

Weight management medicines and services: a review of GPhC inspections and concerns

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Contents

About the GPhC	1
Executive summary.....	2
Background	4
What we did	5
What we found.....	6
Review of inspection data.....	6
Themes across inspection data	7
Review of concerns data	7
Themes across concerns data	10
Theme 1: prescribing practice	10
Theme 2: advertising practices.....	12
Theme 3: product concerns.....	12
Theme 4: customer services.....	13
Theme 5: dispensing practice and dispensing errors	14
Theme 6: unlawful supply	14
Recommendations	16
Resources	18
References.....	19

About the GPhC

Who we are

We are the regulator for pharmacists, pharmacy technicians and pharmacies in Great Britain.

We are a statutory organisation set up by the UK and Scottish parliaments, and we are independent from government and those we regulate. Our role and functions are set out in legislation called the Pharmacy Order.

We are funded by fees paid by the pharmacists, pharmacy technicians and pharmacies that register with us.

What we do

Our main role is to protect, promote and maintain the health, safety and wellbeing of members of the public by upholding standards and public trust in pharmacy.

We set standards to make sure that every pharmacy provides safe and effective care. And we provide guidance to help pharmacy owners achieve this.

We also inspect pharmacies to assess whether they are meeting our standards and to help them improve their systems and services.

Executive summary

Public demand for weight management medicines and services, particularly GLP-1 receptor agonists has increased significantly in recent years, alongside rapid growth in pharmacy led provision through General Pharmaceutical Council (GPhC) registered premises.

To assess the safety, quality, and governance of these services, and to identify actions for improvement for pharmacy owners, pharmacists and pharmacy technicians the GPhC reviewed pharmacy inspection reports and concerns received between January 2024 and December 2025.

The findings highlight the need for pharmacies providing weight management medicines and services to strengthen clinical governance and risk assessment processes to ensure that they meet GPhC **standards** for registered pharmacies. In line with GPhC **guidance for providing pharmacy services at a distance**, it is essential that medicines are supplied in a way that is safe and clinically appropriate, ensuring that there is independent verification of Body Mass Index (BMI), clear communication and accessible support.

Key findings

One in twenty pharmacy inspection reports referenced weight management medicines or services. Across these inspections, 106 standards (5.3%) were recorded as 'not met' or 'requiring improvement'. Common issues included:

- insufficiently documented or outdated risk assessments and clinical governance processes
- poor documentation of clinical consultations and decision making
- inadequate assurance of safety and safe processes when working with third-party prescribing services
- lack of independent verification or information to determine BMI and inconsistent clinical follow up

During the same period, the GPhC received 1,307 concerns relating to weight management medicines and services. The principal areas of concern were:

- prescribing practice (27%), including unsafe or inappropriate prescribing and poor clinical oversight
- customer service (25%), including delivery delays, refund disputes, and a lack of clear communication or accessible complaints processes
- advertising (17%), including non-compliant promotion of prescription only medicines
- additional concerns (31%) relating to product quality, cold chain failures, dispensing errors, and potential unlawful supply

Increased public awareness, supported by updated GPhC guidance and joint enforcement activity, is likely to have contributed to the rise in concerns received in 2025.

In line with **the GPhC's strategic aims**, this review sets out targeted actions for improvement to empower and support pharmacy owners, pharmacists, and pharmacy technicians in meeting GPhC standards, delivering safe and patient centred weight management medicines and services that protect the public and maintain public trust in pharmacy services.

Actions for improvement

For pharmacy owners and superintendent pharmacists

- Maintain robust risk assessments and up to date standard operating procedures (SOPs), with evidence of regular review. Ensure these are accessible and adhered to by all staff.
- Carry out due diligence checks on third-party prescribing services, ensuring they are appropriately registered, competent, and working in line with UK national prescribing and best practice guidelines.
- Conduct regular audits of service delivery, prescribing activity, and the effectiveness of clinical governance processes. Ensure understanding and compliance with all relevant GPhC standards and guidance.
- Ensure supply of weight management medicines and services follow national and local prescribing guidelines for the UK and good practice guidance including GPhC, MHRA and ASA.
- Ensure medicines procurement, storage, supply and delivery are safe, secure, and legally compliant with UK legislation and guidance.
- Ensure pharmacy teams are suitably trained and competent to carry out their roles and know how to respond to clinical queries from individuals using the service.
- Provide visible and accessible complaints and customer service procedures ensuring people can access timely clinical and administrative support.
- Provide accessible services with reasonable adjustments for people with protected characteristics or additional needs.
- Audit feedback and concerns to identify opportunities for continuous improvement.

For prescribers

- Independently verify medical history as well as weight and height to determine BMI, rather than relying solely on self-reported questionnaires.
- Clearly document all consultations and clinical decision making, including refusals of treatment and reasons for discontinuation.
- Review each supply individually to confirm ongoing clinical appropriateness

For pharmacists and pharmacy technicians

- Use good judgement and behave professionally when online and using social media and maintain clear professional boundaries.
- Ensure familiarity with and adherence to GPhC standards, guidance and other resources, including guidance on distance selling and other regulatory and best practice documents.

Background

Rising rates of obesity continue to present a significant public health challenge. Obesity is associated with reduced life expectancy and increased risk of numerous chronic conditions, including cardiovascular disease, type 2 diabetes, certain cancers, liver disease and respiratory illness, as well as **adverse impacts on mental health**. National survey data indicate that the prevalence of adults living with obesity is approximately 30% in **England**, 31% in **Scotland**, 25% in **Wales**.

Public interest in weight management medicines has grown substantially: **a recent poll reported** 21% of adults and 35% of those aged 16–34 years had tried to obtain weight management treatments from pharmacies. The availability of **GLP-1** receptor agonists licensed for weight management such as Semaglutide (Wegovy®) and Tirzepatide (Mounjaro®) have transformed the landscape of weight management services: their prescribing and supply remains high profile, attracting significant media coverage.

Access to weight management medicines is usually via private services, including those provided by both bricks-and-mortar and online GPhC registered pharmacies. All pharmacies, pharmacists and pharmacy technicians in Great Britain need to adhere to the GPhC **standards for registered pharmacies** and **standards for pharmacy professionals**, to ensure patient safety and uphold public confidence in pharmacy services.

In line with **our strategic aim** to empower pharmacy owners and the people we regulate to provide trusted, safe and effective care, this review shares insights to enhance pharmacy practices, promotes professionalism and continuous improvement in pharmacy and provides recommendations on how the people and premises we regulate can meet the standards we set.

What we did

We analysed two datasets held by the GPhC to complete this review: published pharmacy inspection reports and concerns data received between January 2024 and December 2025, that referenced weight management services or related medicines.

To identify the inspection reports for pharmacies providing weight management medicines and services, reports were searched for pre-defined search terms, which included the names of known medicines used for weight management and the terminology associated with 'weight management'. The reports were then reviewed against the **GPhC standards for registered pharmacies** for standards marked as 'not met', 'requiring improvement', or 'showing good practice' to identify and understand the reasons behind these ratings.

Concerns that contained the pre-defined search terms were extracted and reviewed. The information gathered was analysed and organised into themes, allowing common patterns and practice related issues to be clearly identified. Concerns were analysed using the initial information provided at the point of reporting. Some concerns were excluded as although they initially met the search criteria, further review showed that they were either unrelated to weight management services or lacked sufficient detail to be categorised into themes. Outcomes and subsequent investigation findings of the concerns were not reviewed: for some concerns there are ongoing fitness to practice investigations.

Emerging themes from inspection reports and concerns data were considered collectively to recommend actions for improvement for pharmacy owners, pharmacists and pharmacy technicians to improve the safety, quality, and governance of pharmacy weight management services. All inspection reports and concerns that met the inclusion criteria were included in the analysis, regardless of whether they resulted in any further regulatory action or not.

In February 2026, the GPhC introduced **new acceptance criteria** for assessing and progressing reported concerns. While all concerns submitted between January 2024 and December 2025 were reviewed, it is acknowledged that some concern types may not meet the new acceptance criteria for investigation in the future.

The GPhC also updated its **guidance for registered pharmacies providing pharmacy services at a distance, including on the internet** in February 2025, which occurred during the two-year period of data discussed within this report.

What we found

Review of inspection data

Between January 2024 and December 2025, a total of 77 inspection reports (5%) made reference to weight management services or associated medicines. Across these inspections, 2,002 individual standards were assessed (26 per pharmacy). Of these, 106 standards (5.3%) were recorded as 'not met' or 'requiring improvement' and one was highlighted 'for good practice'. The findings were drawn from 62 standards from bricks-and-mortar pharmacies and 44 standards from online pharmacies.

The 106 unmet or requiring improvement standards all related to 8 of the 26 regulatory **standards for registered pharmacies**, summarised in Table 1. The most frequent standards not met or requiring improvement were 1.1 (46%), 4.2 (28%) and 1.6 (15%).

Table 1: The GPhC standards for registered premises that were not met or required improvement

Standard	Number reported as not met	Number reported as area for improvement
1.1 The risks associated with providing pharmacy services are identified and managed	42	7
1.2 The safety and quality of pharmacy services are reviewed and monitored	3	0
1.6 All necessary records for the safe provision of pharmacy services are kept and maintained	10	6
2.2 Staff have the appropriate skills, qualifications and competence for their role and the tasks they carry out, or are working under the supervision of another person while they are in training	0	1
2.6 Incentives or targets do not compromise the health, safety or wellbeing of patients and the public, or the professional judgement of staff.	0	1
3.1 Premises are safe, clean, properly maintained and suitable for the pharmacy services provided	0	2
4.2 Pharmacy services are managed and delivered safely and effectively	26	4
4.3 Medicines and medical devices are: <ul style="list-style-type: none"> • obtained from a reputable source • safe and fit for purpose • stored securely • safeguarded from unauthorised access • supplied to the patient safely • disposed of safely and securely 	3	1

Themes across inspection data

Themes were identified from the inspection reports where pharmacies did not meet standards or required improvement.

Standards 1.1 and 4.2

Pharmacies did not adequately demonstrate:

- robust risk assessment processes. In many cases, risk assessments were absent, only partially completed, insufficiently documented, or not reviewed and updated in a timely manner.
- assurance that third-party prescribing services they worked with had robust risk assessments or appropriate clinical safeguards in place to manage service risks.
- processes for independently verifying a person's weight and BMI.
- follow up arrangements to ensure ongoing treatment remained appropriate and safe.
- adherence to their SOPs, particularly regarding the requirement for appropriate clinical checks before supplying medicines.

Standard 1.6

Pharmacies did not provide appropriate documentation of clinical consultations and prescribing decisions. Records lacked the level of detail required to demonstrate safe and clinically appropriate decision making.

Standards 1.2, 2.2, 2.6, 3.1, and 4.3

Pharmacies were unable to evidence:

- processes for regular service audit and review.
- ongoing training and continuous professional development for staff, including prescribers to maintain up to date skills and knowledge.
- compliance with advertising standards.
- accurate public facing information about the services provided.
- that medicines were stored in accordance with manufacturer requirements, particularly concerning cold storage. Pharmacies were also unable to provide assurance that an appropriate cold chain was maintained throughout the delivery process.

Good practice

One inspection report highlighted good practice for standard 4.2: the pharmacy was commended for providing its weight management service in a safe and holistic way, providing additional support to people to improve their lifestyle to help their overall health outcomes.

Review of concerns data

Within the GPhC concerns dataset, 1,307 concerns were received that referenced weight management services or medicines, as seen in Figure 1.

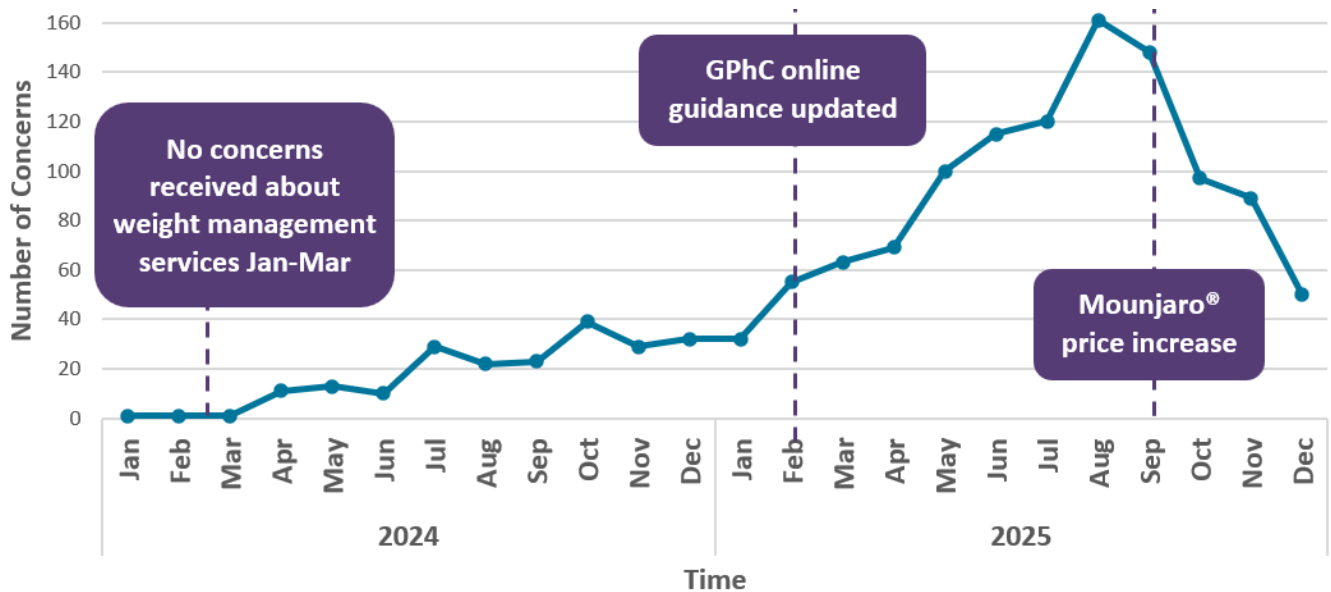


Figure 1: Concerns received that reference weight management medicines or services (2024- 2025)

Of the 1,307 concerns:

- ninety-three concerns were excluded for the reasons previously outlined.
- two hundred and eight concerns were received in 2024 compared to 1,099 concerns in 2025. The increase from May 2025 was mostly related to customer services and product concerns.
- the Mounjaro® price increase was announced in August 2025 to be implemented from September 2025, explaining the peak in concerns received between August and September 2025, with 78% of the total pricing related concerns occurring within these 2 months.
- seventy-six percent of concerns were submitted by members of the public and 10% were raised by pharmacists, pharmacy technicians, pharmacy owners or employers. The remaining 14% of concerns were received from other healthcare professionals, other healthcare bodies such as the Medicines and Healthcare Products Regulatory Agency (MHRA) or via the internal GPhC referral process following an inspection or receipt of relevant intelligence.
- The highest number of concerns received related to online pharmacies (49%) and bricks-and-mortar pharmacies (26%).
- The most common type of concern related to delivery and refund issues.

Concerns were reviewed and categorised into one of the following six overarching themes:

- Theme 1: prescribing practice
- Theme 2: advertising concerns
- Theme 3: product concerns
- Theme 4: customer services
- Theme 5: dispensing practice including dispensing errors
- Theme 6: unlawful supply

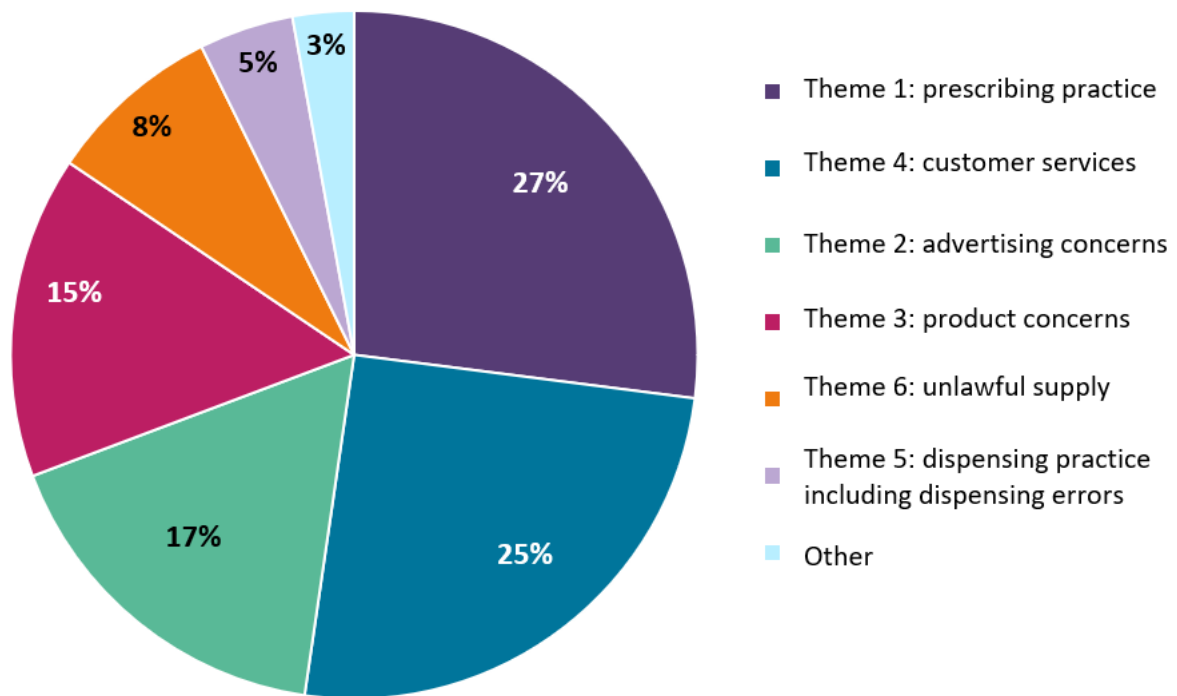


Figure 2: Concerns data by theme

Three percent of concerns could not be categorised into the 6 main themes so have not been included. They related to general patient and public feedback, employment concerns (target setting), General Data Protection Regulations (GDPR) breaches, staff members not following processes and provision of inaccurate healthcare information.

Themes across concerns data

Theme 1: prescribing practice

Concerns regarding independent BMI verification

- Inadequate or inappropriate verification of BMI, as required by the **GPhC guidance for registered pharmacies providing pharmacy services at a distance Including on the Internet** represented the third most frequently reported area of concern (11%). Of these, 72% were submitted by members of the public. Examples of these concerns included:
 - individuals with a history of eating disorders without appropriate BMI verification or without undergoing a thorough clinical assessment.
 - healthcare professionals reporting unsafe practice, including the absence of BMI or weight verification, or reliance on methods that were clinically inappropriate.
 - public concerns about the ease of accessing medicines, including instances where BMI could be self-declared through online questionnaires alone, or supported by photographs that could be easily manipulated.
- A notable increase in BMI related concerns occurred from February 2025, coinciding with the publication of GPhC's updated online guidance. This increased visibility and public awareness of the requirement for robust BMI verification.
- Members of the public also raised concerns about the professionalism and suitability of the methods used by some pharmacies to verify BMI and weight and how these were communicated to the individual. Examples included:
 - rejecting evidence submitted by wheelchair users, such as weight measurements recorded using a hoist scale, on the basis that it was 'insufficient'.
 - requests for photographs of individuals in 'tight-fitting clothes' or underwear to evidence body weight.
 - pharmacies attributing such requests to GPhC requirements, despite these practices not being aligned with regulatory expectations.

Concerns regarding people not meeting eligibility criteria

- Concerns were raised regarding medicines supply to individuals where they were contraindicated, or where the person did not meet the licensed indication criteria. This included individuals who were pregnant or actively trying to conceive, people with a history of eating disorders, and other vulnerable groups, including those under 18 years of age.
- Individuals with medical conditions that had special warnings or precautions for use, were supplied medicines without receiving any appropriate clinical monitoring, review, or follow-up.
- In one concern, an online questionnaire stated the list of contraindicated medicines, which more easily enabled individuals to provide inaccurate answers to avoid being declined treatment or having treatment discontinued.

Concerns regarding inadequate clinical follow-up and ongoing monitoring

- There were concerns highlighting inappropriate or insufficient clinical follow up after treatment initiation. These included instances where people did not receive timely or meaningful responses from pharmacies when raising clinical issues, such as questions about their treatment, concerns about medicines, or reports of adverse effects. In some cases, individuals received automated email responses promising clinician contact that never materialised.
- There were reports of medication being automatically titrated without clinical review, even when people had submitted information as to why this may be inappropriate, for example adverse effects.
- Several people stated they were confused or distressed when treatment was abruptly discontinued without any clinical assessment, explanation, or contact from the supplying pharmacy.
- There were also examples where people had received conflicting or in some cases unsafe advice, with one concern stating they had been advised to administer their injections intramuscularly rather than via subcutaneous injection, as licensed.

Concerns with record keeping

Concerns were identified regarding the accuracy, completeness, and governance of record keeping associated with weight management medicines. These included:

- Incorrect entries in medical records, noting that an individual had been prescribed weight management medicines despite never having received a prescription.
- Failures in accurate record keeping, including clinical records being sent to a retired GP and the continued prescribing of weight management medicines to a deceased person.
- GP practices reporting administrative and clinical governance concerns relating to online prescribers requesting that GP teams confirm whether weight management medicines were clinically appropriate before issuing prescriptions. Practices noted that this placed an undue administrative burden on them and inappropriately shifted clinical decision-making responsibility to GP services.
- Reports that GPs were informed of prescriptions issued by online providers, but that key information such as dose or treatment regimen was omitted. This resulted in incomplete or inaccurate GP records.
- One person reported that their GP had not been informed of their treatment, despite the individual having explicitly consented for the prescriber to share relevant clinical information with their GP.

Theme 2: advertising practices

Reported issues included:

- Websites displaying the names of prescription only medicines and using promotional discount codes to encourage treatment uptake.
- The use of social media influencers, particularly on platforms such as TikTok, with reports that pharmacies were paying influencers to promote weight management medicines using discount codes.
- Evidence of pharmacies engaging with online weight management forums to highlight ways of bypassing eligibility checks, or to promote pharmacies that lacked appropriate verification processes.
- Examples of direct marketing practices, including:
 - cold-calling individuals to advertise weight management services
 - inserting promotional leaflets into prescription bags or distributing them locally
 - displaying external posters and banners at bricks-and-mortar pharmacy premises

Theme 3: product concerns

Concerns with appropriate cold storage and stability of products

- Of the 184 concerns received relating to product issues, the majority focused on the condition of the medicines upon delivery, specifically whether the cold chain had been maintained during transit. Individuals commonly reported that products felt warm on arrival, that cool packs were melted, or that no cool packs or equivalent temperature control measures had been included.
- Many concerns related to medications being sent via postal or courier services, with items being left outside in food recycling bins, overnight in delivery vans, or returned to postal depots when recipients were not home or otherwise exposed to uncontrolled temperatures.
- In most cases, pharmacies informed individuals that the product remained safe to use due to manufacturer guidance indicating 30-day stability once in use. However, this often led to confusion about when the 30-day period commenced, whether from first use or from the point the product left refrigerated storage. Many people contacted the manufacturers directly and received conflicting advice about whether their product remained safe. People often felt they had no option but to dispose of the medication.
- Individuals reported receiving products in damaged outer packaging, as well as items where the manufacturer's packaging was not sealed or showed signs of having been opened. Recipients expressed significant worry that the device may have been compromised, or tampered with before delivery.
- For all product concerns, individuals were unable to resolve the issue with the supplying pharmacy and expressed ongoing worry regarding the safety of delivery methods, integrity of medicines, and the confidence in the pharmaceutical advice provided.

Concerns with faulty devices

- Concerns were raised regarding the functionality, reliability, and authenticity of weight-management injection devices supplied. Reported issues included:
 - devices failing to deliver the full four doses expected by the user
 - devices becoming jammed or failing to engage properly
 - devices “exploding” and releasing liquid unexpectedly
 - visible particles within the injection fluid, raising safety concerns
 - individuals reporting that the clinical effect of a product supplied by one pharmacy was noticeably different from the same medicine supplied by another provider, leading them to question the authenticity or quality of the product they received
- Across these reports, people consistently described difficulty obtaining clear or appropriate advice on how to manage faulty devices. Some were advised by pharmacies to return the device, while others were told the issue was likely due to user error. In most cases, individuals were informed that refunds would only be issued once the manufacturer confirmed a fault, requiring them to purchase a replacement device at their own cost while the investigation was ongoing.
- Several people disposed of faulty devices at their local community pharmacy, leaving them without a device to return, further complicating complaints, refund processes, and access to replacement medicines.

Theme 4: customer services

Concerns with delays in delivery or refund issues

- Customer service-related concerns accounted for 23% of concerns, with many individuals’ expressing significant difficulty in obtaining timely deliveries, securing refunds for undelivered medicines, or contacting the supplying pharmacy. Common issues included:
 - inability to reach the pharmacy due to limited or absent contact details
 - unanswered emails, nonfunctioning or disconnected phone lines, and a lack of an identifiable or accessible complaints process
 - ignored requests to cancel orders
- Many individuals reported requesting refunds for medicines they had not received. Some ultimately sought assistance from their bank or payment provider to recover the cost and contacted the GPhC after feeling they had exhausted all available routes to obtain their money. In several cases, individuals expressed a belief that the pharmacy’s behaviour appeared fraudulent or that there was no intention to supply the medication.
- Delivery delays frequently resulted in individuals missing scheduled doses, leading to emotional distress as well as adverse effects associated with interruption of treatment after gradual dose titration. These issues were further compounded by individuals being unable to obtain clinical advice regarding their symptoms or concerns due to the lack of a functioning or responsive customer services or clinical support channels.

Concerns with price changes

- Price changes accounted for 3% of concerns, with almost all reports received during August and September 2025. Individuals described being contacted by pharmacies with revised options after their order had already been approved and paid for. These options included:
 - accepting a lower dose of treatment than originally intended, in some cases representing a significant reduction
 - paying an additional fee to release the order from hold once stock was available
 - switching to an alternative weight management medicine
 - seeking a refund, although this option was not consistently offered
- Some people who attempted to request a refund were informed that a cancellation or administrative fee would be applied. Those who were able to request a refund frequently experienced the same delays and difficulties as previously outlined.

Theme 5: dispensing practice and dispensing errors

- Dispensing related issues accounted for 4% of concerns, highlighting a range of dispensing errors including:
 - wrong medicine supplied
 - incorrect quantities issued
 - medicines past their expiry date
 - medicines with an expiry insufficient for the prescribed treatment duration
- Concerns about medicines that had reportedly been given an extended expiry date by the MHRA, but individuals had not received adequate explanation or communication of this.
- Several concerns regarding receiving the wrong strength of medication which resulted in adverse effects due to deviation from the recommended titration schedule. One person required admission to hospital following administration of an incorrect dose.
- Several people receiving the wrong person's medication, with labels or contents belonging to another individual.
- Concerns also highlighted examples of unsafe or unprofessional dispensing practice, including:
 - medicines delivered without any dispensing label or instructions on how to administer the dose
 - supply of needles intended to facilitate extraction of additional doses from the device

Theme 6: unlawful supply

Concerns relating to misconduct

- Six percent of all weight management concerns related to the potential misconduct of pharmacists or pharmacy technicians. At the time of writing, most of these cases are still under investigation.
- Most reports centred on the diversion of weight management medicines, including allegations of medicines being obtained or supplied unlawfully.

- Other concerns described behaviour inconsistent with the **GPhC standards for pharmacy professionals**, including:
 - unlawful use or misuse of patient information
 - acting in breach of GPhC enforcement actions
 - conduct that may bring the profession into disrepute
 - completing unlawful tasks on behalf of another individual or organisation
 - providing misleading or unsafe medicines advice on social media platforms

Concerns related to legislation

- Concerns relating to unlawful supply for example involving international supplies were usually raised by regulatory authorities or border control agencies in the destination countries. These included:
 - supply of weight management medicines outside of the UK, to countries such as New Zealand, Canada, the USA, and Brazil
 - pharmacies sending medicines to Northern Ireland using ‘parcel motel’ services, with the intention of onward supply to the Republic of Ireland
- There were also concerns linked to online pharmacy websites imitating registered pharmacies, not showing GPhC registration numbers or using the names and GPhC registration numbers of other registered premises or pharmacists.
- Additional examples of unlawful supply or practice included:
 - pharmacies supplying weight management medicines to beauticians for onward, unauthorised supply
 - supplying medicines without appropriate GPhC registration
 - pharmacies working outside of contractual arrangements
 - individuals without appropriate qualifications or registration supplying prescription only medicines while impersonating pharmacists or prescribers

Recommended actions for improvement

Our findings will be shared with key stakeholders including other regulators, relevant government departments, professional leadership bodies and representative organisations in Great Britain, to help build shared understanding and support collaborative working.

These recommended actions for improvement support pharmacies, pharmacists, and pharmacy technicians delivering weight management medicines and services to meet the **standards for registered pharmacies**, and highlight areas for improvement to ensure compliance with other GPhC standards and guidance, including those relating to **pharmacy professionals**, **distance selling**, and **pharmacist prescribers**.

Actions for pharmacy owners and superintendent pharmacists

- There must be documented risk assessments for all aspects of the weight management services provided, that are regularly reviewed with updates clearly recorded. These must identify any potential risks to patient safety and demonstrate how these risks will be managed.
- All services provided must be supported by SOPs that are regularly updated and reviewed. Pharmacies should also be able to demonstrate that all staff members are familiar with and follow the most up to date SOPs.
- Pharmacies should ensure that any third-party clinics or prescribers they work with are registered with the relevant regulator within the UK and follow UK guidelines. Due diligence checks must be completed to ensure the service providers it works with operate safely and that relevant third-party documents are available to the pharmacy team for reference.
- Pharmacies are expected to regularly review the services they provide and carry out audits to make sure that its procedures are being properly followed and that they can demonstrate any changes or improvements made as a result.
- Pharmacies must keep all records required by law and any other appropriate records that demonstrate it provides safe and effective services. If providing a prescribing service, this includes records of all clinical consultations.
- Pharmacies are expected to undertake clinical audits and demonstrate any changes or improvements made. Prescribers must evidence ongoing continued professional development and have their prescribing audited and monitored by a suitably qualified person, to provide assurance they are working safely, effectively, and in line with national/local guidance.
- The supply of weight management medicines must follow UK national and local prescribing guidelines and good practice guidance. This should include specific consideration to guidance available to support vulnerable groups including individuals with eating disorders.
- All healthcare professionals involved in weight management services must maintain their clinical competence through appropriate continuing professional development.
- There should be robust processes to enable suitably trained staff to respond to clinical queries from people using their services in a timely manner, and ensure information on this process is clearly signposted and easily accessible to the public.
- Medicines should be obtained from licensed wholesalers or authorised suppliers and accompanied with appropriate information for the person to safely administer their medication.

- Medicines should be delivered safely and in line with manufacturer’s storage recommendations. There should be regular risk assessments and audits to provide assurance that:
 - the suitability and timescale of the chosen method of supply, dispatch and delivery are appropriate and protect temperature sensitive medicines
 - the chosen packaging is suitable, ensuring that it is tamper proof and/or temperature controlled
 - packages are tracked and monitored to ensure they reach the right person in the expected timeframe and to monitor any unexpected interruptions in delivery
 - there are robust, documented processes to manage any deviations to expected deliveries
 - the terms, conditions and restrictions of the carrier are in accordance with the service requirements
- If medicines are sold or supplied to people who are outside the UK, the laws that apply in the countries the medicines are being sent to (and via) must be followed. This includes making sure any medicines supplied are appropriate for use in the country of destination.
- Services should be reviewed regularly to ensure they are easy to access for all people and provide reasonable adjustments to improve access for people with protected characteristics or additional needs.
- The pharmacy should provide clear information on how people contact the pharmacy service if they have any concerns, require further advice or wish to raise a complaint.
- The pharmacy should have an ongoing process for auditing feedback and concerns to support service improvement.
- Pharmacies must adhere to the **joint enforcement notice** issued by the Committee of Advertising practice (CAP), the MHRA and the GPhC on the advertising of prescription only weight management medicines.

Actions for prescribers

- There should be clear documentation of any prescribing decisions made, including treatment prescribed and any follow up action or monitoring. There should also be documentation of any refusals of treatment with the associated rationale.
- If records need to be altered, it should be clear what was altered, when it was altered and by whom. All changes should be clearly communicated to the individual.
- When supplying weight management medicines, the prescriber should not rely on questionnaire models alone. They must independently verify the person’s BMI as per the **GPhC guidance for pharmacist prescribers**.
- Every supply request should be individually reviewed for clinical suitability.

Actions for pharmacists and pharmacy technicians

- Pharmacists and pharmacy technicians should use good judgement and behave **professionally when online** and using social media and **maintain clear professional boundaries**.
- Ensure familiarity with and adherence to GPhC standards, guidance and other resources, including **guidance on distance selling** and other regulatory and best practice documents.

Resources

GPhC guidance

[GPhC standards for pharmacy premises](#)

[GPhC standards for pharmacy professionals](#)

[Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet](#)

[In practice: Guidance for pharmacist prescribers](#)

[In practice: guidance on confidentiality](#)

[In practice: guidance on maintaining clear sexual boundaries](#)

[In practice: guidance on consent](#)

[Demonstrating professionalism online](#)

[Equity guidance for pharmacies](#)

GPhC information

[GPhC Inspection decision making framework](#)

[Providing weight management services FAQs](#)

[Weight loss medications FAQs](#)

[Safeguards to prevent diversion of medicines from registered pharmacies](#)

GPhC / BEAT joint information: [Supplying medicines for weight management](#)

ASA/ MHRA / GPhC: [Joint enforcement notice](#)

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