Weight Management Clinical Pathway for Adults

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Version 1.0

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Document Control

The latest and master versions of this document are held by the Clinical and Quality Portfolio Pan GM

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Approvals

This document must be approved by the following before distribution:

Name	Date approved	Version
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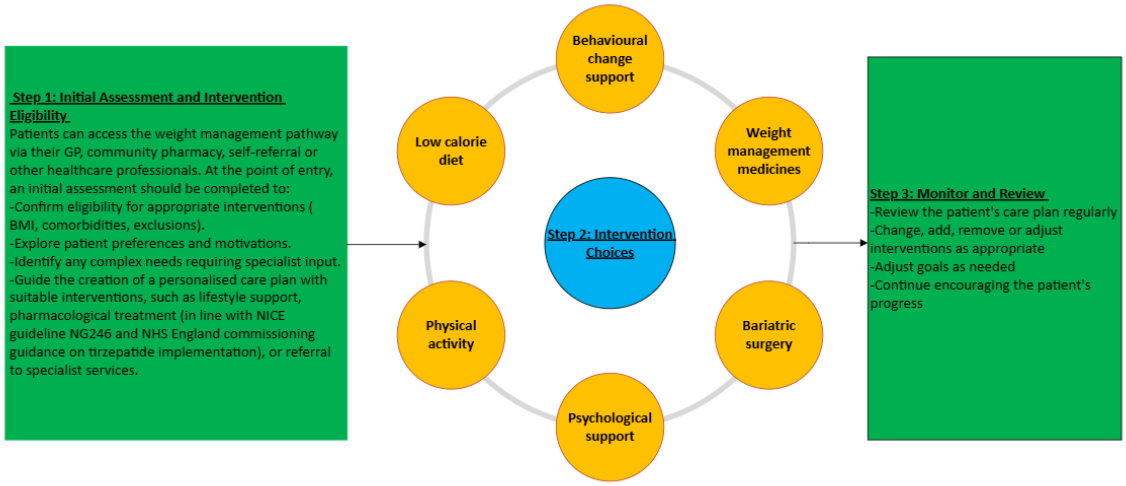
1.Introduction

Obesity affects 27.1% of adults in Greater Manchester, with an estimated cost of £3.2 billion in 2023. This condition impacts both individual health and healthcare resources. Addressing obesity through an evidence-based approach is essential for improving outcomes and reducing healthcare costs.
This pathway offers a structured, patient-centred approach to managing obesity, overweight, and central adiposity in adults, integrating lifestyle interventions, pharmacological treatments, bariatric surgery and regular reviews.

2.Purpose of the Pathway

This clinical pathway provides a practical guide for healthcare professionals across Greater Manchester, promoting consistent, evidence-based care for adults affected by obesity, overweight and central adiposity. It aims to improve patient outcomes through structured management and ongoing support.
The diagram below summarises the clinical pathway, from initial assessment to interventions and reviews.



3. Identifying and Assessing Overweight and Obesity in Adults

Assessment of overweight, obesity and central adiposity should be conducted sensitively and with patient consent. The following principles apply:

- Body Mass Index (BMI) is the primary indicator for classifying overweight and obesity.
- For adults with a BMI <35 kg/m², measurement of waist circumference to calculate the waist-to-height ratio is recommended to assess central adiposity and associated health risks. A waist-to-height ratio ≥0.5 indicates increased risk. A ratio ≥0.6 indicates further increased risk.

3.1 Classification of overweight and obesity

BMI categories are as follows:

- Healthy weight: 18.5–24.9 kg/m²
- Overweight: 25.0–29.9 kg/m²
- Obesity Class 1: 30.0–34.9 kg/m²
- Obesity Class 2: 35.0–39.9 kg/m²

- Obesity Class 3: ≥40.0 kg/m²

BMI and waist-to-height ratio should be interpreted with clinical judgement, particularly in adults aged ≥65 or those with high muscle mass.

People with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean background are prone to central adiposity, and their cardiometabolic risk occurs at a lower BMI. Therefore, lower BMI thresholds should be used as a practical measure of overweight and obesity:

- Overweight: BMI 23–27.4 kg/m²
- Obesity: BMI ≥27.5 kg/m²

3.2 Assessment of comorbidities

Following initial assessment it is recommended to :

- Identify comorbidities and any additional factors that may affect or be affected by the person's weight.
- Take into account the degree of excess weight, its duration, and any prior assessments.
- Begin managing comorbidities immediately; weight loss should not be a precondition for treatment.

4. Weight Management Intervention Choices

Weight management follows a stepped approach, guided by clinical assessment, eligibility, patient preferences, and treatment response. After assessment, the appropriate starting point should be agreed upon with the patient.

In line with NICE NG246, dietary, physical activity, and behavioural interventions should be initiated and evaluated before considering pharmacological or surgical options.

The treatment options outlined below are recommended in accordance with NICE guidance and local clinical priorities, ensuring a tailored approach to each patient's needs.

A range of NHS advice and tools to support weight loss and help patients get started is available here. This includes the downloadable NHS Weight Loss Plan and information on the links between weight and health conditions such as type 2 diabetes.

5. First-Line Treatment: Dietary, Physical Activity, and Behavioural Interventions

Initial treatment should focus on evidence-based interventions, including dietary modifications, increased physical activity, and behavioural strategies. These interventions should be tailored to the individual's needs and circumstances to support sustainable, long-term weight management.

5.1 Locally Commissioned Public Health Services (sometimes referred to as tier 2 services)

- Usually include structured support programmes, often delivered over 12 weeks
- Focus areas may include low-calorie diet education, increased physical activity, and behavioural change support

- Service models, availability, and eligibility criteria vary by GM locality (usually BMI 25–30) and some areas are moving toward holistic, stigma-aware approaches within broader healthy lifestyle pathways
- Most services allow self-referral

5.2 Locally Available Community Resources

In addition to commissioned services, local community-based initiatives offer supportive tools to help individuals increase activity and adopt healthier habits. These include:

- Bee Active – Active travel (cycling and walking)
- GM Walking – Walking groups
- Social prescribing services
- MECC Very Brief Advice – Physical Activity and Healthy Diet
- Green Social Prescribing - GMnatureforhealth

5.3 NHS Digital Weight Management Programme

This 12-week online behavioural and lifestyle programme is available to individuals who meet defined criteria and can access support via a smartphone or computer with internet access.

- Members of the public can be referred via GP practice or community pharmacy
- Eligibility criteria:
  - Aged 18 and over
  - Body mass index (BMI) of 30 or more (adjusted to ≥27.5 for people from Black, Asian and ethnic minority backgrounds)
  - Diagnosis of diabetes (type 1 or type 2), hypertension, or both
- Exclusion criteria:
  - Moderate or severe frailty
  - Pregnancy
  - Active eating disorder
  - Bariatric surgery in the last two years
  - People for whom a weight management programme is considered to pose greater risk of harm than benefit.
- For people aged over 80 years, the referrer will need to confirm on the referral form that a weight management programme is considered likely to pose greater benefit than harm.

5.4 Specialist Weight Management Services (sometimes referred to as tier 3 services)

Where more intensive support is required due to complexity of need or insufficient response to interventions listed in sections 5.1,5.2 and 5.3, referral to Specialist Weight Management Services (SWMS) should be considered.

Key features of SWMS :

- Multidisciplinary, case-managed support
- Delivery through face-to-face and group-based interventions
- Comprehensive outcome monitoring
- Service availability and eligibility criteria vary across GM (usually BMI 35 and above)

- Patients must be referred by their GP

6. Second-Line Treatment: Pharmacological Interventions

- After dietary changes, increased physical activity, and behavioural interventions have been initiated and assessed, weight management medications may be considered, typically when lifestyle interventions alone do not lead to sufficient weight loss or when a patient has more complex needs.
- These medications should always be used alongside a reduced-calorie diet and increased physical activity to support weight management.
- NICE-approved medications for weight management include options such as orlistat (long-acting inhibitor of gastrointestinal lipases), liraglutide (GLP-1 receptor agonist), semaglutide (GLP-1 receptor agonist), and tirzepatide (long-acting GIP and GLP-1 receptor agonist), which should be prescribed when appropriate, based on individual patient needs, clinical judgement and in line with local commissioning arrangements. Please see Table 1 for further information on the treatment options available in Greater Manchester.

Table 1: Pharmacological treatment options in Greater Manchester

	Tirzepatide	Semaglutide	Liraglutide	Orlistat
Treatment GM RAG status	Interim Red RAG status (anticipated to change to Green/Grey from June 2025)	Red RAG status	Red RAG status	Green RAG status
Treatment eligibility criteria	Please see section **5.1** for further information Can only be prescribed if wrap around care is available and only for patients who agree to undertake the wrap around care support.	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.* Use lower BMI thresholds (reduced by 2.5 kg/m^2) for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds.	An initial BMI of 35 kg/m^2 or more **and** non-diabetic hyperglycaemia **and** a high risk of cardiovascular disease.* Use lower BMI thresholds (reduced by 2.5 kg/m^2) for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds.	A BMI of 30 kg/m^2 or more **or** a BMI of 28 kg/m^2 or more and associated risk factors.
Setting	Prescribed in primary care (from June 2025) or a specialist overweight and obesity management service (from March 2025)	Prescribed in a specialist overweight and obesity management service.	Prescribed in secondary care by a specialist overweight and obesity management service.	Prescribed in all settings and available in a lower dose from a pharmacy.
Route and frequency	Weekly subcutaneous injection.	Weekly subcutaneous injection.	Daily subcutaneous injection.	Oral capsule, up to 3 times a day.
Pregnancy	Do not use (refer to tirzepatide SPC)	Do not use (refer to semaglutide SPC)	Do not use (refer to liraglutide SPC)	Caution in pregnancy (refer to orlistat SPC)
When to consider stopping the treatment	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.
Total length of treatment recommended by NICE	Tirzepatide does not have a defined stopping rule or maximum treatment duration. Decisions regarding ongoing prescribing should be made on a case-by-case basis by an appropriately trained healthcare professional, in consultation with the patient, and based on clinical response and engagement with wraparound care.	Use for a maximum of 2 years, and within a specialist weight management service providing multidisciplinary management of overweight or obesity.	Liraglutide is recommended for use within specialist weight management services, which are usually accessed for up to 2 years.	Not specified by NICE and in the orlistat SPC.

*** Note: Eligibility criteria for semaglutide and liraglutide currently reflect the NICE TAs. NHS GM is proposing to align these with the NHSE-defined criteria used for tirzepatide. This proposed change is pending.**

6.1. Tirzepatide

- Tirzepatide is a long-acting GIP and GLP-1 receptor agonist used in the management of obesity, particularly in patients with significant health risks related to their weight. It is prescribed through both primary care and specialist services, but due to high demand and limited resources, eligibility must be carefully managed.
- Initially, it will not be accessible to all patients, but will be prioritised for those with the greatest health needs and the most significant health risks related to obesity.

- NHS England has defined three cohorts of eligible patients based on clinical prioritisation criteria and timelines for rollout. These cohorts are outlined in Table 2 below and comorbidities linked to eligibility criteria defined by NHSE are outlined in Table 3 below.

Table 2: Staged Implementation of Tirzepatide Treatment (3-Year Plan) Based on NHSE Eligibility Criteria

Funding variation year	Estimated cohort duration	Cohorts	Comorbidities	BMI
Year 1	12 months	I	4 or more qualifying comorbidities (hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes mellitus	40 or more*
Year 2	9 months	II	4 or more qualifying comorbidities (hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes mellitus	35-39.9*
Year 2/3	15 months	III	3 qualifying comorbidities (hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes mellitus	40 or more*

*For people from minority ethnic backgrounds (South Asian, Chinese, other Asian, Middle Eastern, Black African, African-Caribbean), lower BMI thresholds (reduced by 2.5 kg/m^2) should be applied

Table 3: Comorbidities for Tirzepatide Prescribing as Defined by NHS England

Qualifying comorbidities	Definition
Atherosclerotic cardiovascular disease (ASCVD)	Established Atherosclerotic CVD (Ischaemic heart disease, cerebrovascular disease, peripheral vascular disease, heart failure)
Hypertension	Established diagnosis of hypertension and requiring blood pressure lowering therapy.
Dyslipidaemia	Treated with lipid-lowering therapy, or with low-density lipoprotein (LDL) greater than or equal to 4.1 mmol/L, or high-density lipoprotein (HDL) <1.0 mmol/L for men or HDL <1.3 mmol/L for women, or fasting (where possible) triglycerides greater than or equal to 1.7 mmol/L
Obstructive Sleep Apnoea (OSA)	Established diagnosis of OSA (sleep clinic confirmation via sleep study) and treatment indicated i.e. meets criteria for CPAP or equivalent
Type 2 Diabetes	Established type 2 diabetes

- All patients prescribed tirzepatide must receive wraparound care, including reduced-calorie diet and increased physical activity, to optimise outcomes.
- Wraparound care is already established in specialist services and should continue as part of commissioned service.
- Wraparound care in primary care will become available from June 2025 and will be directly commissioned by NHS England during 2025/26.
- If less than 5% of the initial weight has been lost after 6 months on the highest tolerated dose, a decision should be made whether to continue treatment, taking into account the benefits and risks of treatment for the person.
- Tirzepatide does not have a defined stopping rule or maximum treatment duration. Decisions regarding ongoing prescribing should be made on a case-by-case basis by an appropriately trained healthcare professional, in consultation with the patient, and based on clinical response and engagement with wraparound care.
- Tirzepatide may reduce the effectiveness of oral contraceptives. Women using tirzepatide and oral contraception should switch to a non-oral contraceptive method, or add a barrier method of contraception, for four weeks after initiation and for four weeks after each dose increase
- Tirzepatide has been assigned an interim RED RAG status by the GMMMG Clinical Reference Group. From 24 March 2025, prescribing is restricted to specialist weight management services in GM for patients within Cohort 1 (as per Table 2).
- Prescribing in primary care will be permitted from 23 June 2025, with an anticipated RAG status change from RED to GREEN/GREY, initially restricted to patients defined in Cohort 1(as per Table 2).

7. Second-line treatment – Bariatric Surgery (sometimes referred to as Tier 4 service)

- NICE recommends a multicomponent approach to managing obesity, which includes dietary advice, exercise, lifestyle changes, and medication. Bariatric surgery is recommended as an option for some patients with obesity and other significant health conditions, who have not lost sufficient weight through other methods.
- Referral for a comprehensive assessment by specialist overweight and obesity management services, which provide multidisciplinary management of obesity, is recommended to determine if bariatric surgery is suitable for patients who meet the following criteria:
    - Have a BMI of 40 kg/m² or more, or a BMI between 35 kg/m² and 39.9 kg/m² with a significant health condition that could be improved with weight loss (use lower BMI thresholds, reduced by 2.5 kg/m², for individuals from South Asian, Chinese, other Asian, Middle Eastern, Black African, or African-Caribbean ethnic backgrounds, as these groups are more prone to central adiposity and experience cardiometabolic risk at lower BMI) **and**
    - Agree to the necessary long-term follow-up after surgery (for example, lifelong annual reviews).
- Conditions that may improve after bariatric surgery include: cardiovascular disease, hypertension, idiopathic intracranial hypertension, non-alcoholic fatty liver disease (with or without steatohepatitis), obstructive sleep apnoea, and type 2 diabetes.

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