should be.

NHS commissioned care

In England, the National Institute for Health and Care Excellence (NICE) produces guidance for the NHS and wider health and care system to help practitioners and commissioners get the best care to patients, fast, while ensuring value for the taxpayer. NICE is an executive non-departmental public body of the Department of Health and Social Care of the United Kingdom and is independent of the NHS.

From the broad range of types of guidance that NICE develops, we should note that 'Technology Appraisals' not only make recommendations on the use of new and existing medicines, but also mandate the NHS is to fund these. All the newer therapies for the treatment of obesity are recommended in NICE Technology Appraisals. These set out which patients should receive treatment from NHS commissioned services, and how. It is important to note that NICE often limits the use of the drugs to a smaller cohort of patients than that outlined in the marketing authorisation issued by the MHRA – as NICE is concerned not only with safety and efficacy, but also with cost-effectiveness.

NICE has issued three relevant technology appraisals in recent years, and these outline which patients are eligible for the respective treatments:

- Liraglutide for managing overweight and obesity TA664 (Overview | Liraglutide for managing overweight and obesity | Guidance | NICE)
- Semaglutide for managing overweight and obesity TA875 Overview | Semaglutide for managing overweight and obesity | Guidance | NICE
- Tirzepatide for managing overweight and obesity TA1026 Overview | Tirzepatide for managing overweight and obesity | Guidance | NICE

The Technology Appraisals for liraglutide (Saxenda®) and semaglutide (Wegovy®) recommended that they be prescribed in specialist weight management services, and this has limited patient access to the treatments to a greater or lesser degree – not all ICBs commission these services (supporting-documentation-12). The Technology Appraisal for tirzepatide (Mounjaro®) notably stipulates that prescribing should be provided either by a specialist weight management service, or in primary care, and this enables a greater degree of access.

Even where an ICB does not commission a specialist weight management service, the patients registered with the primary medical services (GPs) in that area can still access treatment via 'NHS Right to Choose'. This allows a service commissioned by any ICB in England to provide treatment to patients from other ICBs. One such provider (Oviva) has

proved controversial in recent years as they have facilitated access to many patients when ICBs were not able to plan for the expenditure this incurred.

The numbers of patients that would be eligible for treatment with the newer therapies is significant. According to the eligible cohort outlined by NICE, ICBs in England would have been required to meet the cost for funding access to tirzepatide (Mounjaro®) for an estimated 3.4 million people from 24 March 2025. Accordingly, NHS England submitted a funding variation request, on behalf of NHS providers and ICBs, to extend the time needed to comply with the recommendations (4 Implementation | Tirzepatide for managing overweight and obesity | Guidance | NICE). This requested that full implementation be phased over 12 years, with the patients likely to benefit most being prioritised. NICE's guidance executive accepted that NHS England's funding variation request was justified.

In practice this means that that ICBs in England were only required to fund tirzepatide (Mounjaro®) from specialist weight management services from 24 March 2025, and then to a larger cohort of patients from primary care from 23 June 2025, with additional cohorts becoming eligible over the 12-year period. NHS England has issued interim commissioning guidance to ICBs (PRN01879-interim-commissioning-guidance-implementation-of-the-nice-technology-appraisal-ta1026-and-the-NICE-fu.pdf), where these cohorts can be viewed in detail.

All ICBs in London are currently working hard to ensure that eligible patients can access treatments via an appropriate service.

Our work to tackle obesity is a good example of the drive in the NHS to deliver the three shifts in care that the government wants to see – most notably, a shift from treatment to prevention. To tackle obesity and other serious and complex conditions we focus not just on new and innovative treatments, but also on the whole treatment pathway. By making earlier interventions in the pathways, before patients become very unwell, we will deliver better outcomes for those patients, reduce the costs to the NHS and deliver better value for the taxpayer.

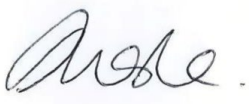
Access for patients in London

Any patient in London who believes that they might be eligible for treatment with the newer obesity drugs should be directed to information from the NHS that will help to inform them about obesity, and how to manage it, as well as to outline which treatments are available on the NHS. This will signpost them to their GP for further advice about losing weight through improved diet and increased physical activity. GPs can also refer eligible patients into the national Digital Weight Management Programme (NHS England » The NHS Digital Weight Management Programme), or into a local weight management service. Many patients will find that under the terms of the existing NICE guidance and NHS England funding variation, that they are not currently eligible for treatment with the newer therapies. Patients who are eligible in London will be contacted by the NHS and invited to a consultation with a healthcare professional so that treatment can be considered. Further, more detailed information is available on the website of the relevant ICB.

Do let us know if we can be of further assistance.

Yours sincerely,

Dr Chris Streather
Regional Medical Director &
Chief Clinical Information Officer



Dr Agatha Nortley-Meshe
Regional Medical Director for Primary Care

Jon Hayhurst
Regional Chief Pharmacist

London Assembly Health Committee | Weight loss medication in London

Written evidence | Novo Nordisk | September 2025

Introduction

Novo Nordisk strongly welcomes the London Assembly Health Committee's investigation into weight loss medication. As the manufacturer of Wegovy® (semaglutide) – referenced in the Committee's call for evidence – Novo Nordisk is a global healthcare organisation with more than 25 years dedicated to advancing obesity research and treatment, building on a 100-year history of innovation and leadership in diabetes care.

The Government's 10 Year Health Plan (2025) commits the UK to an ambitious target: launch a moonshot to 'end' the obesity epidemic[1]. Novo Nordisk shares this ambition. With our majority shareholder owned by the Novo Nordisk Foundation – the largest not-for-profit in the world[2] – we are not immediately influenced by traditional market drivers like many pharmaceutical companies, but a long-term social purpose to defeat obesity and other serious chronic diseases.

1. What are the benefits and risks of weight loss medicines?

Chronic disease prevention and progression

Weight loss can play an important role in the prevention and progression of chronic cardiovascular, renal and metabolic diseases[3,4,5]. For example:

- It is estimated that 8 in 10 people who are hospitalised with cardiovascular disease also have obesity[6], and while cardiovascular mortality has decreased over the past two decades, obesity-related cardiovascular deaths have increased, with two in three obesity-related deaths worldwide being linked to cardiovascular disease[7]
- For those living with type 2 diabetes and obesity, weight loss of more than 15kg has been shown to lead to diabetes remission in almost 9 in 10 cases (86%)[8], while intentional weight loss has been associated with a 25% reduction in total mortality[9]

As such, investment in services and interventions to reduce obesity can play an important role in reducing the burden of chronic metabolic disease in the UK.

GLP-1s have a long-standing history, having been used for more than 15 years to treat type 2 diabetes, including Novo Nordisk GLP-1 products such as semaglutide and liraglutide that have been on the market for more than 8 years[10,11]. Semaglutide has been extensively examined in clinical development programmes, real-world evidence studies and cumulatively over more than 9.5 million patient-years of exposure[12]. It has also been approved in the UK as a treatment to reduce the risk of major adverse cardiovascular events such as cardiovascular death, heart attack and stroke in those with established cardiovascular disease and obesity[13].

In a joint paper published earlier this year by the Tony Blair Institute, Professor Andrew Scott explored the macroeconomic implications of a 20 percent reduction in six long-term health conditions. Specifically modelling a weight loss medicine that reduces the prevalence of obesity, the study found

that such an intervention could result in a combined 20 percent decrease in both cardiovascular disease and musculoskeletal disorders, leading to an estimated 0.3 percent boost in annual GDP, equivalent to £8.1 billion within five years[14].

Pressure on NHS resources

The NHS is under pressure, with record demand, capacity issues and inflation leading to key waiting times not being met and a reduction in timely access to services[15]. In 2023 the Government announced a pilot programme to increase access and uptake of GLP-1s with an ambition to '*help cut NHS waiting lists by reducing the number of people who suffer from weight-related illnesses, who tend to need support from the NHS and could end up needing operations linked to their weight*'[16].

Indeed, emerging evidence highlights how GLP-1s can play a role in reducing healthcare resource use, including:

- A retrospective UK study found that weight loss of 10-25% was associated with lower overall healthcare use, including immediate reductions in the number of prescriptions and contact with primary care[17]
- A US study has also signalled that people treated with a GLP-1 may have lower medical costs and healthcare resource use [18,19].

With an estimated annual NHS spend of £6.5 million on obesity-related illnesses alone[20] – equivalent to 40% of the 21/22 budget allocated to police forces in England and Wales[21] – policies to build a healthier population, grounded in effective weight management could help break cycles of poor health; improve population health resilience; and help transform the NHS from a 'sickness service' to one that prevents ill health and improves health and wellbeing.

UK productivity

Emerging evidence suggests that GLP-1s can also play a role in economic growth. A study presented at the 2025 European Congress on Obesity estimated that giving a GLP-1 to everyone in the UK eligible for them could boost the economy by £4.5bn[22]. This was based on examining data from 2,660 participants in three clinical trials in the UK who were living with obesity and / or type 2 diabetes. The study found that taking a GLP-1 enabled them to each work five extra days and carry out 12 days of unpaid work such as volunteering or childcare, as well as reducing their consumption[23]. Indeed, several real-world evidence studies are examining the wider benefits of GLP-1s, including NICE which is exploring how digital weight management services can impact psychological outcomes and healthcare resource utilisation[24].

2. What plans do the NHS in London have to roll out weight loss medicines in the coming years, and will this be enough to meet demand?

Although Wegovy® (semaglutide) and Mounjaro (tirzepatide) – the two medicines named in this inquiry – have been approved by NICE as cost-effective for the management of obesity in a population

of up to 3.4 million people[25,26], data from analytics company IQVIA suggests that less than 10% of the approximately 2 million people currently using a GLP-1 or GLP-1/GIP medicine for weight management in the UK are accessing them on the NHS[27].

Novo Nordisk is concerned about the growing disparity in GLP-1 and GLP-1/GIP access for weight management in England and Wales, particularly following NHS England's unprecedented introduction of a 12-year phased rollout plan[28] for Mounjaro on the NHS. This is a significant departure from the 90-day legal requirement for NHS commissioners to make funding available for new treatments recommended by NICE[29]. Indeed, the rollout plan stipulates that a maximum of 220,000 people living with obesity would be able to access treatment over the first three years[30]. This represents 6.7% of the eligible population. Given the health risks associated with obesity, effectively limiting access to those who are willing and able to pay out of pocket in the short-term risks exacerbating existing inequalities between the richest and poorest in society.

Further, with some Integrated Care Boards (ICBs) in London – and across England – placing additional restrictions on access to GLP-1s and GLP-1/GIPs[31,32] , even patients who meet eligibility criteria may have limited access to these treatments on the NHS. In some cases, this has led to perverse incentives as some digital providers have used the Right to Choose framework to accept referrals from patients across England[33,34]. This means that even in ICBs where GLP-1s have not been approved for use locally, a patient could be referred to a digital provider via Right to Choose, with the ICB remaining liable for the cost. This risks creating further financial instability for ICBs due to unexpected demand or claims from providers without prior agreements.

3. On what scale are Londoners accessing weight loss medicines through private suppliers?

Currently, over 90% of UK patients access GLP-1 or GLP-1/GIP medicines for obesity through private channels[35], highlighting the need for better collaboration and knowledge exchange between the public and private sectors. A public-private partnership could leverage the extensive patient experience, wraparound service design, and approaches to achieve sustainable weight loss and maintenance developed within the private sector. Notably, many private providers also operate in the NHS, offering practical insights into policy solutions. For instance, Professor Barbara McGowan who is the Chief Medical Officer of the private weight management service, Roczen, also oversees the obesity bariatric service at Guy's and St Thomas' NHS Foundation Trust, chairs the UK Obesity Management Collaborative, and was part of the Royal College of Physicians Advisory Group on Weight and Health. Clinical leaders such as Professor McGowan – who play a role in the NHS and private sectors – could be valuable advisors to the NHS in this capacity.

Commissioning private sector providers to deliver NHS services

It is crucial for the NHS to expedite the transformation of care pathways and increase access to specialist services. This urgency is necessary to prevent perverse incentives, such as reliance on frameworks like Right to Choose, and to avoid exacerbating inequalities by allowing access to be determined by the ability to pay rather than by need.

As recommended by the Tony Blair Institute, there could be an opportunity for the NHS to accelerate access to weight management services by commissioning private sector providers[36] —many of whom are already recommended through the NICE early value assessment[37] — to deliver cost-effective services on the NHS, provided that strict clinical governance standards were established. These providers, who could be set up under the Any Qualified Provider (AQP) policy[38], could remain accountable through ongoing reporting and evaluation metrics set by NICE, and help to generate evidence that aligns with the ambitions of the 10-Year Health Plan.

This collaboration could also aim to iterate and scale future care models, and generate real world evidence to address critical questions, such as: the mix of interventions to maximise risk reduction for cardiovascular diseases and other metabolic conditions; or the interventions that will sustain long-term weight loss and shape an affordable healthcare system capable of treating millions of patients across the UK while also preventing obesity in those at high-risk. One important, related evidence gap is on duration of use. Better understanding of which patients may require lifetime use, those who may be able to come off treatment and maintain their weight, or those who only require episodic use could better inform guidance on use of pharmacotherapy, as well as manage NHS affordability.

Data gathered from these efforts could benefit not only the UK but other international healthcare systems as well, positioning the UK as a leader in establishing international standards in weight management. Given the complex, multifactorial, and progressive nature of obesity, the needs and priorities of patients evolve throughout the disease's progression and therefore research, policy and practice in weight management will have to be iterative.

For instance, the most effective interventions will vary substantially between: (i) predicting and preventing obesity during weight gain for people living with overweight (BMI 25-30), (ii) reducing and maintaining weight for people living with obesity (BMI 30+), and (iii) treating and mitigating the broader cardiometabolic consequences associated with obesity (such as cardiovascular disease, type 2 diabetes, and chronic kidney disease).

Additionally, socioeconomic status, cultural factors, and other variables further complicate the heterogeneity of patient needs, and should be considered in future policy and practice.

4. Are Londoners who are not medically eligible acquiring weight loss medicines, and if so, what are the risks of them doing this?

Patient safety risk from counterfeits and compounding

Novo Nordisk has seen an increase in illicit sales of counterfeit products online, including semaglutide. Falsified medicines represent a serious and growing threat to public health as illicit products can contain dangerous ingredients, incorrect dosages or harmful substances, that may cause severe adverse effects. The increasing prevalence of unregulated online providers and marketplaces exacerbates this risk.

Patient safety is a top priority for Novo Nordisk and we are working in close collaboration with the MHRA to identify and eliminate counterfeits from the UK. Every counterfeit case we are made aware of is investigated and reported to the authorities. We also work with a third party specialised in monitoring and taking down of illegal online offers to specifically address this. But the scale and scope of this threat is growing and global.

There is a need to strengthen regulation to combat counterfeit medicines in the UK. This includes the role of the Advertising Standards Authority, MHRA and General Pharmaceutical Council in combatting illegal promotion of weight loss prescription-only medicines to the public, particularly online.

Alongside counterfeit and falsified medicines, compounded GLP-1s – unapproved and unlicensed versions of semaglutide and liraglutide[39] – present a safety and health risk to patients as they have not been clinically evaluated by the MHRA for safety, quality or efficacy. In the United States, where compounding is more common, the Food and Drug Administration (FDA) received 542 reports of harm from compounded 'semaglutide' in 2022. Of those, 124 involved hospitalisation and 10 resulted in death[40]. Such harms can be related to dosing errors resulting from healthcare professionals miscalculating doses and from patients self-administering incorrect doses[41]. The presence of compounded GLP-1s in the UK could also increase the risk of fraudulent compounding, for which the FDA and Swiss regulatory authority[42] have issued a warning to consumers. To reduce risks to patients in Australia, the Government legislated to make GLP-1 compounding illegal in 2024[43]. Novo Nordisk recommends a similar approach is considered in the UK to prevent the emergence of illegal compounding, which should be treated as a public health and national security threat.

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London Assembly | Weight Loss Medications in London Enquiry

Numan Submission - 2025

Executive Summary

Obesity is one of the most pressing public health challenges in the UK. As a complex and chronic condition, obesity acts as a gateway to numerous comorbidities - from type 2 diabetes to heart and kidney disease - shortening healthy life expectancy for patients and placing increasing strain on already stretched NHS services.[1]

London faces a unique combination of higher awareness, higher demand, and deep inequalities in access. Whilst London's adult overweight and obesity rates are among the lowest in the country (59%), the numbers still show that more than one in five Londoners is diagnosed as living with obesity.[2] Research from Numan's State of Obesity Report 2024 shows that Londoners report a greater level of education and awareness of obesity, being twice as likely to strongly agree that obesity is a disease compared to the UK average.[3] The same research shows they are much more familiar with anti-obesity medications (AOMs) than other regions in the UK, with nearly half of Londoners reporting (45%) that they are familiar with medications such as Wegovy or Mounjaro. The same report shows that just 13% of Londoners reported that they didn't know what a GLP-1 medication was, lower than the UK average of 21%.[3]

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With millions of people in the UK already accessing AOMs, it's imperative that engagement takes place at the local level as well as the national one.[4] National strategies - like the NHS 10 Year Plan and Industrial Strategy for Life Sciences - will set the framework, but it is at the level of London boroughs, ICBs, and communities that demand is felt most acutely - and where practical solutions must be delivered. This is why we welcome the London Assembly's investigation. As one of the UK's leading digital health providers, we were pleased to be able to join the panel in City Hall and share our verbal evidence for the enquiry.[5] We now aim to deliver this in writing, providing insight into how Londoners are already engaging with these treatments outside the NHS, and how regulated private provision can work in partnership with local services to expand safe access, manage overflow, and reduce inequalities. We believe the Assembly has a critical role in shaping a London model of provision that is pragmatic and patient-centric - one that supports close collaboration with the NHS whilst also recognising the complementary role of regulated private providers in expanding safe access and innovative pathways.

Summary of insights and recommendations

- **GLP-1 based AOMs offer evidence-based benefits for weight loss and health:** Modern AOMs (notably GLP-1 analogues like semaglutide and tirzepatide) are clinically proven to help patients with obesity achieve significant weight loss (around 15-20% body weight reduction over a year of treatment on average) and improve health outcomes.[6] Studies have linked GLP-1 treatment not only to weight reduction but also to lower risks of heart attack, stroke, and other complications of obesity. These drugs represent a *breakthrough* in tackling obesity, offering new hope to thousands of Londoners struggling with weight-related health issues.[7]

- **NHS rollout alone is insufficient to meet demand:** While the NHS in London (and nationally) has begun to introduce obesity management injections (Wegovy, Mounjaro) through specialist clinics and a very limited GP prescribing pilot, the capacity falls far short of demand. Only a small fraction of eligible patients can access these medications via NHS pathways – fewer than 200,000 nationally – due to strict inclusion criteria and constrained Tier 3 specialist services. Meanwhile, an estimated 64% of adults in the UK are diagnosed with overweight or obesity, indicating millions of

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potential patients.[8] Many Londoners face long waitlists or lack access altogether. In short, the current NHS rollout will not, by itself, satisfy the demand and need for these treatments, nor deliver the benefits.[9]

- **The regulated private sector is safely filling a clinical gap in care:** A growing number of patients are turning to accredited private providers to obtain obesity management medications safely and promptly. Alongside community and highstreet pharmacies, responsible digital health clinics and pharmacies, like Numan *(Vir Health Ltd.)*, operate under Care Quality Commission and General Pharmaceutical Council oversight to prescribe GLP-1 medications within established clinical frameworks. In a city where demand far outstrips NHS supply, these providers serve as a pressure release valve – offering safe and timely access with medical supervision, wraparound support, and thorough monitoring. By handling cases that do not require specialist NHS intervention, the private sector can reduce the burden on London's NHS services while upholding high patient safety standards. Whilst there are clear benefits to a multipronged approach - given the complementary roles for the NHS and private providers - we also see an increased public-private partnership approach as essential to broaden access without compromising care.

- **Unregulated access is the primary threat to patient safety:** The Committee should note that the greatest risks in this arena come not from licensed medications themselves, but from illicit or inappropriate access. There is alarming evidence of Londoners obtaining AOMs or weight loss products through unregulated channels - from social media "skinny jab" sellers, to salons and personal trainers offering black-market injections.[10] Such routes bypass any clinical screening, leading to serious and sometimes dangerous outcomes. The priority must be to clamp down on these unsafe sources and guide people toward regulated, clinically supervised options.

Our view and recommendation is to recognise that AOMs are most effective when used as part of a holistic approach to weight loss and health gains. However, the NHS currently cannot reach everyone who could benefit, which means regulated private providers are crucial allies in expanding safe access and ensuring Londoners avoid unregulated grey or black market routes. This is paramount for public safety but also for improving the long-term health, productivity, and life expectancy of London's population.

Context on Numan and our response

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Numan is a UK-based digital health provider and one of the organisations at the forefront of offering obesity management treatment through a regulated, patient-centric model. We are responding to this call for evidence because we have direct, extensive experience managing obesity care for Londoners and a firm commitment to clinical safety and partnership with the wider health system.

To give some background on who we are and our mission, Numan launched as a digital health clinic in 2018 (initially focused on men's health) and has since grown into a holistic service tackling prevention, delivering diagnostics, and focusing on chronic conditions like obesity and metabolic health. We serve hundreds of thousands of patients across the UK, including a significant footprint in London.

We are headquartered in London (Farringdon) and more than one in ten of our patients are London residents. Our digital care model means that patients complete detailed health assessments on our platform and consult with our UK-licensed clinicians (doctors, pharmacist independent prescribers, nurses, dietitians, and health coaches) remotely. Treatment plans are personalised to each patient, combining prescription medication (when clinically appropriate) with robust holistic wraparound care, including lifestyle coaching and digital monitoring. Medications are delivered to patients' homes with safety checks at every step, and regular follow-up is built into the service.

Importantly, Numan is fully regulated by the Care Quality Commission (CQC) – we hold a current rating of "Good", our distribution services are regulated by the MHRA under Good Distribution Practices and our online pharmacy services are registered with the General Pharmaceutical Council (GPhC) .[11,12,13] We adhere to NICE obesity care guidelines (NG246), are committed members of DiCE, and hold ourselves to all professional standards for prescribing and providing care.[14] Our focus is on providing accessible care without ever compromising on clinical appropriateness or patient safety.

As a London-based company, we have deep insight into the local demand for obesity management medications. Many thousands of Londoners have used Numan's service to help manage their weight. Demographically, our London patient population skews toward

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middle-aged adults (early-to-mid 40s on average) and, notably, about 68% of our weight-loss patients in London are female.[15]

The majority are working professionals (often in demanding jobs and/or with families), with typical household incomes in the £75k–£100k range. They come from all across the capital - though our data shows a higher concentration in some areas (for example, South West London accounts for ~15% of our London patients, with strong representation also from South East and East London) and lower engagement in others (outer boroughs like Sutton or some parts of East Central London are under-represented).[16] This suggests that awareness and access to weight loss interventions still vary across different communities in London, an inequality we are keen to help address in partnership with local services. This insight is illustrated in Figure 1 (below), which shows the distribution of Numan patients across postcodes in London.

What nearly all of our London patients share is a history of struggle with obesity – 61% report cycles of dieting and weight regain in the past – and a desire for a medically-supported, sustainable solution after finding that purely lifestyle-based approaches were unsustainable or insufficient for them.[17] Compared to other parts of the country, they are also most likely to say that their struggles with weight gain or weight loss are tied to periodic or chronic stress,[18] and that they struggle with environmental triggers like the availability of fast food, food industry advertising.[19]

[15] Data is based on external data attributes from caci, data collected between August 2022 and August 2025, accessed Sept 2025.

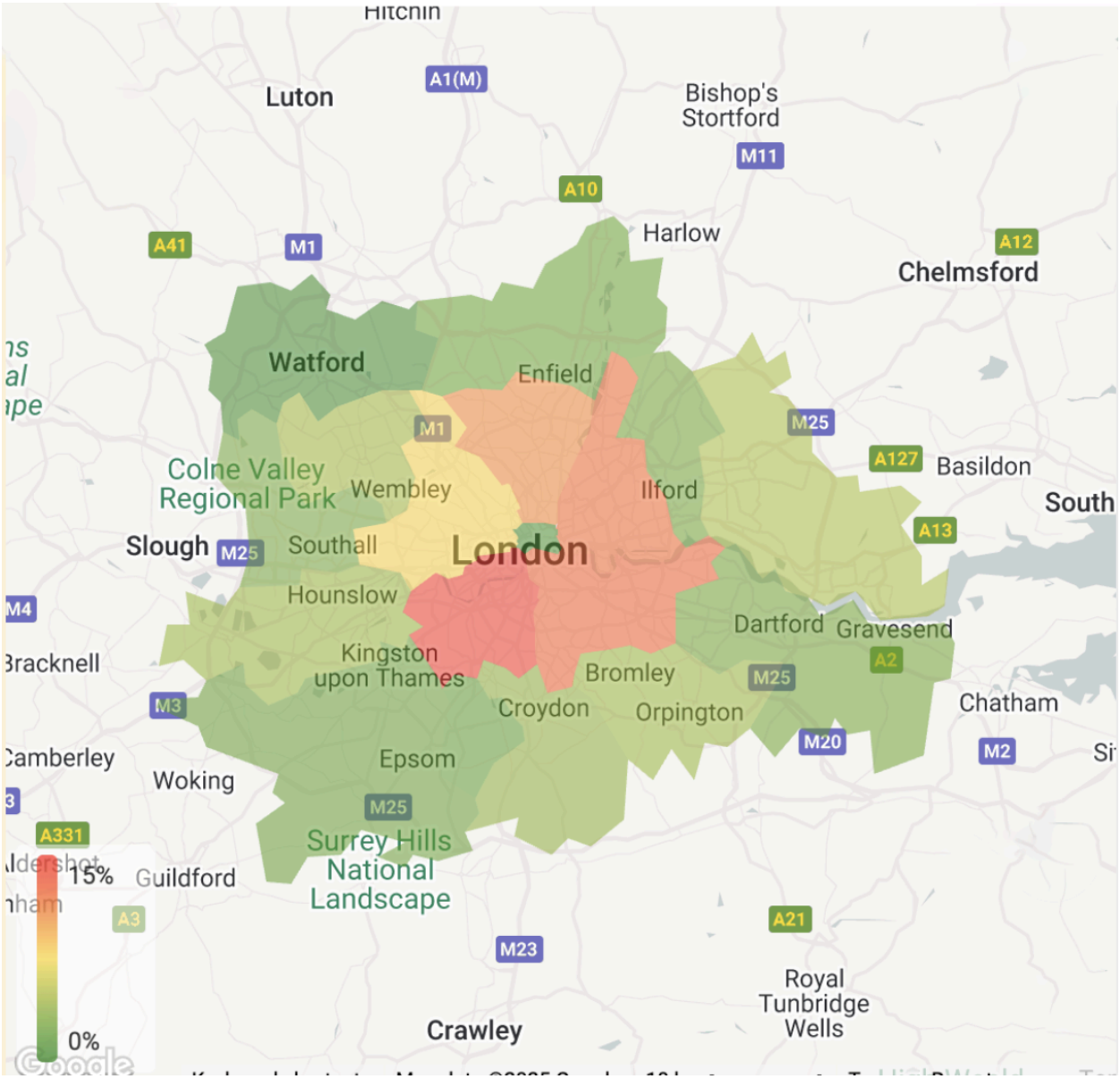
[16] Data is based on external data attributes from caci, data collected between August 2022 and August 2025, accessed Sept 2025. The applicable copyright notices can be found at http://www.caci.co.uk/copyrightnotices.pdf

[17] Data is based on external data attributes from caci, data collected between August 2022 and August 2025, accessed Sept 2025. The applicable copyright notices can be found at http://www.caci.co.uk/copyrightnotices.pdf

[18] Data is based on external data attributes from caci, data collected between August 2022 and August 2025, accessed Sept 2025. The applicable copyright notices can be found at http://www.caci.co.uk/copyrightnotices.pdf

[19] Numan data team. 2025. Internal Numan data gathered from our 2025 lifestyle questionnaire. Accessed 17 Sep 2025.

Figure 1: Numan patient density by London postcode



Enquiry Questions & Response

Q1. What are the benefits and risks of weight loss medicines?

a) The benefits and opportunities

Modern AOMs - including GLP-1 receptor agonists like semaglutide (Wegovy) and tirzepatide (Mounjaro) - have demonstrated significant benefits for patients with obesity. These medications work by affecting appetite and metabolism, leading to substantial, sustained weight loss when combined with lifestyle and behavioural changes and ongoing treatment.

Clinical trials show average weight reductions of up to 15% - or 20% for some patient cohorts - after about a year of weekly GLP-1 injections.[20] This level of weight loss is unprecedented compared to older therapies, and approaches the efficacy of some metabolic and bariatric surgeries, reflecting what many consider to be a paradigm shift in obesity care.

Beyond the weight loss itself, the health benefits are considerable: improved control of blood sugar (many pre-diabetic patients return to normal blood glucose levels),[21] lowered blood pressure and cholesterol, relief of weight-related joint pain and obstructive sleep apnea, and enhanced overall quality of life.[22]

There is also emerging evidence of reduced risk of serious cardiovascular events. For example, the 2023 SELECT trial that found that semaglutide significantly cut the risk of heart attacks, strokes, or cardiovascular death in overweight patients.[23] This has been further reinforced by new studies from August 2025, revealing that Novo Nordisk's Wegovy® cuts risk of heart attack, stroke or death by 57% compared to tirzepatide in real-world study of people with obesity and cardiovascular disease.[24] Many individuals prescribed AOMs report, anecdotally, a newfound ability to be active because they've shed enough weight to move more freely - an improvement in day-to-day wellbeing and confidence. These benefits

[20] Alqatari SG, Alwaheed AJ, Hasan MA, Al Argan RJ, Alabdullah MM, Al Shubbar MD. Pharmacologic Disruption: How Emerging Weight Loss Therapies Are Challenging Bariatric Surgery Guidelines. *Medicina (Kaunas)*. 2025;61(7):1292. Published 2025 Jul 18.
[21] Kahn SE, Deanfield JE, Jeppesen OK, et al. Effect of semaglutide on regression and progression of glycemia in people with overweight or obesity but without diabetes in the SELECT trial. Diabetes Care. 2024;47(8):1350-1359.
[22] Moiz A, Filion KB, Tsoukas MA, Yu OHY, Peters TM, Eisenberg MJ. The expanding role of GLP-1 receptor agonists: a narrative review of current evidence and future directions. EClinicalMedicine. 2025;86(103363):103363.
[23] Early cardiovascular benefits of semaglutide seen within months in SELECT trial. News-Medical. 2025. [accessed 17 Sept 2025] Available from: https://www.news-medical.net/news/20250512/Early-cardiovascular-benefits-of-semaglutide-seen-within-months-in-SELECT-trial.aspx
[24] NOVO NORDISK INC. Novo Nordisk's Wegovy® cuts risk of heart attack, stroke or death by 57% compared to tirzepatide in real-world study of people with obesity and cardiovascular disease. Cision PR Newswire. 2025. [accessed 17 Sept 2025] Available from: https://www.prnewswire.com/news-releases/novo-nordisks-wegovy-cuts-risk-of-heart-attack-stroke-or-death-by-57-compared-to-tirzepatide-in-real-world-study-of-people-with-obesity-and-cardiovascular-disease-302542590.html

underscore why GLP-1 medicines have been hailed as a game changer and why NICE endorsed Wegovy and Mounjaro for certain patients after rigorous review of their safety and efficacy.

However, as Sokratis Papafloratos, CEO of Numan, told the London Assembly's Health Committee on the 10th September 2025:

> *"We're still in the early phases of understanding the full benefits of an integrated approach to obesity care through a combination of pharmacotherapy and behavioral change. At the moment, we're seeing some of the first order effects [for AOMs]. People are losing weight, people that have struggled to lose weight in some cases for the whole of their lives. They have been struggling, but now they have a reliable way to lose weight. We're already seeing improvements in key biomarkers around their HbA1c, their hormonal health, and we know that some of those medications are being proven to have also cardio-protective benefits.*
>
> *What we're working on is doing the research and collecting the evidence to be able to understand some of the second order benefits that this approach is having too on productivity, quality of life, and the prevention of conditions that we know are related to obesity, such as diabetes, cancer, hypertension, and a whole bunch of other comorbidities."*

In other words, right now we are seeing and measuring the early benefits of access to AOMs, but it is very likely that we'll soon be able to share evidence that proves the overall preventative and healthspan benefits of these medications as well.

In summary, when used appropriately for the right patients, AOMs can be life-changing, helping patients achieve clinically significant weight loss, improving obesity-related conditions (from diabetes to heart disease), and potentially extending lives.[20-22]

b) Risks and considerations:

Despite their benefits, AOMs are not a magic bullet or quick fix, and they do carry risks as per any medication. As with all medications, there are side effects. These are well-documented; the most common are gastrointestinal: nausea, vomiting, diarrhea or constipation, acid reflux and bloating are frequently reported, especially in the first weeks of therapy.[25] For most patients these side effects are mild-moderate, transient, and manageable, but in some cases they can be severe enough to cause dehydration or malnutrition among other issues if not

[25] Filippatos TD, Panagiotopoulou TV, Elisaf MS. Adverse effects of GLP-1 receptor agonists. Rev Diabet Stud. 2014;11(3–4):202–30.

managed - with particular concerns if a patient drastically reduces food intake without suitable guidance for nutritional quality and density.[26]

Serious adverse events can occur, though these are far less common. GLP-1 medications carry warnings about the rare but still potential risk of pancreatitis (inflammation of the pancreas), gallbladder problems (rapid weight loss can sometimes precipitate gallstones), and in people with certain genetic predispositions, a possible risk of thyroid tumors.[24] It is worth noting that the MHRA has also included GLP-1 medications under the "Black Triangle" scheme used for increased safety monitoring of UK licensed medicines and reminded clinicians to be vigilant about known side effects, continued reporting via the Yellow Card Scheme and the *potential for misuse*.[27]

There are also short and long-term risks to consider where patients do not engage with wraparound care. GLP-1 medicines are clinically proven tools for managing obesity as a chronic, relapsing disease, but they deliver the most effective and sustainable outcomes when combined with holistic dietary and nutritional support, physical activity, and behavioural support.[28] Without that support, patients may not address the underlying behavioural and emotional drivers of weight gain, which in part may contribute to weight regain once medication is stopped.[29] The short-term risks of taking medication in isolation include issues such as excessive rapid weight loss, weight regain after discontinuation, under-nutrition from reduced appetite or nutritionally inadequate diets, development of disordered eating behaviours, and excessive loss of muscle mass where activity and protein intake are inadequate.

Long-term, the concern is that these issues can compound, leading to reduced muscle mass, impaired bone density, and a higher risk of frailty, leaving patients worse off than when they started. This may be particularly concerning in older people and women going through menopause who are already at risk of muscle loss. Without integrated lifestyle change, there's the risk of trading one set of health challenges for another.

A further risk is that if these medications are viewed as a slimming aid rather than anti-obesity medications by the general public, there's a risk people with a healthy weight might seek them out inappropriately. This could lead to health harm, since the medications haven't been

[26] GLP-1 receptor agonists: reminder of the potential side effects and to be aware of the potential for misuse. Gov.uk. 2024. [accessed 17 Sept 2025] Available from: https://www.gov.uk/drug-safety-update/glp-1-receptor-agonists-reminder-of-the-potential-side-effects-and-to-be-aware-of-the-potential-for-misuse
[27] The black triangle scheme (▼ or ▼*). Gov.uk. 2014. [accessed 17 Sept 2025] Available from: https://www.gov.uk/drug-safety-update/the-black-triangle-scheme-or
[28] Rippe JM. Lifestyle medicine and GLP-1 therapy for obesity: Time to get real. Am J Lifestyle Med. 2025;15598276251336677.
[29] Bawden A. People who stop weight loss drugs return to original weight within year, analysis finds. The guardian. 2025 May 14; [accessed 17 Sept 2025] Available from: https://www.theguardian.com/society/2025/may/14/people-who-stop-weight-loss-drugs-return-to-original-weight-within-year-analysis-finds

studied in that population and carry more risks without much health benefit. The Health Secretary has rightly warned that "These are not cosmetic drugs. They're serious medicines and should only be used responsibly and under medical supervision."[30] However, more should be done to emphasise that these are not 'skinny jabs' but powerful prescription-only medications that need to be carefully prescribed as part of a holistic treatment for obesity.

It was also recognised by NHS representatives attending City Hall for the in-person enquiry that in the case of side effects, adverse reactions, and long-term health problems, there is the risk of the burden of these falling on NHS colleagues where community pharmacy and digital health providers are not designed to support acute illness.

Finally, during the verbal evidence-gathering session at City Hall, an important point was made about the psychological and behavioural risks that clinicians and pharmacists need to consider. In particular, it was noted that some patients experience changes in how they relate to food – which can be positive (reduced cravings) but occasionally negative (a fixation on eating as little as possible in order to maximise weight loss).

Joanna Hollington, Principle Dietitian for NHS Trust at Guys and St Thomas', explained that there are concerns about a niche pattern of disordered eating emerging in some individuals misusing GLP-1 medications. An example was given of patients who were excited by their loss of appetite and deliberately began to undereat to a dangerous extent. When asked to eat more for health reasons, they felt panic or sadness – potentially hinting at an evolving pattern of disordered eating. Whilst such cases are still anecdotal, they illustrate the need for behavioral patterns and psychological monitoring. It further highlights the importance of holistic wraparound services that monitor patients for side effects, coach them to ensure they consume adequate nutrition, and support is there to help them build a healthy and positive relationship with food that can be sustained for the long term, avoiding new fears of food or eating.

c) Recommendations and considerations:

As outlined above, the benefits of AOMs are significant, but they must be balanced with careful risk management. When prescribed to the right individuals, with proper medical oversight and lifestyle interventions, the benefits (significant weight loss, improved lifestyle behaviours, and downstream benefits when it comes to healthspan and productivity) greatly outweigh the risks.

However, without safeguards, there are dangers - which is why we urge the Committee to focus on ensuring all Londoners access these medications only through qualified, regulated

[30] Balogun B. Weight loss medicines in England. 2025 Oct.

channels and only when there is also access to wraparound care. This will maximise positive outcomes and minimise adverse effects or misuse.

We also recommend:

- **Holistic, wraparound care must be provided as part of any treatment plan**

  Integration with lifestyle support is critical. GLP-1s should be prescribed as an adjunct to diet and exercise efforts, not as a standalone solution. This is what NICE outlines in its guidance on prescribing semaglutide and tirzepatide.[31] [32]

  In practice, this means providing dietary guidance, activity coaching, and behavioural tools alongside the AOMs. Numan's programme is structured to deliver exactly this kind of care, with each patient being assigned a dedicated health coach or dietitian, receiving educational materials and tracking tools, and having access to support whenever needed. This kind of comprehensive care is, we believe, essential to mitigate risks like micronutrient deficiencies or excessive muscle loss. Moreover, our research due to be published at Obesity Week 2025 and that of others shows that engagement with a holistic approach to obesity management improves adherence and outcomes (patients lose more weight when they engage in a programme of care in tandem with taking the medication).[33] It also helps identify and manage side effects or issues early.

- **Every patient should have a personalised healthcare journey**

  Patients' experiences of obesity vary. Underlying causes, relationships with food and allergies, and triggers such as *food noise* must be factored into care alongside consideration of personal background, socioeconomic status, levels of education, and native language. These are all factors that could influence the accessibility of foods, the types of nutrition that would be appropriate, level of understanding of obesity as a chronic condition and how the medication or holistic programmes work together. It may also mean that certain types of provision are more appropriate than others; where one person hugely benefits from the convenience and flexibility of digital provision, another may benefit from a face-to-face consultation at their community pharmacy, or require more intensive intervention through NHS weight management services.

[31] Recommendations. Semaglutide for managing overweight and obesity. NICE. [accessed 17 Sept 2025] Available from: https://www.nice.org.uk/guidance/ta875/chapter/1-Recommendations
[32] Recommendations. Tirzepatide for managing overweight and obesity. NICE. [accessed 17 Sept 2025] Available from: https://www.nice.org.uk/guidance/ta1026/chapter/1-Recommendations
[33] Johnson H, Huang D, Liu V, Ammouri MA, Jacobs C, El-Osta A. Impact of digital engagement on weight loss outcomes in obesity management among individuals using GLP-1 and dual GLP-1/GIP receptor agonist therapy: Retrospective cohort service evaluation study. J Med Internet Res. 2025;27:e69466. Available from: http://dx.doi.org/10.2196/69466

Londoners are a prime example of why personalisation is essential. For example, our latest research on the experience of food noise in the UK, which will be formally published at the British Lifestyle Medicine conference in September 2025, revealed that nearly a third of Londoners (30%) report experiencing food noise - higher than the UK average (25%). Londoners are also more influenced to eat when they are not physically hungry by fast-food availability and food advertising (20% vs 12% UK average). Any holistic support needs to be able to give patients the tools to address the intense environmental and lifestyle factors that make food noise more difficult to manage and behavioural changes harder to start and maintain.

This is why a personalised approach matters, both in behavioural support and medication management. Best practice is to start with a lower dose and titrate up slowly over months, checking in with the patient frequently. If a patient isn't achieving at least ~5% weight reduction by 6 months at an adequate dose, guidelines say the medication should be stopped - continuing beyond that point likely exposes the patient to risk with little benefit, so we and other good providers follow this stop rule.[29] At Numan, we also continue to provide behavioural change support, and there is the option in some cases for eligible patients to try an alternative AOM if one has not been effective.

- **Safe prescribing frameworks must be built in tandem with innovation**

To maximise benefits and minimise risks, AOMs must always be prescribed and monitored within a clear clinical framework such as those provided by the GPhC and NICE. These include guidelines that cover eligibility, ID verification, two-way communication during consultation processes, ongoing health monitoring, and more. NHS and regulated private providers already operate to these standards - but clarity, consistency, and enforcement remain essential.

The next step is for regulators and innovators to work more closely together. Digital providers bring particular strengths: building safeguards into patient pathways from the outset, using technology and real-world data to track outcomes, and offering personalised support at scale. Features such as automated ID verification, flagging of inconsistent responses, and app-based side-effect tracking allow earlier intervention and more consistent follow-up. The NHS Digital Weight Management Programme demonstrated this potential — showing that a structured digital model achieved clinically relevant outcomes at scale, with an average 3.9kg weight loss among over 14,000 completers, and providing monitoring that traditional episodic services struggle

to replicate.[34] However, providers on the current approved list do not reflect all regulated, responsible providers, and hence, this should be revisited.

Our recommendation is that regulation and innovation move in step. The Committee should press regulators to continue to co-design practical standards with all accredited providers - digital and traditional - to ensure rules are clear, consistently applied, and able to support safe access at scale. This will also have the added benefit of making it clearer and easier for patients to recognise good and bad actors.

Q2. What plans do the NHS in London have to roll out weight loss medicines in the coming years, and will this be enough to meet demand?

a) NHS roll out of weight loss medications

The number of people who need obesity treatment in the UK is significant.[35] NICE's eligibility criteria means that obesity management medication via the NHS is restricted to adults with BMI ≥40kg/m^2 (with more than four 'qualifying' comorbidities and type 2 diabetes).[36] Whilst the guidance wants to expand to those with a BMI ≥35kg/m^2 with weight related comorbidities in the future, this roll out is much slower than demand.

Meanwhile, private uptake has surged. IQVIA's data shows that around 2 million people are currently accessing medication through private providers.[37] This contrasts to the 220,000 expected to be treated on the NHS in the first three years of roll-out.

The fact is that even at a national level the NHS's specialist clinics reach only a tiny fraction. In 2022-23, only about 0.6% – 1.1% of eligible patients accessed Tier 3 services - with some regions this being effectively 0%.[38] Since Wegovy's approval, GPs have been inundated with inquiries from patients, but many GPs have nowhere to refer them – numerous areas lack Tier

[34] NHS England. *NHS Digital Weight Management Programme*. NHS England website. https://www.england.nhs.uk/digital-weight-management/nhs-digital-weight-management-programme/. Accessed August 22, 2025.
[35] Byrne J. Severe obesity and current treatment in the UK: a call for radical reshaping of services. Bull R Coll Surg Engl. 2024;106(6):330–3.
[36] NHS England. *Interim Commissioning Guidance: Implementation of the NICE Technology Appraisal TA1026 and the NICE Funding Variation for Tirzepatide (Mounjaro®) for the Management of Obesity* (PRN01879). Published March 27, 2025. Accessed August 22, 2025. https://www.england.nhs.uk/wp-content/uploads/2025/03/PRN01879-interim-commissioning-guidance-implementation-of-the-nice-technology-appraisal-ta1026-and-the-nice-fu.pdf
[37] Gregory A, *NHS begins mass rollout of weight-loss jabs to patients in England,* The Guardian. June 2025. Accessed August 28th 2025: https://www.theguardian.com/society/2025/jun/23/nhs-begins-mass-rollout-of-weight-loss-jabs-to-patients-in-england
[38] Finer N, Fragkas N, Miras AD, Pyper C. Commissioning of Tier 3 obesity services by Integrated Care Boards in England: An analysis of responses to Freedom of Information requests. *Clin Obes.* 2025;??(??):e70038.

3 services or have year-long waits.[39] This is not unique to AOMs, It's worth noting that whilst evidence shows that non-pharmaceutical interventions can deliver meaningful benefits, access similarly remains patchy, and the majority of people who could benefit from behavioural and lifestyle support are still not receiving it.[40]

In London, NHS services are similarly in the early stages of rolling out obesity management medications, following recent approvals by NICE. According to London Assembly's own data, in March 2025, just 170 prescriptions for Wegovy were recorded in London.[41] Whilst this is a 233% increase compared to March 2024,[42] it's still a tiny proportion of those who would qualify for support in London. Whilst around 2.2 million people in London currently live with obesity, if we just go on the NICE roll out criteria, which currently only spans those with a BMI >40, the number of eligible Londoners could be as many as 300,000.[43]

London historically has more provision than some regions, but within London there are also gaps. Certain boroughs may have no easily accessible specialist clinic, making it hard for patients to get an NHS referral for medication. In fact, it is worth noting that - whilst out of the eight Integrated Care Boards (ICBs) issuing the highest number of Wegovy prescriptions nationally, five of them were in London - in 2024, two London ICBs (North West and North Central) were reported as having no Tier 3 provision at all.[39, 44]

The fact is that the NHS's plan is a controlled, gradual scaling-up. This involves first using specialist services, then running a primary care pilot for the sickest patients, with an aim to learn and then possibly widen access over a few years. NICE has mandated a review in 2028 to decide on broader access criteria depending on outcomes.[45] The approach is understandable too. GLP-1 medications represent a significant new cost pressure. In BBC's 2024 Panorama, Prof Naveed Sattar, who leads the UK government's Obesity Healthcare Goals programme, said if everyone eligible was given the drug right away "it would simply bankrupt the NHS."[46] Our belief is that this doesn't have to be the case, but neither is the

[39] Ansari S, Mazaheri T, O'Donnell K, Waite M, Cann A, Abdel-Malek M, et al. Time to unshackle the medical treatment of obesity in the NHS. *Clin Med (Lond).* 2024;24(3):100206.
[40] Sample I. NHS restricting access to obesity services across England, BMJ finds. The Guardian. September 11, 2024. Accessed August 22, 2025. https://www.theguardian.com/society/2024/sep/11/nhs-restricting-access-to-obesity-services-england-bmj-finds
[41] Weight loss jabs in London. London City Hall. [accessed 17 Sept 2025] Available from: https://www.london.gov.uk/who-we-are/what-london-assembly-does/london-assembly-work/london-assembly-current-investigations/weight-loss-jabs-london
[42] RETIRED - English Prescribing Dataset (EPD) - open data portal. Nhsbsa.net. [accessed 17 Sept 2025] Available from: https://opendata.nhsbsa.net/dataset/english-prescribing-data-epd
[43] Main findings. NHS England Digital. [accessed 17 Sept 2025] Available from: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019/main-findings
[44] Finer N, Fragkas N, Miras AD, Le Brocq S, Pournaras DJ, Wass J, et al. Commissioning of Tier 3 obesity services by Integrated Care Boards in England: an analysis of responses to Freedom of Information requests. medRxiv. 2024.
[45] England NHS. NHS England » Weight management injections. Nhs.uk. [accessed 17 Sept 2025] Available from: https://www.england.nhs.uk/ourwork/prevention/obesity/medicines-for-obesity/weight-management-injections/
[46] Walsh F. 'I feel blessed to get weight-loss jab'—but can the NHS afford it for all? BBC News. January 13, 2025. Accessed August 22, 2025. https://www.bbc.co.uk/news/articles/clyn92j4nn2o

current NHS roll out enough to meet demand.

b) Is NHS provision enough to meet demand?

The short answer is no. Under current plans, the NHS will reach only a small fraction of the potential demand in the next year or two. The system meant to deliver these medications isn't keeping pace with the rapid rise in public interest.[6] We anticipate that many Londoners who need help will remain untreated if relying solely on NHS pathways – not because clinicians don't want to treat them, but because of capacity and restrictive criteria.

c) Considerations

- **The NHS is inherently limited by capacity and cost constraints.**

  The number of patients who can be served in specialist clinics is relatively small – these clinics were already handling only hundreds of patients per year even before weight-loss injections, due to staffing and resource limits. Now they are expected to incorporate AOM prescriptions, but many have long waiting lists. In London, some leading hospitals like Guy's and St Thomas, have well-established weight management programs, yet they can only take on so many new cases at a time. Data from across England indicate huge variation in access: some regions have comprehensive Tier 3 services, others have very few.[6]

- **Demand continues to rise.**

  Obesity prevalence in London is around 55% of adults (lower than some UK regions, but still more than half of the adult population is living with excess weight or obesity), and media awareness of these 'game changer' AOMs has made many thousands of people inquire about them.[47] GPs in London have reported being inundated with patient questions about Wegovy/Mounjaro since NICE approval was announced, yet those same GPs often have to tell patients they do not qualify for NHS access or that services aren't available to them.[48] This is something that was echoed by Joanna Hollington, Principle Dietician for NHS Trust, during the panel at City Hall.

  From our own data, we can see that demand for anti-obesity medication is extremely high in London and that awareness is also significantly higher than in other regions. We can therefore confidently say that London is mirroring the national trend where a

[47] Gallagher P. GPs swamped by requests for NHS Mounjaro – but hardly anyone qualifies. The i Paper. 2025. [accessed 17 Sept 2025] Available from: https://inews.co.uk/news/health/gps-swamped-by-requests-for-nhs-mounjaro-but-no-one-qualifies-3774098
[48] Anderson EWA. GPs unable to prescribe GLP-1s to patients who need to reduce BMI for lifesaving surgery. Pulsetoday.co.uk. 2025. [accessed 17 Sept 2025] Available from: https://www.pulsetoday.co.uk/news/clinical-areas/gastroenterology-obesity/gps-unable-to-prescribe-glp-1s-to-patients-who-need-to-reduce-bmi-for-lifesaving-surgery/

substantial majority of Londoners on Wegovy or Mounjaro to date have obtained it privately rather than via the NHS.

- **Another limiting factor is funding and supply.**

  Not only are the medications expensive (several hundred pounds per month per patient at list price), but providing holistic, wraparound support is also resource intensive for the NHS. As Dr Tamara Hibbert - Chair, Newham Local Medical Committee (LMC), explained to the Committee, appointments are required to teach patients how to safely take their medication, to monitor their progress, to provide nutritional and lifestyle advice, to titrate doses, manage side effects and so on. Scaling up the cost of medication as well as the cost of time and resource required to reach tens of thousands of NHS patients would quickly become unaffordable. Understandably, the NHS is moving cautiously to ensure sustainability. However, this caution creates a *bottleneck*: patients who *are* eligible on paper might still wait months or years for an NHS slot, and others who could benefit (even if slightly outside criteria) have no route in.

This is where the role of private providers plays a key role in creating safe, accessible pathways for patients that complements the work of the NHS.

Trusted digital health services can act as a pressure release valve for the NHS by managing patients who fall just outside NHS criteria or who cannot secure a timely NHS spot. For example, someone with a BMI of 35 and one or two comorbidities (rather than four) may not get tirzepatide from their GP today, but they can be safely treated in a private setting with appropriate monitoring. By caring for such a patient privately, we prevent a scenario where that patient goes untreated, sees their health worsen, or even seeks unsafe black-market alternatives.

In our experience, many Londoners are willing to self-fund treatment if it means getting started earlier, rather than waiting years for their obesity to worsen enough to meet NHS thresholds. A regulated private route gives them that option in a safe manner. This doesn't undermine the NHS but should support it, by reducing the number of people competing for scarce NHS weight management slots, and by potentially yielding health improvements that avert future NHS costs (ie. preventing diabetes progression).

It's worth noting that the UK Government itself, in its recent 10-Year Health Plan, acknowledged that *"Government can only go so far on its own... we will need to harness*

scientific innovation, including recent breakthroughs in weight loss medication"[49]. This implies partnering with innovators and the private sector to expand delivery is something that should be front of mind.

We firmly believe London can lead the way. London's ICBs and public health bodies could work with accredited digital providers, like Numan, to pilot expanded access programs – for instance, referring and/or recommending patients who don't meet the 'four comorbidity' rule but would benefit from losing weight now, into a private-digital pathway. This could possibly be supported with a co-pay or shared care model that also supports wider access for those who are not able to afford medicated treatment programmes currently. Such a public-private collaboration would ensure more people receive treatment, more data is collected on outcomes, and the NHS can focus its resources on the most complex cases.

Numan stands ready to be a partner in such efforts. We already have the clinical infrastructure to manage obesity treatment at scale remotely. We believe we can act as an extension of the system - taking on patients the NHS is unable to accommodate, under agreed protocols, and sharing the results.

In conclusion, the NHS's current rollout in London is an important start but is insufficient to meet the full demand for obesity management medications. Without additional capacity, many patients will remain untreated or seek help elsewhere - including from unregulated grey and black market sellers.

We urge the Committee to recognise the value of a mixed delivery model – one that maintains a strong NHS core service but also leverages safe private sector capacity. NHS and private pathways together are better than either alone: the NHS alone cannot do it fast enough nor can it meet the cost demands, and private alone risks fragmentation and creating a two-tier system where those who are most in need are missed due to a lack of personal means. Embracing regulated private providers as part of the solution (rather than seeing them as competitors) could significantly amplify access for Londoners.

Q3. On what scale are Londoners accessing weight loss medicines through private suppliers?

a) The scale of private access in London

[49] 10 Year Health Plan for England: fit for the future. Gov.uk. 2025. [accessed 17 Sept 2025] Available from: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

We recognise that it is challenging to quantify precisely how many Londoners are accessing obesity management medicines privately, because unlike NHS services, private providers each hold their own data and there is no single reporting system.

However, everything indicates that the scale is large and growing rapidly, with the private sector becoming the dominant means of accessing obesity management medications. As previously shared, national estimates compiled by researchers show that while under 200,000 patients may be on AOMs via the NHS, around two million people in the UK may be using these medications through private channels.[50] In other words, for every one patient getting anti-obesity medication on the NHS, several others are obtaining it privately.

London, being a major urban center with high awareness and relatively high incomes, is likely a significant contributor to the two million figure. We would not be surprised if tens of thousands of London residents are currently taking a GLP-1 medication for weight management through private means (this includes those using digital clinics like Numan, community pharmacy services, or private prescribers at weight loss clinics).

b) **A view on London private patients**

Using Numan's own data and research, we can provide a useful window into the private uptake in London. We have seen strong demand from Londoners since we launched our obesity management service in early 2023 - and whilst we cannot publicly disclose exact patient numbers for competitive reasons, we can share trends.

For us, London is one of the single largest patient bases in the UK – roughly one in ten of our obesity care patients are London residents. This equates to many thousands of Londoners treated by Numan alone in the past three years and our data paints a picture of who those patients are as well.

For example, the typical profile of a London patient is a working adult in their early forties who has consistently struggled with their weight, with more than three in five having previously tried traditional weight loss programmes or diets. They have come to Numan because they either do not currently qualify for NHS help due to the current roll out criteria, or did not want to wait for support given their health concerns.

A significant proportion are female (68%), which aligns with trends seen in other weight management programmes as women often seek help more proactively for weight issues,[51]

[50] Refsum C, Bradshaw A, Calvello I, Joshi R. Anti-obesity medications: Faster, Broader Access Can Drive Health and Wealth in the UK. Institute.global. Tony Blair Institute; 2025. [accessed 17 Sept 2025] Available from: https://institute.global/insights/public-services/anti-obesity-medications-faster-broader-access-can-drive-health-and-wealth-in-the-uk
[51] Corfe S. Shepherd J. Gendered experiences of obesity. 2021 Nov.

though obesity affects men and women alike. Over a quarter (26%) report that they have struggled with weight gain as a result of menopausal or hormonal issues, rising to more than a third (38%) when just looking at women (for whom it is the top answer), whilst 9% are concerned about postnatal weight gain.

Many patients are in professional occupations with busy lifestyles that made earlier weight loss attempts difficult. Emotional and stress-related eating are the biggest challenges Londoners face with two thirds reporting this as a reason they've struggled to lose weight, followed by lack of time for meal preparation (53%) and prioritising the needs of family or others (32%). Similarly, when asked what they think may have caused any weight gain, the most common reasons are periodic (34%) and chronic stress (26%). This sense of being time-poor and leading pressurised lives is a key reason why they appreciate the convenience of a digital service.

Income-wise, private London patients skew above the national average, with the average sitting in the £75,000 to £100,000 household income range. We do have patients from a range of socioeconomic backgrounds – it's not exclusively affluent people – but certainly the cost is a barrier for many. In fact, only around one in ten of our private London patients earn less than £50,000 (compared to 61% of patients in the North West, for example). This is a concern we acknowledge and address in more detail in later questions, but which is also likely exacerbated due to the high cost of living and working in London.

In terms of geography within London, our data shows a higher level of uptake in central and some suburban areas. Southwest London postcodes form the biggest private segment, followed by Southeast and East London. These areas may correspond with greater awareness (of new treatment options and digital health provision), or less NHS access.

In contrast, more deprived boroughs (for instance, parts of East Central or outer London postcodes) see fewer private patients. This is unlikely to be because need is lower, but due to cost barriers or lower levels of awareness. This could hint at both a potential digital divide as well as health inequality within the private sphere that needs to be addressed.

Data on whether London's diverse communities have different levels of engagement is still pending. However, data suggests that a high proportion of people from ethnically diverse groups are seeking access and support. For example, the largest ONS demographic segment among London patients is "Ethnicity Central", at 34%. This suggests the message about obesity treatments is reaching a broad audience, but there are likely cultural or economic factors influencing who accesses private care.

There are other external trends to consider as well. As we know, private demand in London has been surging especially since mid-2023 when the new GLP-1 medications started making headlines. Spikes corresponding to major news events – like celebrity endorsements or new studies - regularly mean that new consultation requests jump.

One particularly striking example in August–September 2025 was when Eli Lilly, the manufacturer of Mounjaro (tirzepatide), imposed a price increase on private supply (over 170% increase in wholesale cost) at short notice. Rather than dampen demand, this news triggered panic among some patients – leading to a rush to secure medication before prices went up. In fact, in the weeks following the announced price hike, online searches for "Mounjaro alternatives" spiked by 5,000% as people scrambled for other options.

At Numan, we found it necessary to temporarily pause onboarding of new Mounjaro patients right after the price change. As our founder explained to City Hall, we did this to protect patients, suspecting that some individuals were attempting to stockpile the medication or start it inappropriately. This was something we were seeing widely discussed on social media and Reddit as well as by the press and in comments sections. It is just one example of how intense the demand has become - significant enough that when external factors shift, we see immediate large swings in behavior. The incident underscores that thousands of patients are actively considering or seeking access to private, medicated treatment pathways that they are not currently eligible for via the NHS.

Recommendations:

- **Data limitations and need for monitoring**

  At present, there is no unified registry capturing how many Londoners are accessing AOMs through private routes. This gap makes it difficult for healthcare professionals to plan services, and for patients to understand the scale of access and availability.

  We believe public health authorities should work with major private providers to capture and share anonymised, aggregated data - for example, the number of prescriptions dispensed in London each month. Numan recognises the benefit of sharing de-identified aggregated data with policymakers to aid understanding of the sector, as we're doing in this response and as part of real-world studies. A coordinated effort between NHS services, community pharmacies, and accredited digital clinics would create a far clearer picture of demand and outcomes. The London Health Committee could also lead a survey of known providers to help quantify the private sector's contribution in the city. Together, these steps would provide the evidence base needed to plan services, ensure equity, and protect patient safety.

- **Collaboration on education and awareness of safe and comprehensive AOM based obesity care access at scale**

  Alongside expanding safe provision, there is a pressing need for joint education and awareness efforts. We recommend a collaborative programme between regulators, NHS London/ICBs, community pharmacies and regulated digital providers to educate patients on what safe access and treatment looks like. This should include clear guidance on eligibility, the importance of lifestyle change alongside medication, and how to report side effects through the MHRA's Yellow Card scheme. At present, too many Londoners still view AOMs as 'skinny jabs' or quick fixes, assuming they can be taken in isolation without behavioural support. Correcting this misconception will require coordinated, city-wide communication. London could lead the way by using this partnership model to deliver consistent, accessible messaging - helping patient patients make informed choices and shifting public perception to there's less demand or reliance on unregulated supply.

In summary, private access is already happening at scale in London.

It has become the primary avenue through which Londoners obtain Wegovy, Ozempic, Mounjaro and similar medications, given the nascency of NHS services. Thousands are engaged in private treatment at any given time, with demand still accelerating. While this reflects positively on innovation and patient proactiveness, it also raises questions about equity and safety (addressed in Q4).

The key point for the Committee's consideration is that private provision is not a minor, fringe occurrence, nor is it something that can be safely turned off. It is a major part of the obesity management medication ecosystem in London and across the UK.

Any policy approach must therefore integrate the private sector, ensuring standards are high and that we harness this capacity for public good. Rather than view the scale of private access as a problem, it should be viewed as an opportunity: people are clearly more engaged in their health and want effective treatments that will let them live healthier, longer lives. Many will also attempt to gain access through unsafe means if safe, regulated and affordable channels are not available. It is therefore essential to incorporate and regulate reputable private options rather than to ignore them.

Going forward, a closer public-private collaboration - such as NHS referral partnerships, data sharing, and joint pilots - could make this large private footprint work even more in favour of Londoners' health.

Q4. Are Londoners who are not medically eligible acquiring weight loss medicines, and if so, what are the risks of them doing this?

The Committee has asked whether Londoners who are not medically eligible are acquiring obesity management medicines, and the risks if so. Unfortunately, the answer to the first part is yes – it is happening, and it is one of the greatest current concerns faced by us and our peers.

We fully agree with the government as well as NHS and sector peers that more needs to be done to understand the scale of ineligible access and the illegal grey and black market, to monitor it and crack down on it.

The challenge can be split into different cohorts:

1. Eligible patients who access medicated weight loss programmes that have robust and holistic wraparound care - whether through the NHS or private providers.
2. Eligible patients who access medicated weight loss programmes that do not have robust wraparound care or who are prescribe medication without access to holistic support.
3. Potentially eligible patients who resort to the black or grey market because NHS access is too restricted whilst private access is not affordable to them.
4. Ineligible patients trying to bypass safeguards in pharmacies and regulated platforms - for example, by using the information of friends or family to access medication, using tools like AI to fake photographs to manipulate identity checks.
5. Ineligible patients knowingly buying from unregulated sellers and seeking weight loss despite not meeting NICE criteria, or looking for cheaper alternatives.

Other than the first scenario - which would include safeguards and support as required from regulated providers - each of these scenarios exposes Londoners to significant risks. We have covered some of the risks posed by lack of holistic lifestyle and behavioural support, so now we turn to the risks posed by counterfeit or unsafe products, unmanaged side-effects, and the absence of any clinical screening or follow-up.

One of the key issues when it comes to people who are ineligible for the medication gaining access is that the benefit-risk calculation is negative if you are not diagnosed with obesity. People who do not meet the eligibility criteria have relatively little health benefit to gain from taking medication since they aren’t clinically obese or ill. However, they still face all the drug’s risks.

Many risks may seem somewhat similar to those who receive medication without holistic wraparound care. For example:

- A person with a healthy BMI taking a powerful appetite suppressant could lose too much weight, leading to malnutrition, muscle wasting, and nutritional deficiencies. Indeed, clinicians have seen cases of patients becoming *undernourished* because they essentially stopped eating enough on these medications without proper guidance. It is essential that patients are monitored and that they do not just stop eating, but know the importance of continuing to eat small, balanced meals. Without that intervention, someone could develop anemia or fainting spells from low blood sugar.
- As noted, psychological harm is another risk: an individual using the medication for cosmetic reasons might develop body dysmorphia or disordered eating behaviours or eating disorders , where they become obsessed with losing more weight even if they are a healthy weight according to BMI. This is dangerous and also hard to detect until it becomes severe, because if their BMI hasn't dropped below 'underweight', they may not be flagged in usual body weight screenings.
- There are also the direct medical side effects which, in unsupervised settings, can spiral. Common GI side effects like vomiting or diarrhea can turn into hospitalisations for dehydration - an unsupported user might not know how to react and end up in A&E.
- Earlier, we cited cases of pancreatitis, gallstones, and even acute kidney problems occurring in patients who got hold of AOMs inappropriately. Pancreatitis is a known rare side effect even in proper use, but in someone who shouldn't be on the AOM or who keeps taking it despite severe abdominal pain, it can become life-threatening. Anecdotally, it has been noted that most of the serious adverse incidents she's seen (pancreatitis, etc.) were in patients who aren't eligible to be prescribed that medication. In other words, avoidable tragedies stemming from illicit access.
- Another scenario is incorrect dosing: in safe practice, doses are escalated gradually with regular check-ins. But someone buying vials online might ramp up too fast to try to lose weight quicker, or use an incorrect dosing pen. Rapid dose escalation can exacerbate side effects and lead to impacts like gallbladder issues (the risk of gallstones increases with faster weight loss).[52]
- There is also risk of drug interactions or contraindications that a layperson wouldn't know – for instance, certain people with endocrine disorders or on certain medications shouldn't take GLP-1 agonists, but an unknowing person could combine them unsafely.

It is also important to recognise the system costs and services risks, particularly the impact on the NHS. As reported in Chemist+Druggist (C+D), GPs have anonymously shared that 'on "every" recent shift, a patient who should not be on AOMs has presented with complications

[52] Dieting & gallstones. National Institute of Diabetes and Digestive and Kidney Diseases. NIDDK - National Institute of Diabetes and Digestive and Kidney Diseases; 2025. [accessed 17 Sept 2025] Available from: https://www.niddk.nih.gov/health-information/digestive-diseases/gallstones/dieting

after illicitly obtaining Wegovy.'[53] Similarly, this was a concern raised by NHS representatives at City Hall, who noted that A&E departments and local NHS weight loss services are already encountering the fallout of misuse. This is a clear sign that Londoners are acquiring these injections despite not meeting medical criteria as well.

Addressing the challenges of ineligible access to regulated services requires not only strong enforcement and robust ID verification from providers (as outlined in earlier sections), but also better data sharing between public and private providers. For example, private providers cannot always easily access Summary Care Records, making it harder to verify information and coordinate care. There is a growing urgency for a model that embraces Open Health - much like Open Banking - where patients control their data and all accredited providers can securely access the information needed to deliver safe, joined-up care.

Yet even the strongest safeguards and clearest regulatory guidance cannot protect patients who turn to grey or black market sellers operating entirely outside the law. This remains the greatest risk to the public, and it underscores the need for decisive action against unregulated supply.

For background: there is a concerning lack of official data on the growing grey and black market for AOMs. However, it is expected that there has been a rise in non-prescribed and inappropriate use of GLP-1 medications in London, driven by social media trends and word-of-mouth around 'skinny jabs' being a 'quick fix' for weight loss rather than seen as treatment for obesity as a disease.

The fact is that when access to these sought-after medications is constrained, a black market and other unscrupulous routes inevitably emerge. We've seen how people who's weight management is vital to their health and wellbeing have started searching online following the September pricing changes from Eli Lilly and the 5000% increase in online searches for cheaper medication alternatives. Similarly, looking to Europe there are reports of a 'sharp rise' in illegal medications being advertised and sold online, with authorities 'identifying hundreds of fake Facebook profiles, advertisements and e-commerce listings, many of which are hosted outside the EU'.[54]

Anecdotal evidence shared in City Hall highlighted how the Londoners are increasingly being solicited by unqualified individuals – beauty salonists, personal trainers, even hairdressers – offering to sell them 'skinny jab' injections. Sukhi Basra, Vice Chair of the NPA, gave a

[53] Bowie K. 'I'm terrified someone is going to die' - Wes Streeting demands tighter regs around Wegovy after C+D story. C+D. [accessed 17 Sept 2025] Available from: https://www.chemistanddruggist.co.uk/CD138280/Im-terrified-someone-is-going-to-die--Wes-Streeting-demands-tighter-regs-around-Wegovy-after-CD-story/

[54] Warning about sharp rise in illegal medicines sold in the EU. European Medicines Agency (EMA). 2025. [accessed 17 Sept 2025] Available from: https://www.ema.europa.eu/en/news/warning-about-sharp-rise-illegal-medicines-sold-eu

powerful example of a patient who forwarded her a photograph of a personal trainer displaying a box of what he claimed were obesity management medications (she noted they were almost certainly fake or unregulated imports) and offering them for sale. This is a familiar story to us as well, with health coaches and clinicians reporting similar enquiries from patients if they've encountered unregulated providers. The concern is that whilst some patients will ask their clinician or pharmacist for advice, many others might be tempted by such offers, especially if they're frustrated with formal channels.

The fact is that taking counterfeit or substandard products can be extremely dangerous and sometimes fatal. If a Londoner buys a 'skinny jab' from a non-regulated source, there's no guarantee of what they're injecting. It could be a different medication altogether, a research peptide that hasn't been through safety tests, or a complete placebo. In the worst case, it could contain harmful impurities. For example, reports in December 2024 emphasised that people were at risk of suffering seizures and comas at the hands of counterfeit medications laced with rat poison or cement sold by 'fake' online pharmacies.[55] As the GPhC's representative pointed out to the Committee, if you don't know what you're injecting, "the risk is anything". There are reports of chemical burns, severe infections, and serious adverse reactions. This is an extreme scenario, but not impossible if illicit trade proliferates.

The MHRA has already issued warnings about unapproved versions of anti-obesity medications being sold online. However, as articles in Business Insider and the Daily Mail highlighted with the example of retatrutide (a medication that is still only available through clinical trials and not at all in the UK), warnings are rarely, if ever, enough.[56][57]

Preventing and addressing access for those who are not eligible must go hand in hand with monitoring grey and black market access.

The core strategy must be to educate and provide safe alternatives.

We need to make sure the public understands that these medications are Prescription-Only Medicines for a reason – they require medical oversight. There should be widespread public health messaging in London (through GPs, pharmacies, social media campaigns) warning against buying obesity management injections from non-healthcare sources. This could mirror past campaigns about fake medicines.

[55] Stearn E. Urgent warning over fake online pharmacies selling 'Ozempic' laced with deadly chemicals including rat poison. Daily mail. 2024 Dec 6; [accessed 17 Sept 2025] Available from: https://www.dailymail.co.uk/health/article-14160895/warning-fake-online-pharmacies-Ozempic-organ-damage.html
[56] Brueck H, de Graaf M. Eli Lilly is close to launching the strongest weight-loss drug ever. Somehow, gym bros are already taking it to shred fat. Business Insider. 2025 Aug 30; [accessed 17 Sept 2025] Available from: https://www.businessinsider.com/eli-lilly-retatrutide-gray-market-in-fitness-circles-before-launch-2025-8
[57] Stearn E. Both Mounjaro and Wegovy failed me and now I'm using this black market 'Godzilla' jab to shed the pounds. I know the risks... but the weight loss is staggering and it's cheaper than the rest. Daily mail. 2025 Sept 4; [accessed 17 Sept 2025] Available from: https://www.dailymail.co.uk/health/article-15058401/Mounjaro-black-market-Godzilla-jab-retatrutide-weight-loss.html

In addition, enforcement is key: regulators and law enforcement should continue to identify and shut down domestic black-market operations. The MHRA and police have in the past conducted raids/confiscations of illegal diet drug supplies; we would urge a focus on GLP-1 trafficking specifically. Social media companies must also take responsibility to curb the advertising of prescription drugs by unlicensed vendors.

Private providers

Regulated digital health and private providers, like Numan, are able to help draw people away from dangerous routes. For example, we implement strict measures to ensure ineligible patients cannot access medication. Our assessment processes do not allow someone with a healthy BMI (or relatively mild weight issues as measured by BMI and comorbidities) to be approved – the system flags it and our clinicians reject those cases. If we suspect someone is falsifying information, we have methods to verify data and may ask for more information such as proof of weight (like a recent clinic letter or a live video weigh-in) if something seems inaccurate. We require a government-issued ID to verify identity and age as well as screening for health issues and any history of eating disorders both in our questionnaire and our clinical reviews. Where there are concerns, patients are not given access to our AOM-based obesity management programme and are instead guided to appropriate care.

Furthermore, our marketing is medically oriented and often focuses on disease awareness, abiding by the UK rules that POMs cannot be advertised directly to the public. Our focus is always on the service we can offer through the programme and patient education. This is important because some less scrupulous businesses have used social media ads that arguably glamorise the weight loss aspect without emphasising the medical context. We support the GPhC's recent guidance which explicitly calls for responsible advertising and against incentivising volume sales of obesity management medications.[28]

We also work to integrate with NHS care to prevent patients from doctor-hopping or duplicating therapy. For example, we always communicate with GPs, with patient consent, when someone begins treatment with us. Similarly, when patients come to us having been advised to consider medication by their doctor, we send a letter to inform them. This prevents situations where a patient might have a private prescription while their NHS doctor is unaware - an issue that could pose risks if they then needed to undergo surgery or other treatments unknowingly while on the medication. By encouraging openness and GP involvement, we reduce the fragmenting of care that can occur with private routes.

Recommendations:

- **Public education and guidance:** We commend the General Pharmaceutical Council for publishing a new guide for patients on how to safely obtain AOMs. This guide, endorsed by multiple regulators, gives practical tips – for instance, how to check if an online pharmacy is registered, and how to spot red flags like being sold a medicine without a prescription. Efforts like this should be amplified in London with the launch of educational programmes and potentially a kitemark that helps identify good actors (such as that being rolled out in the EU). Numan has also contributed educational content: we've produced articles on how to verify legitimate providers and warn about scams. We'd be happy to partner with public health agencies to disseminate these messages further or collaborate on a joined up campaign to raise awareness on safe and effective care.

- **Counter the narrative of AOMs being 'skinny jabs'.** One reason ineligible people seek the drug is a misconception – seeing it hyped online or mislabelled as a 'skinny jab' (even by the MHRA[58]) means that some think it's safe to take medication despite not meeting the eligibility criteria or having access to wraparound support. We need to reinforce that these are medical treatments for obesity, not a solution for any weight management approach. They come with injections, side effects, and a need for monitoring – not a trivial undertaking for someone who doesn't medically need it. Making that clear can deter casual misuse. We therefore strongly recommend that London moves to recognise obesity as a disease, that the language used around these medications focuses on their anti-obesity benefits or on obesity management.

- **Risks to the wider community:** Another risk of illicit use is that it could tarnish the reputation of these medications unfairly. For instance, if a well-known incident occurs (someone gets seriously ill or worse from a counterfeit jab they bought in a salon), it could create fear and stigma around the medication that might discourage genuinely eligible patients from seeking help. That would be a tragedy - we don't want the irresponsible actions of bad actors and fake sellers to undermine a therapy that could benefit many millions of people. Cracking down on the grey and black market is also important for maintaining public trust in the legitimate use of obesity management medicines.

To summarise: there are Londoners who are obtaining medications (or fake substances) through illicit or inappropriate means, and this poses serious risks ranging from medical emergencies to psychological harm.

The best way to combat this is twofold:

[58] Healthcare products Regulatory Agency. Women on "skinny jabs" must use effective contraception, MHRA urges in latest guidance. Gov.uk. 2025. [accessed 17 Sept 2025] Available from: https://www.gov.uk/government/news/women-on-skinny-jabs-must-use-effective-contraception-mhra-urges-in-latest-guidance

1. Expanding and promoting the safe, regulated avenues (NHS or reputable private clinics) so that people are less tempted to go underground;
2. Enforcing regulations and public education to root out the unsafe suppliers.

Numan is eager to be part of the solution – by continuing to enforce our safeguards and work with regulators, by educating our patient community about dangers, and by collaborating with public health services to create greater dialogue and share more insights that can only benefit patients in the long-term.

We believe that by setting a high bar for private services, we can ensure there is a 'flight to quality' where patients will choose regulated providers and shun grey or black market options due to an understanding of safety and risk. The Committee can assist by working with the NHS, private providers and community pharmacies, to publicly emphasise that any Londoner considering these medications should go through a qualified healthcare professional – not social media or backdoor channels.

Conclusion

London has a unique opportunity to shape what comes next for AOM access in a way that maximises public health benefits while minimising risks. Numan's core recommendations, reinforced by the evidence above, are that:

- **A multi-pronged model covering public, private, and public-private partnerships is essential for addressing obesity at scale.** The NHS does not have to be (and realistically cannot be) the only provider of AOM based obesity care. By working in tandem with reputable private providers, the overall system capacity increases and the likelihood of people turning to unsafe, unregulated sources decreases.

  We urge the Committee to support collaboration models, such as integrated care pilots where digital clinics help manage less complex patients or overflow from NHS clinics, with both referral and recommendation avenues. This would enable more Londoners to receive treatment in a timely manner. We would welcome the chance to participate in an NHS London or borough-led pilot scheme to demonstrate how such collaboration can work – for example, a 6-12 month project where Numan, under NHS governance, treats a cohort of patients who are currently unable to get into NHS services, providing full engagement, safety and outcome tracking.

This could take place in an under-served borough and target communities with high obesity rates but low NHS uptake. An example of this is the Innovate UK call for funding submission in September 2025.[59]

- **Robust regulation and enforcement should target the informal and unsafe supply of these medicines.** We ask the Committee to shine a light on the unregulated market and recommend actions to combat it. We need to make sure there is greater sharing of data and insights between services that reveal how and where people are gaining access to illicit medication.

  Public education must be part of the strategy – similar to how London authorities educate about counterfeit medications or unsafe cosmetic procedures. This might include public campaigns to combat misinformation around so-called 'skinny jabs' or to raise awareness of reporting systems like the Yellow Card scheme. These could be driven or supported by private digital health providers, community pharmacies, regulated clinics, and the NHS, ensuring all potential patient touchpoints are engaged.

  It also needs to be made easier for Londoners to spot good actors. This means clear messaging that if someone wants help for obesity, they need to go to a licensed healthcare service. We have to keep supply channels open (through NHS or reputable private services) and loudly warn against dangerous alternatives. Numan stands ready to assist in education efforts, sharing patient-friendly materials about how to verify legitimate providers and why going outside the system is risky.

- **Ensuring equity and safety through standards must be prioritised**: We encourage the Committee to advocate for consistent standards across all providers of AOM based obesity care. The safest approach for Londoners is if every clinic – NHS or private – abides by guidelines on assessing eligibility, monitoring, and support.

  Regulators like the GPhC have already set guidelines that should be strictly enforced. However, more could be done to help patients identify trustworthy providers and medications - for example, with the introduction of a quality kitemark (like that proposed by DiCE) could be developed for obesity services. Providers that invest in comprehensive care (dietitians, coaches, follow-up calls) should become the norm, not the exception.

  We also support greater data sharing between private and NHS – for example, a

[59] Competition overview - obesity pathway innovation programme (OPIP): Strand 3 - innovation funding service. Gov.uk. [accessed 17 Sept 2025] Available from: https://apply-for-innovation-funding.service.gov.uk/competition/2186/overview/e51c18bc-21b3-450d-bdbc-2f43dad3b268

mechanism for private providers to send a summary to a patient's NHS record with the patient's consent. This integration will enhance safety (so GPs know their patient is on semaglutide, for instance) and facilitate continuity of care. On the flip side, measures to protect patients who choose private care – such as ensuring they can go back to the NHS for other services without prejudice – are important as well. Essentially, we want to see a London where AOM-based obesity care is accessible to those who need it through a seamless ecosystem where whether you get it via your GP or a digital clinic, you're held to the same safety standards and get supportive care.

- **Support for innovative models and preventative approaches is necessary.** The Committee's investigation is timely not just for current access issues, but for what comes next. More than 157 new AOMs are in development[60] - but demand is likely to grow even more if an oral pill form becomes available such as those in development from Eli Lilly and Novo Nordisk. London should prepare by fostering innovation. This could mean supporting ICBs to partner with tech-driven services (like apps for behavioural and lifestyle services) to augment what medication alone does. The economic case for treating obesity is strong – healthier residents mean lower long-term NHS costs and a more productive workforce.

  We encourage the Committee to view responsible private providers as allies in prevention. Our services don't only prescribe drugs, we emphasise lifestyle change and education - this is what we've aimed to do with our research on issues such as food noise. By incorporating these kinds of resources, London can amplify public health messaging around nutrition and activity.

In closing, Numan is grateful for the opportunity to contribute to this inquiry. We have seen firsthand the difference that safe, clinically guided use of AOMs can make in individuals' lives – people in London (and the UK) who, after years of struggling, are shedding weight, reversing type 2 diabetes, reducing their blood pressure, and feeling hopeful about their health future. We also recognised the pitfalls when things are done improperly – cases that underscore every point we've made about the need for proper oversight.

We urge the Health Committee to take a pragmatic, patient-centric stance: support making these effective treatments widely available with the necessary safeguards. That means endorsing a greater role for regulated digital health providers to work alongside the NHS, calling for crackdowns on the black market, and ensuring that any Londoner pursuing weight loss therapy does so under competent medical supervision and with holistic support. By doing so, London can lead the nation in demonstrating how to harness these game changing obesity medications responsibly, maximising health gains for our population, while avoiding the harms of misuse.

[60] Sarah Rickwood VPITL. Shaping a healthier future: the power of policy in addressing the obesity crisis. 2025 Summer 3.

Together, the NHS and private sector can reverse the obesity crisis. We stand ready to play our part, and we look forward to continued engagement with the Committee on turning these recommendations into reality.

Pharmacy2U submission to London Assembly call for evidence: Weight loss medication in London

Introduction to Pharmacy2U and its weight loss service business model

Established in 1999, Pharmacy2U is the UK's largest digital-first pharmacy. We liaise directly with GPs to deliver NHS prescriptions straight to people's homes from our centralised automated dispensing facilities. We operate at scale, dispensing around 3.5 million NHS prescription items per month to over 1.6 million patients, with enhanced clinical accuracy. Our repeat dispensing service provides huge convenience to patients who rely on timely and regular access to repeat prescriptions, while easing the burden of repeat dispensing on High Street pharmacies and GP surgeries, allowing them to deliver a greater range of face-to-face clinical services.

Pharmacy2U is one of the UK's largest private pharmacy suppliers of weight loss medications, having safely supplied over 1 million doses to date. Patients must complete an online clinical assessment, driven by sophisticated algorithms that gather a complete medical history and scan for areas of clinical risk. This information is made available to the prescribing team, which allows them to deal with both straightforward and complex cases more easily. Further information about our service is included under question 3.

Answer to question 1: What are the benefits and risks of weight loss medicines?

An important benefit associated with weight loss medicines is their potential to reduce the burden on both the NHS and wider economy.

Obesity places a heavy burden on both the NHS and wider economy due to NHS treatment, formal and informal social care costs, welfare payments and decreased productivity. It is also one of the main risk factors driving health-related economic inactivity.[1] Obesity costs the UK an estimated £107 billion each year, which includes a cost of £9.3 billion to the NHS.[2]

More broadly, obesity is associated with over 200 complications[3] and weight loss can significantly reduce the risks of associated health conditions: 5-10% weight loss improves triglycerides, lipids, cholesterol and can halt progression to type 2 diabetes, whilst 10-15% weight loss improves cardiovascular disease (CVD) morbidity.[4]

Therefore, while the cost of treating obesity through weight loss medications is high, the burden of obesity is higher. Just a 10% reduction in obesity prevalence could lead to significant cost savings to the NHS, as well as improved quality of life, workplace productivity, with a total social gain of around £6 billion a year.[5] Supporting people to achieve weight loss, utilising weight loss medications to do so, will significantly reduce these burdens and release capacity and resources within the NHS.

To realise the benefits presented by weight loss medications, there are a number of opportunities that can be considered in the context of the Government's three strategic shifts to support those living with obesity, reduce pressure on the NHS and contribute to economic growth:

- **Hospital to community**: there is an opportunity for community pharmacy – given its growing role in clinical services – to provide accessible, community-based wraparound support for people on weight loss medications, facilitating a shift away from hospital-based weight management services. Community pharmacy has already

proven its ability to effectively deliver clinical services such as Pharmacy First, highlighting its potential to increase access to care and alleviate pressure on stretched parts of the NHS

- **Sickness to prevention:** there are opportunities to embed new preventative pathways within weight management, particularly given the strong association between obesity and CVD.[6] For example, Pharmacy2U partnered with PocDoc earlier this year to deliver an at-home, digital-first, CVD screening programme to over 3,000 patients.[7] This type of preventative initiative could be integrated into obesity care for patients with higher CVD-risk due to obesity, ensuring early identification and intervention, and ultimately, improving patient outcomes

- **Analogue to digital**: digital-first models of weight management offer opportunities to scale services nationally – recognised by the 10 Year Health Plan.**Error! Bookmark not defined.** Fully-digital models of providing weight loss medications and wraparound care – like those provided by Pharmacy2U – could support expanded rollout, whilst reducing pressure on general practice. In turn, improving efficiency and cost effectiveness, addressing resourcing issues, increasing accessibility and reducing waiting times. The rapid expansion of the private market demonstrates the potential of digital delivery – as of March 2025, there were an estimated 1.5 million users of weight loss medication and online providers accounted for around 80% of these purchases.[8] Learnings around digital delivery from trusted, regulated providers in the private market can be applied to the NHS to safely expand access whilst mitigating cost and capacity constraints

Alongside these benefits and opportunities, there are also risks and challenges associated with weight loss medicines.

At present, NHS weight management services are not set up to provide weight loss medications and wraparound care at scale. Given the Government's ambition to roll-out weight loss medications through primary care services, it will be essential to address the significant capacity and resource constraints within the sector. While pharmacy has increasingly been positioned as part of the solution to the growing demand on general practice, pharmacy is not immune to capacity and workforce constraints seen across the healthcare system. These challenges will need to be addressed to ensure community pharmacy can support general practice to deliver the roll-out of weight loss medications and services at scale.

NICE guidance stipulates that wraparound care should be provided to those on weight loss medications[9] – this is essential to empower patients to make long-term lifestyle changes and to maximise lasting benefits treatment.[10] However, there is currently no dedicated primary care weight management service to provide wraparound care within the community, and existing services, such as general practice, are already overstretched and have voiced concerns about implications on workload and capacity.[11]

The slow national rollout of weight loss medications across the NHS means access is currently inequitable, with a two-tier system for those that can afford to buy the medicines privately. This is exacerbating health inequalities and can present an additional safety risk whereby individuals turn to unregulated online suppliers selling products, at a cheaper price, that may contain toxins and harmful ingredients.[12] Pharmacy2U believes stronger action is needed to prevent unregulated operators from supplying weight loss medications and without the rigorous checks needed to ensure medicines are prescribed within their marketing authorisation.

Answer to question 2: What plans do the NHS in London have to roll out weight loss medicines in the coming years, and will this be enough to meet demand?

While we welcome the NHS's plans to phase the roll out of weight loss medicines, including in London, through general practice,[13] we believe that weight management services need to go further to facilitate Government ambitions to accelerate rollout across the NHS and meet demand.

Leveraging community pharmacy

The skills of all partners across primary care, such as community pharmacy, should be leveraged to alleviate pressure on general practice and expand access. Pharmacy – particularly online and digital pharmacy – can play an important role in providing remote medical consultations and wraparound care, increasing accessibility and convenience for patients. Pharmacy2U is already doing this and is one of the UK's largest pharmacy suppliers of weight loss medications in the UK, having safely supplied over 1 million doses to date.

Funding and contracting

To truly deliver on ambitions for weight loss services and medicines, the NHS must ensure robust contracting processes are in place with providers, as well as sufficient and sustainable funding for delivery. To ensure weight loss services can deliver equitably for patients across the country, nationally defined contracts should be developed to standardise and solidify the approach to weight management across ICBs, whist allowing sufficient local flexibility to effectively meet population needs.

Robust contracts will enable providers to implement the rigorous checks needed for medicines optimisation and care. Any committed funding must also include funding for wraparound care, as well as just reimbursement for dispensing of medicines. This stands to incentivise providers to deliver high-quality programmes in line with NICE guidelines, with sufficient follow-up with patients even after they've stopped taking the medication to support with lasting lifestyle changes. This should be separate to existing budgets for contracting for healthcare providers (such as the Community Pharmacy Contractual Framework (CPCF), to ensure the funding is ring-fenced. An innovation trial, similar to the NHS Innovation Accelerator, could be used to evaluate appropriate models of funding for new services, including those that incorporate both digital tools and the wider pharmacy sector in their delivery.

Digital-first services

Digital pathways for weight management need to be expanded to enable expert, trusted, regulated providers to support the rollout of weight management services. A digital-first delivery model would enable the NHS to expand access to weight loss medications and services significantly faster than under current plans, which do not take into consideration a digital-approach. It would also help to reduce the impact on already stretched capacity across the NHS, improve efficiency, cost-effectiveness and reduce waiting times, and ultimately, improve access for patients.

A first step should be broadening the NHS Digital Weight Management Programme beyond its current, restrictive eligibility criteria, to cover a wider population and incorporating prescribed weight loss medications within the programme. In an expanded digital programme, online and digital pharmacists could work alongside dieticians, psychologists and physical activity experts to provide comprehensive support seamlessly across digital

platforms. Expanding access to all patients with a BMI over 30 could also enable earlier intervention, helping to prevent the onset of related health complications such as type 2 diabetes and CVD.

There are, however, a number of key barriers to expanding digital pathways within weight management services. Firstly, interoperability between community pharmacy and general practice must be improved to enable pharmacy to access and update patients' health records and receive referrals. The commitment to link community pharmacy to the Single Patient Record in the 10 Year Plan was welcome, but there must be clear timelines for delivery of this as well as the inclusion of online pharmacy in designing functionality from the start, to ensure a model that works for the whole sector.

Similarly, commitments in the Plan to transform the NHS App into a world-leading tool for patient access, empowerment and care planning is long overdue and we welcome the ambition for the App to be "a full front door to the entire NHS".[Error! Bookmark not defined.] Weight management services should be considered within that redesign to ensure digital services can be integrated within the App. Again, the needs of the online pharmacy sector must be considered when designing this functionality. For example, the NHS App should allow one-click nomination of distance-selling pharmacies – as it does with bricks-and-mortar pharmacies – to ensure an equitable and seamless experience for patients, with access to weight management consultations, wraparound support and medication, all in one place.

Medicines supply

Medicines supply issues also need be addressed. Given the existing levels of private market demand and future NHS demand for weight loss medications, shortages are likely to increasingly become an issue. The actions set out in both the Health and Social Care Committee's inquiry into Pharmacy[14] and the Pharmacy All Party Parliamentary Group (APPG)'s report on medicines shortages[15] should be taken forwards to mitigate this. For example, publishing a UK-wide medicines shortages communication and patient support strategy, commissioning an independent review of the medicines supply chain and developing a medicines supply tool to provide accurate and consistent information. In response to ongoing medicines shortages within the sector, Pharmacy2U has already developed a Medicine Stock Checker for patients, which could be used as a prototype for a national tool.

Answer to question 4: Are Londoners who are not medically eligible acquiring weight loss medicines, and if so, what are the risks of them doing this?

As part of our private service, Pharmacy2U uses comprehensive means to validate patient identity, and to ensure they meet eligibility criteria for being prescribed weight loss medicines. During the initial consultation, patients are required to record a video of themselves showing their face next to valid photo ID, to enable an identity check to be performed. The patient is also required provide a real-time video of themselves standing on scales so their BMI can be confirmed. Our approval processes are robust, and in line with guidelines set by the General Pharmaceutical Council.

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London Assembly
Health Committee
Call for evidence: Weight loss medication in London
September 2025

Executive Summary

We are submitting this evidence following the London Assembly Health Committee session on 10 September 2025. Our submission aims to build on that discussion, provide additional real-world data from our own patient population and address areas where further clarification or evidence may assist the Committee.

Our key messages are:

1. Digital delivery is safe and effective (supported by peer-reviewed data), and delivering care at scale.
2. Voy reaches deprived boroughs and hard-to-reach populations within London. Twice as many deprived borough patients access Voy compared to affluent ones.
3. Regulation and infrastructure must be modernised to align with the NHS 10-Year Plan and a digital world.
4. Price shocks and affordability (e.g. Mounjaro) threaten safe access for Londoners

Who we are:

Voy is a CQC-regulated digital health provider with a track record of delivering safe, accessible and evidence-based care at scale. Our model of obesity management supports key priorities for London: tackling health inequalities, preventing long-term conditions, strengthening the health and care workforce, and using digital innovation to improve access.

- https://www.joinvoy.com
- Digital health provider "Building more good years into life"
- CQC Registered, GPhC Registered Pharmacy
- 1 million+ patients served across the UK
- 250 K weight loss patients served, 18% of patients are London based.

London demographics:

- 56% of Londoners are considered overweight or obese, while 21% of Londoners are considered obese (BMI >30). 29% (1.8m) of working-age Londoners reported a long-term health condition, highlighting a sizeable population health opportunity,
- We serve patients in all 32 boroughs and the City of London,
- London user gender split: 24% are men, 76% are women - consistent with the typical uptake of these medicines
- We have the greatest number of users in the boroughs of Wandsworth, Lambeth and Southwark.
- Havering has the highest rates of obesity in London where we serve approximately 1000 individuals.
- We serve twice as many patients from the most deprived boroughs as from the most affluent (bottom 3 deciles vs top 3 deciles), demonstrating our ability to serve hard-to-reach populations.

Our Real-World Impact At a Glance:

- 58,000 UK Patients: The largest peer-reviewed obesity study of its kind for a UK digital provider.[1]
- 53% More Weight Loss: Achieved at 4 months by engaged users compared to medication alone.[1]
- <1% Discontinuation Due to Side Effects, demonstrating how digital health can deliver a safe, well-tolerated model.[2]
- Reversal of pre-diabetes in 100% of at-risk patients within 6 months.[2]
- Mean Patient Age of 45: supporting London's working-age population and productivity.

1. Assessment of Eating Disorder Incidents

Eating disorders remain a serious concern in the UK, with an estimated 6.4% of the population affected[1]. Against this backdrop, we have closely monitored the impact of GLP-1 medicines on disordered eating within our patient population using validated health questionnaires, including the Binge Eating Scale, PHQ-9 for depression and the TFEQ hunger score.

[1] Kałas M, Stępniewska E, Gniedziejko M, Leszczyński-Czeczatka J, Siemiński M. Glucagon-like Peptide-1 Receptor Agonists in the Context of Eating Disorders: A Promising Therapeutic Option or a Double-Edged Sword? J Clin Med. 2025 Apr 30;14(9):3122. doi: 10.3390/jcm14093122. PMID: 40364152; PMCID: PMC12072339.

Following 12 months of treatment with Voy we observe over 9 in 10 of our patients see an improvement in binge eating, nutrition and hunger control, and 3 in 4 patients see an improvement of their low mood. Our results will be presented at the upcoming 2025 Royal College of GPs Conference.

We recognise that GLP-1 medications may exacerbate pre-existing eating disorders by reducing appetite and altering eating behaviours. For this reason, we have strict safeguards in place:

- Exclusion criteria: Patients with a history of anorexia, bulimia or binge-eating disorder are not eligible for treatment.
- Strict safeguarding measures: to verify identity and suitability, including BMI verification.
- Ongoing monitoring: BMI thresholds are enforced (treatment halted if BMI <19).
- Clinical escalation: If any suspicion arises, patients are assessed and referred to our CBT team for specialist support.
- Regular audits: Six-monthly reviews of prescribing, side effects, and safeguarding processes.

Our most recent safety audit, covering 1,400 patients, identified an incident rate of 0.93% related to eating disorders (13 cases)[2]. Of these, two patients were identified as having active anorexia with BMIs below the licensed treatment thresholds, and treatment was terminated immediately in line with our safeguards. We also provided additional support to these patients, their families and carers.

The remaining 11 patients had a documented history of eating disorders or binge eating disorder. While their BMI placed them within a safe range for treatment, our clinical pathways required discontinuation to prioritise their safety. In each case, subscriptions were proactively ended and patients were guided toward appropriate support. Of note, anecdotal feedback from our patients with binge and disordered eating is that GLP-1 medication has a positive impact on their conditions. This is beginning to be reflected in literature, with evidence to state that GLP-1 medication is having a positive impact on patients that present with binge eating disorders[3]. Early research suggests that the GLP-1 hormone positively impacts the neurobiological regulatory systems.

All incidents were formally reported and investigated. We undertook investigations to understand how these cases had arisen, reviewed our systems and processes and identified measures to further reduce the risk of recurrence. This demonstrates that our

[2] Study of 1400 incidents reported between December 2024 and September 2025 based on incidents reported on all digital services at MANUAL.

[3] Kałas M, Stępniewska E, Gniedziejko M, Leszczyński-Czeczatka J, Siemiński M. Glucagon-like Peptide-1 Receptor Agonists in the Context of Eating Disorders: A Promising Therapeutic Option or a Double-Edged Sword? J Clin Med. 2025 Apr 30;14(9):3122. doi: 10.3390/jcm14093122. PMID: 40364152; PMCID: PMC12072339.

safety governance is working in practice, with clear escalation pathways and continuous learning built in.

Our audit data shows no evidence that eating disorders are increasing within our patient population. Instead, we find that reported concerns remain below background national prevalence. While the risk profile of GLP-1s is often amplified in media coverage, our evidence supports that, with appropriate safeguards and monitoring, these medicines can be delivered safely without contributing to a rise in eating disorders.

2. Impact of Private Providers on Pharmacies and the NHS.

London benefits from strong pharmacy coverage, with every resident living within a 20-minute walk of a pharmacy. Despite this, services are already under significant pressure, as community pharmacies manage a wide range of both acute and chronic conditions.

~1.7m people are on WL medicines, but >15m are overweight or obese, and the majority access treatment through private online and digital providers, suggesting demand exceeds what bricks-and-mortar pharmacies could absorb. Critical staffing emergencies have resulted in increased workforce pressure[4], so forcing additional workloads into pharmacies will likely overstrain the system while offering unclear incremental safety gains.

Instead we advocate for a more coordinated effort between services that also aligns with the NHS 10 year plan. This includes expedited data sharing between digital providers, local community pharmacies, local authorities and the NHS; and improved information that gives patients the choice on how and where they wish to access services.

Regarding impact on the wider NHS system we are undergoing a health economic analysis and will share results on productivity, cost effectiveness and cost savings in early 2026.

3. Existing Safety Protocols in the Private Digital Market

With a rapidly expanding private market for GLP-1 medicines, it is crucial to differentiate between providers. UK-based, CQC- and GPhC-regulated services with a strong evidence base, such as Voy, operate to high clinical standards, while other providers may not have equivalent safeguards in place.

Evidence-led approach

Voy's model is grounded in large-scale, peer-reviewed research (58,000 patients) which

[4] https://cpe.org.uk/our-news/critical-staffing-pressures-in-community-pharmacies-hitting-patients/

shows our programme achieves 53% more weight loss than medication alone, with a discontinuation rate of less than 1% due to side effects . This data demonstrates not just safety, but effectiveness at scale. We believe evidence generation and peer review must be a core criterion for differentiating responsible providers in this growing market.

Internal Safeguards

- Online clinical consultation: All patients complete structured medical questionnaires reviewed by clinicians, approximately 18% are filtered out as not suitable.
- Safeguards and checks, including suitability verification.
- Staff training and competency framework
- Informed consent and transparent patient journey
- Automated system flags (e.g. multiple accounts, changed answers etc.)
- Dedicated product and technology safety leads
- Clinical Safety Officer
- Continuous monitoring: Weight and photo updates are required; treatment is stopped if thresholds are not met.

External Safeguards

- ID and age verification: Independent verification through Onfido.
- Towards NHS integration: work ongoing to connect with NHS systems such as the Summary Care Record (SCR) and GP Connect to strengthen information sharing.

Safety touchpoints throughout the journey

Safeguards do not stop at diagnosis and prescription. Patients have:

- Side effect hotlines with rapid clinician access.
- Direct clinician and coaching support 7 days a week.
- AI-powered in-app coaching for real-time support.
- Ongoing customer service contact points.

Safety audit findings

- 30.8% of patients reported side effects, with only 5.5% discontinuing treatment, compared with literature showing ~44% experience side effects and >20% discontinue.
- Incident rate: 0.83 per 1,000 people (1.57 per 1,000 person-months).
- By contrast, NHS patient safety data shows a 25% chance of incidents in hospital settings.

This demonstrates that robust internal safeguards, continuous monitoring and an evidence-led model can deliver safe, effective care. However, to ensure patient safety across the entire market, internal controls must be matched by robust external regulation and oversight.

4. The Adequacy of the GPhC's Updated Guidance in a Digital Health Context

We embrace regulation, and as a GPhC-registered provider we support efforts to strengthen safeguards for patients. However, we feel that the GPhC's update to "Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet" (February 2025) was not fully fit for purpose. It did not provide the clarity that providers need, nor did it sensibly address the key issues emerging in digital obesity care.

Like many regulators, the GPhC does not yet have a full understanding of the digital health landscape. The current guidance reflects a traditional pharmacy model, whereas digital-first providers like Voy operate in a fundamentally different way, with online consultations, digital verification, continuous monitoring and multi-channel patient support. The pace at which responsible digital providers can move and iterate to improve safety and outcomes is not well captured in the existing regulatory framework.

It is also important to underline that GLP-1 medicines have a relatively safe profile. Our most recent large-scale real-world study of 106,653 adults prescribed GLP-1/GIP and GLP-1 receptor agonists through a national digital service found:

- An incident rate of 1.57 per 1,000 patient-months, with almost 90% of incidents classified as no harm or minor harm.
- Side effects accounted for 30.8% of incidents, but discontinuation was rare.
- Prescribing errors occurred at a rate of 1.71 per 1,000 patients, significantly lower than the 4.4% error rate reported in wider digital prescribing literature.

Beyond safety, there is now compelling evidence of effectiveness:

- Engaged patients achieved 21.5% mean weight loss at 11 months vs 17.0% in non-engaged patients, a 4.5 percentage point advantage (26.5% relative improvement).
- 79.4% of engaged patients achieved ≥5% weight loss (vs 36.3% of non-engaged), and 12.2% achieved ≥20% weight loss (vs 4.3%).
- Critically, this enhanced efficacy was achieved without any excess safety risk (incidence rate ratio 0.83, 95% CI 0.60–1.15).

These findings demonstrate that GLP-1s are safe and effective when delivered through a digital-first, evidence-led model with appropriate safeguards and monitoring.

This matters because digitally delivered care is a core pillar of the government's 10-Year Health Plan. Regulation should therefore aim to facilitate and promote safe digital provision, not inadvertently obstruct it. Unfortunately, the February GPhC guidance update does not achieve this. Instead, it introduces additional complexities that lack clarity, add administrative burden, and do not meaningfully enhance patient safety. The update appears to be driven more by media coverage and anecdotal concerns than by clinical evidence, creating the risk of unintentionally obstructing the growth of safe, scalable, evidence-based digital care.

We have been disappointed by this misalignment, but we remain committed to working collaboratively and constructively with the GPhC. We, along with other responsible providers, continue to offer to strengthen the GPhC's knowledge base and to demonstrate the high standards of safe, effective care that are already being delivered digitally, at scale. Our view is that patient safety would be best served by regulation that is modernised, proportionate, and aligned with both the realities of digital healthcare delivery and the ambitions of the 10-Year Health Plan.

5. **Support from Manufacturers on Launch of New Medicines.**

Voy has a good working relationship with the pharmaceutical industry, including manufacturers that are still yet to release drugs onto the market. Science in this space has progressed rapidly and we maintain an open dialogue to ensure immediate notification of new developments, while feeding back insights regarding patient outcomes, behaviour and safety.

A two-way dialogue allows manufacturers to respond to feedback we receive from patients, allowing them to invest in further studies and educate the market where there are questions.

6. **Assessing the Effect of Mounjaro Pricing on Patients and Services**

We were disappointed by Eli Lilly's decision to increase the price of Mounjaro and equally disappointed by the lack of a strong government response to challenge this. While NHS supply is protected by statutory pricing regimes, the increase has clear indirect consequences for patients and the wider system. For many, the higher cost will make private access unaffordable, forcing them either to seek support through already stretched NHS services or to abandon weight loss treatment altogether, with predictable longer-term impacts in terms of obesity-related morbidity, mortality and healthcare costs.

As a provider, Voy was able to adapt quickly; drawing on our combined expertise across commercial, clinical, strategy and operations. We put in place switching pathways, strengthened communications, provided education and content to patients and secured additional stock to minimise disruption. This ensured not only that our patients remained safe but also that they were able to continue on their treatment journey, sustain weight loss and realise the health benefits of these medicines without interruption. We have not seen an increase in patients ceasing medication about our usual figures.

However, not all providers were able to respond in this way. The GPhC emailed all pharmacy owners, pharmacists and pharmacy technicians regarding concerns around supply of Mounjaro and Wegovy and other weight-management medicines[5]. These concerns raised serious patient safety concerns including patients receiving advice about switching medicines that is not in line with good practice, people being incentivised to "bulk buy" GLP-1s and customer services requests not being timely. This increases the risk of patients turning to grey or black market supply routes, creating significant safety issues as individuals attempt to self-manage their treatment without regulated oversight.

This highlights how pricing decisions, and the capacity of providers to adapt, directly influence patient safety and access. It also underlines the importance of having resilient, regulated providers in the market who can safeguard patients through these kinds of shocks.

7. Actions needed to Increase Access to Weight Loss Medicines and Address Risks Associated with them.

Digital-first care is the most effective and scalable way to deliver safe weight loss treatment at population level. Through our real-world studies of over 106,000 adults we demonstrate the Voy programme delivers over 35% better patient outcomes when compared to medication alone, accompanied by market-leading safety - with an incident rate of just 1.57 per 1,000 patient-months, and over 90% of the events classified as no harm or minor harm (incident rate ratio 0.83, 95% CI 0.60–1.15).

To increase access while managing risk, the London Assembly should recommend:

- **Endorse the need for a better framework of regulations for digital-first providers.**
- **Recognise Digital Health providers as part of London's obesity and inequities strategy**

[5]https://mailchi.mp/0901bccc021e/concerns-around-supply-of-medicines-focus-on-mounjaro-wegovyand-other-weight-management-medicines?e=ff0e568d73

- **The Mayor's Health Inequalities Strategy (published in 2018) should be refreshed and recognise the significant change in the digital health provider landscape[6].**

Taken together, these actions would increase safe access, protect patients, and unlock the health and economic benefits of GLP-1 medicines for London. The evidence is clear: digital-first delivery, backed by modernised regulation and better data access, is the safest and most effective way forward.

[6] https://www.london.gov.uk/programmes-strategies/health-and-wellbeing/health-inequalities
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