Bromley

THE LONDON BOROUGH



Adults living with obesity in Bromley

Annual Public Health Report 2026

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Foreword

Obesity is one of the most common and important conditions affecting adults in Bromley today. Its prevalence continues to rise across London and the rest of England, while treatments for obesity are rapidly evolving, creating both opportunities and challenges for equitable access, public understanding, and long-term support. This is why I have chosen adult obesity as the focus of this year's Annual Public Health Report.

This report is intended primarily for health and care professionals who engage with Bromley residents. Whether working in primary care, community services, hospitals, public health, or health service commissioning, we all have a role in supporting healthy weight, preventing obesity, and ensuring that people living with obesity receive appropriate, compassionate care.

Obesity is a significant risk factor for a wide range of physical and mental health conditions, including osteoarthritis, cardiovascular disease, type 2 diabetes, certain cancers, restriction of routine activities of daily living and poor mental wellbeing.

Importantly, obesity is a complex condition with multiple causes. While individual eating and activity behaviours are important, obesity cannot be understood simply as a matter of personal responsibility or willpower. The environments in which people live, work, learn and socialise, alongside wider social, economic and commercial determinants of health, all influence the choices available to them and their ability to maintain or reach a healthy weight. Obesity prevalence is not distributed evenly across Bromley, and action should be informed by the needs and experiences of communities experiencing the greatest burden.

Primary care teams are especially important in identifying obesity early, discussing weight sensitively, assessing risk, and supporting residents to access appropriate services. Bromley residents with obesity have access to a broad range of publicly commissioned weight management services, including community-based, digital and specialist programmes, with pathways available for the general population as well as for people with learning disabilities, diabetes, hypertension, or more complex obesity-related health needs.

People living with obesity frequently experience weight bias and stigma, including within healthcare settings. Such stigma impacts on mental health, worsens eating and activity behaviours, and discourages engagement with services. It is therefore essential that we, as health professionals, reflect on our biases and address them.

There are important opportunities to improve how obesity is identified, discussed and managed in our borough. This includes supporting clinicians to have compassionate conversations about weight, improving assessment and referral processes, and ensuring residents can access the available services.

I hope this report provides insight into the scale and drivers of obesity in Bromley, highlights opportunities for action, and supports all of us in working together to enable healthier lives for our residents.

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Acknowledgements

Person	Job title	Role
Andrea Mazzella	Public Health Medicine Registrar	General literature review Structured literature review of weight stigma interventions Epidemiological analysis Data visualisation Write-up Cover illustration
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Special thanks also to all partners who participated in interviews for the Adult Obesity Health Needs Assessment, including colleagues from NHS South East London Integrated Care Board, Bromley GP practices, Slimming World, Enable Adult Weight Management Programme for people with learning disabilities, and Mytime Active.

Methods

This report drew on a mixed-methods approach.

- We undertook a pragmatic review of publicly available information using authoritative organisational sources as well as peer-reviewed research.
- We conducted a structured review of the literature to identify interventions that are effective in reducing weight stigma among clinicians.
- We obtained demographic data and geographical boundaries from the Office for National Statistics (ONS), and deprivation metrics from ministerial datasets.
- We acquired patient data from Bromley GP practice records and analysed them in R for epidemiological assessment, data visualisation and mapping.
- We compared local findings with publicly available national and Bromley-specific indicators, including data on diet and physical activity from Fingertips and OHID reports.
- We gathered stakeholder views through seven semi-structured interviews with GPs, commissioners and service providers, and analysed using a pragmatic descriptive approach, with key insights attributed to individual participants.
- We also reviewed tier 2 service data on uptake, engagement and outcomes.
- We synthesised all evidence to identified opportunities for improvement.

> Detailed methods are listed in the 2026 'Obesity and weight management services for adults in Bromley' Health Needs Assessment (Bromley Public Health, 2026).

How do we assess weight?

Obesity and the body mass index

Obesity is a chronic condition characterised by excess body fat that poses a risk to health (World Health Organization, n.d.; Lingvay, RV, CW, & P, 2024).

Body mass index (BMI)[1] is a convenient but imperfect method of estimating fat mass, mainly used for epidemiological purposes and in clinical practice as a screening tool (World Health Organization, 2000; Lingvay, RV, CW, & P, 2024). For adults, overweight is pragmatically defined as BMI 25-29.9 kg/m² and obesity ≥30 kg/m² (with three classes) (World Health Organization, 2000), as shown in Figure 1.

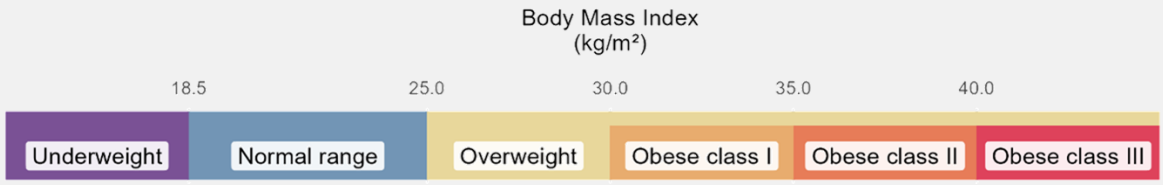


Figure 1. WHO classification of adults according to BMI

A weight assessment may be undertaken through self-assessment, preventative health services such as the NHS Health Checks or Vital 5 Checks, or primary or secondary healthcare. In general practice, body weight assessments may be carried out when patients first register, as part of long-term condition reviews, or opportunistically during consultations for other issues.

Despite these opportunities, weight assessment is not consistently offered to all patients in Bromley, as identified during interviews with local partners. One interviewed GP noted that patients are not routinely offered a body weight assessment that would allow calculation of BMI, unless they already have an obesity-related condition (interviewee G2). A commissioner similarly highlighted that identification of people with obesity is largely reactive, relying on patients presenting to services. This approach risks widening health inequalities. As an interviewed provider observed, many people accessing weight management services were signposted during opportunistic weight assessment carried out in primary care for other reasons, rather than through appointments specifically booked to discuss weight (P2). There are, however, plans to strengthen proactive case finding, particularly as part of the tirzepatide pilot (C1).

[1] BMI is calculated by dividing the body weight (in kg) by the square of the height (in m²).

Epidemiological data also support these observations. Out of 296,193 people aged 16 years and over registered with a Bromley GP practice, 45,395 (15.3%) did not have a recorded BMI. This might be because the patient was never offered a weight assessment, or because they declined it, or because the BMI was calculated but not recorded. The lack of BMI recording varies considerably across practices, from a minimum of 1.1% (Bromleag Care Practice) to a maximum of 26.6%.

> While many individuals without a recorded BMI may reasonably have been judged to be of a healthy weight, some will have undiagnosed overweight or obesity. This represents missed opportunities for early identification and referral to weight management services.

Even when BMI values are recorded, many are out of date or inaccurate. In our analysis of GP data for patients with a BMI of 25 or above, the latest BMI was recorded more than 5 years ago in 20% of cases. A small minority of patients (0.3%) had values over 90 kg/m², which are physiologically unlikely[2]. Such values are likely to reflect invalid calculation or incorrect recording of height or weight. For example, 0.4% of patients had recorded heights that were implausibly low or high (<50 cm or >220 cm), often suggesting entry in metres or in feet and inches rather than centimetres. A smaller proportion of patients (0.2%) had implausibly low or high recorded weights (<40 kg or >400 kg), which may reflect values entered in stone or simple transcription errors. In addition, a small number of records appeared to have height and weight inverted[3] or the same value entered in both fields, leading to grossly overestimated BMIs. Finally, we could not gauge from the available data how often heights and weights were self-reported or measured by a clinician.

Although BMI values are recorded relatively frequently, diagnostic labels are used far less consistently. Among patients with a recorded BMI of 30 or above, only 21% have the term ‘obesity’ (or equivalent) explicitly mentioned in their GP record. More remarkably, just 2.4% of those with a BMI between 25 and 30 have ‘overweight’ recorded.

This may indicate that clinicians did not recognise the condition, or that they preferred omitting it from the patient record.

[2] For example, a person who is 175 cm tall would need to weigh more than 275 kg to reach this BMI.

[3] For example, a height of 52 cm paired with a weight of 160 kg.

Limitations of BMI

BMI may be underestimated when based on self-reported weight and height rather than measurements taken by a clinician (World Health Organization, 2000), or imprecise when height and weight are measured while the person is wearing clothes or shoes.

Even when accurately measured, BMI is a crude indicator of fat accumulation because it does not distinguish between fat and lean mass. For this reason, while BMI is a useful metric at the public health level, relying on BMI alone at the individual level can lead to misclassification in a minority of cases:

- overestimating adiposity in people with high lean mass, for example, some athletes or people with fluid overload (National Institute for Health and Care Excellence, 2025; Rubino, et al., 2025), and
- underestimating it in those with reduced lean mass, for example, amputees or people with muscle atrophy.

> Moreover, not all body fat is the same: its distribution matters. Fat stored in or around the abdomen (central adiposity) carries greater health risks than fat elsewhere (Rubino, et al., 2025).

Waist-to-height ratio and central adiposity

To better assess this, NICE recommends measuring waist circumference in people with BMI below 35 kg/m² and use it to calculate the **waist-to-height ratio** (waist circumference divided by height). This can then be classified into **central adiposity** categories: healthy (waist-to-height ratio 0.4 to 0.49, i.e. waist measurement less than half the height), increased (0.5 to 0.59) and high (0.6 or more)[4] (National Institute for Health and Care Excellence, 2025).

Despite the NICE recommendation, only 32% of patients with a BMI between 25 and 35 in the GP dataset had a recorded waist measurement. Across practices, this ranged from a high of 54% in Summercroft Surgery to a low of 16%. Younger patients were much less likely to have a recorded waist measurement: only 1.4% of people aged 18-25 and 3.8% of those aged 25-35 had one, compared with 37% of those aged 45-55 and 46% of those aged 55-65. This age disparity may indicate that waist circumference is infrequently measured outside the NHS Health Checks programme. Black and White British patients were equally likely to have a waist measurement (34%), whereas Asian, Mixed/Other and Other White groups had lower recording rates (approximately 27%). Men and women were equally likely to have a recorded waist circumference.

[4] For those with class 2 or 3 obesity, measuring waist adds little to risk prediction, as these people are already highly likely to have a high waist-to-height ratio (National Institute for Health and Care Excellence, 2025).

Clinical obesity

Noting that many people with excess fat accumulation have no signs of illness, a large multi-specialty commission set up by The Lancet Diabetes & Endocrinology in 2025 recommended differentiating between preclinical and **clinical obesity**, based on the absence or presence, respectively, of alterations in the function of organs or the entire body that are directly induced by excess adiposity (Rubino, et al., 2025) (see section **The consequences on people's physical health**, within this report).

Challenges in primary care assessment

Interviewees described several challenges when discussing excess body weight with patients.

Interviewees highlighted that **weight stigma** (see section **Weight stigma and how to address** it, within this report) continues to shape patient experiences. One commissioner emphasised that both patients and clinicians often frame excess weight as the fault of the individual rather than the result of multiple factors, including external ones (C1). They described this as a mindset that is beginning to shift but remains far from resolved. Patients may also perceive the term 'obesity' itself as stigmatising (G2). Internalised stigma may reduce openness to conversations about weight and limit opportunities for support.

A GP observed that some primary care staff, particularly in expanding teams, hesitate to raise weight-related issues because they anticipate negative reactions from patients (G2). These factors may contribute to inconsistent practice and missed opportunities for constructive, non-stigmatising engagement with patients living with overweight or obesity.

Interviewees also highlighted that GPs are pressured to work within **10-to-15 minute consultation slots** (G1, G2, C1), often focused on a presenting complaint unrelated to weight, which leaves limited time for a sensitive conversation.

> Two interviewed GPs noted that men with excess weight might be less motivated to lose weight compared to women (G1, G2). A GP noted that this expectation leads clinicians to be less likely to initiate discussions around weight with male patients (G2).

Epidemiology of obesity in Bromley

The prevalence of obesity

Overall prevalence

Analysis of GP records as of February 2026 identified 56,702 adults in Bromley living with obesity, and a further 84,942 were overweight based on recorded BMI values. Among the 15.3% of patients without a recorded BMI, we estimated an additional 2,566 people with unidentified obesity and 3,844 with overweight.

Taking both recorded and estimated cases together, the prevalence of obesity was 20.5% and overweight 30.7% among adults registered with a GP practice (Table 1). Overall, this means that it is slightly more common for adults in Bromley to carry excess body fat than to be within a healthy weight range.

> Among patients with recorded BMI in the obesity range, median BMI was 33.3 kg/m² (IQR 31.3 to 36.6); 65% of them were classified as having class I obesity, 23% class II, 12% class III.

BMI category	People with recorded BMI in category	Estimated undiagnosed people	Prevalence (per 100 adults registered)
Overweight	84,942	3,844	30.7%
Obesity	56,702	2,566	20.5%
~ Class I	36,887	1,669	13.3%
~ Class II	12,958	586	4.7%
~ Class III	6,857	310	2.5%

Table 1. Overall counts and estimated prevalence of overweight and obesity, Bromley, 2026

Central adiposity

Among the Bromley overweight adults who had waist and height measurements, 18% had healthy or low central adiposity, 65% had increased central adiposity, 18% had high central adiposity.

As expected, on average the waist-to-height ratio was substantially higher among those with Class I obesity: 56% of people in this group had high central adiposity. However, there are many people with a BMI in the overweight range who have higher central adiposity than many people classified as having obesity (Figure 2).

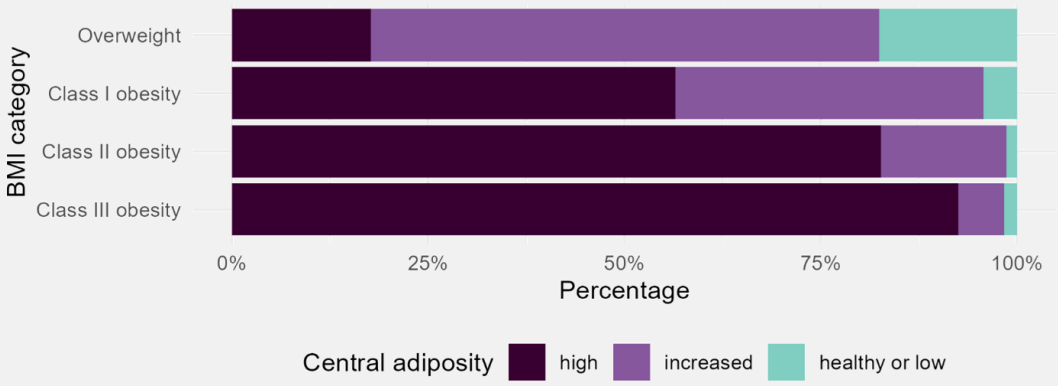


Figure 2. Distribution of central adiposity by BMI category, Bromley, 2026

Comparisons with London and England

> **Context:** Bromley is the London borough with the highest median age (Office for National Statistics, n.d.). In order to compare prevalence with London and England, age-standardised metrics need to be used.

In 2023/24, the age-standardised prevalence of obesity among adults in Bromley was 21.4%, based on Sport England's Active Lives Adult Survey data reported through Fingertips. This placed Bromley in the lowest quartile of local authorities in England, compared to a London-wide prevalence of 20.2% and an English prevalence of 26.5% (Figure 3) (Department of Health & Social Care, n.d.). The lower prevalence in Bromley is likely because Bromley's population profile is more socioeconomically advantaged than the English average (see section The prevalence by area deprivation, within this report).

> When overweight and obesity are considered together, during the same period, the age-standardised prevalence among Bromley adults was 60.4%, also in the lowest quartile nationally, against a London prevalence of 57.8% and an English prevalence of 64.5% (Department of Health & Social Care, n.d.).

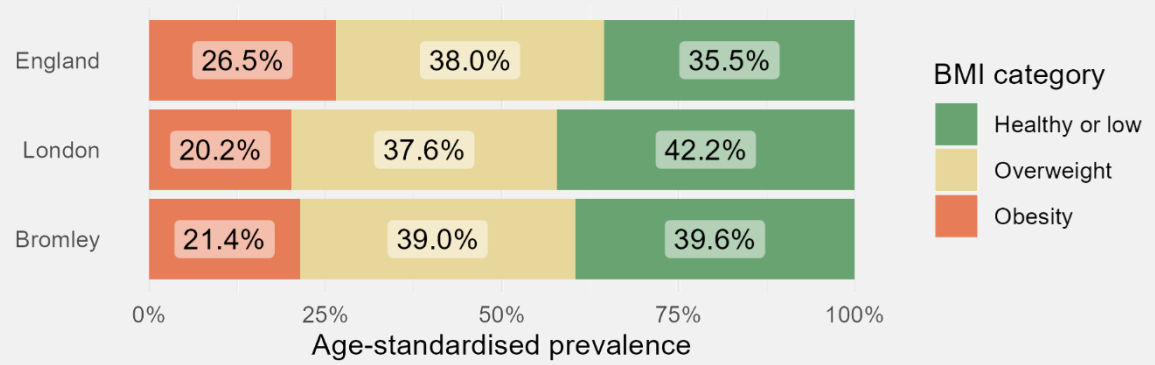


Figure 3. Comparison of age-standardised prevalence of overweight and obesity between Bromley, London and England, 2023/24 (Department of Health & Social Care, n.d.)

Although Bromley performs better than the England average, these borough-wide figures mask significant variation across local neighbourhoods and demographic groups. These disparities are explored in the next sections.

International comparison

Moreover, obesity in England compares unfavourably with other similar European countries. In 2022, the prevalence of obesity in England was 29%, compared to 24% in Germany, 22% in Italy, 19% in Spain, and 11% in France (Figure 4). Higher rates were seen in most Eastern European countries and especially the United States, Egypt and Saudi Arabia, among other countries (Figure 5). While the prevalence of obesity in Bromley appears comparable to that in Italy, it is substantially higher than in France.

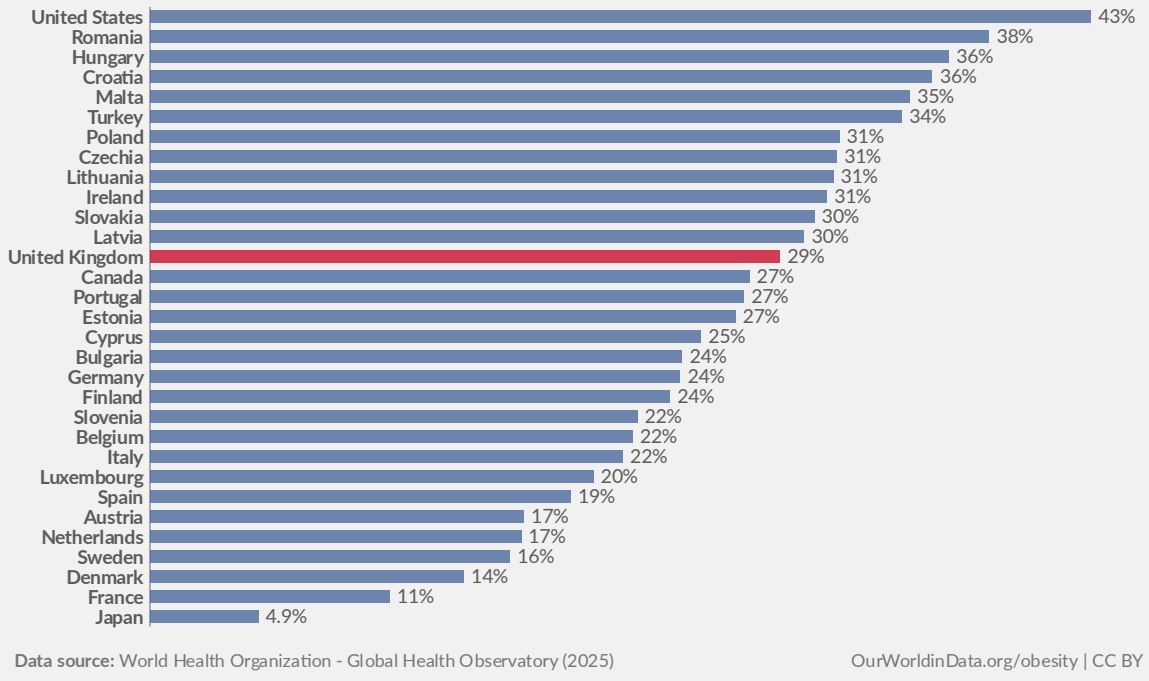


Figure 4. Share of adults who are obese by country, European Union and G7 countries, 2022 (Our World in Data)

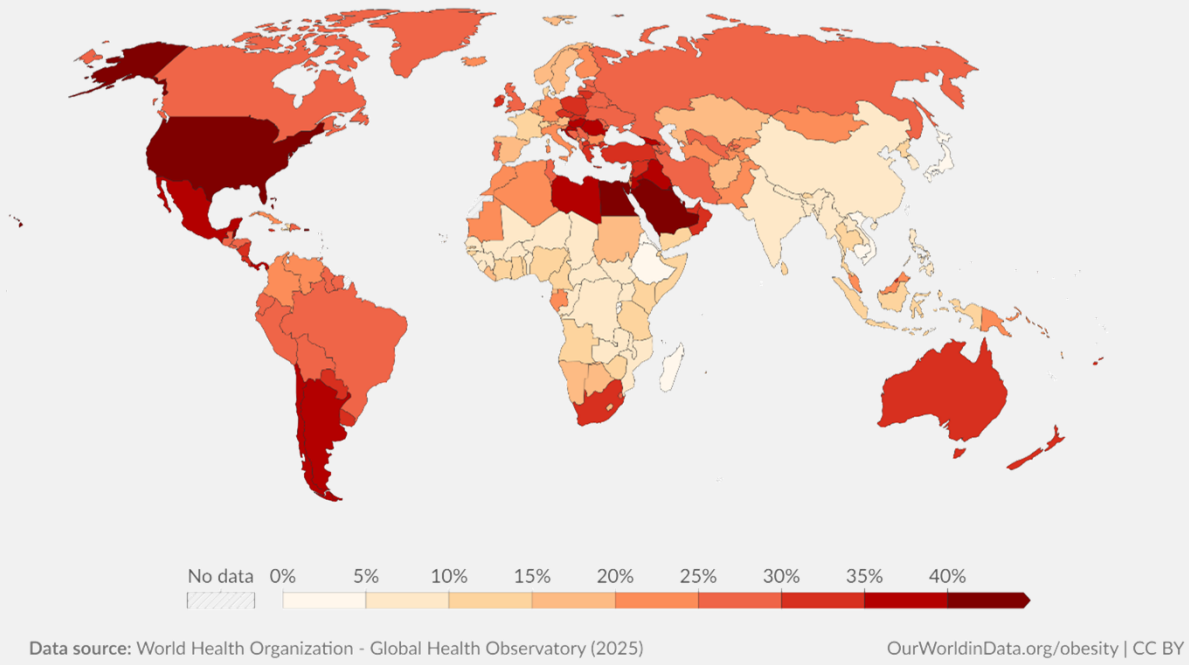


Figure 5. Prevalence of obesity among adults, by country, 2022 (Our World in Data)

Time trends

The prevalence of obesity in England increased substantially over the past thirty years (Figure 6). In 1993, 16% of adults were classified as having obesity; by 2024, this proportion had risen to 30%, representing an 87.5% increase (Department of Health & Social Care, n.d.; NHS England, 2026). Only part of this increase is due to the English population becoming older, as it is known that obesity is more common in older age groups.

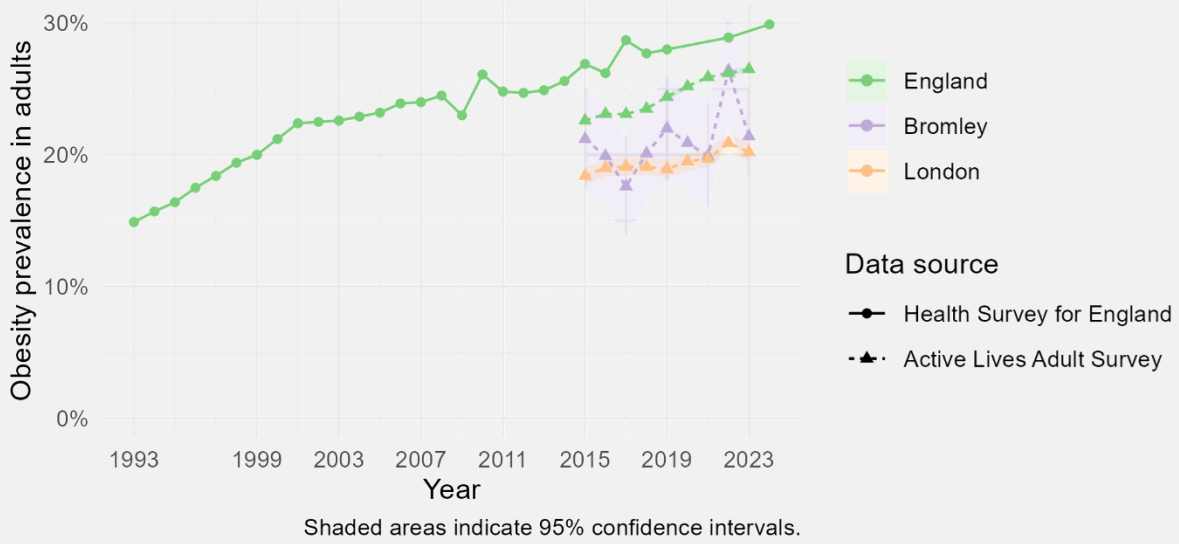


Figure 6. Temporal trends in prevalence of obesity among adults: England, London and Bromley, 1993 to 2024

Data specific to London and Bromley has been available since 2015 through the Active Lives Adult Survey, which relies on self-reported height and weight adjusted for known reporting biases and may therefore underestimate prevalence of obesity (Department of Health & Social Care, n.d.). At the London level, there was a modestly upward trend, with obesity prevalence rising from 18% in 2015/16 to 20% in 2023/24 (Figure 6).

However, it is not possible to reliably assess time trends for Bromley. The borough-level estimates fluctuate considerably from year to year (Figure 6), and these apparent increases or decreases are likely due to small sample sizes rather than genuine changes in underlying obesity prevalence.

> The increase in prevalence of obesity is common to most countries, with some notable exceptions: France and Spain, for example, managed to reduce this prevalence from the late 2000s, while Germany stopped its previous increase (Figure 7).

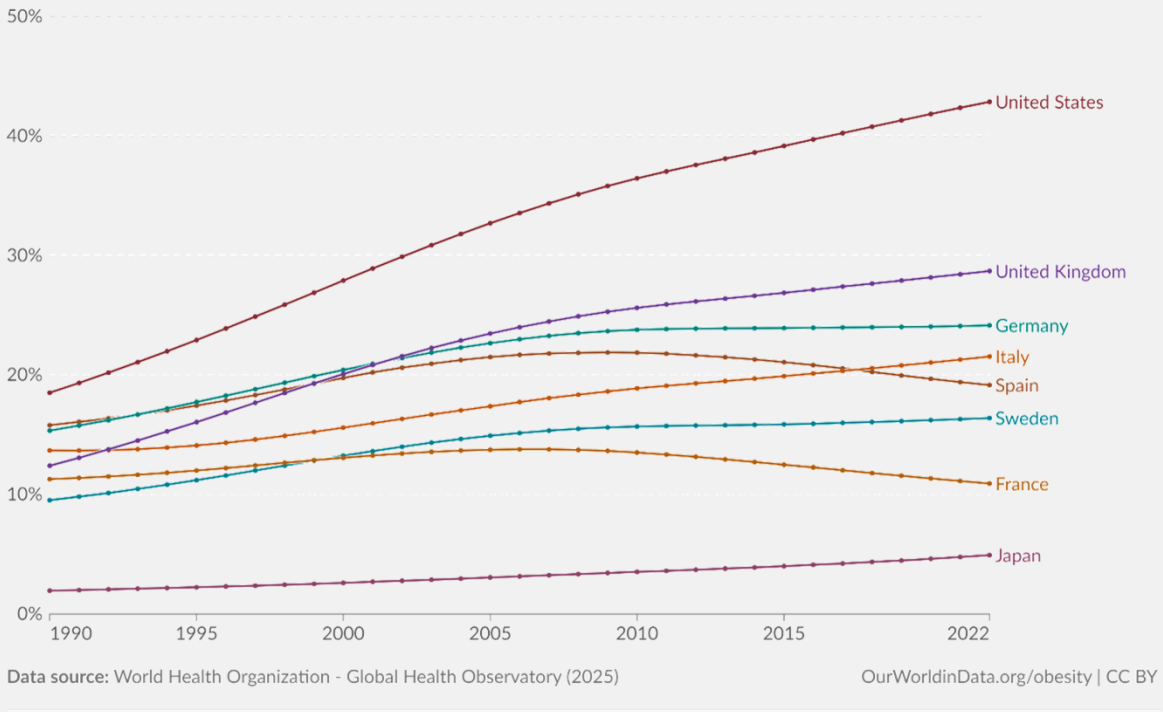


Figure 7. Trends in prevalence of obesity among adults, comparison between selected countries, 1990 to 2022 (Our World in Data)

The prevalence by age group

In Bromley in 2026, the median age of adults living with obesity was 55 years, with 75% aged between 42 and 66. The prevalence of overweight and obesity generally increases in older age groups (Figure 8, Table 2), likely reflecting longer-term high-calorie food intake.

Approximately 14.7% of people aged 25-35 are estimated to be living with obesity, and this steadily increases up to a peak of 30.7% in those aged 55-64.

Beyond this point, prevalence declines in older age groups, likely due to a combination of premature mortality among people with obesity-related conditions and unintended weight loss due to comorbidities or frailty.

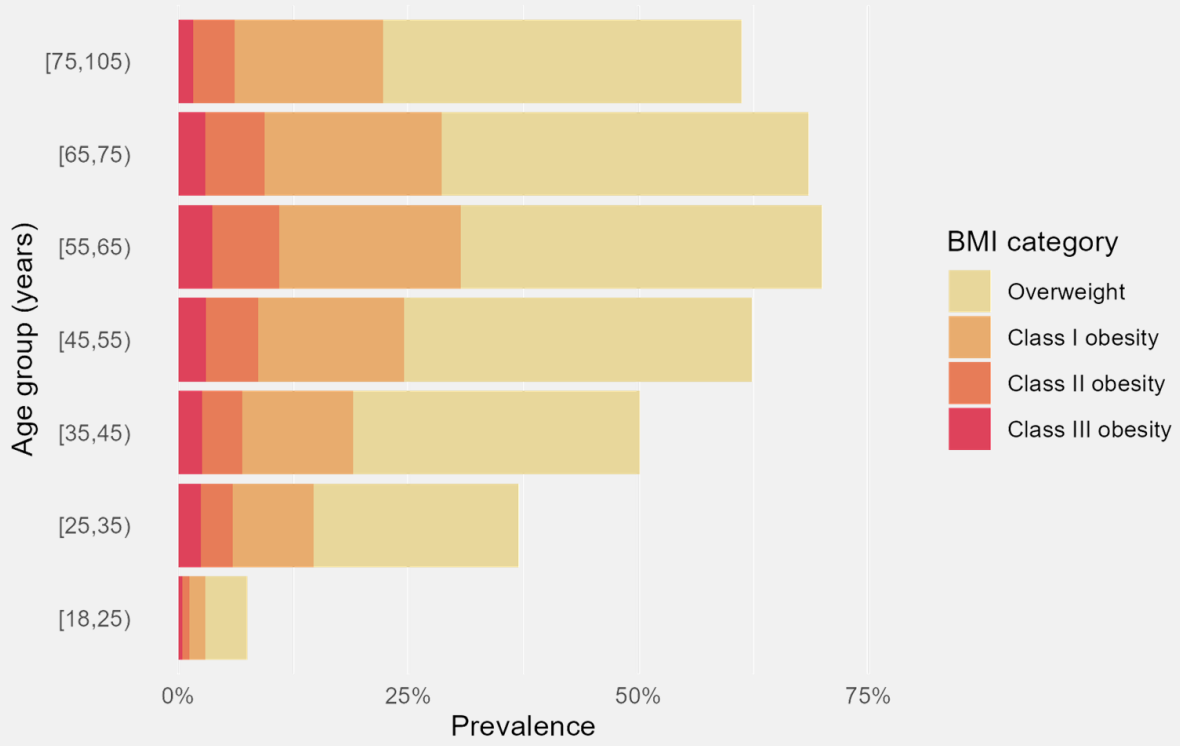


Figure 8. Prevalence of overweight and obesity by age groups, Bromley, 2026

Age group	People with overweight	Prevalence of overweight (per 100 adults registered)	People with obesity	Prevalence of obesity (per 100 adults registered)
18-25	1,729	4.6%	1,093	2.9%
25-35	9,050	22.3%	5,981	14.7%
35-45	16,339	31.1%	9,972	19.0%
45-55	18,603	37.8%	12,097	24.6%
55-65	17,576	39.2%	13,767	30.7%
65-75	12,434	39.9%	8,918	28.6%
75-105	13,054	39.0%	7,440	22.2%

Table 2. Counts and estimated prevalence of overweight and obesity by age group, Bromley, 2026

Central adiposity substantially increases with increasing age among people with class I obesity (Figure 9).

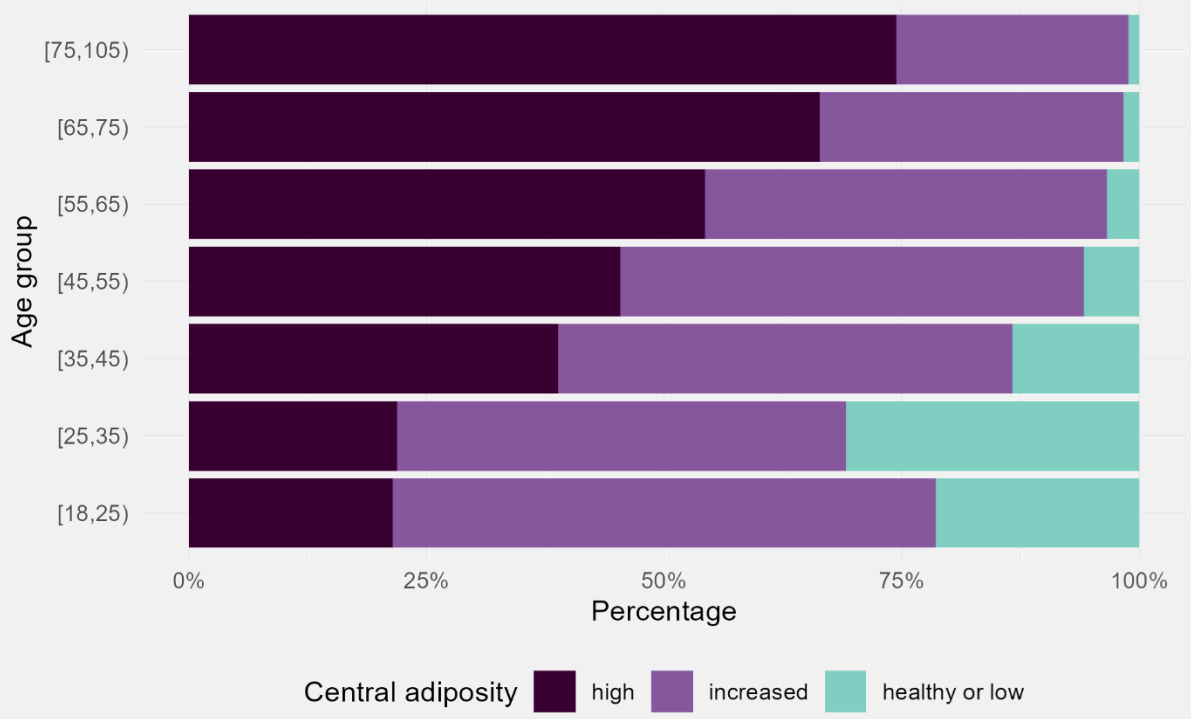


Figure 9. Comparison of central adiposity by age groups among people with class I obesity, Bromley, 2026

The prevalence by gender

As of 2026, in Bromley, 56% of people living with obesity are women and 44% are men. This reflects the slightly higher prevalence of obesity among women (22.2% compared with 18.6%). Women also have a higher prevalence of more severe forms of obesity (classes II and III). On the other hand, men have a higher prevalence of overweight (33.5% versus 28.0%) (Figure 10).

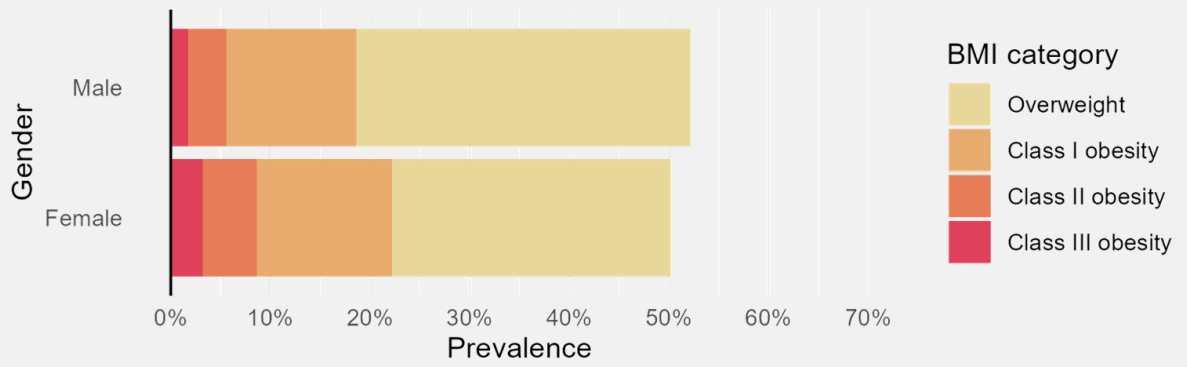


Figure 10. Prevalence of overweight and obesity by gender, Bromley, 2026

Gender	Number with overweight	Prevalence of overweight (per 100 adults registered)	Number with obesity	Prevalence of obesity (per 100 adults registered)
Female	41,703	28.0%	33,110	22.2%
Male	47,073	33.5%	26,148	18.6%

Table 3. Estimated counts and prevalence of overweight and obesity by gender, Bromley, 2026

Unlike the general trend, younger women (aged 18-34) have a higher prevalence not only of obesity but also of overweight compared with men in the same age groups. In increasingly older groups, however, the prevalence of overweight and obesity rises more markedly among men than among women. Obesity prevalence becomes broadly similar between genders in the 55-74 age groups, while overweight is consistently higher among these men (Figure 11).

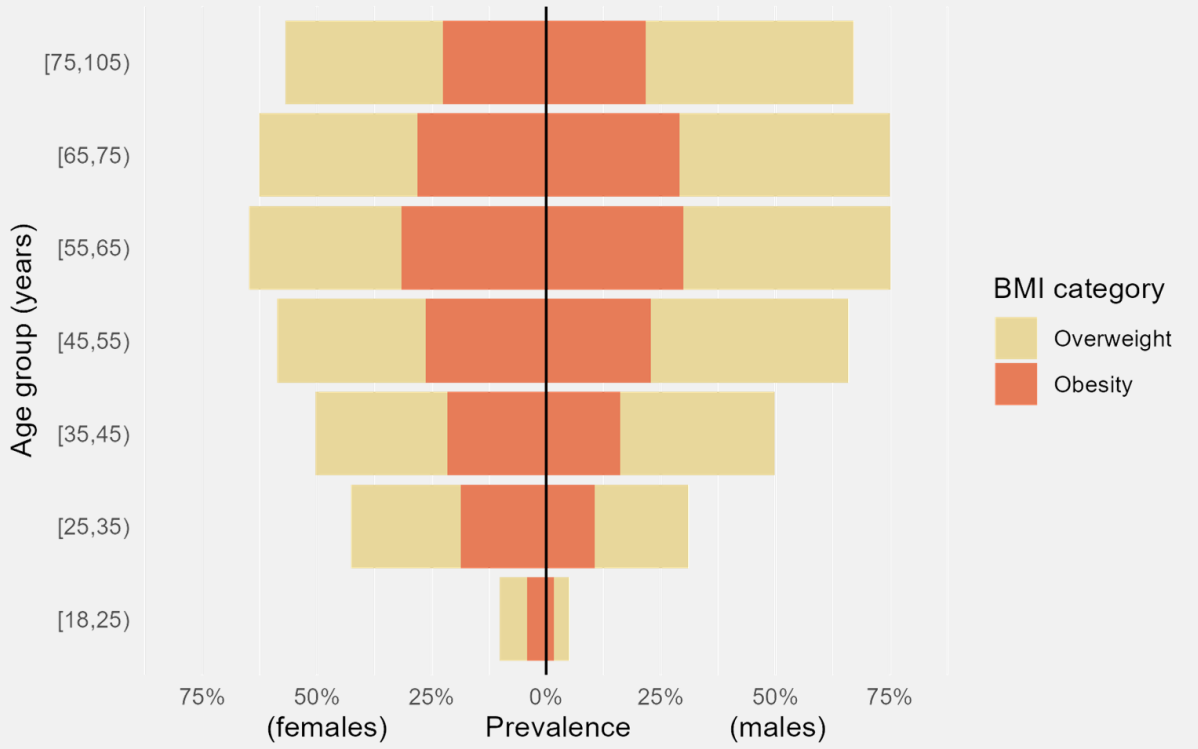


Figure 11. Prevalence of overweight and obesity by age group and gender, Bromley, 2026

Similarly, high central adiposity is less prevalent among younger men with class I obesity than among women. With increasing age groups, however, the prevalence of high central adiposity increases in men more than it does among women (Figure 12).

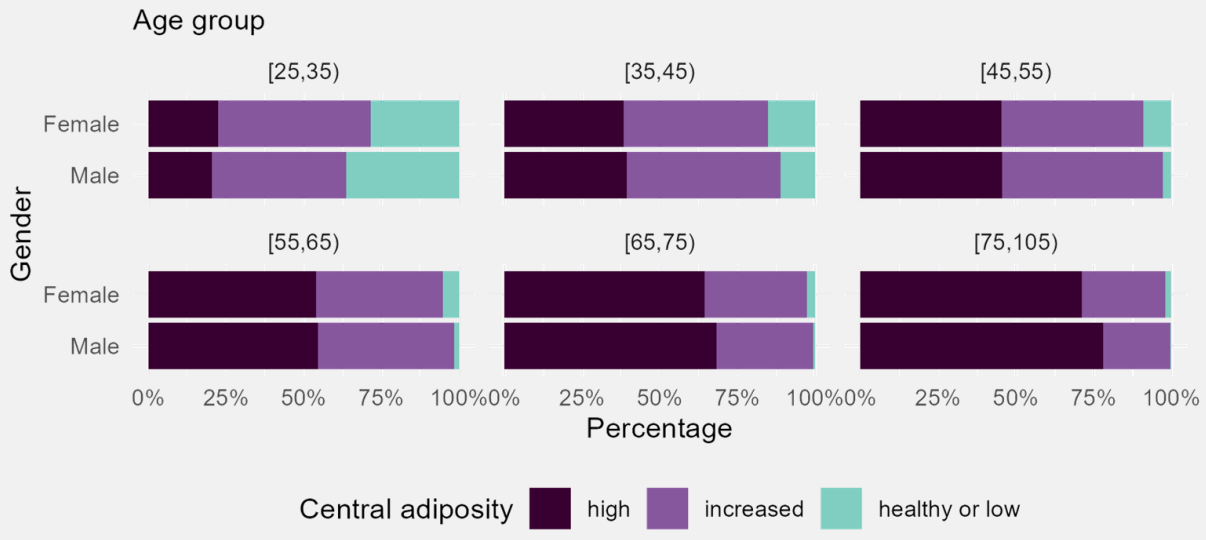


Figure 12. Comparison of central adiposity by gender and age groups among people with class I obesity, Bromley, 2026

The prevalence by neighbourhood

The prevalence of obesity varies considerably across the borough (Figure 13). The areas with the highest prevalence are Anerley North & Penge West, where 31.6% of residents live with obesity, St Mary Cray East (29.8%), St Mary Cray North (29.5%), Mottingham (27.9%), St Mary Cray South (27.6%) and Orpington East (26.8%). In contrast, prevalence is about half as high in areas such as Langley Park (14.4%) and Chislehurst West & Elmstead (15.3%).

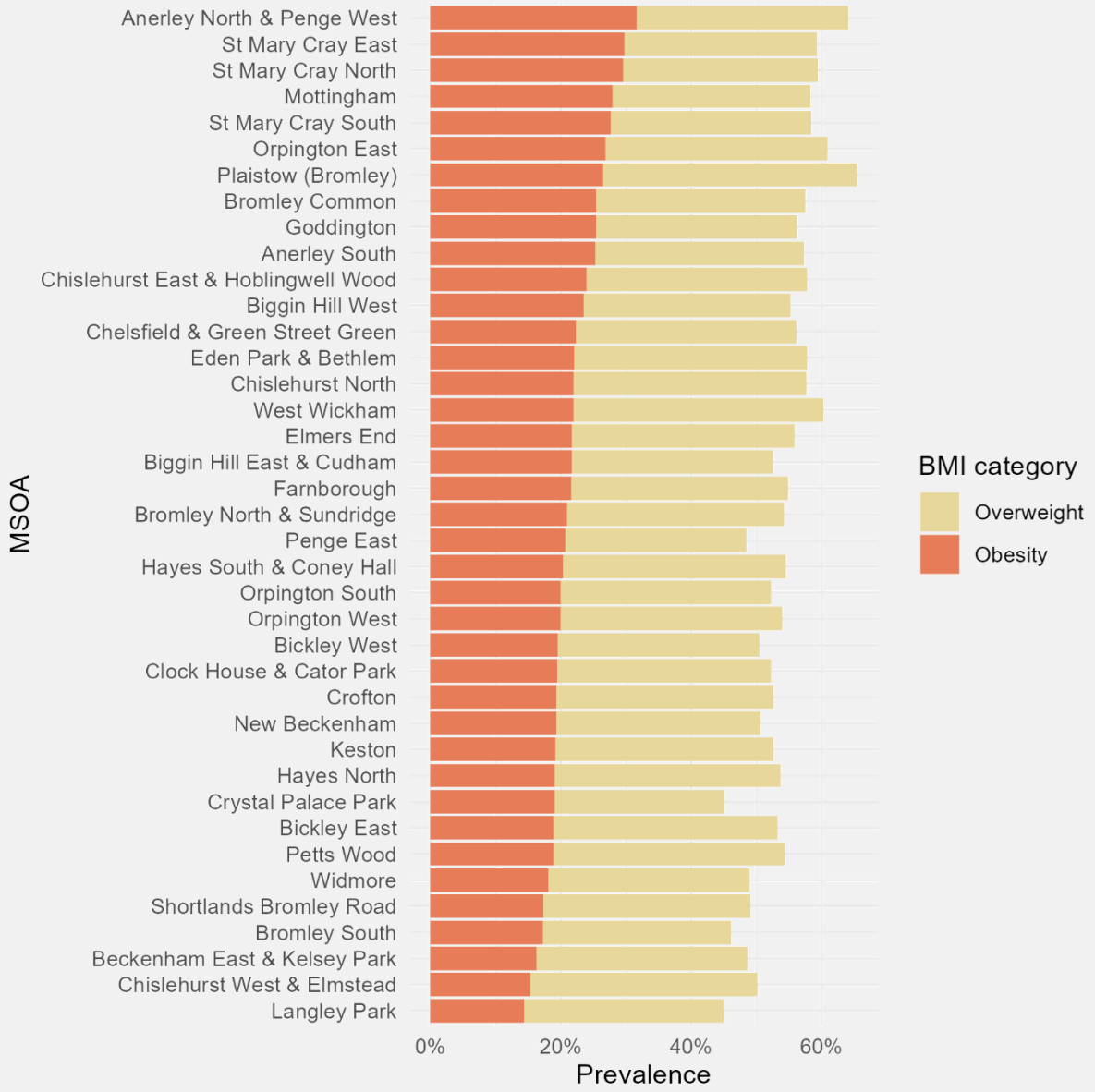


Figure 13. Prevalence of obesity and overweight by geographical area (MSOA) of residence, Bromley, 2026

> Variation also exists within MSOAs, where individual Lower layer Super Output Areas (LSOA) may have substantially higher prevalence of obesity than their wider area average (Figure 14).

For example:

- While the Goddington MSOA has an average prevalence of 25.4%, its LSOA Bromley 032B (around Plantation Drive) has a prevalence of 35.7%.
- While the Penge East MSOA has an estimated prevalence of 20.7%, its LSOA Bromley 004A (around the High Street between Royston Road and Penge Lane) has a prevalence of 26.2%.

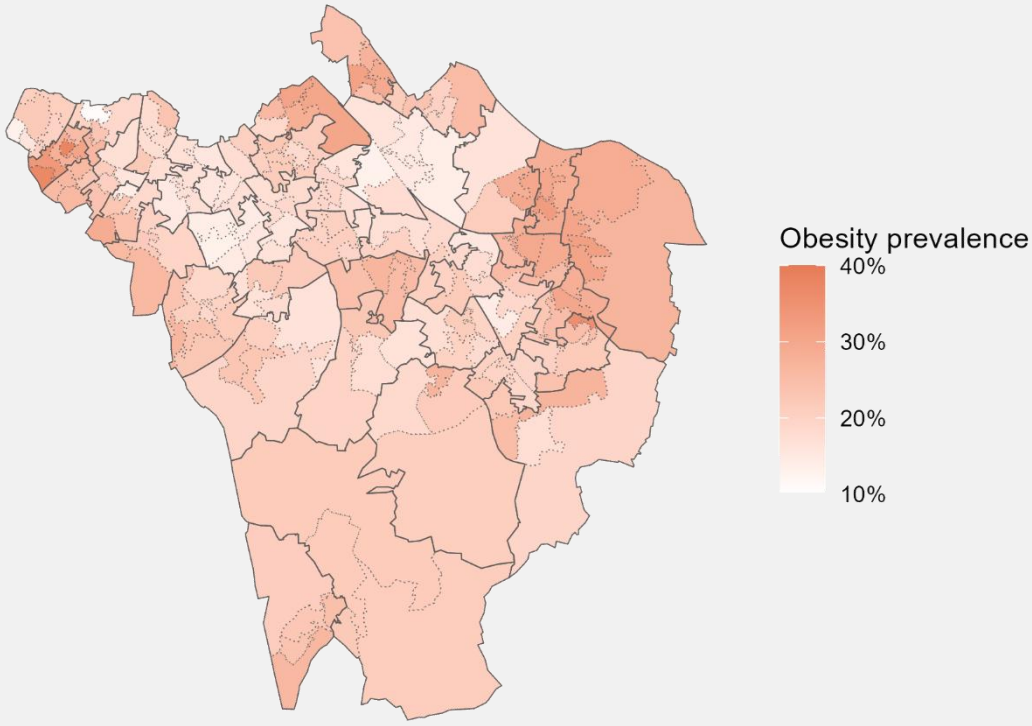


Figure 14. Prevalence of obesity by small geographical area (LSOA) of residence[5], Bromley, 2026.

Prevalence alone does not capture differences in how many people live within each area. Areas with similar prevalence may therefore have very different absolute numbers of cases. Assessing obesity case density helps identify where cases cluster most tightly, which is relevant to decide where to plan and promote local services.

[5] In this map, solid lines indicate MSOAs, while dotted lines indicate LSOAs.

The prevalence by area deprivation

Much of the geographic variation in obesity across the borough is linked to socioeconomic deprivation.

> **Context:** In Bromley, socioeconomic deprivation is substantially lower than in most London boroughs: 44% of residents live in areas ranked among the 20% least deprived of England. However, 6% of the population lives in areas classified among the 20% most deprived, particularly in the Crays (northeast), Anerley and Penge (northwest), and Mottingham (north) (Figure 15).

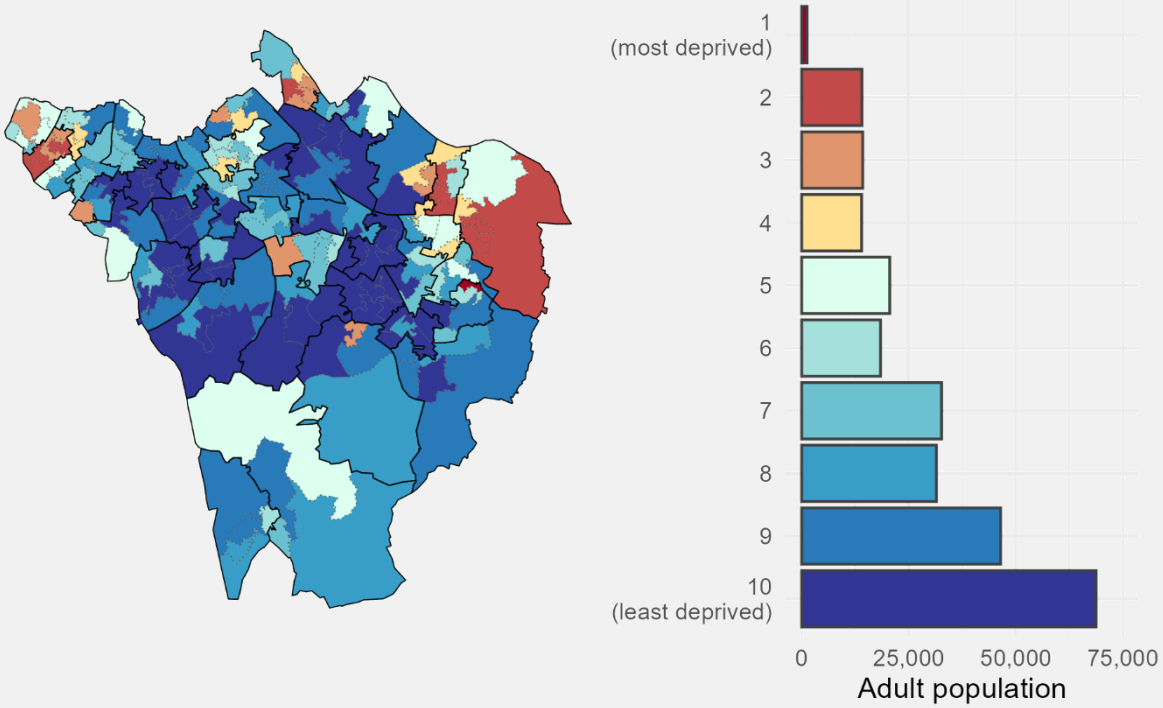


Figure 15. Bromley's deprivation profile: geographic distribution[6] and mid-2024 adult population size by 2025 Index of Multiple Deprivation decile

There is a clear deprivation gradient in obesity prevalence: more deprived areas tend to have higher levels of obesity (Figure 16). For example, the only Bromley LSOA in the 10% most deprived nationally[7] has the highest obesity prevalence in the borough (35.7%). Prevalence is 28.6% in areas in the second-most deprived decile, decreasing progressively to 20.9% in decile 5. The gradient then becomes less steep between deciles 5-10, with only 17.8% of people living in the least deprived decile having obesity.

[6] In this map, solid lines indicate MSOAs, while dotted lines indicate LSOAs.

[7] Part of the Goddington MSOA, near Orpington.

> Interestingly, the prevalence of overweight follows a slightly different pattern, with overweight being more prevalent in the least deprived areas.

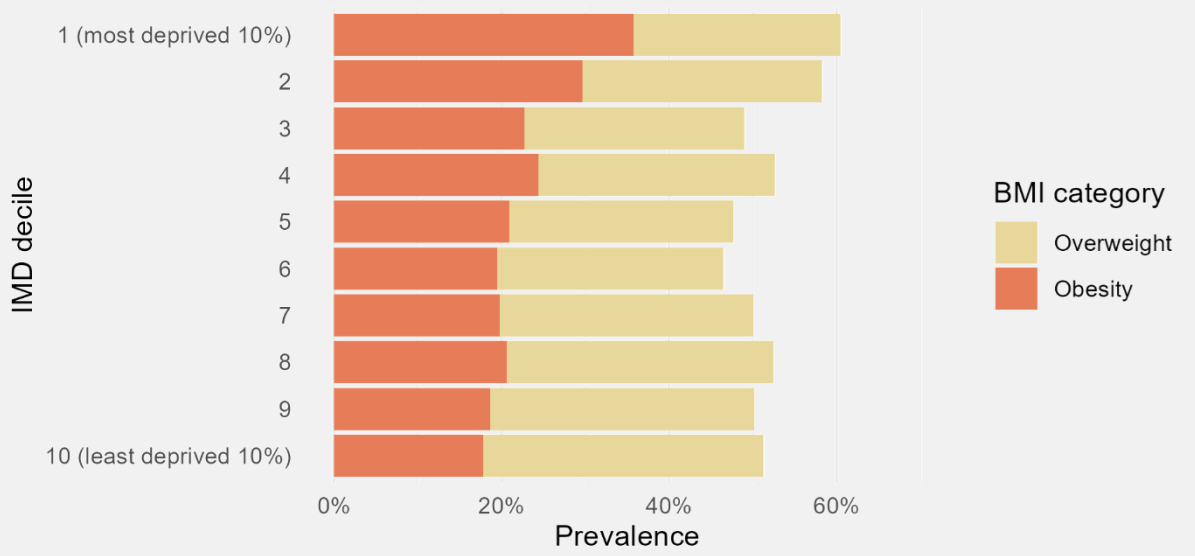


Figure 16. Prevalence of obesity and overweight by 2025 Index of Multiple Deprivation decile, Bromley, 2026

However, people living in more deprived areas tend to be younger on average, and would therefore be expected to have a *lower* prevalence of obesity. After adjusting for age, prevalence in the most deprived decile was more than double that in the least deprived areas (prevalence ratio 2.28, 95% CI 2.06 – 2.51), and in the second-most deprived decile it was 85% higher (prevalence ratio 1.85, 95% CI 1.76 – 1.95).

The Index of Multiple Deprivation is a composite metric incorporating several dimensions, including education, income, employment and local environment. Many of these components are known to contribute to obesity. To explore which specific domains may be most relevant in Bromley, we conducted an exploratory area-level analysis incorporating all relevant deprivation domains into a multivariable model.

Education

In Bromley, areas with higher proportions of adults with no or low qualifications, or with limited English language proficiency[8], have substantially higher obesity prevalence, with a clear gradient across quintiles. After adjusting for all other domains, this was the area-level deprivation factor most strongly associated with obesity.

Although it was not possible to analyse obesity by educational level in Bromley at the individual level, national data from the Active Lives survey (Office for Health Improvement & Disparities, 2025) provide useful context. In England, obesity is strongly patterned by educational

[8] During the 2021 Census, 2,707 Bromley residents (10.5%) reported they could not speak English well, and 442 (1.7%) that they could not speak English (Office for National Statistics, 2024).

attainment: prevalence is 35.9% among adults with no qualifications compared with 21.9% among those educated to level 4 or above (Department of Health & Social Care, n.d.).

Low educational attainment may contribute to obesity through several pathways, including lower health literacy, limited skills in food budgeting and meal preparation, and greater difficulty making healthy food choices in environments where unhealthy options are easier, cheaper, or more heavily marketed.

Occupation and income

Similar gradients are seen by working status in England, with obesity affecting 26.3% of people in work, rising to 33.8% among people who are economically inactive and 35.0% among those who are unemployed. A gradient by occupation group is also evident. Obesity prevalence is highest among people who are in semi-routine or routine occupations (29.0%). Prevalence is progressively lower in groups with greater job security and autonomy, including intermediate occupations (26.4%), the self-employed and small employers (22.3%), and managerial, administrative and professional occupations (21.8%). Students have the lowest prevalence at 20.8% (Department of Health & Social Care, n.d.), likely because they tend to be younger.

> **Context:** Bromley has a markedly more socioeconomically advantaged profile than England overall, with substantially higher proportions of residents in managerial and professional occupations and correspondingly fewer in routine, semi-routine, and supervisory roles, indicating a workforce that is generally more affluent than the national average (Office for National Statistics, n.d.).

However, in our area-level analysis, after adjusting for other deprivation domains, there was no evidence that areas with high employment deprivation had higher obesity prevalence. Of note, the IMD employment domain says nothing about job types.

In our area-level analysis, Bromley areas in the most income-deprived quintile had higher prevalence of obesity when compared to the least deprived quintile.

However, after adjusting for the associated deprivation in adult skills and health, areas in the most income-deprived quintile had *lower* prevalence of obesity. This counterintuitive finding may reflect a statistical artefact due to the strong overlap between different deprivation domains, but we cannot exclude the impact that lower income has on restricted food intake.

Food and activity environment

Differences in obesity prevalence between neighbourhoods in Bromley likely also reflect local factors that could not be assessed in this analysis but are known to be linked to obesity (Government Office for Science, 2007), such as:

- Limited access to shops selling affordable, healthy groceries
- Greater exposure to outlets selling energy-dense foods, such as fast-food premises
- Outdoor advertising of foods and drinks high in sugar or fat
- Features of the local activity environment, including lack of green spaces, gyms, and active travel infrastructure

The prevalence by ethnic group

Context: The borough is less ethnically diverse than London as a whole. Among adults, 69% identify as White British; ethnic minorities include 11% Other White, 8% Asian (mainly Indian), 7% Black (mainly African), and 6% Mixed or Other (Office for National Statistics, 2023). People from ethnic minorities tend to live in the northwest and northeast of the borough (Figure 17). Bromley has a relatively large Irish Traveller community (0.2% of the total population), particularly in St Mary Cray East (1.5%) (Office for National Statistics, 2023). English is the main language of 92% of the population; the most common other languages are Portuguese (0.59%), Polish (0.58%), Romanian (0.56%), Spanish (0.54%), each spoken by approximately 1,700 residents (Office for National Statistics, 2023).

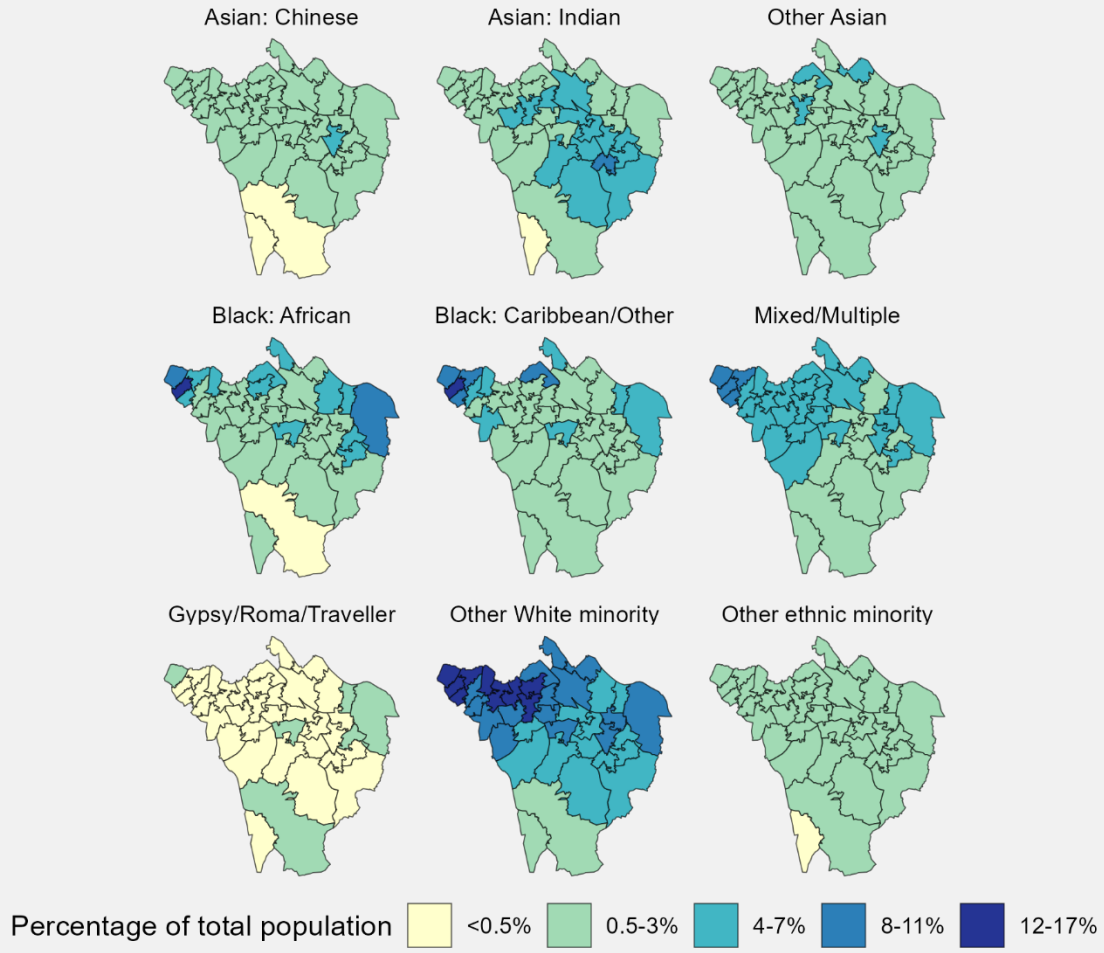


Figure 17. Distribution of minority ethnic groups in Bromley, 2021

The prevalence of obesity is highest in the Black ethnic group (29.9%), followed by Other White (20.2%), White British (19.5%), Mixed or Other ethnic groups (16.4%), and Asian (15.9%) (Figure 18).

Conversely, the prevalence of overweight is highest among Asian residents (37.7%), followed by Other White (33.9%), Black (30.9%), White British (28.8%) and Mixed or Other ethnic groups (24.5%) (Figure 18).

The absolute numbers of people with obesity and overweight are much higher in the White British group, reflecting population size (Table 5).

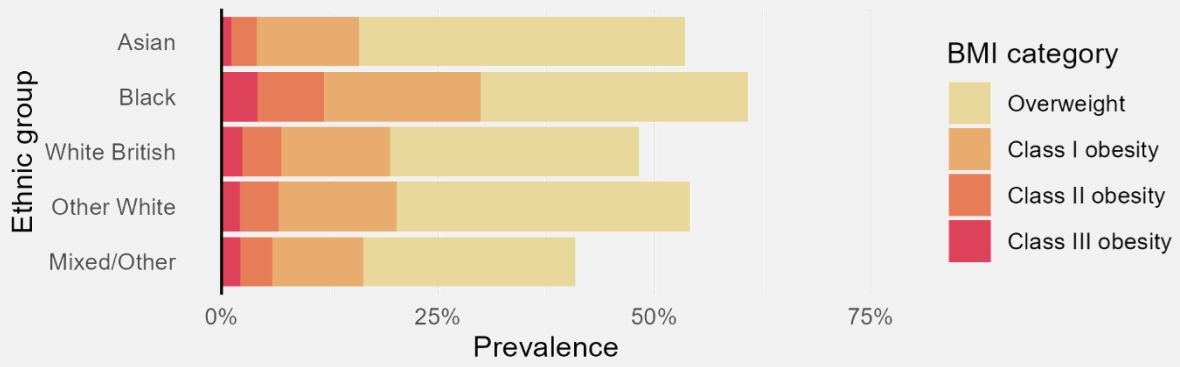


Figure 18. Prevalence of overweight and obesity by ethnic group, Bromley, 2026

Ethnic group	Resident adult population	People with obesity	Prevalence of obesity (per 100 adults)	People with overweight	Prevalence of overweight (per 100 adults)
Asian	20,115	3,194	15.9%	7,581	37.7%
Black	17,925	5,368	29.9%	5,534	30.9%
White British	176,555	34,422	19.5%	50,794	28.8%
Other White	27,018	5,453	20.2%	9,172	33.9%
Mixed or Other ethnic groups	14,166	2,325	16.4%	3,473	24.5%

Table 4. Counts and prevalence of obesity and overweight by ethnic group, Bromley, 2026

GP data quality did not allow calculation of prevalence using more granular ethnic categories (e.g., Indian, Polish). However, among detailed ethnic groups that were available, the highest numbers of residents living with obesity, after White British, were: White Other excluding Irish (4,189), Black African (3,159), Indian (1,536) and Black Caribbean (1,527). 19 people with obesity (and 19 people with overweight) had ethnicity recorded as White Gypsy or Irish Traveller, or Gypsy/Romany, but this may be an underestimate as people might not identify as such when registering at a GP practice.

The disproportionately high prevalence of obesity in the Black ethnic group, and of overweight in almost all ethnic minorities, is particularly notable given the different age distributions of these populations.

> **Context:** Bromley residents from minority ethnic groups are younger on average than those who are White British: 28% of White British residents are aged over 65, compared to 12% of Other White, 11% of Asian, 6% of Black and 5% of residents from Mixed or Other ethnic groups (Office for National Statistics, 2023).

A younger population would be expected to have a lower prevalence of obesity. After adjusting for age, the Black ethnic group has an even higher prevalence of obesity compared to the White British group (prevalence ratio 1.83, 95% confidence interval 1.56-2.14).

Similarly, age-adjusted prevalence of overweight is higher across minority ethnic groups: Asian (40% higher), Black (33%), Other White (29%) compared with White British residents.

These health inequalities by ethnicity likely reflect a combination of social, economic and structural factors.

> **Context:** In England, people from minority ethnicities are less likely than the White British group to follow national guidance on 5-a-day fruit and vegetable consumption, and physical activity (Department of Health & Social Care, n.d.). Black people in England are disproportionately affected by unemployment (Office for National Statistics, 2024) and low income (Office for National Statistics, 2025) and are more likely to live in deprived neighbourhoods (Office for National Statistics, 2020), which can limit access to healthy food and safe, convenient places for physical activity. Limited English language skills, affecting around 12.2% of Other White people, 7% of Asian Indian people and 3.8% of Black African people in England (Office for National Statistics, 2024), may act as a barrier to health information, behaviour-change support and navigation of NHS services. In addition, around one in five Bromley residents were born outside the UK (Office for National Statistics, n.d.). People from minority ethnic groups who were born abroad (Office for National Statistics, 2024) may be less familiar with how to access preventative or weight-management services in England.

Although Black residents show the highest prevalence of obesity, the pattern differs when examining central adiposity, which is more strongly linked to metabolic risk. These findings are based on the 34% of adults with known waist circumference.

Among people with class I obesity aged under 65, Black residents have the lowest likelihood of central adiposity, while Asian people have the highest. For example, among those aged 40-55 with class I obesity, only 35% of Black people had high central adiposity, compared to 46% of White British people, 47% of Other White, and 57% of Asian people (Figure 19).

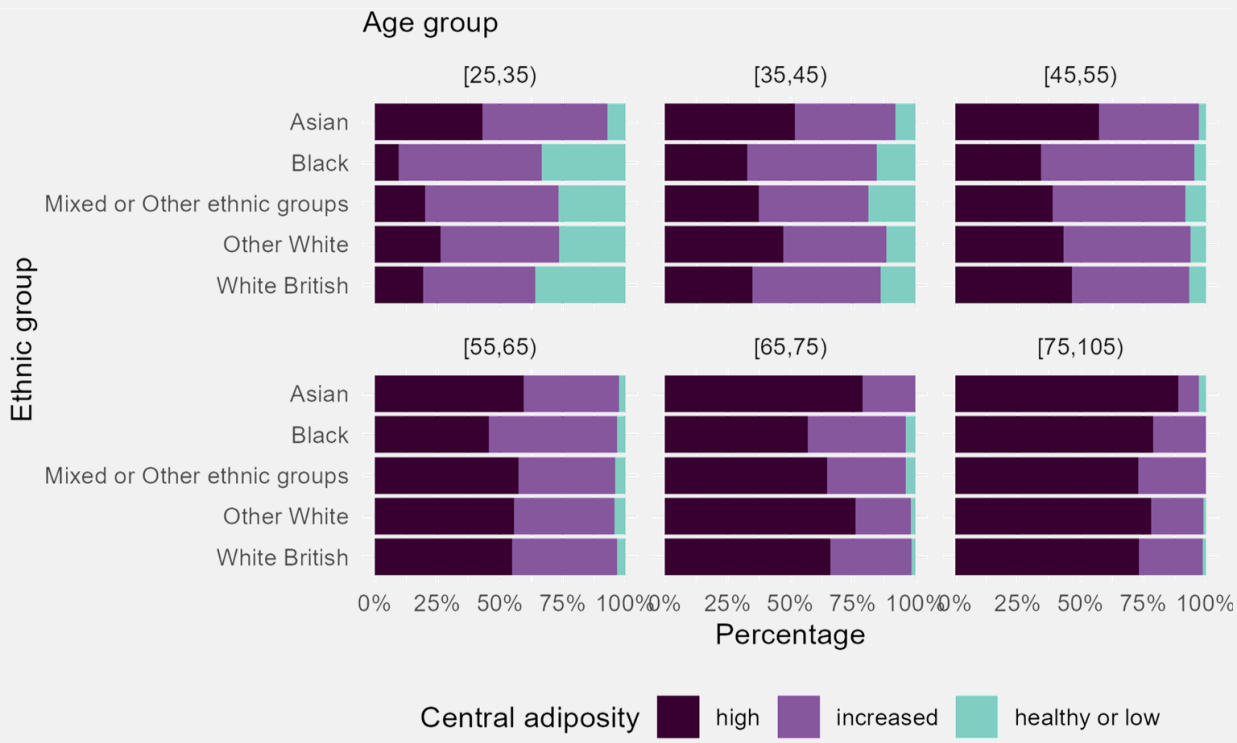


Figure 19. Comparison of central adiposity by ethnicity and age groups among people with class I obesity, Bromley, 2026

This suggests that, while Black residents may be more likely to fall into an obese BMI category, they are comparatively less likely to store fat centrally in the abdomen. This finding is in direct contrast with NICE guidance NG246 (section 1.8), which notes, on the basis of the committee's professional judgement rather than robust data, that people from Black (as well as Asian) backgrounds are thought to have a higher risk of central adiposity (National Institute for Health and Care Excellence, 2025). Our finding, however, aligns with recent research indicating that people of African ancestry tend to have lower visceral fat and higher subcutaneous fat due to genetic factors (Sun, Kovacs, & Guiu-Jurado, 2021).

> These results highlight the importance of measuring waist circumference and calculating waist-to-height ratio to assess adiposity patterns alongside BMI when evaluating metabolic risk at the individual and population level.

The causes of obesity

The cause of obesity might seem simple: body fat accumulates when, over time, we eat and drink more energy than we use.

However, behaviour is not only a product of free will: this explanation overlooks that our dietary choices and levels of physical activity are strongly shaped by a complex interplay of factors, which are not only personal (biological and psychological) but also at the wider level (societal, environmental and commercial), as summarised in Figure 20 (Government Office for Science, 2007). The current scientific consensus is that rising obesity in the UK over the past century reflects changes in the food and physical activity landscape that make it harder to limit calorie intake and maintain physical activity ('obesogenic environment'), acting on an underlying biological susceptibility to putting on weight (Government Office for Science, 2007).

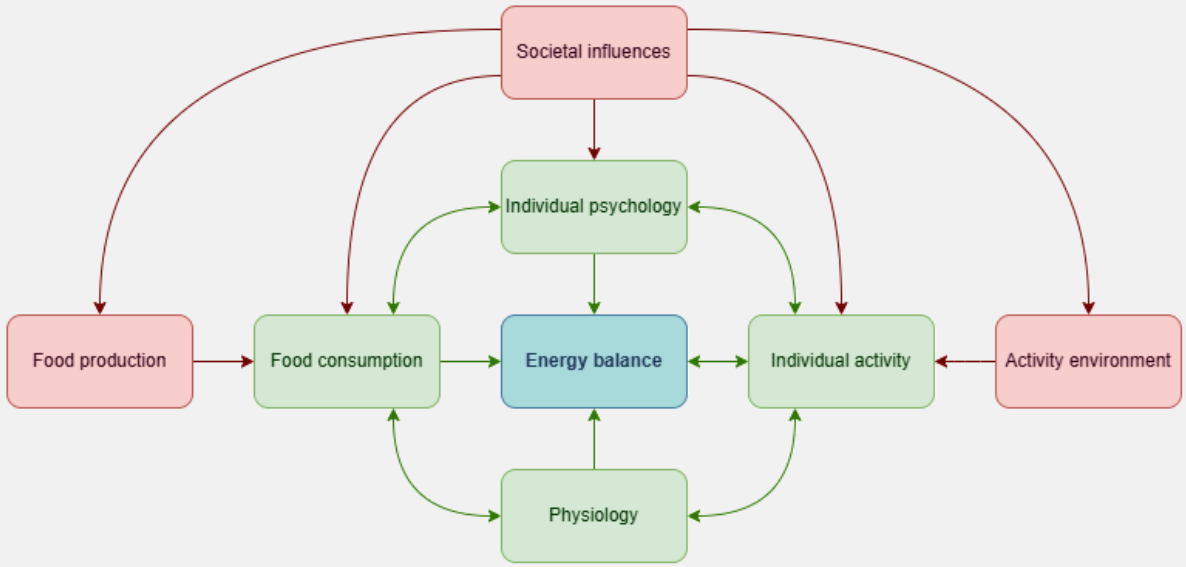


Figure 20. High-level factors influencing energy balance. Adapted from the 2007 Foresight report obesity system map (Government Office for Science, 2007).

Physiology

Oue bodies use a homeostatic biological system to regulate energy intake and expenditure, that would normally limit the need for conscious behaviour control (Lingvay, RV, CW, & P, 2024). However, this system evolved during times of great food scarcity (Government Office for Science, 2007), leading our bodies to have an appetite for foods that are high in sugar and fat.

Not everyone exposed to obesogenic environments develops obesity; many genetic variations influence weight gain, each with a small effect but collectively with large effects, most acting through central nervous system pathways (Lingvay, RV, CW, & P, 2024). Some people may be genetically predisposed to eating more food than is necessary, and the current surplus of energy-dense food has exposed this metabolic sensitivity (Government Office for Science, 2007). Conversely, research has failed to find evidence to support the belief that people with obesity must have slower metabolic rates. In fact, the opposite is true: people with higher weight expend more energy at rest, in order to maintain metabolism for the additional tissue (Government Office for Science, 2007).

Weight gain is influenced by certain diseases and some medications, but only in rare cases may it be directly caused by these (Rubino, et al., 2025).

Intentional attempts to lose weight by eating less or being more active trigger compensatory neuroendocrine adaptations that promote weight regain, via decreased energy expenditure and increased appetite (Lingvay, RV, CW, & P, 2024).

Food consumption

Adults typically need to consume 2,000 kcal per day for women and 2,500 kcal for men to maintain weight. Eating food with higher energy density, diets high in fat and low in fibre, drinking sugary drinks, and eating large portion sizes all increase the risk of obesity. This can occur by eating food not prepared at home, such as fast food and deliveries, as well as via comfort eating (Government Office for Science, 2007). Emerging evidence also suggests that increasing consumption of ultra-processed foods may be one of the drivers of the rising prevalence of obesity (Monteiro, et al., 2025). Diet is a preponderant factor in weight management, more so than physical activity (Department of Health & Social Care, 2026).

In 2023/24, only 35.2% of adults in Bromley reported meeting the '5-a-day' fruit and vegetable consumption recommendations, according to Active Lives survey data (Department of Health & Social Care, n.d.; National Health Service). While Bromley ranks 8th among London boroughs for this metric and performs better than London (29.7%) and England (31.3%) overall, this still means that nearly two thirds of adults are not achieving this basic dietary guideline.

More data for Bromley are not available. However, the latest national diet and nutrition survey (Office for Health Improvement and Disparities, 2025) showed that, in England:

- Only 1 in 25 adults (4%) met the fibre recommendation (at least 30 g per day)
- About 4 in 5 adults consumed more saturated fats than recommended (maximum of 10% of energy from saturated fats)

- About 4 in 5 adults consumed more free sugars than recommended (less than 5% of energy from free sugars)
- Among adults, men aged 19 to 64 years consume the highest amount of sugar-sweetened soft drinks (108 grams per day), but this steadily decreased in all age groups since 2008
- 77% of adults aged 19 to 64 years reported buying food or drink from the out-of-home sector in the 7 days prior to the survey

Data on ultra-processed foods are not routinely collected in England.

> What we eat and drink is partly a result of individual decisions, which are influenced by individual psychological factors, but they are substantially influenced by societal influences and the food environment (Government Office for Science, 2007).

Food environment and commercial determinants

Consumer demand for foods that are convenient, cheap, and palatable drives industry to produce long-lasting products that are high in fat, sugar and salt and low in fibre.

In the food industry, the growing dominance of profit-driven, transnational corporations has enabled the creation of an obesogenic environment and shifting its costs onto society, increasing health and environmental damage while weakening governments and other actors, leading to stalled policy action despite available solutions (Gilmore, Fabbri, Baum, Bertcscher, & al., 2023).

The food that the food industry produces, makes available, advertises and promotes in our surroundings, and the prices it sets, is a substantial driver of what we eat and drink. For example, the food industry decides which foods are available in supermarkets, canteens and vending machines (Government Office for Science, 2007). High-calorie food has become cheaper, more convenient and is heavily promoted by the food industry. Household income affects the quantity and quality of food bought; of note, the proportion of household income dedicated to buying food is higher in lower-income households (Government Office for Science, 2007).

However, the food industry needs to operate within legal regulations, so it can be influenced by government. In France, where obesity prevalence reduced from 14% to 11% in the last twenty years, food policy has included since 2004 measures to improve the food environment (Chauliac & Hercberg, 2012; Ministère de la Santé, des Familles, de l'Autonomie et des Personnes handicapées, 2026), for example by:

- facilitating reformulation of mass-produced foods to improve their nutritional profile
- banning vending machines in schools
- facilitating distribution of free fruit once a week for students.

The UK has more recently introduced measures to limit the promotion and placement of products that are high in fat and sugar in retail environments to reduce their influence on people's food consumption (Department of Health & Social Care, 2023).

Living close to fast food outlets, which mostly sell unhealthy or ultra-processed foods, is associated with higher levels of obesity, while the reverse is true for those who live close to supermarkets and greengrocers: urban planners may positively influence people's dietary habits by strategically placing these health-promoting shops in residential areas (Pineda, Stockton, Scholes, Lassale, & Mindell, 2024).

Data on the local food environment in Bromley are extremely limited. The borough had an estimated 90.3 fast food outlets per 100,000 population in 2024, according to Food Standards Agency data analysed by the Office for Health Improvement and Disparities (OHID) (Department of Health & Social Care, n.d.), corresponding to approximately one fast food outlet per 1,107 residents. This placed Bromley among the healthier boroughs, with the 4th lowest fast-food outlet density in London, well below overall London (138.5, 1 per 722) and England (115.9, 1 per 862) values.

However, people are exposed to foods and drinks high in fat, sugar and salt through a range of other channels, including retail outlets and food delivery services. These products are heavily marketed through outdoor advertising, television, social media, and smartphone notifications. Data on these sources of exposure are largely unavailable.

Bromley Borough owns digital billboards in Bromley High Street and Orpington High Street, managed by JCDecaux. At our request, JCDecaux provided information on advertising displayed on these billboards between November 2025 and April 2026. During this period, advertising included brands that produce food and drink high in fat, sugar and salt, as well as alcoholic drinks. These were Burger King Restaurants, Chicago Town Pizza, Ferrero Rocher, Capri-Sun, AG Barr Soft Drinks, and Campari.

Individual physical activity

Physical activity is any bodily movement produced by skeletal muscles for transport, work, or recreation.

While physical activity leads to energy consumption and can therefore contribute to healthy weight management (Department of Health & Social Care, 2026), studies on self-reported physical activity do not reveal a clear link with overweight, which may reflect the difficulty in measuring physical activity (Government Office for Science, 2007) or that increased physical activity leads to partial compensation because of increased eating or metabolic adaptation (Doucet, McInis, & Mahmoodianfard, 2018). Physical activity plays a supporting role in maintaining a healthy weight, regardless of our weight. Among people with overweight or obesity, it can support weight loss efforts, support the prevention of weight regain after weight loss, and it also reduces risk of cardiovascular disease and has other health benefits, irrespective of any change in weight (Department of Health & Social Care, 2026).

The CMO's physical activity guidelines for adults and older adults also apply to people living with obesity. Adults should aim to be physically active every day, with any activity being better than none. Adults should do muscle strengthening activities at least twice a week and, each

week, should accumulate 150 minutes of moderate intensity activity (or equivalent). They should also minimise the amount of time being sedentary (Department of Health & Social Care, 2026).

In 2023/24, three quarters (75.3%) of adults in Bromley reported being physically active[9], according to Active Lives survey data (Department of Health & Social Care, n.d.). This makes Bromley the 7th most active borough in London, outperforming both the London average (66.7%) and the England average (67.4%). However, it also means that about one in four adults in Bromley were not meeting national physical activity guidance.

Looking at active travel, in 2022/23 just over a quarter of adults (26.6%) in Bromley walked for travel at least three days a week, based on Active Lives survey data (Department of Health & Social Care, n.d.). While this figure is low, it is broadly in line with London overall (28.3%) and notably higher than the England average (18.6%).

In Bromley, physical activity levels are assessed during NHS Health Checks, Vital 5 Checks, and using the General practice physical activity questionnaire (GPPAQ), a screening tool used to identify people who are Inactive, Moderately Inactive, Moderately Active and Active (Department of Health and Social Care, 2013). People with coronary heart disease can be referred to exercise programmes.

> Our level of physical activity is influenced by multiple factors, including biology, psychology, social influences and the physical activity environment.

Physical activity environment

The work we do, where we live, the transport options available, and social norms all influence our levels of physical activity. Technological advancement has reduced the need for physical effort in the past century (Government Office for Science, 2007):

- The rise of sedentary employment and labour-saving devices and services (such as online shopping) have led to a reduction in the level of occupational and domestic activity
- Living environments that are unsafe or unpleasant for pedestrians, cyclists and wheelchair users reduce the level of transport activity
- The cost of physical exercise, lack of suitable venues and uptake in sedentary hobbies pose barriers to recreational activity

[9] Doing at least 150 minutes of moderate intensity physical activity (or equivalent) per week.

The Sport and Leisure Strategy 2026-2036 sets out how Bromley Council and its partners work together to help residents lead active lives by improving access to sport, leisure and opportunities for everyday physical activity (Bromley Council, 2025). The plan is structured around five themes:



Active Health

Seeking to reduce health inequalities through inclusive and accessible activity programmes



Active Young People

Aiming to increase participation among children and young people in safe and supportive environments



Active Places

Focusing on providing high-quality, sustainable and accessible indoor and outdoor facilities



Active Communities

Supporting thriving sports clubs and encouraging participation through community and mass-participation events



Connecting & Delivering

Promoting a shared strategic vision across partners to ensure physical activity opportunities are well coordinated, clearly communicated, and aligned with wider health and wellbeing objectives

Individual psychological factors

In obesogenic environments there is a psychological conflict between people's desire to be healthy or slim and what they find rewarding (e.g., foods high in fat and sugar; seeking comfort through eating). While no one escapes this psychological ambivalence, some people feel it more than others (Government Office for Science, 2007).

Heavier weight in adults is associated with certain cognitive traits, psychosocial factors, and mental health problems, as identified in a 2020 umbrella review: people that have certain cognitive traits may find it more challenging to regulate behaviours around eating and being physically active (Robinson, Roberts, Vainik, & Jones, 2020). Some common mental health problems, such as depression, are also associated with obesity; depression is likely both a driver and a consequence of obesity, because negative emotions can lead to overeating and weight stigma damages mental health (Robinson, Roberts, Vainik, & Jones, 2020).

> Most of these factors are only weakly associated with obesity, meaning that people with a healthy weight also often have these factors, just to a lower extent on average: people with heavier and healthier weight are psychologically relatively similar (Robinson, Roberts, Vainik, & Jones, 2020).

Finally, individual psychology is shaped by both social factors (such as stress) and biological factors.

Societal influences

Cultural attitudes towards food, activity and body size affect behaviours related to diet and physical activity. The value that a community puts on food affects the quantity and quality of food consumed by its members, while cultural norms around physical activity influences how active people are. Similarly, the attitudes towards fatness, including weight stigma, can affect peer pressure, body image and self-esteem (Government Office for Science, 2007).

In addition, early life experiences contribute to long-term behavioural patterns. During childhood, education and modelling by parents, peers and formal education influence food literacy, cooking skills, motor development and later habits. Broader societal factors also matter: media exposure increases contact with advertising of unhealthy foods, encourages unnecessary snacking and sedentary behaviour, and reduces time available for physical activity. At the same time, longer working hours and commuting contribute to time poverty, limiting opportunities for home meal preparation and regular exercise (Government Office for Science, 2007).

Weight stigma and how to address it

Weight stigma

Most people living with overweight or obesity experience weight bias and stigma (Rubino, Puhl, Cummings, & al, 2020).

Weight bias refers to prejudiced attitudes, beliefs, or assumptions overemphasising personal responsibility as the main driver of obesity and depicting people with obesity as gluttonous, lazy, lacking in self-discipline, unmotivated to improve their health and non-compliant with medical treatment.

Weight stigma results when these biases translate into devaluation, discriminatory behaviour, or marginalisation (Ginsburg, Daley, & Sheer, 2024) (Rubino, et al., 2020). Weight stigma comes from many sources, including workplaces, educational settings, traditional and social media, social interactions, fitness environments, and, crucially, healthcare professionals (Rubino, et al., 2020). In some instances, because of weight stigma, doctors, dietitians and physiotherapists do not provide people living with obesity with the advice, support and care that they need (British Dietetic Association, 2021). Moreover, shaming individuals for their weight not only does not motivate positive behaviour changes but can also lead to worsened disordered eating (such as extreme dieting, binge eating, and fasting) and avoidance of exercise, which can further harm physical health (Nutter S, 2024).

> People living with obesity often start accepting these degrading misconceptions ('internalised weight stigma').

People who experience or internalise weight stigma are at risk of substantial psychological harm, such as low self-esteem, self-hate, social isolation, depression, as well as physical harm, for example through cortisol dysregulation as well as the aforementioned negative changes in eating and activity behaviour (Nutter S, 2024).

Identifying weight bias

Weight bias can be **explicit**, involving consciously held negative attitudes towards people with obesity that are typically measured through self-report, or **implicit**, involving automatic negative stereotypes and assumptions that operate outside conscious awareness: healthcare professionals may not recognise they are biased against people of heavier weight (Ginsburg, Daley, & Sheer, 2024).

Several questionnaires have been developed to identify bias against people with obesity (Saxena I, 2021), including:

- Attitudes Towards Obese Persons (Allison DB, The measurement of attitudes toward and beliefs about obese persons, 1991)
- Beliefs About Obese Persons (Allison DB, https://psycnet.apa.org/doiLanding?doi=10.1037%2Ft76490-000, 1991)
- Fat Phobia Scale (Bacon JG, 2001)
- Implicit Association Test for Weight (Project Implicit)

> The latter has been proposed specifically to identify unconscious weight bias.

Strategies to reduce weight stigma among healthcare professionals

Our structured review of the literature identified that some interventions designed to reduce weight stigma among healthcare professionals have reported somewhat encouraging results (Wang, 2025).

The intervention types that appear most promising include:

- Educating professionals about the causes of obesity that are outside of the people's control
- Increasing awareness of the stigma experienced by people living with obesity in healthcare settings
- Facilitating discussion on weight stigma between healthcare professionals and people living with obesity
- Encouraging healthcare professionals to conduct reflective learning about their personal weight biases

However, the evidence indicates that reducing weight stigma is challenging. Studies suggest that unconscious weight bias cannot be effectively addressed through sensitisation lectures alone, highlighting the need for more comprehensive approaches. There is also some evidence that university-based interventions may be more effective than workplace-based programmes, potentially because they can be delivered over a longer period and allow greater opportunities for reflection and discussion.

The overall evidence base remains limited by study quality, short follow-up periods, and a reliance on attitudinal outcomes, making it unclear whether observed changes translate into lasting improvements in behaviour and patient outcomes (Wang, 2025).

An international consensus statement concluded that while raising awareness of the harms caused by weight stigma is important, this alone is insufficient to eliminate it, and that a broader shift in the public narrative around obesity is required (Rubino, et al., 2020).

Considerations to avoid reinforcing weight stigma in healthcare

NICE guideline 246 on overweight and obesity management contains advice to avoid reinforcing weight stigma during clinical consultations (National Institute for Health and Care Excellence, 2025), including:

- Addressing presenting complaints before attributing symptoms to overweight or obesity
- Thinking about social determinants before and during any discussions about obesity
- Asking permission before discussing overweight and obesity
- Exploring the person's own preferred terms to talk about obesity
- Using non-stigmatising language, such as "person living with obesity" (instead of "obese person")
- Talking about health and wellbeing improvements rather than simply focussing about weight loss

> The Office for Health Improvement and Disparities (OHID) has produced an e-learning module for healthy weight coaches that includes advice on how to have supportive and non-stigmatising conversations with patients with obesity (Office for Health Improvement and Disparities, 2021). The Royal College of General Practitioners (RCGP) has also prepared e-learning courses on management of obesity and overweight (RGCP Learning, 2026).

The impact of obesity

Obesity has wide-ranging impacts on health and wellbeing, including physical health, mental health and social wellbeing (Lingvay, RV, CW, & P, 2024); however, not all people living with obesity have health consequences (see section Clinical obesity, within this report). Obesity also has economic consequences for both the individual and society.

The consequences on people's physical health

Obesity directly causes alterations via the physical effect of higher fat tissue mass, the presence of additional fat within tissues, metabolic effects, and inflammation (Rubino, et al., 2025). These effects include osteoarthritis (particularly of the hips and knees), obesity hypoventilation syndrome, breathlessness and wheezing, lymphoedema of the legs, lipoedema, dyslipidaemia, gonadal dysfunction (which reduces fertility), steatotic liver disease, idiopathic intracranial hypertension, and restriction of routine activities of daily living (Rubino, et al., 2025).

Obesity-related diseases are those with partially overlapping aetiology and include: type 2 diabetes mellitus; obstructive sleep apnoea; atherosclerotic cardiovascular disease including

hypertension, stroke and vascular dementia; gallbladder disease; and many types of cancer (World Health Organization, 2000; Rubino, et al., 2025).

Comorbidities directly caused by excess weight are common in the analysed GP dataset. Osteoarthritis affected 16% of people with obesity (vs 12% of those with overweight), particularly in weight-bearing joints. Dyslipidaemia was present in 17% of people with obesity and 14% of those with overweight. Metabolic dysfunction-associated steatotic liver disease was less frequently recorded but still twice as common in obesity (3.5% vs 1.7%). Lymphoedema (1.1%) and lipoedema (<0.1%) were uncommonly recorded but may be underdiagnosed or under-recorded.

We estimated that, out of the 56,702 people living with obesity in Bromley, at least 17,240 (30%) have clinical obesity (Rubino, et al., 2025). Clinical obesity shows a much stronger association with central adiposity than with BMI-based obesity class. Among people with obesity in Bromley, the prevalence of clinical obesity increases from 23% in those with healthy/low central adiposity to 32% in those with increased central adiposity, and 42% in those with high central adiposity. In comparison, the prevalence based on BMI categories remains relatively uniform, at 30% in Class I obesity and 32% in both Class II and Class III obesity. This suggests that the waist-to-height ratio is a much more clinically relevant metric than BMI-based obesity classes.

Hypertension affected one-third of people with obesity (33%) compared with one-fifth of those with overweight. Type 2 diabetes mellitus was twice as common in obesity (15% vs 7.7%), and obstructive sleep apnoea (OSA) was recorded in 5.1% of the obese group. Cardiovascular conditions such as ischaemic heart disease, atrial fibrillation, and previous stroke were slightly more common among people living with obesity than among those who were overweight, or were comparable between the two groups.

Weight stigma, covered earlier, also contributes to physical harm, including worsened disordered eating, avoidance of physical activity, and professional misattribution of symptoms to obesity (Rubino, et al., 2025; Rubino, et al., 2020). Bias and stigma based on weight also make preventing and treating obesity more difficult (Rubino, et al., 2025).

Obesity is a major contributor to premature mortality: from age 40, people living with obesity have an average life expectancy around four years short than those of healthy weight (Bhaskaran, dos-Santos-Silva, Leon, Douglas, & Smeeth, 2018).

The consequences on mental health

Obesity is associated with poorer mental health, especially depression. As discussed in the previous section, the relationship is bidirectional; however, the balance of evidence suggests that excess body weight is more likely to contribute to psychological distress than vice versa. Several mechanisms may explain this, including the adverse effects of weight stigma and discrimination on mental wellbeing, as well as biological pathways such as increased systemic inflammation and dysregulation of the hypothalamic-pituitary-adrenal axis (Steptoe & Frank, 2023).

Mental health conditions were common in the analysed GP dataset. Anxiety disorders were reported in a quarter of people with obesity (25%, vs 22% in those with overweight). Severe mental illness was more common in obesity (2% vs 1.2%); this includes psychosis, bipolar

disorder and severe depression. Although comparison with people of healthy weight was not possible in this analysis, the observed gradient between overweight and obesity is consistent with the established association. However, these findings should be interpreted with caution. Mental health conditions are multifactorial, with other risk factors, confounding factors contributing to both obesity and mental ill health (e.g., deprivation), and bidirectional causation.

The impact on the economy

Obesity also has significant economic implications for both individuals and society. These include (World Health Organization, 2000):

- Tangible and intangible costs borne to the individual (for example, specialist equipment, lower income, psychosocial impact, additional healthcare costs, insurance premiums)
- Direct costs borne to the NHS associated with managing obesity and its related illnesses
- Indirect costs due to productivity losses and social care linked to obesity-related morbidity and mortality

> Frontier Economics estimated in 2023 that overweight and obesity cost the UK £98 billion annually, with about two thirds of this burden falling on affected people and one third (£35 billion) on the state and wider society. These costs are expected to rise with increasing prevalence (Bradshaw & Dace, 2023).

Weight management services in Bromley

Weight management principles

The primary aim of obesity management is to improve health and wellbeing, with weight loss serving as a practical surrogate marker of treatment effectiveness (Lingvay, RV, CW, & P, 2024).

Among people with obesity, losing weight produces clinically meaningful, dose-response improvements in health. Losing 5-10% of body weight is associated with improvements in glycaemic control, lipid profile, blood pressure, liver fat and medication requirements, with additional benefits seen in conditions such as sleep apnoea, urinary incontinence and depression. Greater weight loss (≥10%) can induce remission of type 2 diabetes and reduce the risk of a range of cardiometabolic conditions, while larger reductions (≥15%) are linked to further decreases in cardiovascular events, renal disease progression, obesity-related cancers and mortality (Lingvay, RV, CW, & P, 2024).

Improvements in health-related quality of life track with the degree of weight loss, particularly in those with higher baseline weight. Gains are typically most pronounced in physical domains (such as mobility, pain and general health) while improvements in mental health are present but generally more modest (Lingvay, RV, CW, & P, 2024).

Weight loss is initially achieved with lifestyle interventions relying on behaviour change support to achieve a nutritionally balanced energy deficit diet and increased physical activity (Lingvay, RV, CW, & P, 2024). Weight loss is variable and, like all obesity interventions, when the treatment is stopped, weight regain is common. When goals of care are not reached with lifestyle interventions alone, medications and bariatric surgery are recommended (Lingvay, RV, CW, & P, 2024), within restrictive inclusion criteria in the NHS.

Local weight management services

In England, weight management services are structured into tiers; in Bromley, they can be funded by NHS South East London ICS, NHS England, Bromley Council Public Health, or by the individual (Figure 21). People can access these services after an initial assessment; some services require additional criteria and a referral from a healthcare professional (Table 5).

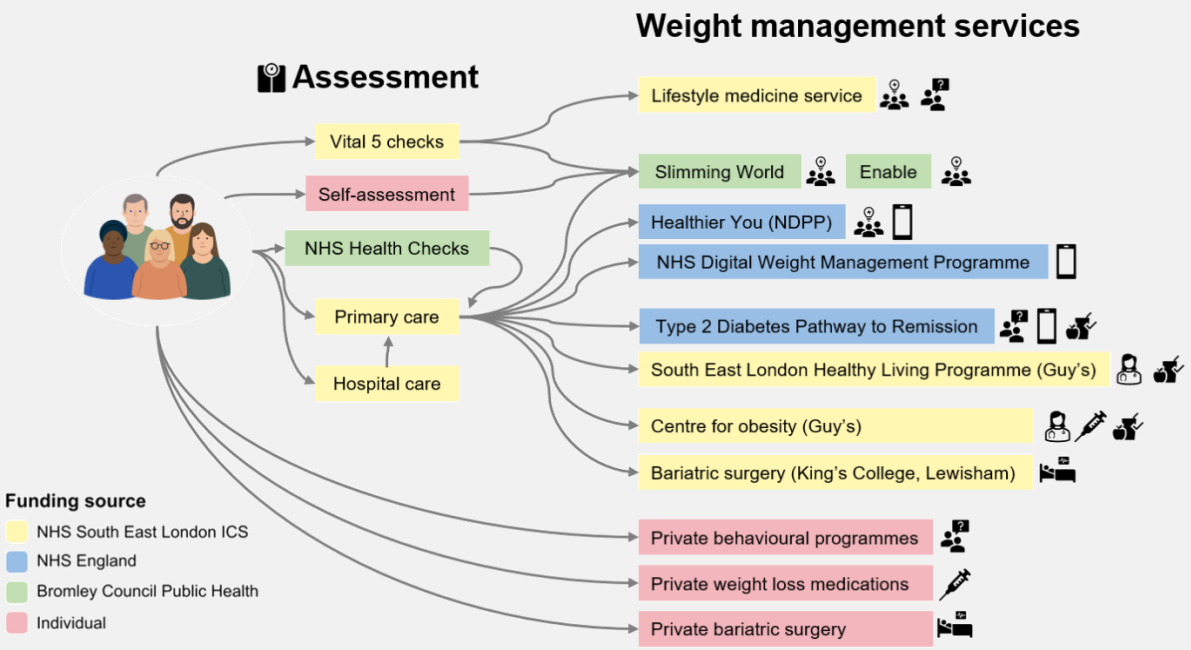


Figure 21. Local weight assessment and management pathways, Bromley, March 2026

Programme	Delivery	Current no. of Bromley venues	Facilitators	BMI	Additional inclusion criteria	Who can refer
Slimming World	Face-to-face group sessions, or Online	21	Previous programme members after specific training	30+ (27+)	None	Self
Enable	Face-to-face group sessions, or Online	2	Nutritionists Personal trainers	30+ (27+)	Learning disability (mild or moderate)	Self Clinicians Other
Lifestyle medicine	Face-to-face 1:1 sessions	1	Advisors with a Level 3 GP Exercise Referral qualification (or above) and specific training	25+ (23+)	None	Vital 5 check
NHS Diabetes Prevention Programme	Face-to-face group sessions, or Online	6	Health coaches	Any	Non-diabetic hyperglycaemia, or Gestational diabetes, or On tirzepatide (started as part of GP pilot trial)	Clinicians
NHS Digital Weight Management Programme	Online	0 (digital)	Health coaches	30+ (27+)	Diabetes mellitus, or Hypertension	Clinicians
NHS Type 2 Diabetes Path to Remission Programme	Face-to-face sessions, or Online	1	Nutritionists	27+ (25+)	Type 2 diabetes mellitus, age 18-65	Clinicians
Southeast London healthy living programme	Face-to-face 1:1 sessions, and Online	0 (hospital in neighbouring borough)	Specialist MDT	40+ / 35+	If BMI 40+: no other criteria If BMI 35-39: diabetes mellitus	Clinicians
Centre for obesity	Face-to-face 1:1 sessions, and Online	0 (hospitals in neighbouring boroughs)	Specialist MDT	35+	If BMI 55+: no other criteria If BMI 40-54: 4 qualifying conditions If BMI 35-39: urgent access criteria, or age ≤35	Clinicians

Table 5. Key characteristics of publicly commissioned weight management programmes accessible to adult Bromley residents

Eligibility overlaps and service navigation

As Table 5 shows, there is considerable overlap in eligibility criteria across the different programmes. To understand this better, we estimated not only how many patients were eligible for each individual service, but also how many programmes each patient was eligible to.

The new Lifestyle Medicine programme has the broadest eligibility criteria, including all people with overweight as well as obesity. People with obesity are always eligible for at least two multiple commissioned programmes: 43% are eligible for both Slimming World and Lifestyle Medicine, 32% for three programmes, 19% for four programmes, and the remaining 6% for five to seven programmes (Table 6).

Programme(s) eligible for	Overall N = 141,644[1]	Overweight N = 84,942[1]	Obesity N = 56,702[1]
Lifestyle Medicine	141,644 (100%)	84,942 (100%)	56,702 (100%)
Slimming World	56,702 (40%)	0 (0%)	56,702 (100%)
Enable LD	252 (0.2%)	0 (0%)	252 (0.4%)
NHS Diabetes Prevention Programme	28,831 (20%)	15,565 (18%)	13,266 (23%)
NHS Digital Weight Management Programme	21,800 (15%)	0 (0%)	21,800 (38%)
Type 2 Diabetes Path to Remission	5,783 (4.1%)	1,572 (1.9%)	4,211 (7.4%)
South East London Healthy Living Programme (T3)	9,080 (6.4%)	0 (0%)	9,080 (16%)
Centre for Obesity (T4)	608 (0.4%)	0 (0%)	608 (1.1%)
Number of programmes eligible for			
1	67,805 (48%)	67,805 (80%)	0 (0%)
2	41,741 (29%)	17,137 (20%)	24,604 (43%)
3	18,364 (13%)	0 (0%)	18,364 (32%)
4	10,553 (7.5%)	0 (0%)	10,553 (19%)
5	2,979 (2.1%)	0 (0%)	2,979 (5.3%)
6	200 (0.1%)	0 (0%)	200 (0.4%)
7	2 (<0.1%)	0 (0%)	2 (<0.1%)

Table 6. Estimated number of patients with overweight and obesity eligible for each programme, and for multiple programmes, Bromley, February 2026
[1]n(%)

We also estimated the number of patients eligible for each intersection, i.e., how many qualified for only one programme and how many for the various combinations (Figure 22).

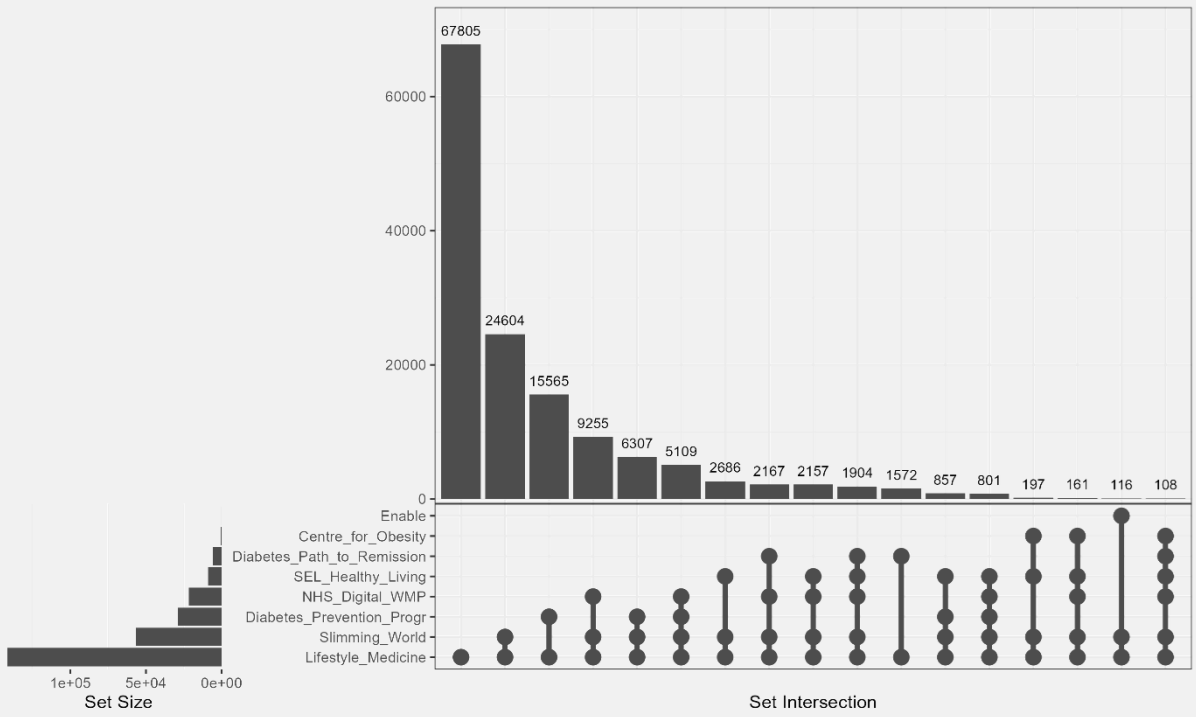


Figure 22. Estimated numbers of Bromley adult residents who are eligible for one or multiple weight management programmes[10], 2026

> This wide range of weight management programmes, combined with the frequent overlap in eligibility, makes it difficult for primary care clinicians to determine which programme to signpost or refer patients to.

To support this, Bromley practices use a referral optimisation protocol (ROP) embedded within their electronic patient records (a resource not currently available elsewhere in South East London). The ROP appears within the right-hand panel of the patient consultation record and, where patients are eligible for weight management support, provides direct links to the appropriate programmes alongside the relevant documentation and referral forms. While this is a valuable decision-support tool for clinicians, it can be easily overlooked. In addition, some clinicians remain unaware of the full range of weight management services (G2, C1, P4).

As a result, the overall offer can feel disjointed, with referral pathways and eligibility criteria perceived as difficult to navigate (C1). In July 2025, the South East London ICS recommended to adopt a **single point of access model** for all tier 3 and 4 weight management services in South East London, with a longer-term plan for including with tier 2 services (South East London Integrated Care System, 2025).

[10] Intersections with fewer than 100 eligible patients are not shown.

> *"Referral pathways for GPs are […] fragmented and uncoordinated, but we are trying to create a mechanism by which there's a much clearer way to navigate [them,] [with] a lower waiting time across our bariatric surgery providers and […] tier 3 providers [as well as] appropriate triaging of patients".*
>
> ***Interviewee C1***

The single point of contact model for tiers 3 and 4 would rely on the Electronic Referral System platform and incorporate proactive case finding (interview C1).

The interviewed commissioner acknowledged that expanding the single point of access model to tier 2 services and other community services, such as the new community tirzepatide services (see NHS prescriptions) has some additional complexities, including the need to use a platform that allows for complex coordination of referrals, which would likely need to be procured externally, and requiring additional funding. This needs to be scoped and co-designed, and it would be a project for financial year starting in April 2027.

An interviewed GP also noted that often obesity clusters in families, and so interventions involving the whole family may be more effective than the current services that target the individual.

Slimming World commissioned service

In 2023, Bromley Council commissioned Slimming World to deliver a 12-week, generalist weight management programme combining dietary advice, physical activity support and peer-led behaviour change.

The approach focuses on improving food choices rather than calorie counting, alongside gradual increases in activity tailored to individual preferences. Delivery is mainly via weekly 1-hour group sessions led by trained facilitators with lived experience, supplemented by resources (app, written materials, podcasts). Sessions include confidential weigh-ins and a structured behavioural support component emphasising goal-setting, problem-solving and peer support. A digital option offers similar content with less interpersonal interaction.

Adults aged ≥18 years with BMI ≥30 kg/m² who live in Bromley or are registered with a Bromley GP can self-refer or be signposted by clinicians; key exclusions include pregnancy and diagnosed eating disorders. Locally, around 56,700 patients are eligible. People may access any group in the UK; Bromley residents usually attend groups in the borough or neighbouring areas (Figure 23), or in central London.

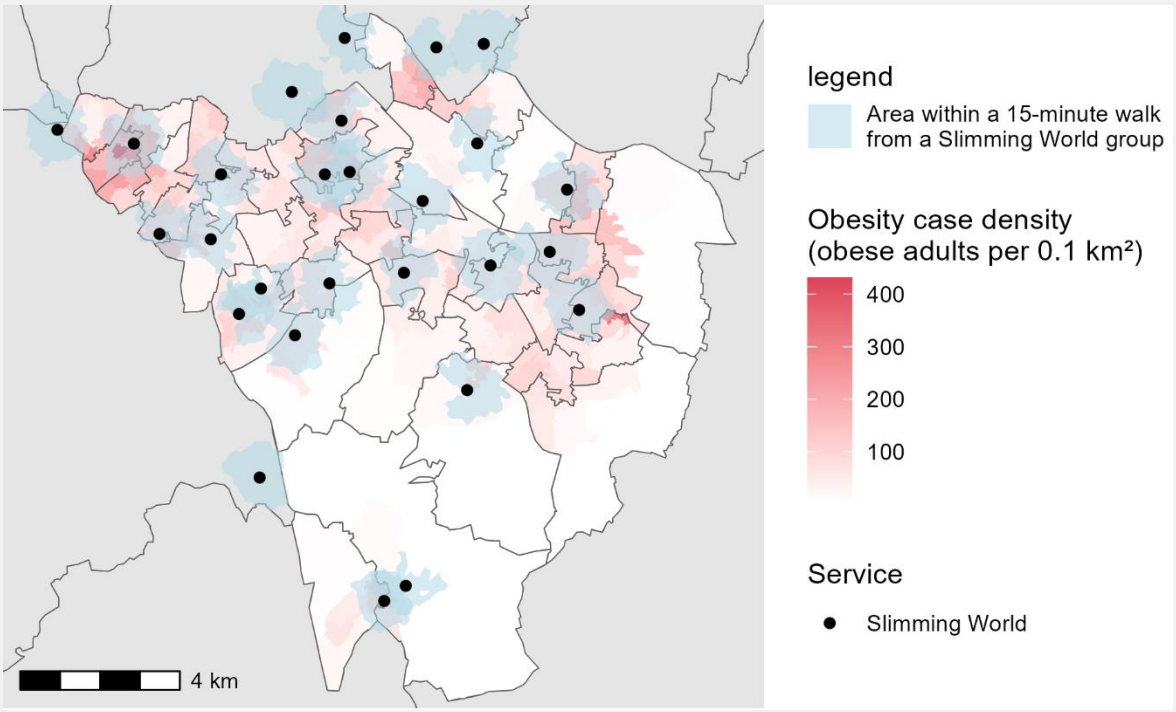


Figure 23. Coverage of Slimming World groups in Bromley[11], February 2026

Enable commissioned service

The Enable Learning Disabilities Weight Management Service, launched in 2025, is a 12-week specialist programme for adults with obesity and mild or moderate learning disabilities who live in Bromley or are registered with a Bromley GP. It is group-based (typically ~5 participants), free at the point of access, and accepts self-referral or referral via carers or GPs. Around 250 patients locally are eligible, most of whom also meet criteria for other weight management offers.

Sessions last two hours and are delivered by two facilitators: a nutritionist-led education component (including diet, sleep and wellbeing) and a tailored exercise session led by a personal trainer. Weights are recorded at baseline, mid-point and programme end. Delivery is primarily face-to-face (with some online provision), currently centred in Bromley South and Orpington, with plans to expand to areas of higher need such as Penge.

[11] In this map, solid lines indicate MSOAs, while obesity case density is plotted at LSOA level.

GLP-1 medications

The situation regarding the new weight management medications is rapidly evolving; the following reflects the position at the time of writing (February-March 2026).

In Bromley, eligible patients may access weight management medications only through GP referral to specialist clinical services (tiers 3 and 4), or by obtaining them privately. GPs are not currently allowed to prescribe these medications directly.

Private prescriptions of GLP-1s

Bromley residents can obtain the new weight management medications through private online pharmacies, after completing a brief online questionnaire and, in some cases, a tele-consultation with a prescriber. As of January 2025, the cost of a four-week supply ranges from £100 to £290 for semaglutide and £140 to £335 for tirzepatide, depending on dose, with introductory discounts commonly offered.

It is currently unclear how many Bromley residents access these medications privately. However, if local use reflects national patterns (an estimated 1.4 million people across the UK purchasing these medications privately) (Refsum, Bradshaw, Calvello, & Joshi, 2025), then approximately 6,900 people may be buying them in Bromley.

NHS prescriptions of GLP-1s

Interviewed GPs and commissioners reported very high demand from patients, contrasted with limited NHS capacity to deliver these treatments (G1, G2, C1).

> *[Many people] are desperate to get Mounjaro or Wegovy, [but] we have very limited access criteria at the moment because they're expensive drugs, which we […] haven't got funding for. […] And that disconnect, I think, hasn't filtered through to patients. So, patients are coming into GPs asking for the drug and they're not able to get them. That's a really fragmented, confusing position for GP referrers to be in.*
>
> ***Interviewee C1***

GPs can refer Bromley residents to the tier 4 specialist service for these medications if they meet Cohort I eligibility criteria or if they have a BMI[12] ≥ 35 kg/m² together with at least one weight-related comorbidity and need to lose weight urgently for one of the following reasons (South East London Integrated Care System):

- Planned, time-sensitive surgery for life-limiting conditions where a high BMI is the main barrier
- Active malignancy where urgent weight loss is required for planned therapy

[12] Lower BMI thresholds are recommended for people from Asian, Middle Eastern or Black ethnic backgrounds (National Institute for Health and Care Excellence, 2025).

- Urgent weight loss needed for organ transplant
- Idiopathic intracranial hypertension, needing frequent lumbar punctures and/or visual compromise
- Under the care of NHS fertility service and weight loss is needed for assisted conception
- Obesity hypoventilation syndrome

The tier 4 service can prescribe tirzepatide or semaglutide and provide wrap-around behavioural support. Prescribing responsibility may be transferred to the patient's GP once the medication has been titrated to the maximum tolerated maintenance dose, with a minimum of three months' prescribing by the specialist service.

Of the 56,702 registered patients with obesity in Bromley, 3,113 (5.5%) have received at least one NHS prescription for a GLP-1 medication. Tirzepatide was the most frequently prescribed (3.8% of patients) followed by semaglutide (1.7%), while liraglutide has been used only rarely. In addition, 1,428 patients with overweight were prescribed a GLP-1 medication (1.7%).

> There has been a rapid increase in the number of residents receiving a GLP-1 prescription over the past two years (Figure 24). This period of rising medication uptake overlaps with a general decline in participation in the commissioned Slimming World programme (Slimming World commissioned service), suggesting that increased availability and use of GLP-1 medications may be one of the factors contributing to reduced engagement with behavioural services.

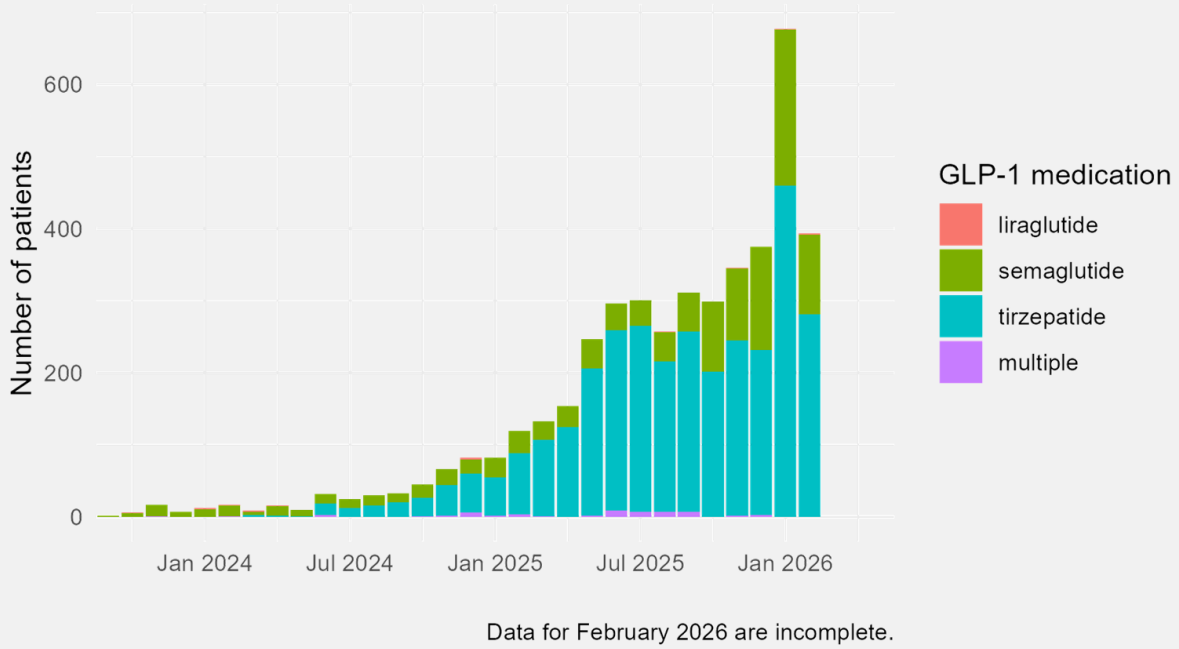


Figure 24. Number of patients with overweight or obesity who have had at least one NHS prescription for a GLP-1 medication, Bromley, October 2023 to early February 2026

Some groups with obesity were more likely than others to have been prescribed a GLP-1 medication: women (6.5% vs 4.2% of men), people aged 35-65 (6.4-6.8%, compared to 5.1% of those aged 18-25 and 4.6% of those aged 65-75), and people from the Mixed/Other ethnic group (6.1%) and White British people (5.8%), compared with 5.4% of Other White, 5% of Asian, 4.1% of Black residents. This poses a risk to widening health inequalities.

Given the restrictive referral criteria, interviewed GPs reported anecdotally that many residents are accessing these medications privately:

> *Because Bromley's fairly affluent, many people are getting [these weight loss drugs] privately, and not always appropriately. Some are even buying them off eBay.*
>
> ***Interviewee G2***

However, GPs recognised the effectiveness of these medications for patients with a clear clinical need who obtain them legitimately:

> *[Patients accessing these medications privately] seem to have been able to keep their weight down […] It helps control comorbidities like hypertension, sleep apnoea syndrome, diabetes much better.*
>
> ***Interviewee G1***

However, GPs also expressed some concerns. The most prominent was that some patients may view these medications as a substitute for lifestyle change, rather than being used in conjunction with them, leading to weight regain once treatment stops:

> *Once they're starting the medications […] I don't think it's a very wholesome lifestyle approach anymore. […] I've seen people who have stopped the injections and the weight comes back because they've not been able to […] motivate themselves.*
>
> ***Interviewee G1***

There was also apprehension that these medications could become long-term treatments without a clear exit strategy (G2, C1). Interviewed GPs further highlighted concerns regarding rare but serious side effects (G1, G2) and the risk of nutritionally incomplete diets due to reduced food intake while on treatment (G2).

An interviewed commissioner highlighted that meeting the full NICE-eligible population for obesity pharmacotherapy would require funding far beyond current levels, noting that both drug costs and the necessary behavioural-support infrastructure in primary and community care would demand a major, long-term reallocation of resources, potentially from hospital services, which has historically been very difficult to achieve (C1).

A **pilot trial** of GP-initiated prescribing of tirzepatide for Cohort I started in December 2025 in three other boroughs in South East London (Lambeth, Lewisham, and Southwark), commissioned using NHS England support funding and including proactive case finding. Behavioural support is provided by the local NHS Diabetes Prevention Programme. The pilot is expected to expand from Cohort II onwards to include Bromley residents by summer 2026 (South East London Integrated Care System), pending decisions on sources of funding and delivery methods. One interviewed GP noted that this change would be welcomed in primary care (G2). An interviewed commissioner mentioned that the future offer of tirzepatide services could be based in primary care or pharmacies, and it might eventually fall under the plans for a single point of access model if funding allows (C1) (see section Eligibility overlaps and service navigation, within this report).

In July 2025, the South East London ICS reviewed adult obesity pathways in South East London (South East London Integrated Care System, 2025) and recommended the development of a community wrap-around care model to support the use of the new weight loss medications, aligning with the work of the developing Integrated Neighbourhood Teams.

According to our analysis of the 141,644 patients with obesity or overweight registered with a GP in Bromley, 174 patients (0.1%) are eligible as part of Cohort I, while 749 (0.5%) will become eligible as part of Cohorts II or III (Table 7). Please see the detailed methods section of the Health Needs Assessment for important caveats on these estimates (Bromley Public Health, 2026).

Cohort	N = 141,6441
Cohort I (by 2026)	174 (0.1%)
Cohort II (by 2027)	294 (0.2%)
Cohort III (by 2028)	455 (0.3%)
Within 12 years	9,214 (6.5%)
Not currently planned	42,045 (30%)
Not MHRA authorised	89,462 (63%)

Table 7. Number of patients with obesity or overweight by estimated cohort of eligibility for pilot trial of GP-initiated prescribing of tirzepatide, Bromley, February 2026

Characteristics of patients in each cohort are listed in Table 8

Characteristic	Cohort I (by 2026) N = 1741	Cohort II (by 2027) N = 2941	Cohort III (by 2028) N = 4551	Within 12 years N = 9,2141	Not currently planned N = 42,0451	Not MHRA authorised N = 89,4621
Age in years	67 (59, 75)	71 (63, 78)	64 (56, 71)	61 (52, 70)	64 (54, 75)	48 (38, 60)
Gender						
Female	78 (45%)	113 (38%)	228 (50%)	5,295 (57%)	20,297 (48%)	45,564 (51%)
Male	96 (55%)	181 (62%)	227 (50%)	3,918 (43%)	21,745 (52%)	43,884 (49%)
Unknown	0	0	0	1	3	14
Ethnic group						
Asian	3 (1.8%)	11 (3.8%)	18 (4.0%)	367 (4.1%)	2,673 (6.6%)	8,291 (9.8%)
Black	11 (6.5%)	26 (9.0%)	41 (9.2%)	1,049 (12%)	3,393 (8.3%)	7,407 (8.7%)
Mixed/Other	4 (2.4%)	8 (2.8%)	17 (3.8%)	327 (3.7%)	1,465 (3.6%)	4,394 (5.2%)
Other White	11 (6.5%)	22 (7.6%)	43 (9.7%)	812 (9.1%)	3,678 (9.0%)	10,935 (13%)
White British	140 (83%)	223 (77%)	326 (73%)	6,359 (71%)	29,451 (72%)	53,960 (63%)
Unknown	5	4	10	300	1,385	4,475
Body Mass Index	43.7 (41.7, 47.6)	37.0 (35.9, 38.3)	43.3 (41.2, 46.7)	38.2 (36.3, 41.1)	30.3 (28.5, 32.7)	27.5 (26.1, 30.2)
Central adiposity						
Healthy or low	0 (0%)	0 (0%)	2 (1.2%)	32 (1.0%)	715 (4.6%)	4,498 (18%)
Increased	0 (0%)	8 (6.6%)	3 (1.9%)	339 (11%)	6,983 (45%)	15,317 (60%)
High	56 (100%)	113 (93%)	157 (97%)	2,752 (88%)	7,706 (50%)	5,781 (23%)
Unknown	118	173	293	6,091	26,641	63,866
Number of qualifying comorbidities						
0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	8,296 (20%)	77,319 (86%)
1-2	0 (0%)	0 (0%)	0 (0%)	8,419 (91%)	29,232 (70%)	10,839 (12%)
3	0 (0%)	0 (0%)	455 (100%)	795 (8.6%)	3,442 (8.2%)	1,019 (1.1%)
4+	174 (100%)	294 (100%)	0 (0%)	0 (0%)	1,075 (2.6%)	285 (0.3%)
Number with one or more weight-related health conditions	174 (100%)	294 (100%)	455 (100%)	9,214 (100%)	39,137 (93%)	13,949 (16%)

Table 8. Characteristics of patients with obesity or overweight by estimated cohort of eligibility for pilot trial of GP-initiated prescribing of tirzepatide, Bromley, February 202

Opportunities

Public Health team

Opportunity A. Explore potential for raising awareness about weight stigma and how to reduce it among clinicians in Bromley.

Opportunity B. Recommission the tier 2 weight management programmes for adults and children.

Opportunity C. Explore the possibility of conducting community engagement in the areas with the highest obesity prevalence (Anerley and Penge, St Mary Cray, Mottingham, Orpington East, Plaistow) to raise awareness and facilitate participation in the tier 2 weight management programmes for adults.

Bromley primary care

These are opportunities for primary care practices in Bromley.

Opportunity D. Encourage staff to complete training on sensitive, non-stigmatising conversations about weight, using the OHID Healthy Weight Coach e-learning module (Office for Health Improvement and Disparities, 2021).

Rationale. Weight stigma and clinician discomfort can reduce engagement; training improves patient trust and increases appropriate referrals.

Opportunity E. Encourage staff to complete training on the management of obesity and overweight using the RCGP e-learning courses on management of obesity and overweight (RGCP Learning, 2026).

Opportunity F. Increase routine measurement and accurate recording of height, weight, and BMI.

Rationale. Significant gaps in BMI recording lead to missed opportunities for early identification and support.

Opportunity G. Increase waist circumference measurement among patients with BMI <35 kg/m² to calculate waist-to-height ratio.

Rationale. Waist-to-height ratio is a stronger indicator of central adiposity and cardiometabolic risk, ensuring better risk stratification.

Opportunity H. Increase use of the Referral Optimisation Protocol for weight management.

Rationale. With most patients eligible for multiple programmes, the Referral Optimisation Protocol can support appropriate referrals.

South East London ICB

These are opportunities for the South East London ICB in collaboration with the Bromley Public Health department.

Opportunity I. Develop clear resident-facing communications to clarify NHS eligibility for the new medications and highlight the risks of unregulated private supply.

Rationale. High demand, restrictive NHS criteria, and widespread private purchasing have created confusion and safety risks; clear communication can reduce inappropriate demand and protect residents from unsafe online suppliers.

Opportunity J. Accelerate the rollout of the primary care pilot for GP-initiated tirzepatide prescribing to include Bromley practices, and with a proactive case-finding approach.

Rationale. Neighbouring boroughs already have access to the pilot, while Bromley, Greenwich and Bexley do not. Accelerating inclusion would support equitable access for Bromley residents and reduce widening inequalities created by uneven rollout.

Opportunity K. Review the Referral Optimisation Protocol for weight management, and to improve it where necessary.

Rationale. The ROP provides a valuable resource to signpost patients. However, anecdotal evidence suggests that ROP use is variable. A joint review would help identify any barriers to use and assess whether the tool could be improved.

Opportunity L. Extend the upcoming Single Point of Access to include tier 2 services in the next phase.

Rationale. Limiting the Single Point of Access model to tiers 3-4 maintains pathway complexity; expanding it improves coordination and ease of access.

Opportunity M. Explore joint commissioning of a tier 2 programme to provide the dietary and behavioural support required for patients using NHS-funded tirzepatide, particularly those with fewer comorbidities or as step-down support after the NHS Digital Weight Management Programme.

Rationale. Established tier 2 programmes are local and provide peer accountability, which could help sustain weight loss and maintain healthy habits once medication-induced weight loss plateaus or treatment ends.

National level

These are opportunities for national health policy.

Opportunity N. Take inspiration from France's National Food & Health Programme 2026-2030 (Ministère de la Santé, des Familles, de l'Autonomie et des Personnes handicapées, 2026) and its Sport & Health National Strategy 2025-2030 (Ministère des Sports, de la Jeunesse et de la Vie associative, 2025)

Rationale. The prevalence of obesity among adults recently decreased in France.

Opportunity O. Refer to Nesta's blueprint to halve obesity in the UK, listing health policies by impact on obesity, evidence quality and cost to government (Nesta, n.d.)

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