

Weight Management in the 21st Century – Applying NICE NG246 and Tirzepatide TA1026 in Real-World Primary Care

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Session Objectives

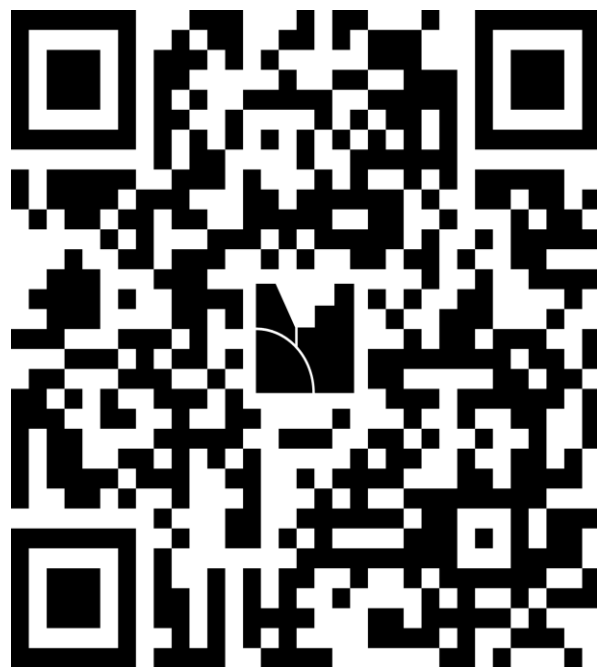
- ☐ Recognise obesity as a long-term medical condition rather than purely lifestyle-driven.
- ☐ Become familiar with the key updates in NICE NG246, TA1026 and the Tirzepatide Phased Rollout.
- ☐ Understand when Tirzepatide can be started, how to titrate it and how continuation can be managed in Primary Care.
- ☐ Gain practical, consultation-focused steps to apply the pathway and support patients effectively in General Practice.



How do you perceive obesity?

In your personal clinical view, how do you perceive obesity?

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Case History 1

- **Name:** Mrs JH
- **Age:** 42years
- **Weight:** 122kgs ; Height: 170cm; BMI: 42.2kg/m²
- **PMH:** Hypertension; NAFLD; Osteoarthritis ; Depression and Anxiety; Hypothyroid; Asthma
- **Medications:** Amlodipine 5mgs od, Citalopram 20mgs od; Levothyroxine 100micrograms od, Naproxen 250mgs bd, Asthma Inhalers
- **GP Visit :** “My weight is making me depressed and I heard there is medication that can help me lose weight”.

Case History 2

- **Mr TK**
- **Age** : 64years
- **Weight**: 143kg ; Height 170cm; BMI 49.5kg/m²
- **PMH**: Type 2 Diabetes, Hypertension, AF, OSA, OA, CKD 3, COPD, Curative Right Nephrectomy for Renal Cell Cancer in 2020, Painful Diabetic Peripheral Neuropathy, and Background Diabetic Retinopathy.
- **Medications**: Novomix 30 32units am and 40units pm, Metformin 1 grams bd, Linagliptin 5mgs od, Dapagliflozin 10mgs od, Amlodipine 10mgs od, Ramipril 5mgs od, Atorvastatin 20mgs nocte, Inhalers, Gabapentin 300mgs tds, Edoxaban 60mgs od, Aspirin 75mgs od.

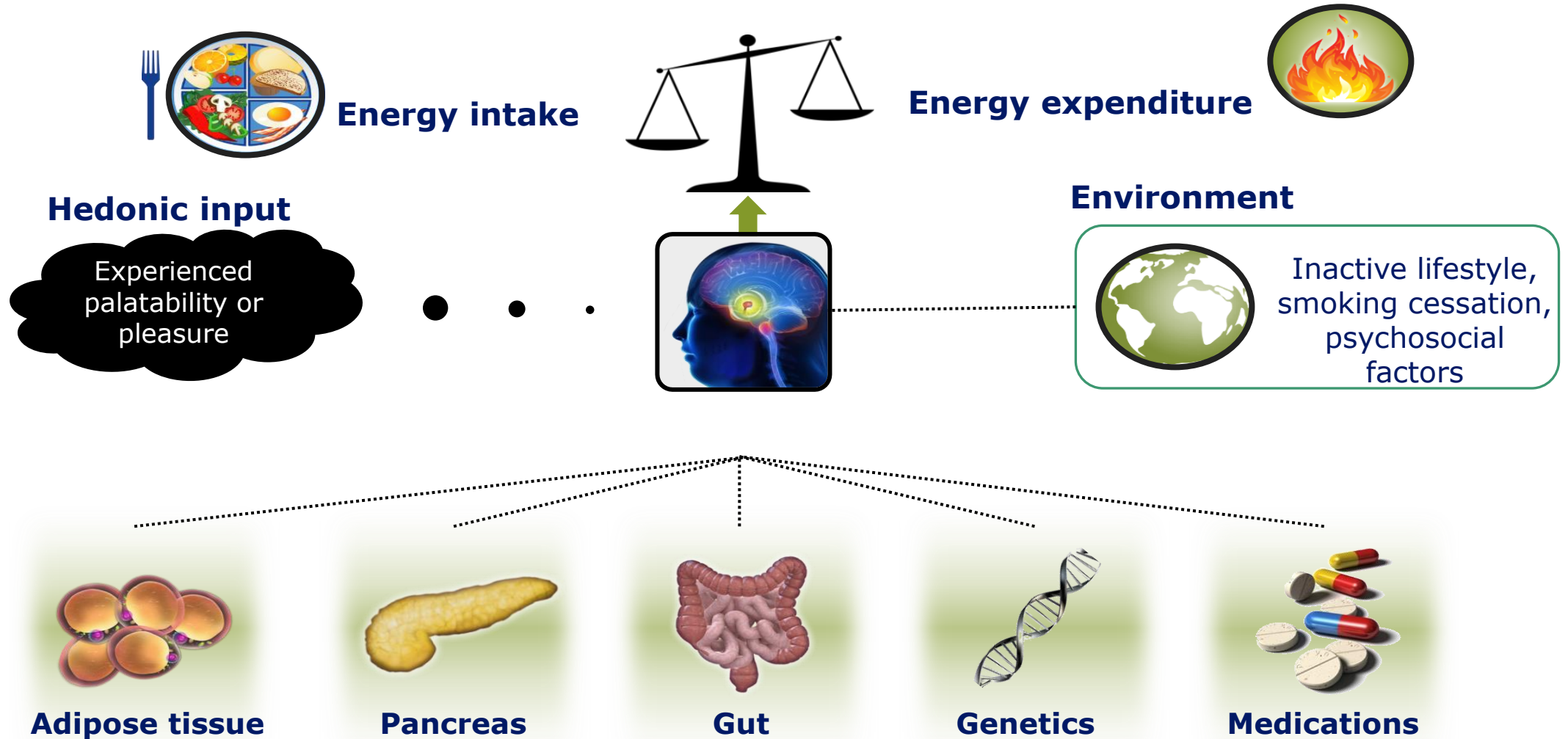
GP Visit: For medication review

Case History 3

- Ms KH
- Age: 38years
- Weight: 125kg Height 172m BMI 42kg/m²
- PMH: PCOS, Overactive Bladder, Asthma, Anxiety and Depression
- Mediations: Fexofenadine 180mgs od, Pregabalin 50mgs bd, Citalopram 20mgs od, Mirabegron 50mgs od, Monteluklast 10mgs od, Trimbaw Inh, Salbutamol Inh, Mebeverine 135mgs tds

GP Visit: Abdominal pain

Obesity is a complex and multifactorial disease



Brain and Obesity

3 Main areas

- The Hypothalamus – arcuate nucleus(hunger center) ; Paraventricular Nucleus(satiety centre).
- The Mesolimbic (hedonic area) – reward and pleasure associated with sight, smell and eating of food (dopaminergic , opioid and endocannabinoid pathway).
- The cognitive lobe – responsible for executive functioning and overrides primal behaviour driven by the mesolimbic system. Works well under optimal conditions – rest, support, less stress etc.

Clinical Relevance of Obesity in UK Primary Care

- 64-65% of English Adult are overweight or living with obesity; around 27% have obesity¹
- Odds of frequent GP Consultation increases with overweight and Obesity compared to normal weight²
- Women with BMI ≥ 40 kg/m² averaged 11.1 consultations per year—nearly double those with BMI 20 to <22.5 ³
- Both childhood and adult obesity rates in Barnsley exceed those of Yorkshire & the Humber (Adults: 26.0%; Year 6: 23.6%) and England overall (Adults: 26.5%; Year 6: 22.1)⁴.
- In Barnsley prevalence remains highest in mid-life, reflecting national risk patterns for chronic disease and primary care workload.
- From 2018 to 2024, Barnsley's rate have climbed from approx. 23%(all ages, 2018) to 33.3%(2024) compared to South Yorkshire's rise from approx. 20-21% to 28-31%.
- National, regional, and Barnsley rates all rose fastest during and immediately after the COVID-19 pandemic, reflecting increases in physical inactivity and food insecurity.

1. [Obesity profile: short statistical commentary, May 2025 - GOV.UK](#)

2. Haase, C.L. et al. (2020) 'Body mass index and risk of obesity-related conditions in a cohort of 2.9 million people: Evidence from a UK primary care database', *Obesity Science & Practice*, 7(2), pp. 137–147. doi:10.1002/osp4.474.

3. 2. Kent, S. et al. (2018) 'Body mass index and use and costs of primary care services among women aged 55–79 years in England: A cohort and Linked Data Study', *International Journal of Obesity*, 43(9), pp. 1839–1848. doi:10.1038/s41366-018-0288-6.

4. [National Child Measurement Programme, England, 2023/24 School Year - GOV.UK](#)

Consequences of excess weight in GP Practice

BMI Category (kg/m²)	Mean GP Consultations/Year (Women 55–79y)	Mean Annual Cost (2016 £)
20 to <22.5	7.0 (6.8–7.1)	£288 (280–295)
22.5 to <25	7.1 (7.0–7.3)	£296 (289–302)
25 to <27.5	7.5 (7.4–7.7)	£314 (307–321)
27.5 to <30	8.1 (7.9–8.3)	£338 (329–347)
30 to <35	9.0 (8.7–9.2)	£376 (366–386)
35 to <40	10.1 (9.7–10.5)	£428 (410–447)
≥40	11.1 (10.3–11.9)	£473 (441–506)

NICE Overweight and Obesity Guidelines – what's new?

- ❑ Changing clinical landscape for obesity management — multiple NICE updates 2006–2024 (CG43; PH42; PH47; CG189; NG7; PH53).
- ❑ Latest: NG246 — key implications for local pathways, commissioning and primary-care practice.
- ❑ Shift to an active primary-care role: identification and treatment, plus screening for obesity-related complications.
- ❑ NG246: practical, evidence-based recommendations for primary care, community pharmacies and MDTs.
- ❑ Stronger emphasis on digital tools (remote monitoring, apps and virtual behavioural support) within weight-management pathways.

NG246 replaced these guidelines below:-

- ❑ CG43: *Obesity prevention* (2006)
- ❑ CG189: *Obesity: identification, assessment and management* (2014)
- ❑ NG7: *Preventing excess weight gain* (2015)
- ❑ PH42: *Obesity: working with local communities* (2012)
- ❑ PH46: *BMI: preventing ill health and premature death in Black, Asian and other minority ethnic groups* (2013)
- ❑ PH47: *Weight management: lifestyle services for overweight or obese children and young people* (2013)
- ❑ PH53: *Weight management: lifestyle services for overweight or obese adults* (2014)

NG246 Vs Guideline Before it – Different approach

- Frames obesity as a clinical, relapsing condition – prior guidelines focused on acute weight loss then discharge.
- Removed “tiers” of weight management access.
- Emphasis on non-stigmatizing , patient-centred language and care planning – clinicians should consider their own feelings and sensitivities about weight to avoid “diagnostic overshadowing”
- Broadened focus – social, cultural, environmental factors not just the individual
- Recommends integrated, multidisciplinary care at all stages Vs fragmented pathways

NG246: Identification and Assessment

- ❑ Addition of routine waist-to-height ratio to BMI for better risk stratification especially in ethnic minorities.
- ❑ Significantly greater attention in early assessment of comorbidities and holistic needs.
- ❑ Active patient involvement – educate patient to monitor their own weight and waist circumference (applies to BMI < 35) correctly.
- ❑ Clearer guidance on assessing mental health, sleep apnoea, liver disease and acute complications.
- ❑ Adopt a **BMI cut-off reduced by 2.5 kg/m²** for specified ethnic minority groups to more accurately capture cardiometabolic risk.
- ❑ Places cultural tailoring and accessibility at the centre of assessment, rather than as an afterthought.
- ❑ Explicitly supports shared decision-making for investigation/referral, with less emphasis on rigid algorithms.

NG246: Interventions and Service Access

- ❑ No mandatory 'stepped care' through service tiers in NG246 – direct referral based on clinical need replaces previous gatekeeping.
- ❑ Increases access to digital and flexible community-based interventions absent from older framework.
- ❑ Introduces and supports new generation GLP-1 agonist pharmacotherapies following NICE technology appraisal.
- ❑ Sets no minimum weight loss thresholds before access to surgery or specialist care.
- ❑ Expands advice and pathways for self-management, social prescribing and peer support networks.

NG246 : Dietary approaches

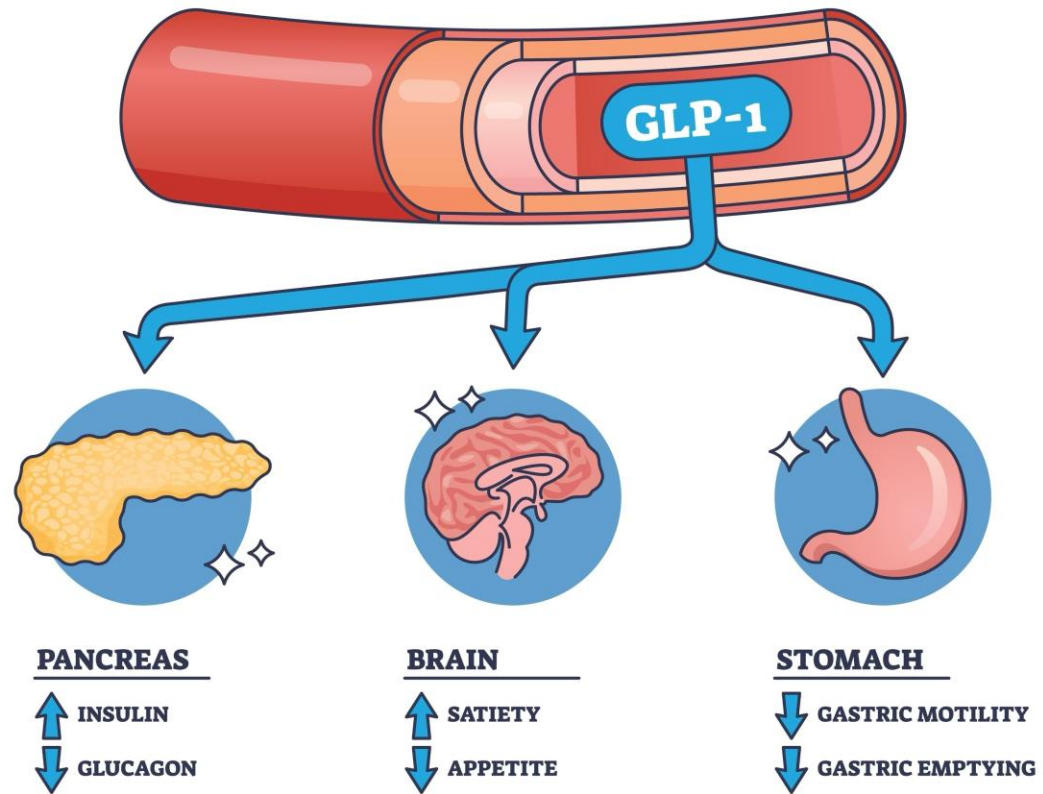
- ❑ Flexible dietary approach – no one size fits all to achieve nutritional balance while reducing energy intake.
- ❑ Consider a calorie deficit (eat less than you burn). Options include low-fat or low-carbohydrate plans tailored to the patient's preference; avoid promoting intermittent fasting as a standard recommendation.
- ❑ Low and very-low-energy diets only under specialist supervision; VLCDs reserved for specific indications (e.g., pre-op) and short courses (≤ 12 weeks). Avoid excessive restriction outside these circumstances — it increases risk of weight cycling and regain.
- ❑ Recommend dietitian or UKVRN-registered nutritionist support for any energy-deficit diet (recognise this may be challenging to arrange in practice).
- ❑ Eating disorders can occur at any weight; screen for them and avoid recommending restrictive diets where they may be present.

What are Incretin Mimetics

- ❑ Mimic natural gut hormones (GLP-1, and/or GIP) released after eating—these are called incretins.
- ❑ Stimulate insulin secretion by pancreatic beta cells in a glucose-dependent manner, reducing risk of hypoglycaemia.
- ❑ Suppress glucagon release (mainly via GLP-1), lowering hepatic glucose output when blood glucose is high.
- ❑ Slow gastric emptying, especially with GLP-1 agonists, which blunts post-meal glucose spikes and increases satiety.
- ❑ Reduce appetite and food intake: Central nervous system effects, leading to significant weight loss (especially GLP-1 agonists).
- ❑ Dual GIP/GLP-1 - Combine enhanced insulin response with synergistic weight loss via both incretin pathways – Tirzepatide.
- ❑ Lower blood glucose, support sustained weight loss, and often improve cardiovascular (Liraglutide, Semaglutide), and metabolic risk factors

GLP-1

GLUCAGON-LIKE PEPTIDE-1



Incretin Mimetics

Effects of GLP1

↑ *Satiety*

↑ *Insulin*
↓ *Glucagon*
↑ *Beta Cell Proliferation*
↓ *Beta Cell Apoptosis*

↑ *Nausea*
↓ *Gastric Emptying*

↓ *Hepatic Glucose Production*

↑ *Insulin sensitivity*

Brain



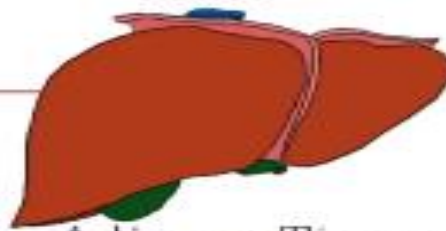
Pancreas



GI Tract



Liver



Adipose Tissue



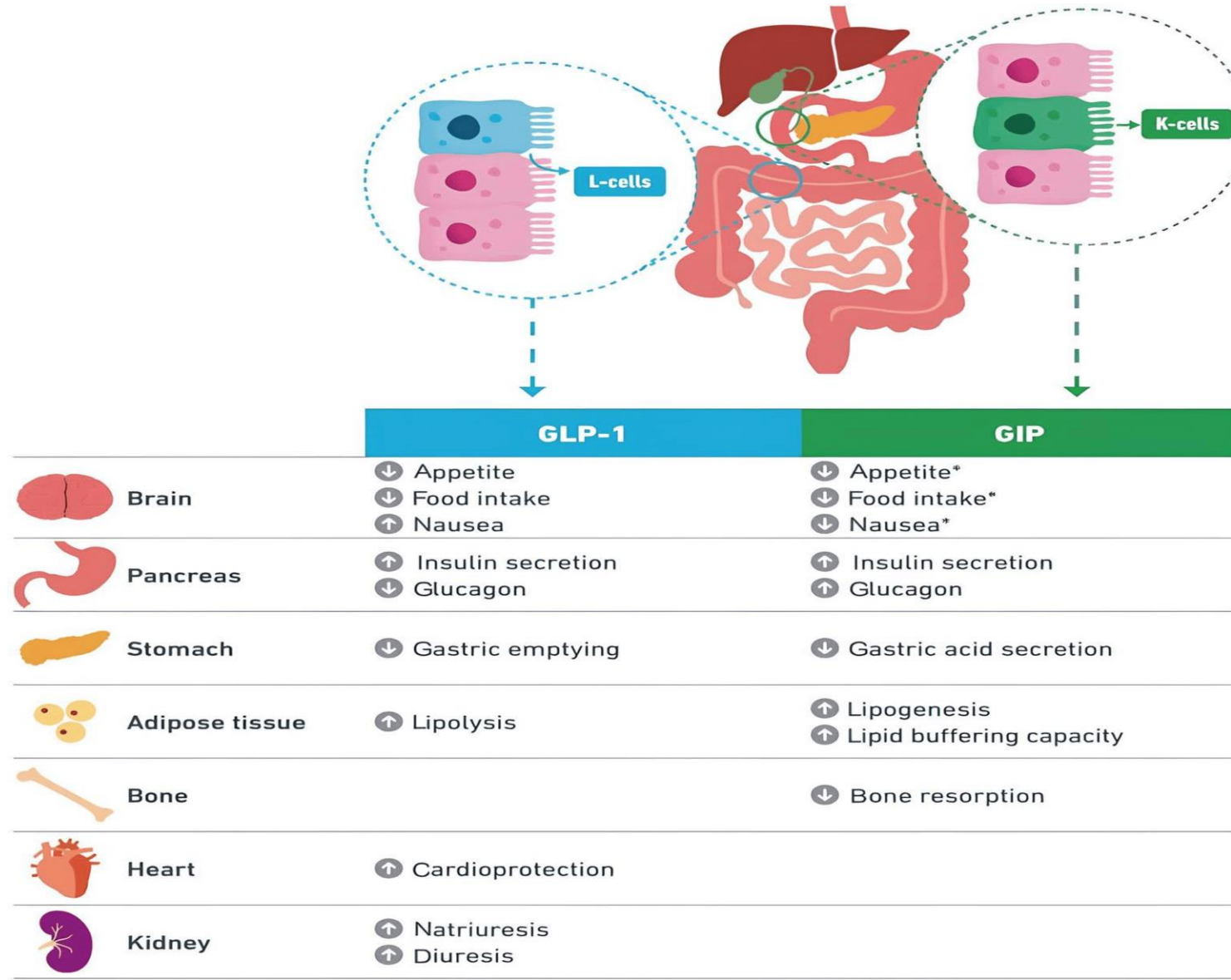
Effects of GIP

↑ *Insulin*
↑ *Glucagon*
↑ *Beta Cell Proliferation*
↓ *Beta Cell Apoptosis*

↓ *Nausea*

↑ *Lipid Buffering Capacity*
↓ *Triglycerides*
↑ *Insulin sensitivity*

The dual agonist action of Tirzepatide on various organs



NG 246: Medication

- ☐ To be considered after behavioral approaches have been instigated and evaluated.
- ☐ Incretin mimetics have completely changed the landscape – Tirzapetide currently approved for use in primary care from 23rd June 2025.
- ☐ Need for ongoing support emphasised.
- ☐ Pay attention to individual factors in order to improve adherence.
- ☐ If there is a concern about micronutrient intake adequacy consider vitamins and minerals supplement especially older adults and children/young people.
- ☐ Offer support to help maintain weight loss to people who are stopping weight management medicines

NG246: Medicines options for weight management in adults

Attribute	Tirzepatide	Semaglutide	Liraglutide	Orlistat
For more details	NICE's technology appraisal guidance on tirzepatide for managing overweight and obesity (TA1026, December 2024)	NICE's technology appraisal guidance on semaglutide for managing overweight and obesity (TA875, March 2023)	NICE's technology appraisal guidance on liraglutide for managing overweight and obesity (TA664, December 2020)	There is no NICE technology appraisal guidance on orlistat
Setting for Use	Prescribed in primary care or a specialist overweight and obesity management service .	Prescribed in a specialist overweight and obesity management service .	Prescribed in secondary care by a specialist overweight and obesity management service .	Any clinical setting (GP or specialist) Available in a lower dose from a pharmacy
BMI Threshold	≥35 + at least 1 weight related comorbidity (lower for some ethnic groups)	At least 1 weight-related comorbidity and : an initial BMI of 35.0 kg/m ² or more, or an initial BMI of 30.0 kg/m ² to 34.9 kg/m ² and who meet the criteria for referral to specialist overweight and obesity management services .	An initial BMI of 35 kg/m ² or more and non-diabetic hyperglycaemia and a high risk of cardiovascular disease.	≥30; or ≥28 + risk factors (lower for ethnicity)
Route & Frequency	Subcutaneous injection, weekly	Subcutaneous injection, weekly	Subcutaneous injection, daily	Oral capsule, three times daily with meals
Pregnancy & Contraception	Not in pregnancy; stop 1 month before planning; non-oral/barrier contraception for 4 weeks when starting/dose change	Not in pregnancy; stop immediately if pregnant; non-oral/barrier contraception at initiation	Not in pregnancy; stop immediately if pregnant; non-oral/barrier contraception at initiation	Contraindicated in pregnancy; additional contraception if diarrhoea
When to Stop	If less than 5% of the initial weight has been lost after 6 months on the highest tolerated dose, decide whether to continue treatment, taking into account the benefits and risks of treatment for the person.	Consider stopping if less than 5% of the initial weight has been lost after 6 months of treatment.	Stop after 12 weeks on the 3.0 mg/day dose if at least 5% of the initial body weight has not been lost.	Stop after 12 weeks if at least 5% of the initial body weight has not been lost.

Bariatric Surgery Pathways

- ❑ Enables earlier and more equitable access to surgery, not restricted by number of failed interventions or time spent in specialist services.
- ❑ Stronger requirements for MDT assessment and life-long follow-up, including nutrition and mental health.
- ❑ Surgery pathway for children/young people clarified – MUST be in expert MDT centres, not simply “adult-style” referral.
- ❑ Explicit focus on reducing barriers in deprived and minority populations.
- ❑ Ongoing post-surgical support and monitoring now a firm requirement, not a recommendation.

Prevention, Equity, and System Change

- ❑ Population prevention (schools, communities, early years settings) a central pillar; prior guidance focused mainly on individual weight loss.
- ❑ System-wide action called for: links obesity to inequalities, food environment, and deprivation—new compared to older document.
- ❑ Workforce training, service audit, and continuous quality improvement mandated.
- ❑ Service evaluation and user feedback are integral, not optional; previous guideline had less on audit.
- ❑ Emphasises the duty to tackle obesity stigma and support healthier environments beyond clinical settings.

Key Primary Care Challenges in Implementing NG246

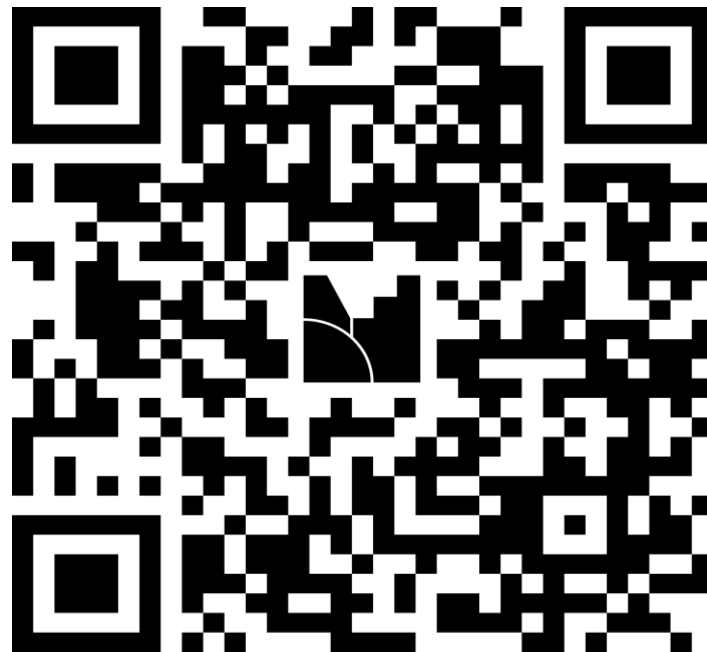
- ❑ Time constraints in 10-minute consultations
- ❑ Insufficient Dietitians, Psychologists, Physiotherapists
- ❑ Prescribing restrictions
- ❑ Patient expectation Vs reality
- ❑ Weight stigma in health care
- ❑ Training and familiarity with NG246 criteria and escalation

Case History 1

- Name: Mrs JH
- Age: 49years
- Weight: 122kgs ; Height: 170cm; BMI: 42.2kg/m²
- PMH: Hypertension; NAFLD; Osteoarthritis ; Depression and Anxiety; Hypothyroid; Asthma
- Medications: Amlodipine 5mgs od, Citalopram 20mgs od; Levothyroxine 100micrograms od, Naproxen 250mgs bd, Asthma Inhalers
- **GP Visit :** My weight is making me to feel depressed and I heard there is medication that can help me lose weight.

What would you do next, and
based on NICE NG246, which
actions are recommended?

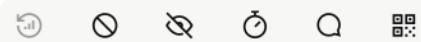
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BEST 5



§ Case Illustration – Applying NICE NG246 Obesity Guideline

49-year-old patient, BMI 42.2 with multimorbidity

Case 1: Patient Profile

- ❑- Age: 42 years
- ❑- BMI: 42.2kg/m² (Class III Obesity)
- ❑- Weight: 122kg, Height: 170cm
- ❑- Sedentary office-based job
- ❑- Lives alone, recently divorced , emotional eating during anxiety episodes

Relevant Medical History

- ❑- Hypertension (on Amlodipine)
- ❑- Hypothyroidism (on Levothyroxine)
- ❑- Anxiety & Depression (on Citalopram)
- ❑- Osteoarthritis affecting mobility
- ❑- Asthma(on PRN Inhalers) affecting breathing

Lifestyle & Psychosocial Assessment – NG246

- ❑- Emotional eating linked to anxiety
- ❑- Pain limiting physical activity
- ❑- Previous unsuccessful weight attempts
- ❑- Patient open to structured support

NICE NG246 – Guideline Application

- ❑- Meets criteria for Tier 3 MDT referral
- ❑- Psychological support integrated into pathway
- ❑- Pharmacotherapy only under MDT supervision
- ❑- Pain management required to support activity
- ❑- Structured 3, 6 month and annual reviews

Management Plan Aligned with NG246

- ❑- Refer to Tier 3 weight management programme
- ❑- Physiotherapy for joint-friendly exercise
- ❑- Consider GLP-1/GIP agonist therapy (Semaglutide, Tirzepatide)
- ❑- Psychological support for emotional triggers
- ❑- Regular review with continuation criteria

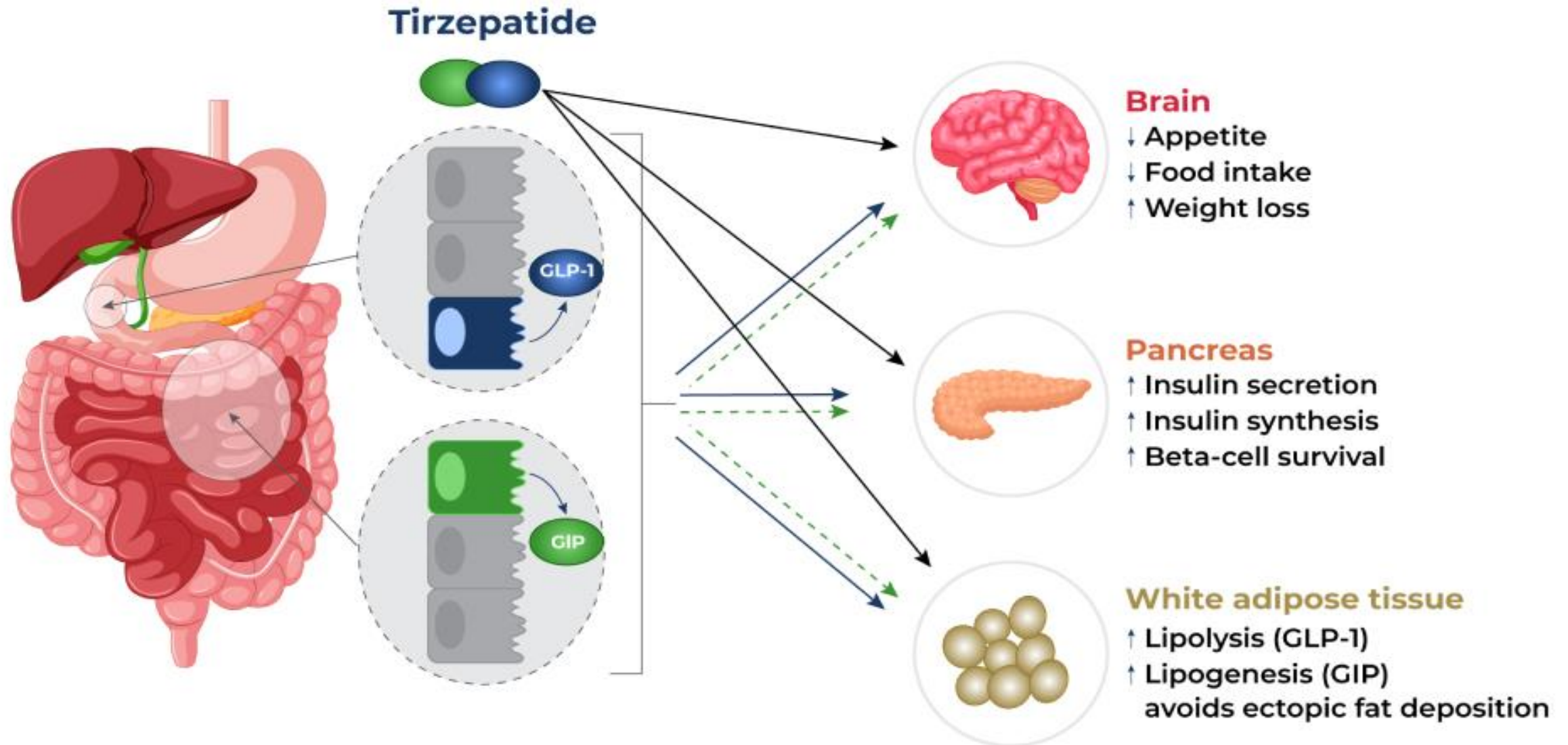
Future Escalation – Bariatric Surgery

- ❑- Consider if <5% weight loss on pharmacotherapy
- ❑- MDT optimisation required before referral
- ❑- Early conversation to support expectations

Current Evidence and Medication Options

- ❑ Diet and physical activity remains first line for adults with overweight or obesity.
- ❑ Behavioral support is key to long term success.
- ❑ Most NHS prescribing of anti-obesity medications has historically required specialist referral.
- ❑ Semaglutide (GLP-1 agonist) can now be offered for up to 2 years in specialist weight management services.
- ❑ Tirzepatide (dual GIP/GLP-1 agonist) is now recommended in both primary and specialist care where criteria are met.

TIRZEPATIDE



Evidence for Tirzepatide Use

- ❑ SURMOUNT-1 trial: Tirzepatide resulted in ~20% mean body weight reduction at 15mg dose, outperforming placebo and semaglutide.
- ❑ Significant improvement in comorbidities: blood pressure, lipids, prediabetes reversal, and CV risk indicators.
- ❑ Available for adults with BMI ≥ 35 kg/m² plus ≥ 1 comorbidity, or lower BMI for eligible ethnicities.
- ❑ Review at 6 months: stop if <5% weight loss at max tolerated dose – see NICE caveat.
- ❑ Most common adverse effects: GI symptoms (nausea/diarrhoea), usually mild and transient.
- ❑ Weight regain expected after stopping; ongoing support is essential.

Comparing Weight Loss Outcomes

Treatment	Typical Weight Loss (%)	Timeframe	Notes
 Gastric Sleeve	25–30% ¹	12–18 months	Restrictive; hormonal appetite reduction
 Gastric Bypass	30–35% ¹	12–18 months	Malabsorptive + restrictive; high diabetes remission
 Saxenda (Liraglutide)	6–8% ^{2,3}	6–12 months	Daily injection; regain likely when stopped
 Semaglutide (Wegovy)	12–15% ⁴	9–12 months	Weekly injection; NICE-approved under MDT
 Tirzepatide	15–22% ^{5,6}	9–12 months	Dual agonist; near-surgical weight reduction in some cases. Can be prescribed in MDT and primary care.

1. Ibrahim, R. *et al.* (2024) ‘Long-term outcomes of bariatric surgery: An Eight-year study at a tertiary care hospital in Lebanon’, *Surgery Open Digestive Advance*, 14, p. 100135. doi:10.1016/j.soda.2024.100135.

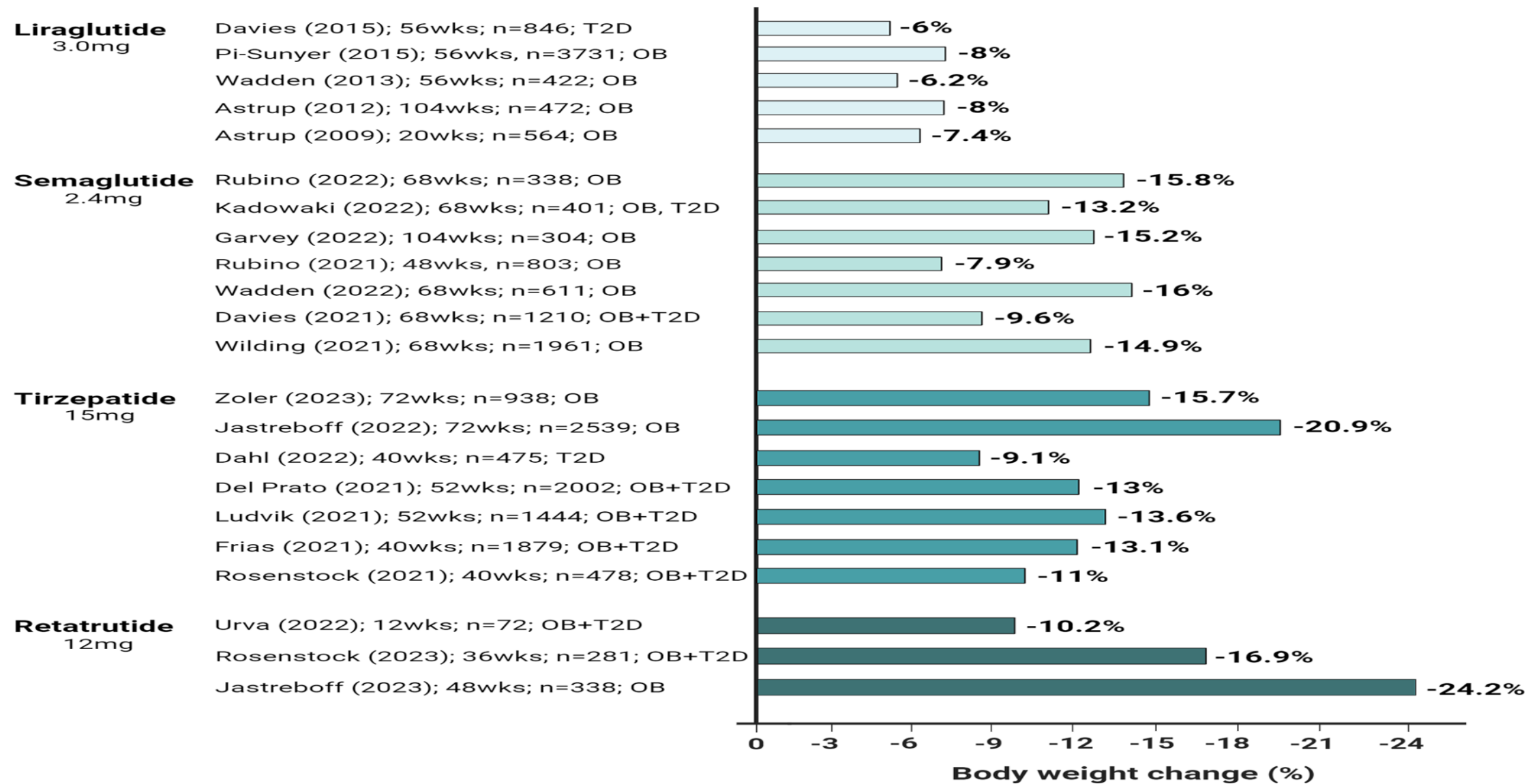
2. Mehta, A., Marso, S.P. and Neeland, I.J. (2016) ‘Liraglutide for weight management: A critical review of the evidence’, *Obesity Science & Practice*, 3(1), pp. 3–14. doi:10.1002/osp4.84.

3. Proietto, J. *et al.* (2019) ‘Liraglutide 3.0 mg in obese/overweight adults with or without prediabetes with baseline BMI <35 vs ≥35 kg/m2 in the scale obesity and prediabetes 56-week randomized, double-blind, placebo-controlled trial’, *Obesity Research & Clinical Practice*, 13(1), p. 103. doi:10.1016/j.orcp.2016.10.266.

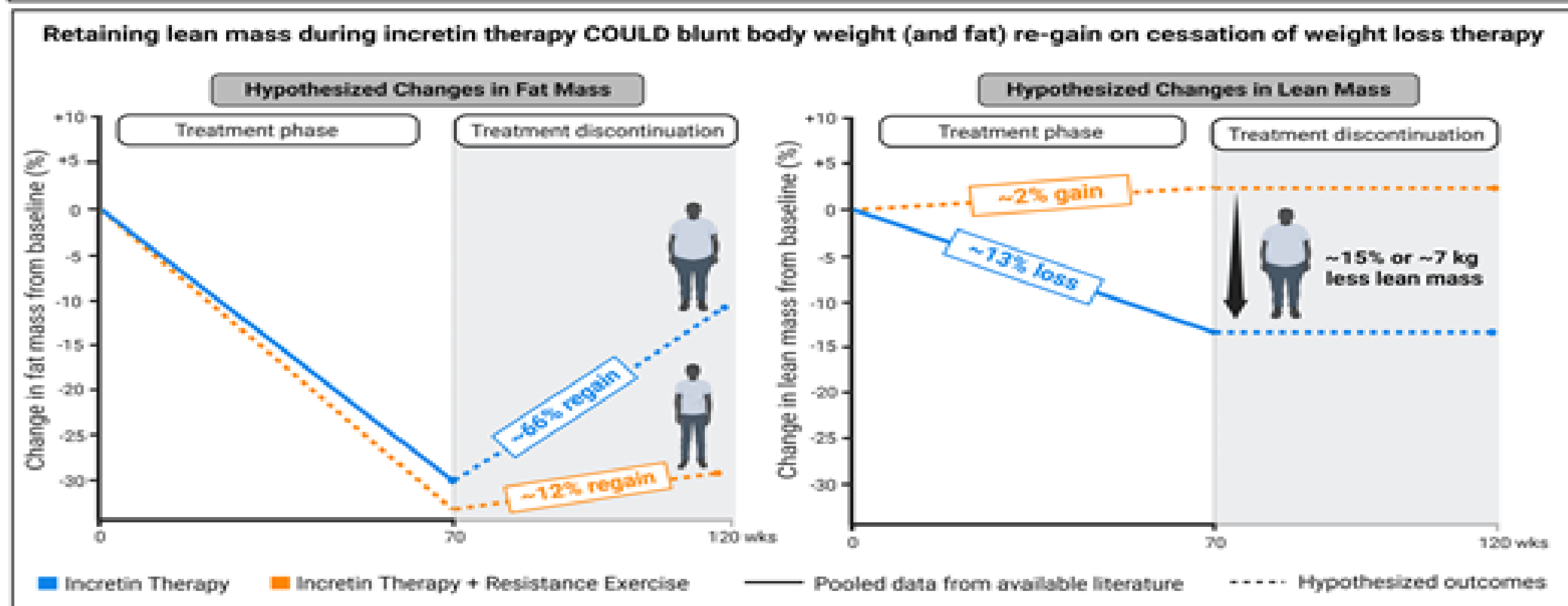
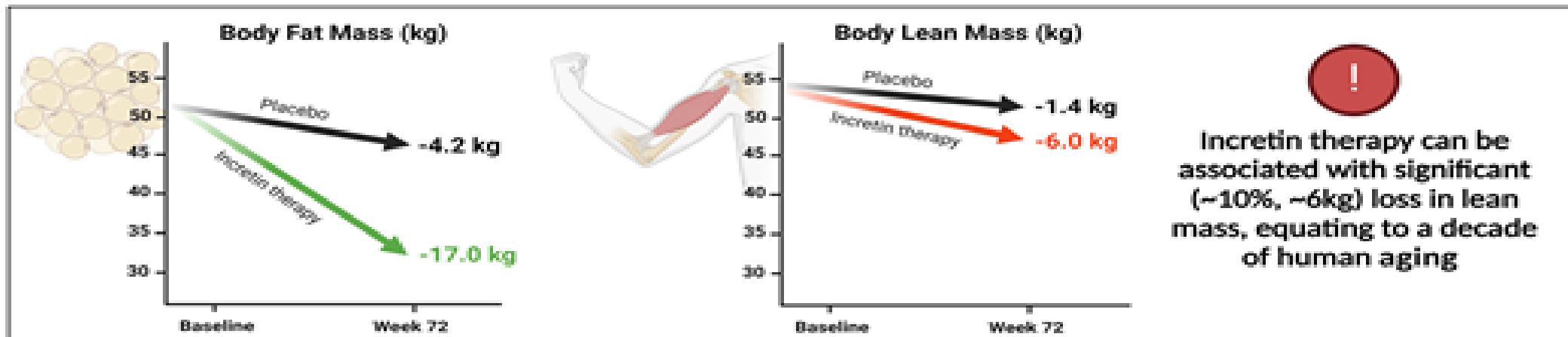
4. (2021) *Review for ‘Once-weekly semaglutide for obesity or overweight: A systematic review and meta-analysis’* [Preprint]. doi:10.1111/dom.14612/v1/review2.

5. Wadden, T.A. *et al.* (2023) ‘Tirzepatide after intensive lifestyle intervention in adults with overweight or obesity: The surmount-3 phase 3 trial’, *Nature Medicine*, 29(11), pp. 2909–2918. doi:10.1038/s41591-023-02597-w.

6. Rodriguez, P.J. *et al.* (2024) ‘Semaglutide vs tirzepatide for weight loss in adults with overweight or obesity’, *JAMA Internal Medicine*, 184(9), p. 1056. doi:10.1001/jamainternmed.2024.2525.



Impact of Lira, Sema, Tz, and retatrutide on body weight in randomized controlled trials. OB, obesity; T2D, type 2 diabetes.

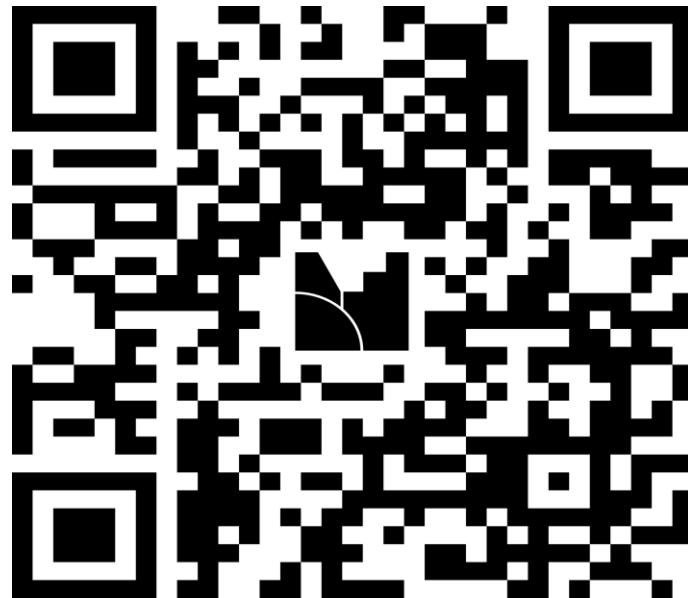




Confidence with Prescribing Tirzepatide

How confident do you currently feel about initiating Tirzepatide in primary care?

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Very confident — ready to
prescribe

0

Somewhat confident — but need
a clear protocol

0

Not confident yet — concerned
about follow-up / safety

0

Unsure — waiting to see how
rollout works

Tirzepatide and Primary Care

- ❑ First injectable weight loss medication to be prescribed in primary care
- ❑ Strict Eligibility and staged rollout
- ❑ Structured wraparound care required.
- ❑ Prescribing and monitoring protocols to be followed.
- ❑ Capacity, training and funding limitations
- ❑ Increased demand

TIRZEPATIDE TA 1026

- ❑ 12-year phased rollout: first 3 years target highest-risk patients, then expand as capacity allows.
- ❑ Initial priority: adults with BMI ≥ 40 plus multiple comorbidities; thresholds lowered progressively and for some ethnic groups.
- ❑ Start prescribing in specialist weight-management services; move into primary care as services and training scale up.
- ❑ All prescriptions must include structured behavioural, dietary and activity support.
- ❑ Review at 3 years, then ongoing audit of effectiveness, uptake, cost and safety to guide commissioning.
- ❑ Aim to reduce health inequalities by prioritising high-need groups and ensuring fair national access.

Obesity Demographics in Barnsley

Cohort 1	502
Cohort 2	655
Cohort 3	1549

B A R T total		People from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds				All other ethnicities				
B M I	27.5-<32.5	32.5-<37.5	37.5-<50	50+	Not known	30- <35	35-<40	40-<50	50+	Not known
Total Number with one or more of the Tirzepatide eligible comorbidities										
All:										
1	244	113	62	11	130	6421	3063	1874	339	3672
2	164	79	62	5	29	8114	3814	2059	399	1112
3	75	30	18	2	7	4198	2295	1257	272	239
4	12	9	8	0	1	1146	635	401	69	27
5	0	0	0	0	0	26	11	21	3	0
Number people with non diabetic hyperglycaemia and one or more of Tirzepatide eligible comorbidities (excluding Type Two Diabetes)										
1	64	30	26	5	19	1200	607	419	77	298
2	36	23	24	2	5	2173	1016	563	110	142
3	10	3	2	0	0	711	329	181	38	38
4	0	0	0	0	0	4	6	7	2	0
Number of people with type two diabetes and one or more of the other eligible Tirzepatide comorbidities										
a) Total										
0	21	12	6	0	6	155	112	93	25	47
1	64	28	22	0	10	1304	773	513	111	75
2	58	20	15	2	4	2528	1556	891	198	69
3	12	9	8	0	1	1132	625	388	65	27
4	0	0	0	0	0	26	11	21	3	0
b) On insulin										
0	2	2	0	0	0	18	10	5	0	3
1	10	3	1	0	2	151	99	53	12	3
2	9	3	0	0	1	320	224	124	32	4
3	1	1	4	0	0	229	144	102	17	5
4	0	0	0	0	0	9	3	7	1	0
c) On GLP1 already										
0	3	2	0	0	0	8	8	12	4	0
1	1	6	2	0	1	193	139	121	27	2
2	6	3	3	0	0	300	276	212	69	3
3	3	1	1	0	0	125	116	94	14	1
4	0	0	0	0	0	8	4	8	2	0

TIRZEPATIDE ROLLOUT

Phase (Cohort)	Start Date	Eligibility Criteria	Notes
Cohort 1	2025/26	BMI ≥ 40 kg/m ² PLUS at least 4 of 5 weight-related health conditions*	Highest priority, earliest access; ethnic adjustments for BMI
Cohort 2	2026/27	BMI 35–39.9 kg/m ² PLUS at least 4 of 5 weight-related health conditions*	Expands eligibility; same comorbidity burden as Cohort 1
Cohort 3	2026 and 2027/28	BMI ≥ 40 kg/m ² PLUS at least 3 of 5 weight-related health conditions*	Reduces comorbidity threshold for highest BMI class
Further phases	To be reviewed	NICE to review and expand eligibility after 3 years (from June 2028)	Subsequent expansion and funding based on system capacity and review

*Qualifying co-morbidities – Type 2 Diabetes

Hypertension requiring blood pressure lowering medication,

Dyslipidaemia treated with lipid lowering therapy or $\uparrow$ LDL/TGs or $\downarrow$ HDL

Obstructive Sleep Apnoea

Established CVD

Case History 2

- **Mr TK**
- **Age** : 64years
- **Weight**: 143kg ; Height 170cm; BMI 49.5kg/m²
- **PMH**: Type 2 Diabetes, Hypertension, AF, OSA, OA, CKD 3, COPD, Curative Right Nephrectomy for Renal Cell Cancer in 2020, Painful Diabetic Peripheral Neuropathy, and Background Diabetic Retinopathy.
- **Medications**: Novomix 30 32units am and 40units pm, Metformin 1 grams bd, Linagliptin 5mgs od, Dapagliflozin 10mgs od, Amlodipine 10mgs od, Ramipril 5mgs od, Atorvastatin 20mgs nocte, Inhalers, Gabapentin 300mgs tds, Edoxaban 60mgs od, Aspirin 75mgs od,

GP Visit: For medication review



NICE TA1026 & Tirzepatide Access

Case Example: Mr TK – BMI 49.5 kg/m² with
Multimorbidity

Patient Overview – Mr TK

- Age: 64 years

- Weight: 143 kg | Height: 170 cm | BMI: 49.5 kg/m²

- Severe obesity with functional limitation

- On complex polypharmacy including insulin

Comorbidities – High Risk Profile

- ❑- Type 2 Diabetes (Insulin-treated)
- ❑- Hypertension / AF / CKD Stage 3
- ❑- COPD / OSA / Osteoarthritis
- ❑- Diabetic Neuropathy & Retinopathy
- ❑- Post-Nephrectomy for Renal Cell Cancer

Current Medication Burden

- ❑- Diabetes: Novomix 30, Metformin, Linagliptin, Dapagliflozin
- ❑- Cardiovascular: Amlodipine, Ramipril, Atorvastatin, Aspirin, Edoxaban
- ❑- Respiratory: Inhalers
- ❑- Pain: Gabapentin
- ❑- Insulin contributes to weight gain risk

NICE TA1026 – Eligibility Assessment



- BMI $\geq$ 40 WITH MULTIPLE OBESITY-RELATED COMORBIDITIES →  MEETS PHASE 1 COHORT



- TIRZEPATIDE CAN NOW BE INITIATED BOTH IN NHS SPECIALIST WEIGHT MANAGEMENT SERVICE AND ALSO IN PRIMARY CARE



- CONTINUATION CRITERIA: $\geq$ 5% TBWL WITHIN 6 MONTHS

Step 2 Assessment



Overweight and obesity management: Principles of care

2

Support me

- **Talk to me** in a sensitive, person-centred, developmentally appropriate and non-judgemental way.
- **Identify and explore** the terms I would prefer you to use.
- **Focus** on improvements in my health and wellbeing rather than simply talking about weight and obesity.
- **Stay positive**, supportive and solution based.
- **Take into account** my thoughts, views and cultural, religious or spiritual beliefs during our conversations.
- **Be mindful** of factors that apply to me that prevent or restrict weight loss (such as some medicines or comorbid conditions).
- **Ensure** my notes are up to date so other healthcare professionals know my views, what we have covered and agreed before, and why.

1

Respect me

- **Ask** my permission to discuss topics around overweight and obesity.
- **Respect** my choices, even if you do not agree with them.
- **Do not assume** all my symptoms are caused by my weight or obesity.
- **Explore** my decisions sensitively, or delay discussions to another time, if I do not wish to talk about any issue you have raised.

3

Know about my life

- **Think about** my family history and weight-related complications.
- **Be aware** of my weight history (and for children and young people, growth history), and previous experiences of related problems (such as eating disorders).
- **Take into account** my experiences of weight stigma, bullying and adverse experiences.
- **Think about** my family and personal context: daily life, ethnicity, culture, money worries, special needs and disabilities, mental health factors and stage in life.
- **Be aware** of my current medicine use and medical history.
- **Find out** if I am ready and able to engage with change. If not, how can you help me?
- **Talk about** how my friends and family can help (this is especially important for children and young people).

4

Help me when we talk

- **Use** non-stigmatising language and images.
- **Ensure** anything you give me to read or watch is suitable and tailored to my particular needs, such as Easy Read literature.
- **Ensure** conversations and communications are appropriate for my age, maturity and level of understanding. For children and young people make sure information is accurate for age (for example, BMI centile).
- **Give me time** to understand and process the information I have been given.
- **Ask me** if I have any questions, and make it clear you are happy for me to ask them either now or later on.

5

Understand how I feel

- **Think about** whether it is appropriate or important to discuss weight or obesity, or take measurements right now.
- **Think about** the impact on my body image or self esteem of taking measurements or the way they are done.
- **Understand** my weight may have been raised many times before.
- **Understand** that I might be affected by an eating disorder at any weight, and I might be vulnerable to disordered eating.
- **Be aware** of your own feelings, sensitivities and bias about weight and obesity.

Step 2 Assessment



Medical History

- Review medical history and comorbidities – confirm date of the last diabetic eye screening and the result
- Screen for OSA (e.g., Epworth Score)
- Discuss contraception/OCP/HRT if applicable and clinical contraindications



Psychological & Behavioural Screening

- Assess psychological readiness i.e. Insight/motivation/coping style/ mental health/support and self-efficacy
- Screen for eating disorder risk – binge eating disorder very common
- Discuss prior weight-loss attempts



Goal Setting & Expectations

- Set weight & comorbidity goals
- Identify personal motivation
- Align expectations with realistic outcomes



Lifestyle & Dietary Review

- Review dietary patterns
- Assess baseline physical activity
- Identify lifestyle barriers



Treatment Planning

- Agree medication plan & duration
- Discuss side effects & pancreatitis risk
- **Confirm wrap-around support**



Criteria for Continuation or Stopping

- Define expected treatment response
- Outline clear stop criteria
- Set follow-up & reassessment points

Step 2 – Baseline Measurements

- Weight
- Height
- BMI
- Blood pressure
- Routine bloods as applicable – FBC,TFTs, U&Es, HbA1c, Lipids , LFTs , B12, Folate etc (to consider setting up a dedicated Tirzepatide blood request panel – to be discussed with Biochemistry and ICE IT Team)
- Confirm date of the most recent diabetic eye screening and the result.

Mr AK

- BMI 49.5
- BP 138/72mmHg
- HbA1c 62mmol/mol(7.9%); eGFR >90mL/min
- Lipids profile unremarkable, no past history of gall stones or pancreatitis, LFTs normal, TFTs normal, Haematinics, B12 and Folate were also normal.
- Most recent eye screening 4 months ago - BDR
- Weight goals – none – said he wants to lose enough weight to be less breathless and to move about more. Weight loss of 10–15% is typically the evidence-based target for the highest probability of stopping CPAP in obese patients with OSA.

Step 3 - Commencement

- ☐ Confirm start date of wrap around care
- ☐ Revisit dietary intake, level of physical activity, provide personalized dietary advice – aim for 1.2 to 1.6grams of protein per kg of ideal body weight or about 20 – 30% total calories to preserve lean muscle mass and support satiety.
- ☐ Discuss importance of physical activity to preserve lean muscle mass – resistance training.
- ☐ Start with the lowest dose for GLP 1 naive patients i.e. Tirzepatide 2.5mgs.
- ☐ Provide Mounjaro Pen device training, sharps bin, appropriate size of pen needles.
- ☐ Review medications and adjust accordingly – Diabetic Meds especially.
- ☐ Discuss dose titration



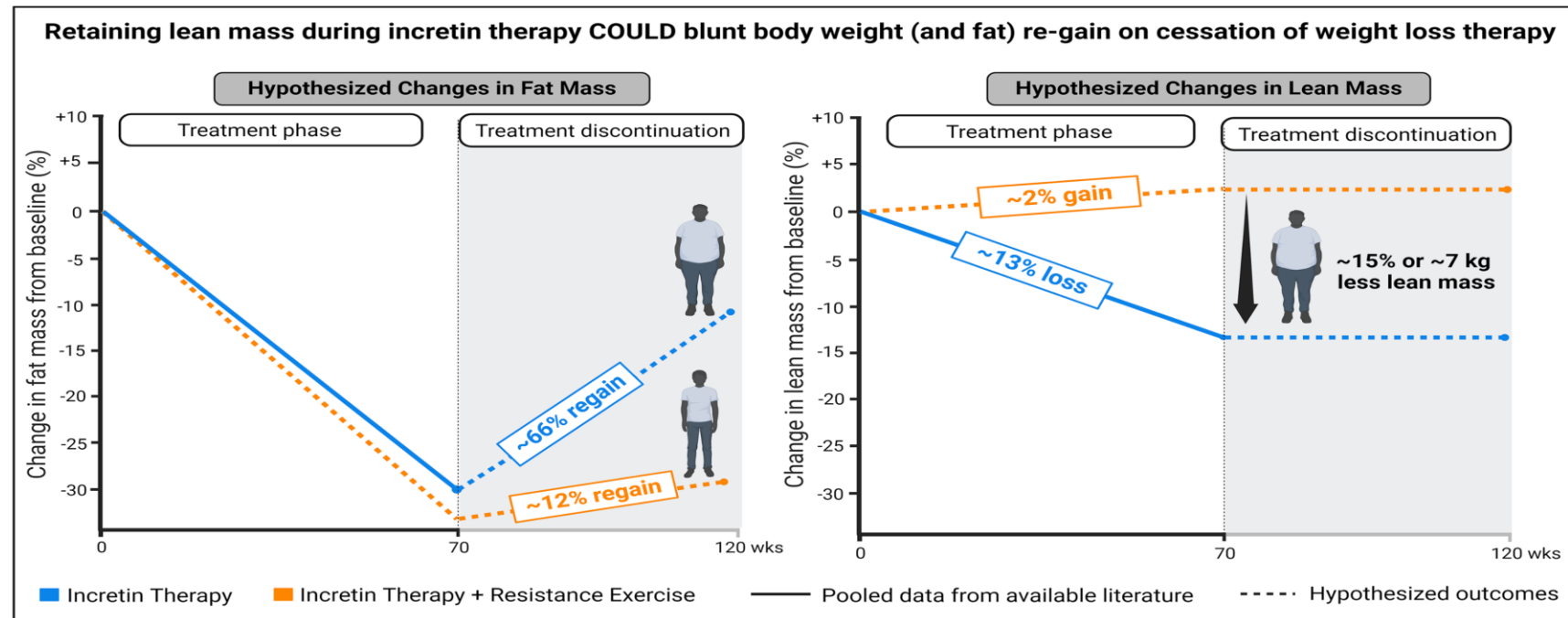
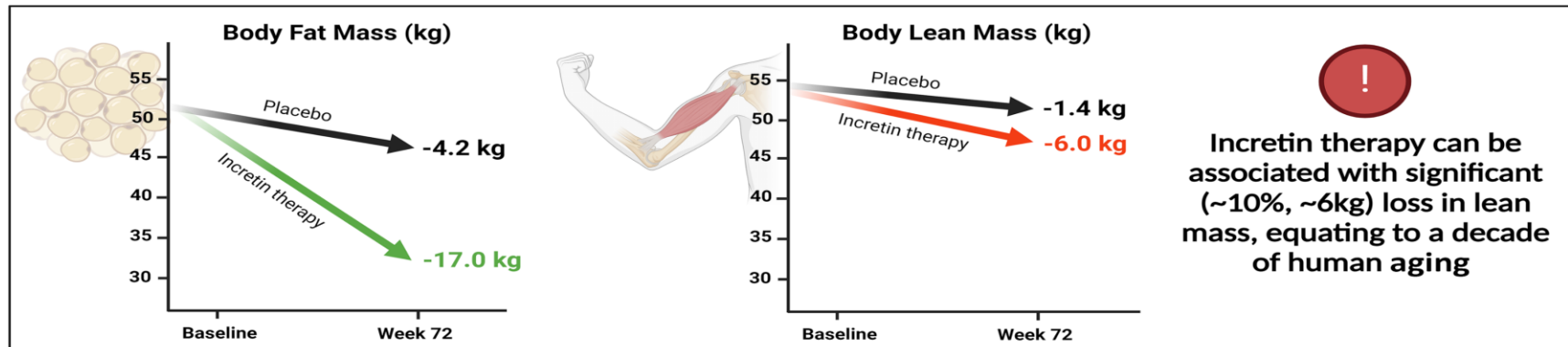
Step 3 –Initiation /review of medications

- Mr AK
- Novomix 30 32units am and 40units pm, - meets criteria for CGM , reduce am and pm insulin by 20 to 30%
- Metformin 1 grams bd, - continue same dose
- Linagliptin 5mgs od, - stop
- Dapagliflozin 10mgs od, - continue same dose
- Amlodipine 10mgs od, - continue same dose
- Ramipril 5mgs od, - continue same dose
- Atorvastatin 20mgs nocte, - continue same dose
- Inhalers, - continue same regime
- Gabapentin 300mgs tds, - continue same dose
- Edoxaban 60mgs od, - continue same dose
- Aspirin 75mgs od, - continue same dose

Step 4: 4 weekly reviews and titration

Week(s)	Dose (mg)	Frequency
Weeks 1–4	2.5 mg	Once weekly
Weeks 5–8	5 mg	Once weekly
Weeks 9–12	7.5 mg	Once weekly
Weeks 13–16	10 mg	Once weekly
Weeks 17–20	12.5 mg	Once weekly
Weeks 21+	15 mg	Once weekly

- ☐ Standard rapid titration schedules are often not tolerated in real-world practice.
- ☐ In my practice, I use a slower, tolerance-led titration based on individual response and side effects.
- ☐ If the patient is losing more than 2kg per month, I maintain the current dose rather than escalating.
- ☐ I only increase the dose once weight loss is < 1.5kg a month or the patient reports increased appetite.



Step 4 : Mr TK

- Review at 4 weeks – overnight fasting glucose averages 6mmol/L – reported early morning hypo, before evening meal 8mmol/L. Checked BP 120/64mmHg. On NoVo mix 30 20units AM and 20units PM. Weight 140kgs. Starting to feel more hungry compared to the first week.

Action – Advised to reduce dose further to 18units AM and 16units PM.

Stop Dapagliflozin

Reduce the dose of Amlodipine to 5mgs OD

Increase the dose of Mounjaro to 5mgs SC OW

Step 4: Mr AK Week 8

- Review at 4 weeks – overnight fasting glucose averages 5.9mmol/L. Before evening meal 7mmol/L Checked BP 128/66mmHg. On NoVo mix 30 18units AM and 16units PM. Weight 137kgs. Slight nausea – manageable, constipated(laxatives prescribed), indigestion – no abdominal pain – PRN PPI Prescribed. LFTs requested.

Action: Continue same dose of Mounjaro 5mgs SC OW

Reduce AM Novomix to 16units AM and PM to 14units PM

PRN Laxatives

PRN PPI; Request LFTs

Step 4 – 4 weekly reviews up to 12months

- Measure weight, calculate BMI, calculate percentage weight loss from baseline, measure BP, Review glucose profile.
- Review diet, physical activity, engagement with wrap around care, any psychological issue, consider OTC vitamin and mineral supplement.
- Review medications
- Titrate dose according to rate of weight loss, aiming to minimize accelerated weight loss, guided by tolerance and side effects
- Titrate to the maximum tolerated dose
- Review at 6months on the maximum tolerated dose , review bloods

Step 5 – Year 2

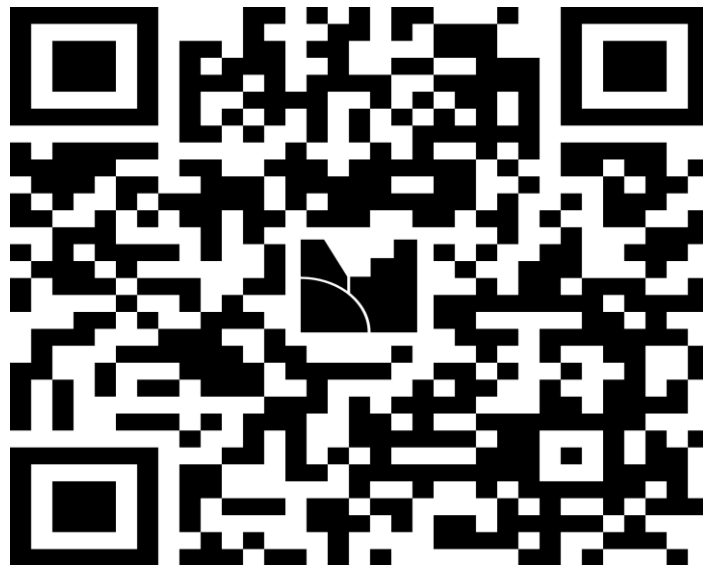
- ❑ Most weight loss occur in the first year – often in the first 6 months.
- ❑ In the 2nd Year review at 3 months, 6months, 9 months and 12months.
- ❑ Begin focusing on weight maintenance strategies in year 2 , in preparation for stopping Tirzepatide at 24months.
- ❑ Weight loss maintenance strategy



Year 2 Challenges

What do you think is the biggest challenge in Year 2 of treatment?

Scan QR code or visit www.menti.com and enter the session code:**2834 2913**



Join at menti.com | use code 2834 2913

 Mentimeter

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Weight maintenance after initial loss

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Protein and muscle preservation

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Patient engagement once appetite returns

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Planning to stop medication at 24 months

Weight Loss Maintenance Strategies

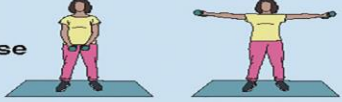
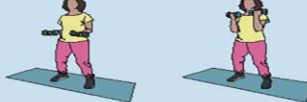
Strategy	Action/Outcome/Brief explanation
Physical activity	≥150 min/week plus resistance exercises
Protein-rich, balanced diet	Satiety, muscle preservation, metabolic support
Self-monitoring	Weight/food/activity tracking
Habit-based behaviour change	Daily routines, meal planning
Mindful eating	Slow eating, hunger cues
Portion/calorie control	Conscious energy intake, avoid excess

Step 5: MR AK Week 52

- ❑ Weight reduced from 143kg to 121 kg, achieving a 15.4% total weight loss.
- ❑ No longer requires CPAP; breathing has improved and walking tolerance has significantly increased.
- ❑ NoVo mix 30 has been stopped — currently maintained only on Metformin 1 g BD, Amlodipine 5 mg OD, and Ramipril 5 mg OD; all other medications unchanged.
- ❑ Tirzepatide titrated up to 12.5 mg SC once weekly — 15 mg dose not tolerated.
- ❑ Tirzepatide Dose reduction discussed, but patient prefers to remain on 12.5 mg due to fear of weight regain.

Examples of Foods with ~20g of Protein per Serving

Food	Portion Size	Protein (approx.)
Grilled chicken breast	3 oz (85 g)	26 g
Cooked salmon	3.5 oz (100 g)	22 g
Canned tuna	½ cup (115 g)	25 g
Extra-firm tofu	1 cup (150 g)	20 g
Greek yogurt (plain, nonfat)	7 oz (200 g)	18–20 g
Cottage cheese (low-fat)	¾ cup (180 g)	20–22 g
Lean ground beef (90% lean)	3 oz (85 g)	22 g
Pork tenderloin	3 oz (85 g)	22 g
Tempeh	3 oz (85 g)	16–20 g
Cooked lentils	1 cup (200 g)	18 g
Seitan (wheat protein)	1 oz (30 g)	~21 g
Protein powder (whey or plant-based)	1 scoop (25–30 g)	20–25 g

Major Muscle Group, accessory muscle group	Example Exercises	
Pectoralis, anterior deltoids, triceps	Chest press 	Push-up 
Deltoids	Shoulder press 	Shoulder raise 
Rhomboids, latissimus dorsi, rear deltoids, biceps	Seated row 	Bent-over row 
Triceps brachii	Triceps extension 	
Biceps brachii	Biceps curl 	
Quadriceps, Hamstrings, and Gluteals	Squat 	Lunge 
Gastrocnemius, soleus	Calf raise 	
Abdominals, obliques	Abdominal crunch 	
Quadratus lumborum	Back extension 	

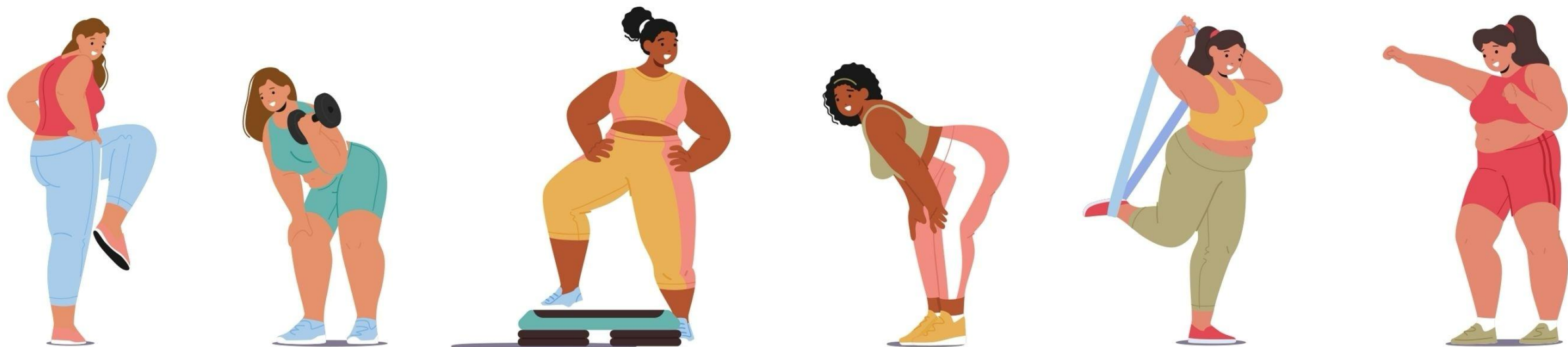
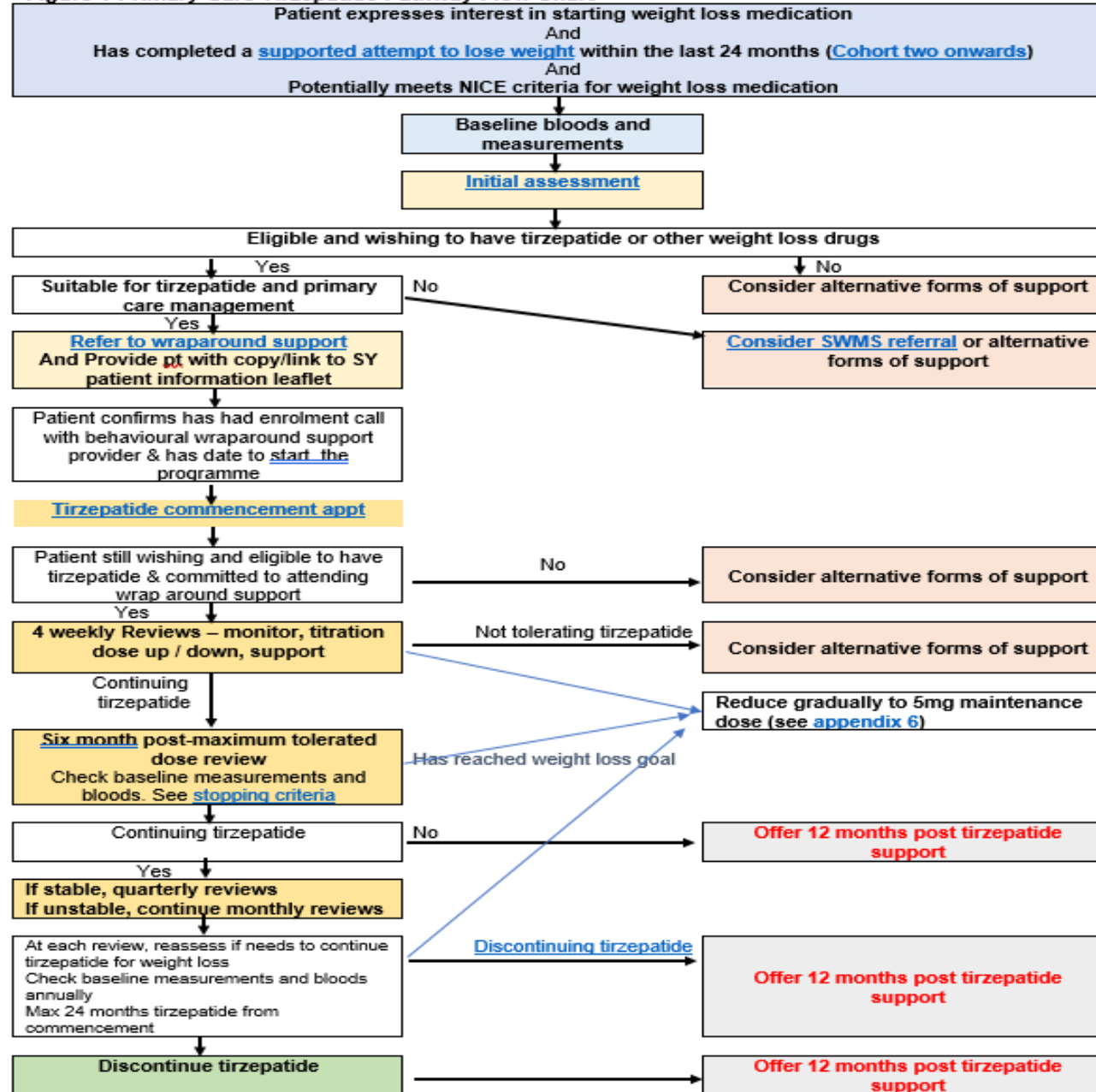


Figure 1 Primary Care Tirzepatide Pathway Flow Chart



Tirzepatide for weight management
Under the rollout programme is limited to a maximum of 24 months from the start date for SY.

Case History 3

- Ms KH
- Age: 38years
- Weight: 125kg Height 172m BMI 42kg/m²
- PMH: PCOS, Overactive Bladder, Asthma, Anxiety and Depression
- Mediations: Fexofenadine 180mgs od, Pregabalin 50mgs bd, Citalopram 20mgs od, Mirabegron 50mgs od, Monteluklast 10mgs od, Trimbow Inh, Salbutamol Inh, Mebeverine 135mgs tds

GP Visit: Abdominal pain

Case 3 contd

- ❑ Appeared to have lost so much weight.
- ❑ Weight 98kg, BMI 33.1
- ❑ Has been purchasing Mounjaro online for the past 4 months and has lost 4 stones, reporting high satisfaction with the result.
- ❑ Abdominal pain started last week but will away.

What will you do?

Take Home Points

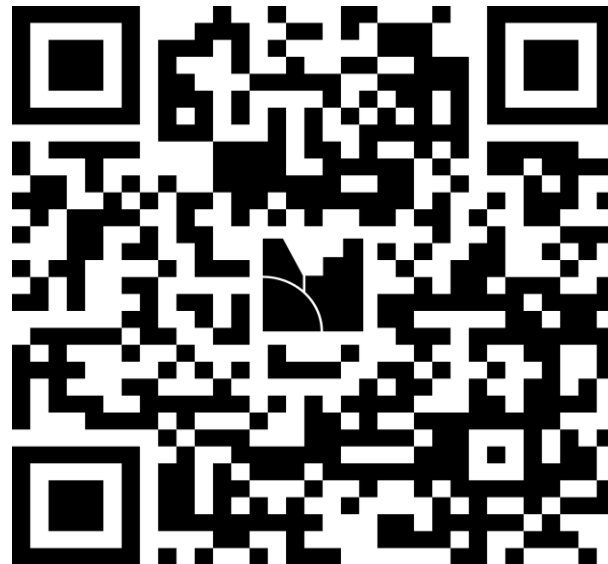
- ❑ Obesity is a chronic, relapsing condition driven by both biological and social factors.
- ❑ NICE NG246 emphasises early MDT involvement and personalised, patient-centred care plans.
- ❑ Tirzepatide is now approved for initiation and follow-up in primary care for eligible patients.
- ❑ Sustaining weight loss requires ongoing support, protein-optimised nutrition, and physical activity.
- ❑ Primary care has a key role in identifying, initiating support, and regularly reviewing patients throughout the obesity pathway.



Confidence with Prescribing Tirzepatide

How confident do you currently feel about initiating Tirzepatide in primary care?

Scan QR code or visit www.menti.com and enter the session code: **6272 3822**



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Very confident — ready to
prescribe

0

Somewhat confident — but need
a clear protocol

0

Not confident yet — concerned
about follow-up / safety

0

Unsure — waiting to see how
rollout works