The NHS Alliance

Overcoming Challenges in Redesigning NHS Weight Management Services Toolkit

This toolkit is an output of a Collaborative Working Project Agreement between the NHS Alliance and Eli Lilly and Company (Lilly). Lilly provided funding for the project and contributed to the development of this resource. The insights presented are drawn from interviews and workshops with NHS leaders and practitioners across England, and the content has been reviewed by participants for accuracy.

This toolkit is intended for use by UK healthcare professionals, payers and other relevant decision-makers interested in weight management services.

START

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Toolkit User Guide

There are interactive features throughout the toolkit. Users can navigate through the toolkit using the hyperlinked buttons

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Introduction

More than one in four adults in England are now living with obesity, and the impact on individuals, communities, and public services are well documented.[1] Addressing these impacts cannot be achieved by the National Health Service (NHS) alone; however, NHS-led Weight Management Services (WMS) remain a crucial component in tackling them.

Often, however, WMS are fragmented across systems.[2] Interviews with NHS leaders reported that inadequate funding and rigid clinical pathways are leaving services unable to meet the scale of demand or respond effectively to service user needs. The outcomes of this disintegration are services that fail to address people's need for holistic support, do not keep pace with growing demand, and allow the complications associated with excess weight and obesity to add to the burden on the wider system and individuals' health and wellbeing.

For the system leaders working across the NHS to change WMS, these challenges are compounded further by the ongoing financial pressures facing the NHS and wider public sector and the constraints this places on organisations and leaders' ability to respond to the need for change.[2,3]

System leaders are also operating in a changing policy and operating environment. England's **Ten Year Health Plan** highlights a strategic shift in NHS priorities, including moving from treating illness to prioritising prevention.[4] Meanwhile, NICE's updated guidance on **Overweight and Obesity Management** no longer organises services around a formal tiered model, enabling services to be redesigned to better reflect the needs of individuals and communities.[5,6] Such change presents an opportunity for service transformation, but we cannot underestimate the scale of disruption this can cause to those trying to achieve change.

To help navigate such an inherently complex environment, The NHS Alliance (the membership body formed from the merger of the NHS Confederation and NHS Providers) and Eli Lilly and Company (Lilly) formed a partnership to support system leaders. This toolkit is the culmination of this partnership and the lessons, insights and good practice collected from those who participated.

References: 1. UK GOV. Accessed June 03, 2026. https://www.gov.uk/government/publications/life-sciences-healthcare-goals/obesity-healthcare-goals. **2.** The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/when-opportunity-knocks-transforming-weight-management. **3.** The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/the-state-of-nhs-finances-202425. **4.** UK GOV. Accessed June 03, 2026. https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf. **5.** NICE. Accessed June 03, 2026. https://www.nice.org.uk/guidance/ng246. **6.** NHSE. Accessed June 03, 2026. https://www.england.nhs.uk/long-read/interim-commissioning-guidance-nice-ta1026-tirzepatide/.

Why This Toolkit?

This toolkit is for anybody working within the NHS, local government or voluntary, community and social enterprise sector seeking to lead the redesign of NHS WMS. It seeks to provide you with tools to support you through the challenges you will face and to apply evidence-based principles of change to this difficult reform ambition.

The toolkit is the culmination of a 12-month programme delivered by the NHS Alliance and Lilly under a Collaborative Working Agreement to:

1. Connect leaders within the NHS and beyond to their peers.
2. Share insights from practical experience of overcoming the challenges of transforming complex services.
3. Identify and develop methodologies and resources that healthcare professionals and leaders can apply to the common challenges they encounter in their day-to-day practice.

A comprehensive overview of this project, including the roles and responsibilities of Lilly and the NHS Trusts involved, can be found **here**.[1] The toolkit is intended as a guide to support service set-up and the considerations provided are not exhaustive. Information provided is for guidance only and Lilly and the NHS alliance take no responsibility for clinical or service-based decisions.

Case studies of NHS partners involved in the collaborative working project are presented throughout the toolkit. A variety of Lilly-funded resources are also available, such as education programmes, budget impact models and population health management tools, which were created independent of this project, but were relevant tools discussed in the workshops.[2] Their use is entirely optional and this toolkit can be used independently of them.

We would like to thank all organisations involved in the initial interviews and workshops, for their contributions to shaping this toolkit.

References: 1. Eli Lilly and Company. Accessed June 03, 2026. https://www.lilly.com/uk/who-we-are/partnerships-UK. **2.** Data on File. Eli Lilly and Company. NHS Alliance Workshops 2025.

Framework of Considerations

The sections below set out considerations for establishing weight management services, based on insights from workshops with NHS system leaders, clinicians and public health professionals.[1] Where additional evidence is referenced, this supplements the project findings.

Click on a section to explore further.

1. Defining Your System

Establish a common understanding about the need to change, and what you are working towards

2. Stigma

Reducing harm in language, pathways and systems to improve equity and engagement

3. Data and Evidence

Building credible, local evidence to inform commissioning decisions

4. Coalition Building

Aligning partners and populations to act as a unified system

Reference: 1. Data on File. Eli Lilly and Company. NHS Alliance Workshops 2025.

Consideration 1: Defining Your System

Redesigning NHS weight management services (WMS) begins with securing agreement across the system that change is needed and that organisations share responsibility for delivering it. Establishing a shared purpose is therefore an essential—but often challenging—first step. Competing views on who services are intended for, the outcomes to be achieved, approaches to delivery, and resource constraints can stall progress before it even begins.

This module provides practical steps to help you build a shared understanding of the challenges, align around a common purpose for change, navigate competing priorities, and define a clear future model for your service.

Tip: Don't rush into redesigning new services. Investing time upfront establishing a shared picture of the problems and the need for change will make co-development more straightforward further down the line.

Defining Your System : Key Challenges (1/2)

Common Barriers	Practical Action
Competing priorities across organisations Different teams may see weight management as peripheral to their core objectives. You will need to shift perspectives on weight management away from the view that it is a distraction from core services or an intrusion into them.	• **Map your stakeholders and invest in understanding what motivates them**. This is foundational for coalition building. Discover more in our module on coalition-building. • **Use data to frame obesity as a system wide issue**. Staffordshire and Stoke-on-Trent Integrated Care Board do not have dedicated transformation funding for obesity services; however, the team are engaging across the organisation to demonstrate the impact of obesity and weight management services on health and care outcomes in an attempt to secure transformation funding.
Divergent visions of what weight management services should achieve Even when partners agree to collaborate, they may disagree on whether services should prioritise illness-based outcomes (such as percentage weight loss) or broader wellbeing outcomes (such as mental health and workforce participation).	• **Use national policy direction to broaden the frame of your discussions**. The government's Get Britain Working white paper links ill health and economic inactivity, with Connect to Work — its flagship delivery programme — currently being trialled in Greater Manchester.[1,2] As obesity is a risk factor for many long-term conditions, this programme creates an opportunity to broaden success markers for future WMS beyond a focus on % loss of body weight.[1] • **Co-develop shared principles before discussing service models and Key Performance Indicators**. Views will differ between stakeholders about what makes a service acceptable, affordable and implementable; however, taking time to define a set of shared principles will ensure that everyone is working from the same starting point.

References: 1. UK Government. Accessed June 03, 2026. https://www.gov.uk/government/publications/get-britain-working-white-paper/get-britain-working-white-paper. **2.** Inspira. Accessed June 03, 2026. https://www.inspira.org.uk/about-us/connect-to-work.

Defining Your System : Key Challenges (2/2)

Common Barriers	Practical action
Stigma and resistance to investment Some workshop participants reported they have experienced resistance from senior leaders who do not think those with obesity are 'deserving' of support or who question whether obesity services are an NHS priority.	• **Bring lived experience into the design process**. Working directly with people living with obesity during the development of new services is one way to constructively challenge this stigma that obesity is exclusively a matter of personal responsibility. • **Use evidence to reframe obesity as a clinical and economic issue**. As a leading cause of multiple long-term conditions, government estimates that the direct cost of obesity to the NHS is £11 billion annually; however, some estimates put this figure even higher.[3,4]
Resource constraints Compared to spending on services for conditions heavily linked to obesity like diabetes and cardiovascular disease (CVD) that have direct costs to the NHS extending into billions every year, weight management services are underfunded, and securing increased investment will require obesity to be strategically prioritised across system portfolios.[5,6,7]	• **Be transparent about the resource envelope early in the process.** Derbyshire Community Health Services NHS Foundation Trust (FT) identified that only 0.08 per cent of the ICB budget is spent on obesity treatment across the system.[7] • **Develop multiple investment options for stakeholders**. There will be a gap between the perfect system approach and the approach that stakeholders are able and willing to invest in. By developing a suite of options that fit various levels of ambition you will be more likely to achieve buy-in.

Case study
Derbyshire used a system-wide pre-sprint to align stakeholders and redesign.

Case study
Suffolk and North East Essex ICB introduced a Single Point of Access model to improve weight management access.

References: 3. UK GOV. Accessed June 03, 2026. https://www.gov.uk/government/publications/life-sciences-healthcare-goals/obesity-healthcare-goals. **4.** Nesta. Accessed June 03, 2026. https://media.nesta.org.uk/documents/The_economic_and_productivity_costs_ of_obesity_and_overweight_in_the_UK_.pdf. **5.** University of York. Accessed June 03, 2026. https://www.york.ac.uk/news-and-events/news/2024/research/diabetes-cost-to-uk/. **6.** House of Lords Library. Accessed June 03, 2026. https://lordslibrary.parliament.uk/cardiovascular-disease-what-is-the-government-doing-about-englands-leading-cause-of-premature-death/. **7.** The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/when-opportunity-knocks-transforming-weight-management.

Case Study: Derbyshire Community Health Services NHS FT

What the System Faced

Derbyshire recognised the need to bring stakeholders from across the system together to begin redesigning weight management services. However, siloed services, fragmented data, and concerns that collaboration would be used for performance management meant there was no shared understanding of what was not working or what needed to change.

What the System Did

- Derbyshire recognised they needed to ground their approach in a collective understanding of the issues they were working to solve. To overcome these challenges, a pre-sprint – a structured session to align partners before moving to solutions – was used to gather disparate data from across numerous providers and commissioners, creating a single picture of where services were falling short.
- The pre-sprint also enabled the team to address an initial reluctance among providers, who feared that collaboration would lead to performance management or unfair comparisons being drawn between organisations.
- The pre-sprint meant that participation was collectively based on working towards the 'bigger picture' that considered the economic and health arguments and was presented to senior leaders.

Results and Benefits

This process enabled all system partners to agree that developing a new system-wide service should take priority over individual service objectives—an essential step to ensure the subsequent design sprint could effectively develop a range of future care models and associated investment options.

Takeaway tips

- Invest time in a pre-sprint before rushing to solutions. Grounding all partners in a shared evidence base reduces resistance and keeps the design sprint focused on what matters.
- Following a pre-sprint, avoid presenting inflexible solutions for the design sprint. Offering stakeholders a suite of options rather than binary choices allows them to balance ambition with the constraints on resources needed to achieve change.

Case Study: Suffolk and North East Essex (SNEE) ICB

What the System Faced

SNEE have worked to move away from a tiered approach to delivering WMS that resulted in a referral pathway causing long waits, administrative inefficiency, and inequitable access to care.

What the System Did

- SNEE has established a digitally enabled, nurse led, Single Point of Access (SPoA) model that triages people to the right support for their clinical needs, including a range of local and national behavioural, lifestyle, specialist weight management, and obesity support services.
- This simple design hides years of development and ongoing coordination to achieve the consensus necessary for successful implementation that is based on shared principles for a better patient/referrer experience.
- Design teams including primary and secondary care clinicians, public health, digital, and provider partners, were used to co-produce the new model and implementation was supported through flexible engagement channels and comprehensive toolkits.
- Senior executive engagement has been maintained through an Executive Oversight Board (EOB), which continues to review data on Return on Investment (RoI) and long-term outcomes to support sustainability.

Results and Benefits

Within the first eight weeks of launch, approximately 1,500 GP referrals were made into the SPoA. Waiting times have reduced and access to specialist treatment has been simplified. Neighbouring ICBs are already engaged and preparing to adopt the model.

Takeaway tips

- SNEE have aligned with national strategy to achieve buy-in and adoption.
- The service design delivers ‘care closer to home’ through their new Neighbourhood Accelerator Access Hubs, leverages Population Health Management (PHM) datasets, and incorporates digital and AI solutions to support decision-making and provider integration.

Consideration 2: Stigma

Reducing stigma is not an optional add-on. It is a core component of delivering person-centred, equitable care and improving engagement with prevention and treatment services.

Although obesity is increasingly understood to be a complex condition, workshop participants highlighted that people living with obesity frequently experience stigma in healthcare settings, including assumptions about personal responsibility, negative language, and reduced quality of care.

Evidence shows that stigma:[1,2]

- Discourages people from accessing services early
- Undermines trust between patients and clinicians
- Is associated with poorer mental health, disengagement and worse clinical outcomes

References: 1. Puhl RM, et al. Am J Public Health. 2010;100(6):1019–1028. (2):182–190. **2.** Sutin AR, et al. PLoS One. 2013;8(7):e70048.

Types of Stigma

Obesity stigma can occur across multiple levels within healthcare systems.[1] There are two forms of obesity stigma, and distinguishing between these helps organisations target action more effectively.

Interpersonal Stigma

This occurs in direct interactions between staff and patients. It is often unintentional and may include:[1]

- Stigmatising language.
- Assumptions about personal responsibility.
- Spending less time with patients.
- Avoidance or discomfort when discussing weight.

This form of stigma directly affects patient experience, trust and engagement with services.

Institutional Stigma

This is embedded in policies, pathway design, commissioning decisions and resource allocation. It may include:[2-6]

- Restrictive Body Mass Index (BMI) thresholds without clear clinical justification.
- Underinvestment in weight management services.
- Pathway designs that disadvantage people living with obesity.
- Lack of strategic ownership of obesity as a complex long-term condition.
- Environments that do not accommodate larger bodies.

This form of stigma shapes access, equity and population outcomes across whole systems.

References: 1. Puhl RM, et al. Am J Public Health. 2010;100(6):1019–1028. (2):182–190. **2.** Pearl RL, et al. Curr Obes Rep. 2025;14(1):11. **3.** The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/when-opportunity-knocks-transforming-weight-management. **4.** Bannuru RR, et al. BMJ Open Diabetes Res Care. 2025;13(Suppl 1):e004962. **5.** Institute For Government. Accessed June 03, 2026. https://www.instituteforgovernment.org.uk/publication/tackling-obesity. **6.** NICE. Accessed June 03, 2026. https://www.nice.org.uk/guidance/ng246.

Core Principles for Reducing Stigma

All actions in this theme are underpinned by the following principles:

Person-first care

- Treat weight as one aspect of health, not an all-defining characteristic. Enable patients to express and discuss their own priorities, which might not be weight-related at any given time.[7]

Trauma-informed practice

- Recognise that many people have experienced repeated judgement about their weight and that trauma and adverse life events contribute to weight gain. Adverse childhood experiences are recognised as part of the wider context influencing overweight and obesity.[7]

Choice and consent

- Weight should only be discussed when clinically relevant and with patient agreement.[1]

System responsibility

- Reducing stigma is a collective organisational task, not just an individual behaviour change – it is also important to bear in mind that members of the workforce will be living with obesity and that system partners have a responsibility to avoid discrimination and stigma as employers.

Reference: 1. NICE. Accessed June 03, 2026. https://www.nice.org.uk/guidance/ng246.

Practical Actions for NHS Organisations

Step	What to do	How to Implement
1. Set clear expectations through leadership and policy	• Explicitly recognise obesity stigma in equality, inclusion and patient experience strategies. • Include expectations on respectful, non-stigmatising care in organisational values and staff behaviours. • Ensure senior leaders understand obesity and visibly champion this agenda, including by naming stigma.	• The 4-stage strategic commissioning cycle establishes the need for Integrated Care Boards (ICB) to develop a "deep and dynamic understanding of their populations", including the use of user feedback.[1]
2. Improve everyday language	• Promote consistent, person-first language across services. • Support staff to have confident, respectful conversations about weight when relevant.	• Develop or adopt a short language guide for staff (e.g. preferred terms, phrases to avoid). See Examples • Build stigma-aware communication into existing training (e.g. Making Every Contact Count). • Encourage staff to ask permission before discussing weight.
3. Review clinical pathways and access criteria	• Identify where BMI thresholds may unintentionally delay or block access to care. • Ensure pathways are clinically justified, transparent and flexible.	• Audit pathways where BMI is used as a gatekeeping criterion. • Involve clinicians and people with lived experience in reviewing impact. • Where BMI is necessary, ensure this is clearly explained.
4. Create more inclusive physical environments	• Ensure facilities and equipment meet the needs of people of all sizes.	• Review availability of appropriate seating, gowns, blood pressure cuffs and weighing equipment. • Involve estates, procurement and clinical teams together. • Prioritise high-impact areas such as waiting rooms and diagnostic services.
5. Build staff confidence and capability	• Support staff to understand the causes and impacts of obesity stigma. • Reduce fear of 'saying the wrong thing' by providing practical tools.	• Use short, scenario-based learning rather than long theoretical training. • Integrate content into existing programmes (e.g. safeguarding, Equality, Diversity and Inclusion (EDI), long-term conditions). • Include lived experience voices wherever possible.

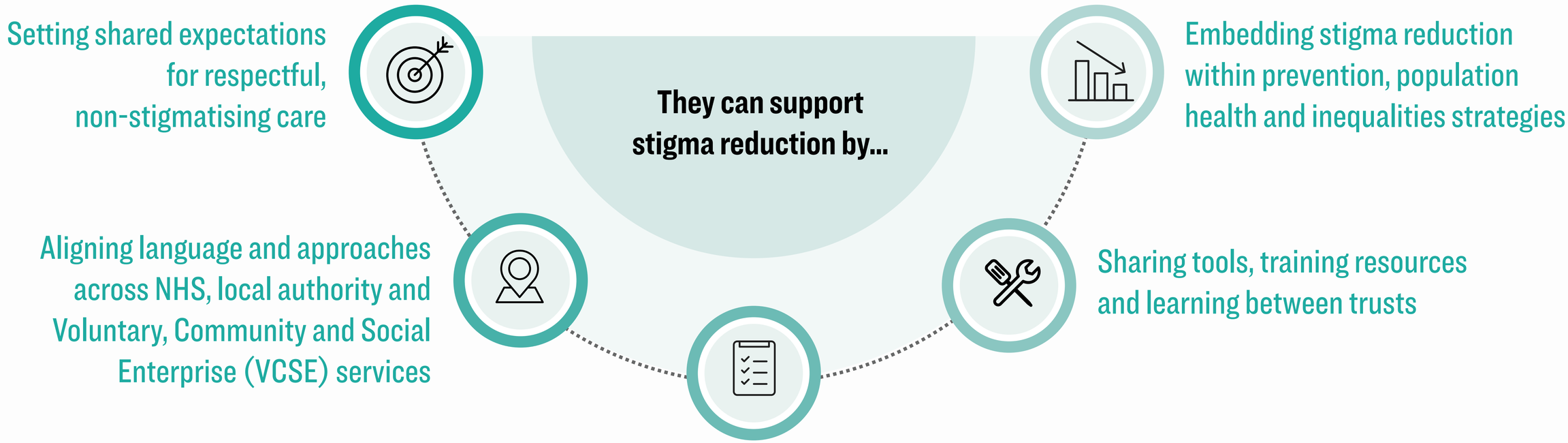
Reference: 1. NHS England. Accessed June 03, 2026. https://www.england.nhs.uk/publication/nhs-strategic-commissioning-framework/.

Language Guide

Phrases to reflect on	Alternative approaches to consider	Reason for change
“You are Obese”	“You are living with Obesity”	Reduces people to a diagnosis; person-first language avoids defining someone by a condition.
[Discussing weight proactively]	“Would it be OK if we talked about your weight today and how we could support you?” “Some people find it helpful to talk about weight and health, others prefer not to. How do you feel about discussing it today?”	Giving people control over the timing of conversations helps them feel emotionally safe and more willing to engage.
Don’t you want to be a normal weight?	"What would you hope to gain from treatments?" "What are your targets? How can we achieve these together?"	Weight and body habitus are influenced by culture and environment. Separately, BMI-defined ‘normal’ weight goals are often unrealistic within typical timeframes and risk disengagement.
If you don’t lose weight you will get diabetes.	"You mentioned that you’d like to be able to kick a ball around with your son; if we can lose a very small amount of weight you’ll find that type of activity much easier."	Fear-based messaging increases shame and disengagement rather than motivation.
Last time we met you said you would do more exercise, but your weight hasn’t changed.	"What’s been working well for you since our last conversation, and where have things felt challenging?"	If someone’s weight hasn’t changed, don’t assume they haven’t followed advice. For many people living with obesity, maintaining weight is a positive outcome.
“You’ve put on weight again.”	“Weight changes can happen for lots of reasons. Can you tell me what’s been going on for you recently?”	Blame-focused language increases self-criticism and disengagement, particularly for people already experiencing poor mental health.
“You just need to eat less and exercise more.”	“Everyone’s situation is different. Let’s look at what feels realistic for you right now.”	Participants described generic advice as failing to reflect real-life constraints such as work, time, finances and health conditions.
“Your weight is the main problem.”	“There are a few things affecting your health — we can talk about weight when and if you feel ready.”	When weight is framed as the sole issue, people feel reduced to a diagnosis rather than treated as a whole person.
“There’s nothing we can do.”	“There are different support options available — let me explain them and we can decide together.”	Lack of clear information about available support led people to disengage or assume help was not available.
“You need more willpower.”	“Stress, mental health and life events can affect weight. Does any of that resonate with you?”	Participants consistently described stress, trauma and life events as shaping their weight, not motivation or effort alone.
“You need to reach a target weight.”	“What would success look like for you — more energy, fewer medications, feeling better day to day?”	People reported greater motivation when goals were linked to quality of life and health outcomes rather than numbers on the scales.
“This is the plan you need to follow.”	“Let’s build a plan together that fits your life and priorities.”	Feeling involved in shaping their own plan increased confidence, ownership and long-term commitment.
“You haven’t stuck to the programme.”	“Setbacks are common. What got in the way, and how can we support you to restart?”	Ongoing encouragement and reassurance were identified as essential to preventing relapse and drop-out.

Role of System Leaders

System leaders have a critical role in addressing both interpersonal and institutional obesity stigma across systems. Workshop participants have already discussed and demonstrated a range of approaches to fulfilling this role.



By working collaboratively across partners, system leaders can address the system drivers of stigma while supporting teams on the ground and patient-facing staff to improve everyday interactions. This creates the conditions for more consistent, equitable care regardless of where people enter the system.

Consideration 3: Data and Evidence

Why Data and Evidence Remain a Barrier

Fundamental to the challenges described by workshop participants is the ability to demonstrate the need for service redesign and impact of interventions. Problems encountered include:

Lack of Data on Demand, Demographics, and Service Expenditure:

- Limited visibility of demand, patient demographics and service costs restricts systems' ability to understand local need and impact of obesity on other services, meaning system-wide pressure is likely underestimated.

Data Fragmented Across Multiple Providers:

- Where data exists, it is often split across numerous providers, preventing a clear picture of obesity's impact on health outcomes, inequality and system expenditure.

Funding Cycles and Stigma Limit Outcome Measurement:

- A combination of short-term funding cycles, stigma associated with obesity, and incomplete outcome data constrains systems' ability to demonstrate the value of interventions over time. In turn, it becomes difficult to evidence return on investment or justify scaling pilots into business-as-usual provision.[1]

Where data and evidence are perceived as incomplete or difficult to use, systems can default to maintaining existing service models rather than redesigning care. However, this inaction carries a significant and growing cost.

Reference: 1. The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/when-opportunity-knocks-transforming-weight-management.

What Makes A Strong Evidence Base

The Strategic Commissioning Framework for ICBs strengthens the emphasis on data-driven, evidence-based decisions.[1] ICBs must produce an integrated needs assessment that identifies population needs, highlights inequalities to generate insights that inform service design and track progress toward equity.

An effective evidence base for weight management should enable systems to answer three critical questions:

1. What is the scale and nature of need in my population?

Including prevalence, demographics, inequalities and future demand.

2. What is the impact of obesity on my system today and in the future?

Including pressure on services, workforce, and wider economic costs.

3. How does this evidence support decisions about service design, investment and scale-up?

Including progression from pilots to business-as-usual.

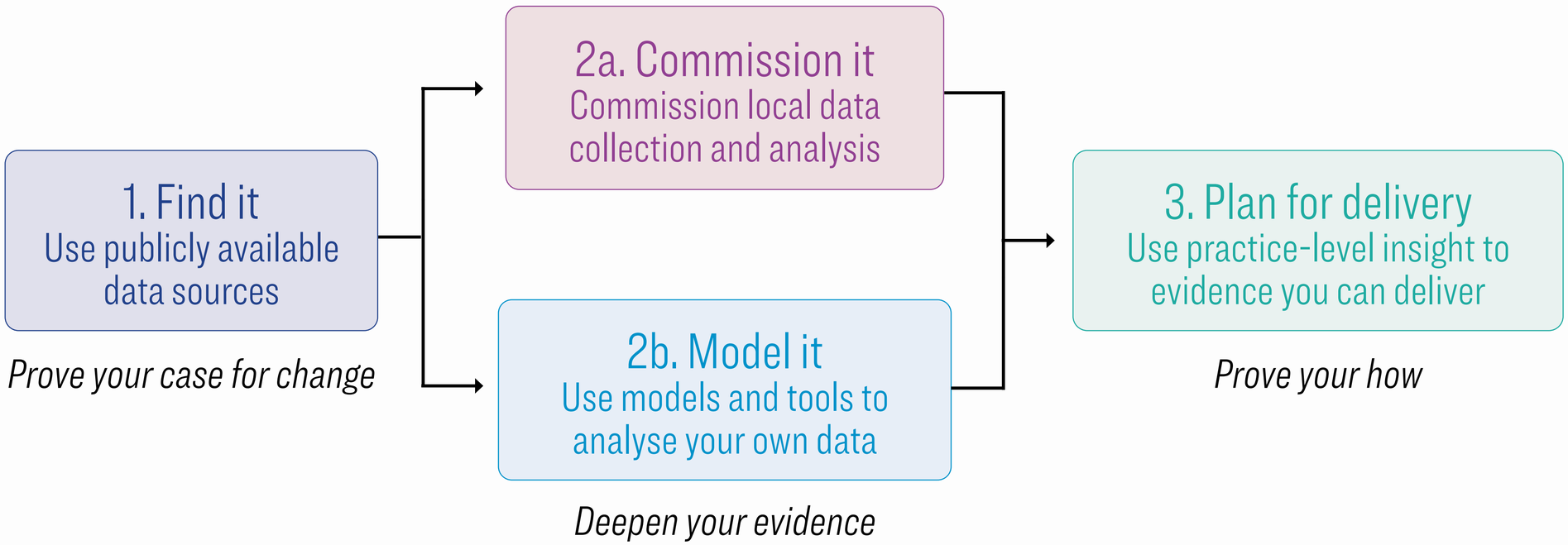
From evidence to action

If you or your team do not have experience in writing a business case, Lilly offer a business case course designed specifically for healthcare professionals and is free to attend.
For more information please email: collaborative_working@lilly.com.

Reference: 1. NHS England. Accessed June 03, 2026. https://www.england.nhs.uk/publication/nhs-strategic-commissioning-framework/.

Building Your Evidence Base

A strong evidence base does two things: it proves the case for change and shows you can deliver. The following three approaches can help you build both parts of that evidence.



Tip: Do not forget about qualitative data. While senior decision makers value quantitative data, well-developed qualitative data can paint a more vivid picture of the individual experience of obesity and navigating services. For more on involving patients and collecting lived experience evidence, see the **Coalition Building** section.

Building Your Evidence Base

1. Find it : Publicly available sources

As mentioned, there is no single, robust, routinely collected dataset for obesity; most data is indirect, or incomplete, making it difficult to measure outcomes or service effectiveness directly.

However, ICBs already hold sufficient data to begin building a credible evidence base for WMS. This includes data from other system areas linked to obesity: for example, because musculoskeletal (MSK) conditions share causal factors with obesity, MSK data can reveal comorbidity prevalence and indicate how obesity may be driving MSK demand and delayed recovery.[1] These sources of publicly available data – each with their respective limitations – can serve to provide an initial picture of need and system pressure before deeper analysis.

Publicly available data sources

Reference: 1. UK Arthritis UK. Accessed June 03, 2026. https://www.arthritis-uk.org/media/flpbvm2m/arthritisuk_state_of_msk_health_-report_2025.pdf.

Building Your Evidence Base

1. Find it : Publicly Available Sources

As mentioned, there is no single, robust, routinely co
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Data Sources	Description
Obesity Profile (Office for Health Improvement and Disparities (OHID)/ Fingertips)	Provides regularly updated national and local authority-level data on adult obesity prevalence, physical activity and diet, including inequalities, to support population health analysis and service planning.
QOF (Quality and Outcomes Framework)	A payment mechanism for primary care, tracking GP practice activities and outcomes across hundreds of clinical indicators, including specific indicators for obesity.
National Obesity Audit	Intended as a national, obesity-specific dataset, similar in structure to other national audits.
Comorbidity Datasets (e.g., cardiovascular, renal, diabetes)	Used to infer obesity prevalence and impact by tracking related diseases. (i.e **National Diabetes Audit**).
Hospital Episode Statistics (HES)	Tracks hospital-level data, including Tier 3 specialist weight management services.
Freedom of Information (FOI) Requests	Used to collect baseline data on weight management services from ICBs and Trusts.

Reference: 1. UK Arthritis UK. Accessed June 03, 2026. https://www.arthritis-uk.org/media/flpbvm2m/arthritisuk_state_of_msk_health_-report_2025.pdf.

Building Your Evidence Base

2a. Commission it: Outsource expert analysis

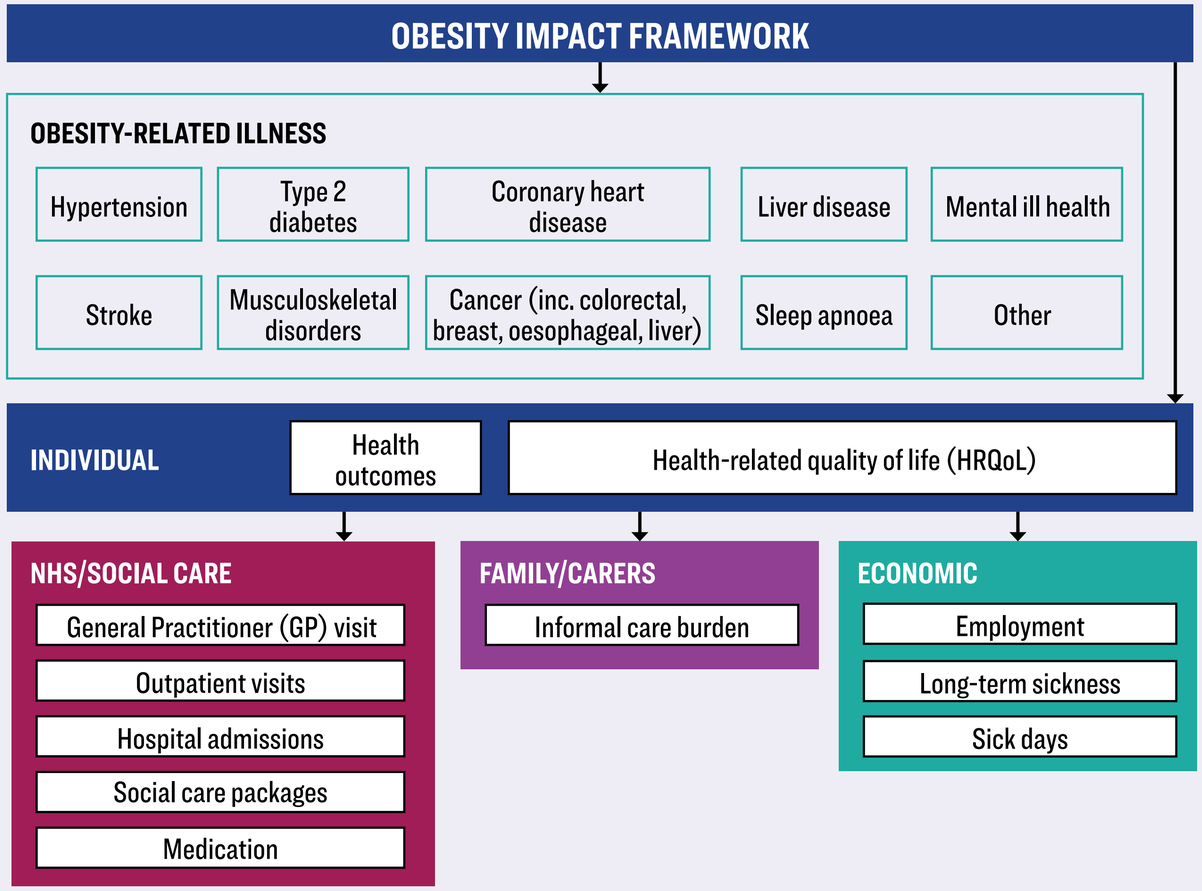
Workshop participants have highlighted that ICBs and individual providers are expected to present their own data for senior leaders on the scale and impact of obesity. One approach is to bring in a health economist to generate system-wide evidence.

Greater Manchester undertook this process to better understand the cost of obesity. Their approach was underpinned by an impact framework, developed through a review of academic, clinical and grey literature and in collaboration with a local Steering Group. (Figure 1).

The Obesity Impact Framework maps the conditions caused by obesity and the costs they generate across four domains: individuals, NHS and social care, family and carers, and the wider economy.

Case Study
Greater Manchester Health Economic Discovery

Figure 1: Impact framework



This work required significant time, resource, and cross-system collaboration. The outputs from Manchester now provide a reusable **Burden of Obesity Model (BOOM)**, developed and funded by Lilly, allowing other systems to produce their own data without duplicating effort.

Case Study: Greater Manchester Health Economic Discovery

A jointly-funded Collaborative Working project with Lilly

What the System Faced

Health Innovation Manchester and system partners recognised that obesity was driving significant costs across health care, social care and the wider economy, but that robust local evidence was lacking.

What the System Did

- Lilly funded a multi-year, system-wide health economic analysis, delivered through a Collaborative Working Agreement with Health Innovation Manchester, to address the following.[1]
  - The annual costs to the NHS and social care sector associated with obesity.
  - The wider costs to individuals, the economy and society associated with obesity.
  - The variation of these costs across subpopulations.
  - The potential avoided costs if rates of obesity were lower.
- An impact framework was used to assess incremental costs attributable to obesity across: Healthcare, social care, individual and the wider economy.
- Local linked datasets were combined with national prevalence data to address gaps. Assumptions were made explicit and transparent, with multiple rounds of validation and refinement.

Results and Benefits

The work delivered robust local estimates of the incremental cost of obesity in Greater Manchester, showing that with around 27% of adults living with obesity, the condition generates substantial, system-wide costs spanning healthcare, social care and the wider economy totalling £3.21bn.[2] Scenario modelling illustrated the scale of opportunity if prevalence were reduced, helping leaders understand the potential impact of prevention and treatment strategies. This enabled more informed conversations about where targeted action could have the greatest system benefit.

Takeaway Tips

- Start with a clear decision question, not the data.
- Use local linked data to show where pressure and inequality sit.
- Capture the full system cost, not just NHS spend, and be transparent.
- System-wide health economic analysis is highly influential for decision-makers but requires long-term (3+ year) investment and specialist capability.

References: 1. Eli Lilly and Company. Accessed June 03, 2026. https://www.lilly.com/uk/who-we-are/partnerships-UK. **2.** Data on File. Eli Lilly and Company. Health Innovation Manchester 2023.

Building Your Evidence Base

2b. Model it: Use models and tools to analyse your data

Rather than commissioning your own analysis from scratch, you can use existing models that draw on data and assumptions from other systems and apply them to your local population.

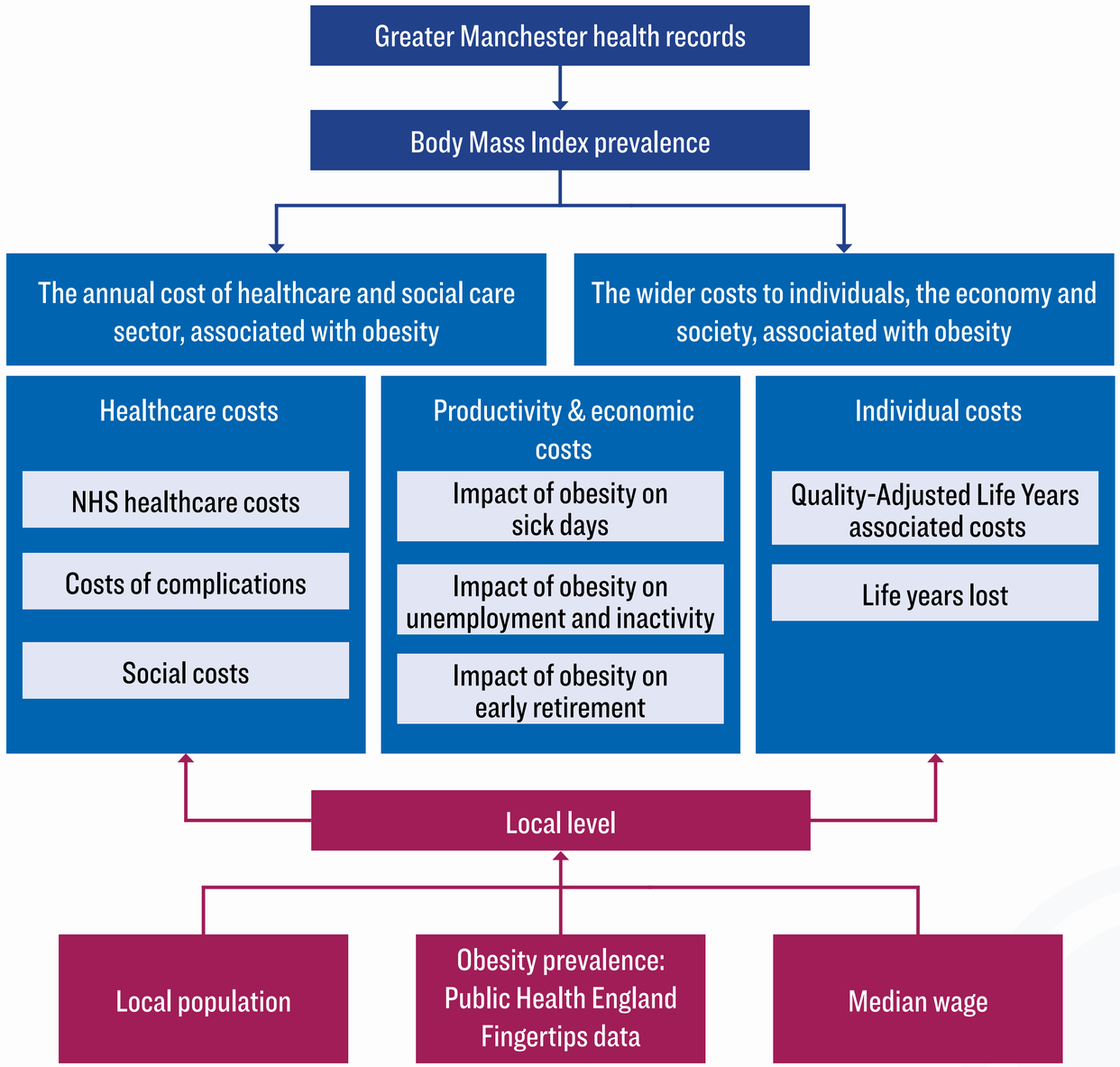
An example of such model is the **Burden of Obesity Model (BOOM). This tool** is fully funded and developed by Lilly following the collaborative work agreement with Health Innovation Manchester.

Drawing on economic analysis originally undertaken in the project, this Excel-based tool enables ICBs to estimate the incremental economic burden of obesity within their own geography.

What does it help you evidence?

- The annual cost to the health and social care sector associated with obesity.
- The wider costs to individuals, the economy and society, associated with obesity.
- The longitudinal projection of these costs over the next 20 years, providing insight into the cost of non-intervention.

For further information, please contact the NHS collaborations team at Lilly at Collaborative_working@lilly.com



A summary of how this data is calculated is shown in the infographic above

Building Your Evidence Base

3. Plan for delivery: Translate your case into a credible delivery plan

Workshop participants noted that weight management commissioning can fail not on strategic intent, but on operational feasibility.

Even when decision makers are convinced of the scale and cost of obesity, finance and delivery teams will still ask: who exactly are we targeting, how many patients are we talking about, and can our services handle the demand? Understanding your patient population at practice level is what moves the conversation from a compelling case for change to a credible plan for delivery.

During the workshops, participants had a discussion around the use of PARM Obesity™ and how it can support understanding their local data. PARM Obesity™ is a tool funded by Lilly, and developed in collaboration with the NHS.

For more information on PARM Obesity™, click here.

Understanding Need at Practice Level

What is PARM Obesity™?

The PARM Obesity™ (ProActive Register Management) Tool is developed and funded by Lilly. It is provided as a donation to healthcare organisations and is independent of any collaborative working arrangements with the NHS Alliance.

PARM Obesity™ is a population health management tool designed to help GP practices visualise and segment adults living with obesity using data already recorded within the clinical system, compatible with EMIS and SystmOne.

It operates within the practice environment — no data leaves the practice. Patient data is presented back through visual Excel dashboards, enabling analysis of prevalence, cohort characteristics, weight-related comorbidities and health inequalities data at practice level.

For further information, please contact the NHS collaborations team at Lilly at Collaborative_working@lilly.com

PARM Obesity example mock-up

What PARM™ contributes

- Practice-level prevalence data
- Identification of priority cohorts
- Health inequalities and Core20 analysis
- Weight-related comorbidity analysis
- Support for pathway design
- Assess quality of data and its coding

Consideration 4: Coalition Building

Introduction

Establishing a Weight Management Service (WMS) depends on a highly complex system of NHS providers, local authorities, public health teams, Voluntary, Community and Social Enterprise (VCSE) organisations, and communities. When these partners work in silos – with separate budgets, priorities and governance structures – services can become fragmented and progress slows. This is further compounded by stigma, limited resources and system-wide restructuring.[1]

Coalition building enables organisations to act as a unified system. Strong coalitions understand who the key stakeholders are, what motivates them, and how their spheres of influence shape decisions. By recognising these dynamics and constraints early, you can create realistic plans, shared ownership, and the conditions for coordinated action.

Example stakeholder values, incentives and rules

Motivation for Change

To improve WMS, you need an understanding of who has control of resources and decision making so you can secure their support. During the workshops, it was highlighted that one effective way to do this is by understanding people's motivation for change.

1. What are their values?

Actions that stakeholders are willing to take are shaped by their beliefs, principles, and priorities. These influence everyday choices, from clinical decisions to organisational strategy. Identifying where values align – and framing shared goals and outcomes accordingly–can bring stakeholders with competing priorities into a common purpose, even where trade-offs are required.

2.What are their incentives?

Even if everyone has a shared goal towards "better health outcomes", their incentives may still differ. Your stakeholders will ask: What's in it for me, my team, or my organisation? Think about what drives people (performance, finance, risk, reputation, etc.) and how you can tailor your case for change and build momentum.

3.What are their rules?

Rules govern how people operate within a system. They tell stakeholders what they can, cannot, and must do. Understanding what these rules are can help you build incentives for them to collaborate.

Q Community's Influencing Plan[2]

To map stakeholders' values, incentives and rules, use the Q Community's Influencing Plan.[3] This tool helps you develop a tailored approach to influencing stakeholders and overcoming engagement barriers. It encourages teams to explore real examples of resistance, analyse stakeholders' motivations for change, and identify what drives behaviour — and how barriers can be worked around or addressed.

References: 1. The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/when-opportunity-knocks-transforming-weight-management. **2.** Q. Accessed June 03, 2026. https://q.thenhsalliance.org/about. **3.** The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/learning-and-improving-across-systems-influencing-plan.

Consideration 4: Coalition Building

Introduction

Establishing a Weight Management Service (WMS)

incentives and rules

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barriers. It encourages teams to explore real examples of resistance, analyse stakeholders' motivations for change, and identify what drives behaviour — and how barriers can be worked around or addressed.

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Influencing Plan

References: 1. The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/when-opportunity-knocks-transforming-weight-management. **2.** Q. Accessed June 03, 2026. https://q.thenhsalliance.org/about. **3.** The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/learning-and-improving-across-systems-influencing-plan.

*These examples are illustrative and will vary across systems.
They are intended as a starting point for local reflection and verification.

Stakeholder*	Values	Incentives	Rules
People living with obesity	Dignity, respect, non-judgemental care	• Equity and access • Personalised and tailored support that uphold their autonomy • Reduced stigma	• Referral pathways
Finance directors	Financial stability and return on investment	• Meeting financial balance and efficiency targets • Avoiding cost growth in long-term conditions • Funding models that show short-term savings	• NHS financial frameworks • Annual planning cycles • Capital vs revenue restrictions • Business case and assurance requirements
Commissioners	Evidence-based, equitable services	• Delivering within tight budgets • Reducing demand on acute services	• NICE guidance • Procurement regulations • Contract management frameworks • National service specifications
Operational directors	Service stability and workforce wellbeing	• Meeting KPIs (e.g., Referral to Treatment, waiting lists, etc.) • Avoiding additional workload • Securing resources for their own service lines	• Workforce capacity limits • Governance and escalation processes • Mandatory reporting requirements
GP partners	Continuity of care and trusted patient relationships	• Reducing appointment pressure • Meeting Quality and Outcomes Framework indicators • Improving chronic disease outcomes • Avoiding unfunded work or additional administrative burden • Maintaining patient satisfaction and practice reputation	• Contracts e.g., GMS, PMS, APMS. • NICE guidance and prescribing rules • Referral criteria and safeguarding responsibilities • 10-minute consultation norms
Clinical directors	Patient safety and quality	• Well-defined pathways • Reduced clinical risk • Opportunities for service development or research	• NICE guidance and specialty standards • Clinical governance and audit requirements • GMC professional responsibilities
Bariatric surgery teams	High quality surgical outcomes	• Stable referral flows • Reduced pre-operative risk • Meeting national bariatric standards	• Bariatric surgery eligibility criteria • MDT assessment requirements • Surgical safety protocols
Public health consultants and registrars	Prevention and community wellbeing	• Reducing health inequalities • Supporting local economics • Achieving public health outcomes • Strengthening partnerships with NHS and VCSE	• Public Health Outcomes Framework • Budget restrictions • Procurement
VCSE Staff	Community empowerment	• Demonstrating community impact • Building equitable partnerships • Securing sustainable funding	• Charity governance and trustee oversight • Grant conditions and reporting requirements • Safeguarding and data protection obligations

Abbreviations: NHS – National Health Service; **NICE** – National Institute for Health and Care Excellence; **KPI(s)** – Key Performance Indicator(s); **GP** – General Practitioner; **GMS** – General Medical Services; **PMS** – Personal Medical Services; **APMS** – Alternative Provider Medical Services; **GMC** – General Medical Council; **MDT** – Multidisciplinary Team; **VCSE** – Voluntary, Community and Social Enterprise

Working Across Different Teams or Organisations

Teams and organisations may have their own priorities, pressures, funding and accountability structures, which makes aligning goals difficult. Below are tips for working across different teams or organisations discussed in the workshops.

Address ambiguity & develop a shared vision

Bring partners together early to clarify key terms (e.g., “trauma-informed care”, “prevention”, “left shift”) and co-design a shared vision statement. A common language reduces friction, aligns expectations and makes cross-organisational work smoother. For example, “risk”, “efficiency”, or “integration” can mean different things to clinicians, managers, or community groups.

Align incentives & remove barriers

Map how weight management services (WMS) link to wider system strategic priorities, such as cardiovascular disease, cancer, health inequalities, as a means of driving the work forward.[1,2] You can do this by analysing motivations for change and utilising Q Community’s Influencing Plan.[3] Align KPIs where possible, create shared funding pots or joint bids, use a Memorandum of Understanding (MOU) to formalise commitments, and remove bureaucratic barriers.

Appoint boundary connectors

Find boundary connectors – people who connect teams, translate between cultures, and keep the coalition moving. These can be clinical champions, community champions, community connectors, or programme managers with cross-system authority.

Build a culture of learning

Communities of practice (CoP) strengthen coalitions because they align partners around a common purpose and create a safe space for continuous shared learning. This can reduce siloed working and allow partners to explore the different drivers of obesity, and their roles in addressing them, as well as different challenges and opportunities together.

Case study

A Community of Practice helped West Yorkshire align stakeholders, share evidence, and drive collective action on weight management.

References: 1. UK GOV. Accessed June 03, 2026. https://assets.publishing.service.gov.uk/media/69dce11fd3e08b8871b6662c/national-cancer-plan-for-england-delivering-world-class-cancer-care.pdf. **2.** UK Government. Accessed June 03, 2026. https://www.gov.uk/government/publications/get-britain-working-white-paper/get-britain-working-white-paper. **3.** The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/learning-and-improving-across-systems-influencing-plan.

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Influencing Plan

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Case Study: Community of Practice (CoP) in West Yorkshire

What the System Faced

NHS West Yorkshire Integrated Care Board (ICB) had a long-term ambition of establishing a WMS that is person-centred, trauma-informed, has a compassionate approach, and is equitable. They discovered that progress required collaboration across many partners, each with their own agendas and priorities.

What the System Did

- It capitalised on the momentum of the communications campaign from their More Than Weight report which explores the costs of obesity. The report serves as a crucial call to action and highlights key system failures and strategic opportunities for change.[1] Since the publication of the report, the Obesity Lead has presented the findings at 16 health and care network meetings across England. The work has been raised in the Scottish Parliament, and the ICB has been invited as speakers to the European Association for the Study of Obesity (EASO) Congress in May 2026.[2]
- It created an Obesity and Weight Management Steering Group, consisting of 30 hand-picked people (ranging from commissioners, GPs, pharmacists, policy leads, programme leads, Healthwatch, people with lived experience, advocates and academics) who were willing to drive the work forward. Alongside this, it created a quarterly Community of Practice, which has now grown to more than 250 members and into a bespoke ICB National Group, attended bi-monthly by 80 people.

Results and Benefits

The ICB has reaped the rewards of being consistent in its offer, messaging and support of obesity stakeholders at all levels. People across England approach the team for advice and guidance. The team also has a strong working relationship with policy colleagues in the Population Health Team at the NHS Alliance as a result.

Takeaway tips

- Establish who the right people are to have around the table, including people with different perspectives.
- Involve councillors and learn more about how their advocacy could help support your cause.
- Present your case for change everywhere, and to people at all levels within and outside your organisation. Fine tune a PowerPoint that relays your message succinctly.
- When engaging with stakeholders, have evidence and data ready to support your case for change.

References: 1. Humber and North Yorkshire. Accessed June 03, 2026. https://humberandnorthyorkshire.icb.nhs.uk/wp-content/uploads/2025/10/More-Than-Weight-report-2025.pdf. **2.** EASO. Accessed June 03, 2026. https://eco2026.org/.

Build Trust Through Early Wins

Partners trust coalitions that deliver. Policy sprints give diverse partners a structured, time-bound space to work on a shared problem and encourage cross-boundary collaboration.[1] In the NHS's resource-constrained operating environment, progress can be slow. However, policy sprints are designed to mobilise resources and accelerate action on an issue more quickly than traditional approaches.

A Policy Sprint Involves[1]:

- Defining the challenge
- Assembling a cross-system team
- Running a time-bound series of collaborative sessions
- Producing tangible outputs
- Testing and refining with stakeholders

Case study

A system-led policy sprint helped Derbyshire align commissioners and strengthen capacity across the obesity pathway.

Reference: 1. GOV.UK. Accessed June 03, 2026. https://openpolicy.blog.gov.uk/2015/01/28/testing-policy-sprints/.

Case Study: Policy Sprints in Derbyshire

What the System Faced

NHS Derby and Derbyshire ICB's Interrelated Care Partnerships (ICP) strategy prioritised reducing early deaths from heart disease and cancer. Obesity was identified as a key system-wide driver, with fragmented pathways and limited capacity constraining progress.

What the System Did

The system adopted a policy sprint approach, involving stakeholders early and using a pre-sprint to align on the current picture before setting priorities. Commissioners across the obesity pathway committed to patient-centred decision-making, supported by:

- Strong visionary leadership grounded in evidence, including NICE guidance – NG246.[1]
- System-wide agreement on fundamental issues such as the dire financial constraint of obesity services receiving only 0.08% of the annual ICB spend.
- Senior leadership involvement to ensure the authority, capacity and commitment needed to influence and drive change.

They Managed Workload by:

- Keeping the sprint timeline tight and avoiding periods of high system pressure (e.g., winter pressures or major commissioning deadlines).
- Distributing leadership across workstreams so no single organisations carried too much of the load.
- Using a clear handover process so outstanding actions could transition into business-as-usual, making it easier for leaders to pause other work for a defined period.

Results and Benefits

The outcomes of the sprint ultimately formed the recommendations for the ICP to consider.

The sprint fostered effective collaboration between community, public health and specialist NHS services – for example, referral routes were implemented between Tier 2 and Tier 3, thus ending the GP referral route. This optimised skill mix and increased overall capacity across the three tiers.

The sprint approach works best when collaboration is strong, and progress is driven by transparent delegation and collective problem-solving. Feedback indicates this model could be effectively applied to other system-level pathway development work.

Takeaway tips

- Position the sprint as a system priority (i.e., prioritised in the ICB strategy) for system leaders to commit time and resources.
- Begin with a 'Time Out' in-person session with all system partners to clarify the issue and set priorities for the sprint.
- Keep the sprint timeline tight and avoid periods of high system pressure.
- Distribute leadership across workstreams.

Reference: 1. NICE. Accessed June 03, 2026. https://www.nice.org.uk/guidance/ng246.

Whole Systems Working

Why Whole System Working Matters

According to workshop participants, effective coalitions enable whole-system working by reaching beyond the NHS to include councils, patient groups, communities, and Voluntary, Community and Social Enterprise (VCSE) organisation. Obesity and weight management are shaped by healthcare, policy, education, housing and culture.[1] Without coordination across these partners, action remains fragmented and system-level impact is limited. NHS and Local Government reorganisation has made establishing and maintaining these cross-sector partnerships more challenging.[2] The following section provides approaches that you can take:

How to Carry Out Whole System Working

Partner with local councils and VCSE

Local councils help shape healthier communities by addressing commercial determinants of health, while VCSE organisations often reach higher-risk or underserved groups more effectively than statutory services.[2]

Working with them enables practical joined-up delivery so people stop falling through gaps.

Shared place-based teams that embed council, VCSE, and NHS staff in neighbourhoods, GP practices or community hubs allow complex patients to be treated as a shared caseload – supporting holistic care and reducing the need for people to bounce between services.[1]

References: 1. 1. Ref: 73623.Humber and North Yorkshire. Accessed June 03, 2026. https://humberandnorthyorkshire.icb.nhs.uk/wp-content/uploads/2025/10/More-Than-Weight-report-2025.pdf. **2.** The NHS Alliance. Accessed June 03, 2026. https://thenhsalliance.org/resources/when-opportunity-knocks-transforming-weight-management.

Patient and Community Engagement

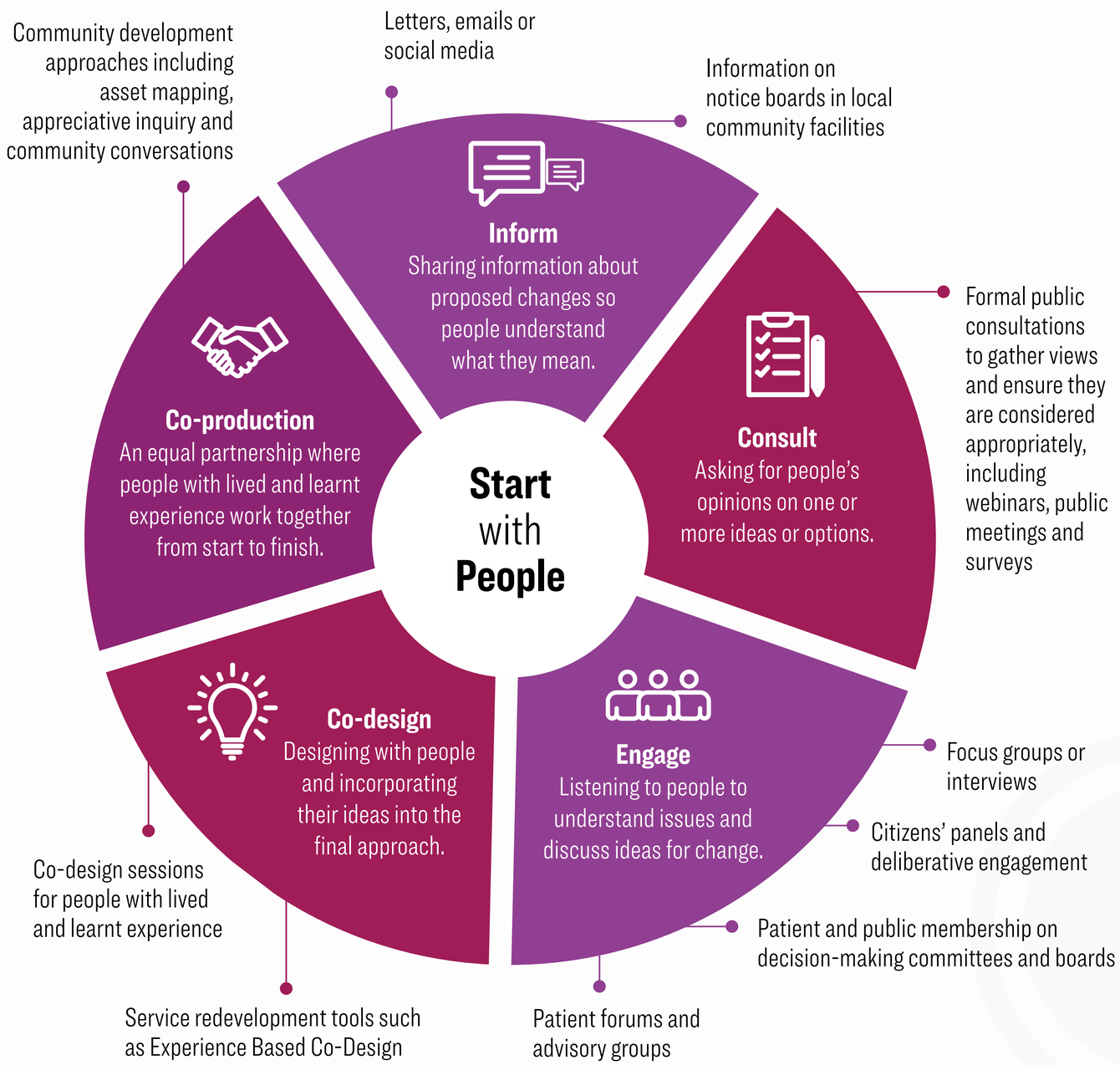
As systems move away from rigid, tier-based weight management models, there is an opportunity to redesign services that reflect the complexity of obesity and its impact on daily life.

By designing services with people rather than for them, local health and care systems can develop integrated, personalised, and inclusive services that reduce stigma, improve outcomes, and better support communities experiencing health inequalities. NICE guidance 246 on overweight and obesity management embeds shared decision-making and service user involvement as core principles of care.[1]

While this is challenging in resource-constrained systems, user-centred design (UCD) offers a practical framework to support implementation.

A range of methodologies can be used for engagement, from short- or long-term approaches to work with specific communities or wider populations. Methods may be time-limited or open-ended and should be selected based on the purpose of engagement and expected impact. Each approach will vary in the time, resources, and expertise required.

Different Ways of Working with People and Communities[2]



Case study

West Yorkshire used system insight to redesign services around trauma-informed, person-centred care.

References: 1. NICE. Accessed June 03, 2026. https://www.nice.org.uk/guidance/ng246. **2.** NHS England. Accessed June 03, 2026. https://www.england.nhs.uk/get-involved/involvementguidance/.

Case Study: Developing Trauma-Informed, Person-Centred Weight-Management Services in West Yorkshire

What the System Faced

West Yorkshire ICB identified that obesity services were fragmented, inconsistent and overly focused on weight loss rather than underlying causes. Evidence showed obesity is closely linked to trauma, mental health, poverty and inequality, while stigma and variation in access continued to undermine engagement. At the same time, much of the workforce lacked confidence to deliver effective, person-centred obesity care.

What the System Did

The ICB undertook system-wide engagement, including:

- Surveys and focus groups with people living with obesity to understand stigma, trauma and barriers to care.
- Engagement with the health and care workforce across primary and community care to assess capability and training needs and support the collection of system-level recommendations to inform service redesign and workforce development.

Results and Benefits

Insights highlighted the complex drivers of obesity and key system gaps:

- Ongoing weight stigma, including within healthcare.
- Inconsistent, hard-to-navigate support.
- Only 35% of professionals feel equipped to deliver effective obesity care.
- Carers experiencing significant, unsupported burden.

These findings shaped a shift towards trauma-informed, equitable, holistic and long-term approaches to obesity care.

Takeaway tips

To improve outcomes and sustainability, systems should:

- Embed trauma-informed and trauma-responsive care across all obesity pathways
- Reduce variation and improve equitable access to behavioural, specialist and evidence-based treatments
- Address weight stigma through training and culture change
- Integrate mental health and peer support into all tiers of care
- Prioritise prevention and early intervention in areas of greatest need

Patient and Community Engagement

Familiarise yourself with relevant legislation, statutory guidance and national policy on involving patients, people and communities. NHS England's statutory guidance, **Working in Partnership with People and Communities,** sets out systems' legal duties and expectations for public involvement, alongside practical principles for putting this into practice.[1]

Recent NHS policy, including the **Strategic Commissioning Framework**, has further strengthened expectations on ICBs to develop adequately resourced co-production approaches that actively involve people and communities in service design and delivery.[2]

For weight management services, which have often lacked sufficient funding and have not always been recognised for their wider system impact, this provides an opportunity to bring the voices and priorities of communities more centrally into commissioning discussions and service redesign.[3]

Case study

Plymouth used Ripple Effects Mapping to strengthen system collaboration.

Case study

Greater Manchester used community-led co-design to reshape weight management services.

References: 1. NHS England. Accessed June 03, 2026. https://www.england.nhs.uk/get-involved/involvementguidance/. **2.** NHS England. Accessed June 03, 2026. https://www.england.nhs.uk/publication/ nhs-strategic-commissioning-framework/. **3.**Humber and North Yorkshire. Accessed June 03, 2026. https://humberandnorthyorkshire.icb.nhs.uk/wp-content/uploads/2025/10/More-Than-Weight-report-2025.pdf.

Case Study: Ripple Effects Mapping in Plymouth

What the System Faced

Plymouth City Council developed a Compassionate, system-wide health and weight approach but identified that existing evidence largely focused on individual behaviour change.[1] They recognised that obesity is a complex issue requiring a whole-systems, compassion-led strategy.

What the System Did

- Ripple Effects Mapping (REM) was used to support this work. REM is a participatory, visual method that helps stakeholders capture how change unfolds in complex, non-linear systems — relational and often emergent — rather than through simple cause and effect pathways.[2] It can be used to show how groups, organisations or services operate in complex systems, and to influence optimisation of systems and outcomes.

Results and Benefits

REM proved especially valuable for the Complications of Excessive Weight service, revealing how interconnected factors – from medical care to education, employment, relationships and wider wellbeing – shaped one young person's journey. By making visible the barriers, enablers and unexpected outcomes that traditional reporting often misses, REM offers a powerful way to demonstrate impact, strengthen collaboration and build shared understanding across the system. REM has since been rolled out across Plymouth.

Takeaway tips

- REM's joint mapping process clarifies individual journeys, highlight benefits and challenges and strengthens shared ownership across the system.
- Apply REM outputs to shape how success is defined and resourced. Their visual and narrative evidence supports flexible commissioning, adaptive practice, strategic investment, and helps senior leaders understand service impact within complex systems. These insights complement and enrich traditional metrics.

References: 1. Plymouth City Council. Accessed June 03, 2026. https://www.plymouth.gov.uk/sites/default/files/2023-03/Compassionate-Approach-to-CYP-Health-and-Weight-Plan-V2_0.pdf. **2.** Nobles J, et al. BMC Med Res Methodology. 2022;22(1):72.

Case Study: In Greater Manchester – Community-Led Insight and Pathway Co-Design

A jointly-funded Collaborative Working project with Lilly

What the System Faced

Despite high motivation, people living with obesity in Greater Manchester face system barriers that restrict access to ongoing support. Fragmented services, poor signposting and inequalities around cost, transport, language and digital access resulted in uneven and short-lived engagement.

What the System Did

Through a Collaborative Working Agreement between Lilly and Health Innovation Manchester, a community-led research and pathway co-design programme was commissioned to better understand lived experience and system gaps. The work focused on understanding where people disengage, why existing support is difficult to navigate, and how the system could better align NHS, community and voluntary provision.

Results and Benefits

The research provided a clear, system-level understanding of why people struggle to access and stay engaged with weight management support, showing that:

- Motivation is frequently undermined by system design rather than lack of willingness.
- Lack of clear information and joined-up pathways prevents early engagement.
- Inequitable access increases the risk of disengagement and relapse.
- Community and VCSE organisations already play a critical role but are not consistently integrated into formal pathways.

These insights are helping to shape a more patient-centred approach to weight management, ensuring future services better reflect people's experiences, needs and priorities.

Takeaway tips

- Don't mistake disengagement for lack of motivation — system design is often the barrier.
- Make support simple, visible and clearly signposted across NHS, community and VCSE settings.
- Design services around people's circumstances, reducing barriers linked to cost, transport, language and digital access.

Conclusion

Throughout this project, we have heard from leaders across the NHS and beyond about the challenges they are facing as they attempt to address the impacts of increasing rates of obesity on individuals, communities, public services and wider society.

Weight management services (WMS) can only ever play one part in addressing the multifaced drivers of societal rises in obesity; however, within this complex system, they will play an important role in ensuring that individuals receive support that is compassionate and responsive to their needs.

As we have covered throughout this toolkit, WMS have not always been set up to perform this function effectively.

Encouragingly though, England's **Ten Year Health Plan** underscores a strategic shift in the NHS' priorities, including moving from treating illness to prioritising prevention.[1] Meanwhile, NICE's updated **Overweight and Obesity Management** guidance moves away from a tiered delivery model, creating an opportunity to redesign services that better reflect the needs of individuals and communities.[2,3]

Such change presents system leaders with the opportunity for meaningful service transformation, but we cannot underestimate the scale of disruption and uncertainly operating in a changing policy and operating environment will cause for the leaders trying to achieve this change.

There will always be external limitation on what NHS leaders can hope to achieve when re-designing services, but we hope that the experiences, insights and methodologies contained within this toolkit will provide guidance through the most common challenges.

References: 1. UK GOV. Accessed June 03, 2026. https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf. **2.** NICE. Accessed June 03, 2026. https://www.nice.org.uk/guidance/ng246. **3.** NHSE. Accessed June 03, 2026. https://www.england.nhs.uk/long-read/interim-commissioning-guidance-nice-ta1026-tirzepatide/.

Glossary

Coalition Building
The process of bringing together organisations, communities and stakeholders across sectors to collaborate towards a shared goal, particularly to address complex health or social challenges.

Early Intervention
Action, services or support delivered as early as possible to identify risks or emerging issues and prevent problems from worsening, improving long-term outcomes.

Equity
Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation).

Evaluation
A systematic process of assessing the design, delivery and outcomes of a programme, service or policy to understand what works, for whom, and why, and to inform improvement and decision-making.

Health Inequalities
Unfair and avoidable differences in health across the population, and between different groups within society.

Inclusion Health Groups
Socially excluded populations who experience overlapping disadvantages and barriers to accessing services, resulting in significantly poorer health outcomes.

Integrated Care Board (ICB)
A statutory NHS organisation responsible for planning, funding and overseeing NHS services for a defined population, working within an Integrated Care System to improve population health and reduce inequalities.

Glossary

Medical Education
Education, training and continuous development for healthcare professionals at all stages of their careers.

National Institute for Health and Care Excellence (NICE)
A national independent body that provides evidence-based guidance, advice and quality standards to improve health and social care, including clinical guidelines and technology appraisals.

NHS Foundation Trust (NHS FT)
An NHS organisation in England that provides healthcare services (hospital / mental health, community or ambulance services) and are accountable to local communities and responsible for delivering healthcare services.

Outcomes
The changes or benefits resulting from an intervention, service or programme, reflecting its impact on health, wellbeing, experience or quality of life.

Personalised Care
An approach to care that supports people to have greater choice and control over decisions about their health, tailored to what matters most to them.

Population Health
An approach focused on improving the health outcomes of groups of people by addressing clinical needs alongside wider social, economic and environmental determinants of health.

Population Health Management
A data-driven approach used to understand population needs, proactively target interventions, improve outcomes and reduce health inequalities.

Prevention
Actions taken to reduce the risk of disease, illness or injury by addressing risk factors and promoting protective behaviours before problems develop.

Glossary

Primary Care
The first point of contact with the health system, including general practice, community pharmacy, optician and dental care.

Q Community
A membership community of people across health and care who share learning and collaborate to improve quality, safety and outcomes.

Return on Investment (ROI)
A measure that helps decision-makers judge an investment's value, by comparing its costs to its returns.

Ripple Effect Mapping
A qualitative and participatory evaluation method used to capture both intended and unintended impacts of programmes across individuals, communities and systems.

Single Point of Access (SPoA)
A consolidated access route that allows referrals, enquiries or service access through one consistent contact point, improving coordination and user experience.

Stigma
Negative attitudes, beliefs or behaviours that unfairly label or marginalise individuals or groups, creating barriers to accessing services and support.

NHS England Strategic Commissioning Framework
The framework sets out what NHS England expects from integrated care boards (ICBs) in the strategic commissioner role.

System Working
Collaboration across organisations and sectors to plan and deliver services collectively, focusing on population needs rather than organisational boundaries.

Glossary

Tiered Weight Management Services

A structured pathway of weight management services, ranging from universal advice and lifestyle interventions to specialist and clinical services based on individual need to achieve and maintain a healthy weight through behavioural, dietary, physical activity and, where appropriate, clinical interventions.

Trauma-Informed

An approach that recognises the impact of trauma on people's health and behaviour and prioritises safety, trust, choice, collaboration and empowerment.

User-Centred Design

A co-design approach that places users' needs, experiences and feedback at the centre of developing services, systems or products.