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UK Healthcare and
Life Sciences Innovation

From Access to Outcomes:

**Building the Treasury
and Delivery Case for
Integrated Obesity Care**

*Findings from the 2026
Parliamentary Obesity Summit
and a programme for Strategic
Innovation Gateways*



Purpose of This Report

A policy and delivery report translating the summit discussion into a Treasury-facing case and a practical programme for NHS systems.

The 2026 summit was designed to move the national conversation from access to treatment towards safe implementation, measurable long-term outcomes, productivity gains, and system-wide delivery. This report draws together what participants said and sets out what that evidence means for the next phase of work: a credible economic case for government and a series of Strategic Innovation Gateways led by UK Healthcare and Life Sciences Innovation (UKHLSI) with integrated care systems (ICSs).

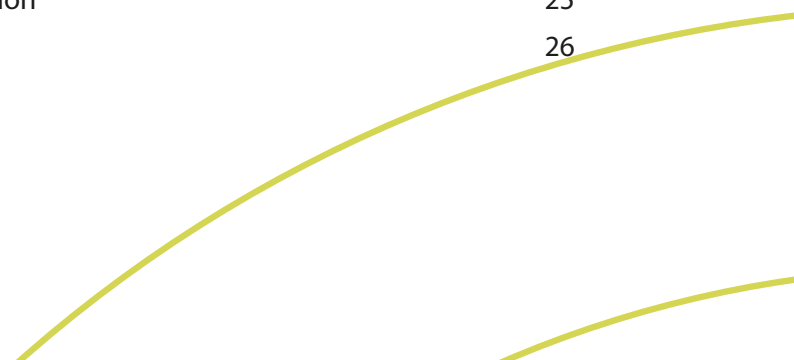
The central proposition is that the value of obesity care cannot be judged by short-term weight loss or by the cost of medicines alone. It must be assessed through a whole-pathway model that measures cardiovascular, renal, and metabolic outcomes; service use; mental wellbeing; trust and safety; workforce participation; inequalities; and the long-term cost of inaction.

Acknowledgements

The summit was hosted in the House of Lords with the support of Baroness Goudie, and chaired by Rt Hon Andrew Stephenson CBE, Chair of Curia's Health, Care and Life Sciences Research Group. The event was commissioned by UKHLSI. OneScript by Blueco and Bolt Pharmacy supported the event. Numan, Sword Intelligence, and other Curia and UKHLSI members contributed to the discussion.

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Forewords

Building Obesity Care Around Safety, Trust, and Lived Experience

Obesity is too often treated as a question of individual responsibility rather than as a chronic, relapsing condition shaped by biology, trauma, inequality, environment, and access to care. For many people, the pathway begins not with support, but with judgement, delay, and repeated thresholds. By the time treatment is offered, trust may already have been lost.

This report sets out why that must change.

The Parliamentary Obesity Summit brought together clinical leaders, policymakers, industry, community organisations, and people with lived experience around a shared challenge: how to move from isolated interventions towards safe, integrated, and sustainable care. The discussion showed that the issue is no longer simply whether effective treatments exist. It is whether the system is ready to deliver them consistently, equitably, and over the long term.

Curia's work with West Yorkshire demonstrated that system readiness does not happen automatically. It requires time, trust, and a shared understanding of the problem. Clinicians, commissioners, pharmacists, industry and independent sector partners, public health teams, community partners, and people with lived experience must be brought together around one pathway and one set of outcomes.

That pathway must be personalised from the first conversation, recognising that obesity care is not one-size-fits-all. It should reflect the individual's clinical needs, circumstances, preferences, and lived experience, with trauma-informed support where indicated. It must ask what support the person needs, what may affect their ability to engage, and what will help them remain engaged over the long term. It must also recognise that maintenance and re-entry are part of treatment, not evidence of failure.

The Strategic Innovation Gateway programme proposed in this report offers a practical route from ambition to implementation. It can help NHS systems redesign pathways, build the evidence base and demonstrate the wider value of earlier intervention.

The cost of doing nothing is not only financial. It is measured in lost health, lost trust, lost opportunity, and lives spent navigating services that were not designed around the people who need them.

This programme is an opportunity to build something better.

Professor Mike Bewick
Chair, Obesity Working Group
and Advisory Board, Curia, Health, Care,
and Life Sciences Research Group



Turning Innovation Into Integrated, Scalable Delivery

The national conversation on obesity has moved forward. There is now greater recognition of obesity as a serious, chronic health condition, alongside growing access to medication and other clinical treatment options. But access to treatment alone will not deliver the outcomes patients, the NHS, or the economy needs.

The next challenge is implementation.

This report translates the findings of the 2026 Parliamentary Obesity Summit into a practical programme for action. It sets out how integrated obesity care could improve health, reduce inequalities, support workforce participation, and generate better public value. It also makes clear that these outcomes will not be achieved through medicines, digital tools, or individual services operating in isolation.

The summit heard that fragmented pathways produce fragmented outcomes. Separate thresholds, budgets, service tiers, and data systems make it difficult for patients to access timely care and for commissioners to understand the full value of intervention. Short-term programmes are poorly matched to a condition that requires long-term support, continuity, and the ability to re-enter care when circumstances change. The summit also heard that some of the most developed long-term models are currently being delivered outside traditional NHS pathways, particularly through independent-sector digital health services that combine medication with ongoing clinical oversight, behavioural support, and wider holistic care.

UKHLSI was established to help close the gap between policy ambition, the adoption of innovation, and delivery. Through our Strategic Innovation Gateway model, we bring NHS and independent sector systems, clinicians, patients, industry, and community partners together to address a defined challenge, assess readiness, and create a governed route to adoption.

The proposed programme will build on this approach. It will support integrated care systems to design and test pathways while generating the economic and real-world evidence required by government and HM Treasury. It will also ensure that trauma-informed practice, equity, workforce capability, and community delivery are treated as core components of the service model.

The opportunity is significant, but so is the need for discipline. Industry support must strengthen independent evidence and implementation capacity, not influence clinical decisions or programme findings.

Our focus now must be on delivery. As we said at the summit, when we say action, we mean action.

Jo Bekis
Chief Executive, UK Healthcare and
Life Sciences Innovation (UKHLSI)



Making the Clinical, Economic, and Delivery Case for Reform

Obesity is one of the clearest examples of a challenge that cannot be addressed by one treatment, one profession, or one part of government. Its consequences are experienced across primary care, hospitals, mental health services, social care, workplaces, families, and the wider economy.

Yet the way services are organised remains fragmented.

The 2026 Parliamentary Obesity Summit was convened to move the discussion beyond recognition of the problem and towards the practical questions of delivery. Which patients should receive support? How should clinical treatment connect with psychological, behavioural, and community services? How can local systems demonstrate value? And what evidence will government and HM Treasury need before making long-term investment decisions?

The discussion reinforced the importance of treating obesity within a wider cardiovascular, renal, metabolic, and mental health framework. Patients rarely experience conditions in isolation, and services should not be designed as though they do. Earlier intervention can improve health and prevent disease progression, but only where it is supported by credible pathways, a trained workforce, and long-term follow-up.

This report also recognises the realities facing NHS leaders. Investment decisions are often made within short financial cycles, while many of the benefits of prevention emerge over several years and across different public budgets. A convincing case must therefore be honest about the difference between immediate savings, released capacity, avoided future costs, and wider economic value.

The proposed Strategic Innovation Gateways provide an opportunity to address this challenge through delivery. By working with a small number of integrated care systems, the programme can test how pathways operate under real-world conditions, establish common outcomes, and identify what is required for wider adoption.

National policy must provide direction, but sustainable reform will depend on local implementation. That means aligning clinicians, commissioners, communities, patients, and delivery partners around shared objectives, transparent governance, and measurable outcomes.

The task now is to build the evidence, demonstrate what works and give NHS systems the confidence and practical support to deliver integrated obesity care consistently across the country.

Rt Hon Andrew Stephenson CBE
Chair, Curia, Health, Care, and
Life Sciences Research Group





The roundtable brought together voices from across the obesity care landscape to explore how policy ambition can be translated into better, more integrated outcomes for patients.

Executive Summary

The case emerging from the summit is both economic and operational: the UK needs to invest earlier, design services around people and demonstrate value through real-world delivery.

The Central Proposition

Obesity should be treated as a chronic, relapsing condition within a wider cardiovascular, renal, and metabolic framework. Medicines can create major health benefit, but only when they sit inside integrated, trauma-informed, and culturally intelligent pathways that support people over the long term.

What the Summit Heard

- Obesity is a driver of multimorbidity, not a standalone lifestyle issue. Participants argued that treating it earlier can reduce cardiovascular risk, kidney disease, hypertension, diabetes, and wider long-term demand.
- The current pathway is fragmented. Separate tiers, thresholds, commissioning budgets, and specialist silos make it hard for people to receive timely, joined-up support.
- Regulated digital providers are already supporting millions of patients in the UK within CQC-registered and GPhC-regulated pathways, often with clinical oversight, behavioural support, and long-term monitoring built into the model. They have the potential to support NHS delivery channels, expand capacity, and provide an important source of real-world evidence for commissioners.
- Access without pathway redesign will not deliver sustained outcomes. Medication should be combined with psychological, behavioural, clinical, digital, and community support, with maintenance rather than discharge as the default.
- Trauma and weight stigma are delivery issues as well as ethical issues. The Numan State of Obesity Report 2025 found that 55 per cent of working-age adults surveyed had felt judged by a healthcare professional because of their weight. This rose to 68 per cent among people living with overweight or obesity, including 22 per cent who experienced this often or always. Such experiences can affect first contact, disclosure, trust, adherence, continuity, and willingness to return to care, weakening both clinical outcomes and the return on investment.¹
- Community delivery must go beyond NHS estate. Pharmacies, workplaces, faith organisations, voluntary groups, local high street businesses, regulated digital platforms, and other trusted settings can reach people who do not engage with conventional services.
- The evidence base is dispersed. NHS, local government, and private digital providers hold valuable data, but it is not routinely linked to show long-term outcomes, inequalities, service use, and economic impact.
- Local systems can be ready to act. As demonstrated through the work Curia and UKHLSI delivered with West Yorkshire Health and Care Partnership, their example as an ICS showed that bringing clinicians, public health, pharmacy, lived experience, and commissioners around one pathway can create a platform for mobilisation, but systems need implementation support and sustainable funding.²

1 <https://www.numan.com/weight-loss/the-state-of-obesity>

2 Reframing Obesity: From Stigma To System Reform, www.chamberuk.com/publications

What the Treasury Case Must Show

A persuasive Treasury case must distinguish between cash-releasing savings, avoided future cost, and wider public value. It must use realistic time horizons and show who benefits across the NHS, social care, welfare, employers, and the tax base. The summit points to five requirements

1. A defined high-impact cohort, with a transparent rationale for prioritisation, and equity safeguards.
2. A credible counterfactual showing the cost of doing nothing and the expected trajectory without intervention.
3. A common outcomes framework covering clinical, service, workforce, patient-reported, and equity measures.
4. A delivery model that is implementable within neighbourhood teams and does not simply move existing fragmentation into a new building.
5. Independent real-world evaluation, including data linkage, and scenario-based economic modelling.

The Proposed Next Phase

UKHLSI propose to commission Curia to deliver a coordinated national programme built around three clearly separated routes: a year-one National Obesity Working Group and policy programme; a non-clinical learning offer; and separately scoped Strategic Innovation Gateway commissions with NHS systems. Curia's role will focus on independent policy, research, reporting, and evaluation, with any delivery activity separately commissioned from UKHLSI members. The programme would create the evidence needed for national policy and continued Treasury engagement while helping local systems deliver safer, more effective services now.

The intended outputs are a small number of demonstrator systems, a Treasury-facing economic case, a national trauma-informed service standard and public implementation guidance, a linked real-world evidence plan, a non-clinical workforce and system-change offer, a community delivery model, and a policy white paper setting out how integrated obesity care can be commissioned and scaled. Any national standard or public guidance would be developed and governed independently.

 **When we say action, we mean action.”**

*Jo Bekis, Chief Executive,
UK Healthcare and Life Sciences Innovation (UKHLSI)*



Jo Bekis, Chief Executive of UK Healthcare and Life Sciences Innovation (UKHLSI), emphasised the summit's focus on delivery.

From Access To Outcomes: the Strategic Context

The 2026 summit was deliberately framed around implementation, evidence, and economic value rather than another debate about whether obesity matters.

The 2025 work focused on access, prevention, the policy landscape, and the arrival of pharmacological interventions. By 2026, the question had changed. The NHS and government are aware that treatments work.³ The debate has moved on to question which people should receive which intervention, through what pathway, with what support, and how success should be measured over time.

The agenda identified a series of shifts that should guide national and local action

- From treatment access to whole-pathway outcomes.
- From weight loss alone to health, trust, safety, dignity, and long-term living well.
- From isolated medication pathways to integrated, trauma-informed system delivery.
- From cohort targeting alone to safe personalised triage and relational continuity.
- From activity-based commissioning to outcomes, equity, experience, and economic value.
- From service utilisation metrics to adherence, relapse prevention, workforce outcomes, and public value.

³ New drugs pilot to tackle obesity and cut NHS waiting lists, Prime Minister's Office, 10 Downing Street, Department of Health and Social Care, <https://www.gov.uk/government/news/new-drugs-pilot-to-tackle-obesity-and-cut-nhs-waiting-lists>

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