The Association of Greater Manchester LMCs

Tirzepatide (Mounjaro®) and the QOF obesity indicators

Information and guidance for practices on QOF indicators OB004 and OB005, 2026/27

TO	All GP practices across Greater Manchester, for the attention of partners, practice managers and prescribing leads
FROM	Association of Greater Manchester LMCs (AGMLMC)
DATE	22.09.2026
PURPOSE	Information and guidance only, to support each practice in reaching its own informed decision
READ WITH	NHS England, "Quality and Outcomes Framework guidance for 2026/27" (July 2026) — the definitive source; BMA / GPC England, "Focus on… the obesity indicator set in the QOF" (July 2026); GMMMG interim commissioning statement for tirzepatide (v1.2, Sept 2025)

About this document. The new QOF obesity indicators OB004 and OB005 have attracted significant attention nationally and locally. The detailed QOF guidance for 2026/27 was confirmed in July 2026, after the QOF year began in April, so practices may be making or reviewing this decision partway through the year. AGMLMC has therefore taken time to review the published guidance, relevant supporting documents and feedback received from practices before issuing this information note. This note is provided by AGMLMC **for information and guidance only**. It does not tell any practice what to do. Its purpose is to help partners review the work involved, assess whether the funding attached meets what is required, and make their own informed business and clinical decision. AGMLMC recognises that practices across Greater Manchester may reasonably reach different conclusions regarding participation in OB005 based on local workforce, infrastructure, financial and organisational circumstances.

In short. OB004 (case finding, referral and coding) is generally achievable within existing resource. OB005 (shared decision-making, the offer of pharmacotherapy within the approved NHS pathway, referral to behavioural support, and ongoing monitoring where treatment is initiated) carries a materially different workload and financial profile, and each practice should satisfy itself that it can deliver it safely and sustainably within its own circumstances before committing. Participation in QOF is voluntary; not pursuing an indicator is not a breach of contract.

1. What has changed

National funding arrangements which previously supported tirzepatide implementation have changed, with the Weight Management Enhanced Service ending and obesity activity now reflected within QOF indicators OB004 and OB005. The table below summarises the position; the Greater Manchester rows draw on the GMMMG interim commissioning statement (v1.2, September 2025).

Element	2025/26	2026/27
Service delivery funding	NHS England funding variation included funding for the management costs of prescribing tirzepatide, payable to ICBs	Withdrawn from the funding variation; obesity activity now reflected within QOF OB004 and OB005
Delivery route	Locally commissioned services and enhanced services	Reframed as core general practice activity, supported through QOF OB004 and OB005

Element	2025/26	2026/27
Formulary status (GMMMG)	RED from 24 March 2025 (specialist services only)	GREEN/GREY from 23 June 2025, access limited to the NHSE priority cohort, with GM sub-prioritisation of Cohort 1 by BMI (1a ≥50, 1b ≥45, 1c ≥40, all with ≥4 comorbidities)
GM funding assessment	GMMMG recorded that the GM allocation for 2025/26 "does not cover the anticipated prescribing costs"	Practices should refer to the current GMMMG position, as the interim commissioning statement may be updated

Note for practices: *The GM figures above are taken from the GMMMG interim commissioning statement v1.2 (September 2025). Practices may wish to check whether a later version has since been published.*

2. OB004 and OB005 are different, and worth considering separately

Indicator	What it requires	Points for practices to weigh
OB004 Case finding **5 points** **10–30%**	The percentage of patients aged 18 or over living with obesity (BMI ≥30 kg/m², or ≥27.5 kg/m² for patients of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background, recorded in the preceding 12 months) who have been referred to a weight management programme within 90 days of the BMI being recorded. Aligns with NICE NG246; the NHS Digital Weight Management Programme and relevant local authority services may qualify.	Case finding, referral and coding, generally deliverable within existing systems. Practices should review the requirements and determine locally how to approach delivery.
OB005 Pharmaco-therapy pathway **13 points** **50–80%**	The percentage of eligible patients (per NICE TA1026 Funding Variation cohorts, accounting for ethnicity and comorbidity status) who have a recorded shared decision-making discussion about the management of obesity and are offered NICE-approved medicines management (pharmacotherapy) for use in a primary care setting, with accompanying referral to a suitable behavioural support programme, in the preceding 12 months. Eligible patients meet the ethnicity-adjusted BMI thresholds and have at least four of five qualifying comorbidities (hypertension, dyslipidaemia, obstructive sleep apnoea, type 2 diabetes, cardiovascular disease), per the NHS interim commissioning guidance.	A materially larger and open-ended commitment. Each practice should assess viability before committing (see Sections 3 and 4).

Personalised care adjustments. The QOF guidance provides a "service unavailable" personalised care adjustment that applies specifically to OB004 and OB005 (recordable at any time in the QOF year), alongside the usual adjustments where the intervention is clinically unsuitable or the patient declines. Before entering a 'service unavailable' code, the contractor is expected to explore fully with the ICB whether a suitable service could be commissioned. Practices should familiarise themselves with the applicable PCA rules and coding requirements in the published business rules.

When considering how OB005 can be delivered, practices may wish to review the detailed business rules and coding requirements relating to the pharmacotherapy pathway and referrals, and to satisfy themselves that any pathway used meets the requirements of the published QOF rules.

Unsure which behavioural support service is available locally? Provision of the behavioural support ("wrap-around") pathway varies by locality and continues to develop. Practices that are unsure which service they can currently refer eligible patients into should contact their local ICB / Place team or the LMC for confirmation of the current route.

> **Note for practices:** *The published 2026/27 QOF guidance and business rules are the definitive source for point values, indicator wording, achievement criteria and personalised care adjustments. This note summarises them for convenience only; where anything here differs from the published rules, the rules govern.*

3. Reviewing the work against the funding

The central question for each practice is whether the funding attached to OB005 meets what is actually required to deliver it safely. AGMLMC would encourage partners to work this through for their own practice rather than assume it either way. Relevant considerations include:

- **OB005 is worth 13 points, with a payment range of 50–80%.** The 13 points are a fixed ceiling at the national QOF point value; the value does not increase with the number of patients assessed or monitored, and no points are earned below 50% achievement. Practices can calculate the cash value for their own list size from the current point price.
- **The headline value does not reflect the full clinical time.** Responsibility for any prescription rests with the prescriber signing it, even where review and follow-up are delegated.
- **Available modelling tends to exclude the surrounding costs** — training, administrative processing, clinical supervision, recall systems, coding, medicines optimisation and supporting infrastructure. Practices should ensure these are reflected in their own assessment rather than relying on the headline points value alone.
- **The GM commissioner has itself flagged a funding gap.** The GMMMG statement records that the 2025/26 GM allocation "does not cover the anticipated prescribing costs," and that full-population rollout would require "substantial unfunded capacity for prescribing and monitoring" in general practice.

> **Sustainability.** Practices may wish to satisfy themselves that the resources required to deliver OB005 are understood and sustainable within their own circumstances. A documented, reasoned view — reached either way — is sound practice.

4. The longer-term commitment: think beyond this financial year

A particular point for partners to weigh is that starting a patient on tirzepatide is not a single-year decision. Obesity is a chronic, relapsing condition, and these medicines are generally taken on a continuing basis; stopping is commonly followed by weight regain. A patient a practice initiates now may reasonably expect, and may clinically require, ongoing prescribing and monitoring for years to come.

The funding position, however, is set year by year and is not guaranteed to continue. The QOF points attached to this activity in 2026/27 carry no assurance that equivalent funding will exist in 2027/28 or beyond.

Indeed the nationally proposed cohorts widen over time — Cohort III (2027/28–28/29) reduces the threshold to three qualifying comorbidities at BMI 40 or above, which materially expands the eligible population — while there is no basis to assume the associated funding will rise in step. A practice could therefore find itself carrying a growing cohort of established, monitoring-dependent patients on medication it initiated, with reducing or absent funding to support that work.

This does not mean practices should decline to help patients. It means the decision to start a patient on tirzepatide should be taken with the **full lifecycle of that prescribing commitment in mind**, not only the incentive available in the current year. Practices may wish to consider how continuing prescribing would be resourced and governed if QOF funding for this area were reduced or withdrawn in a future year, and to factor that into both the practice-level decision and the shared decision-making conversation with patients. Conversely, commissioning arrangements may evolve over time, and practices should keep their local arrangements under review.

Starting and stopping are different decisions. A practice's decision on whether to participate in OB005 is a practice-level business and clinical decision. Continuity of care for individual patients already established on treatment is a separate matter. A practice may change its approach over time — services are withdrawn or redesigned for legitimate reasons — but decisions affecting patients already receiving treatment should rest on valid, documented and non-discriminatory clinical or service grounds, applying normal continuity-of-care and equality principles, rather than being made on an ad hoc basis. This is a further reason to consider the position carefully before initiating treatment.

5. Clinical and medico-legal considerations

Whatever a practice decides on the QOF question, the responsibility for any prescription signed rests with the prescriber, and that responsibility is not reduced by the level of funding attached to the work. Where a practice does prescribe, the following are important:

- Prescribing by an appropriately trained, competent and confident independent prescriber only.
- Adherence to the approved cohort criteria. Prescribing outside the approved cohorts is not supported by NICE TA1026, NHS England interim commissioning guidance, or GM commissioning arrangements.
- Behavioural support alongside any pharmacotherapy. NICE TA1026 and the associated implementation arrangements envisage pharmacotherapy being provided alongside behavioural support rather than as a standalone intervention; the OB005 indicator itself requires accompanying referral to a suitable behavioural support programme.
- Documented shared decision making, baseline assessment and ongoing monitoring, including a six-month review with discontinuation where less than 5% weight loss is achieved at the highest tolerated dose or where continued treatment is no longer clinically appropriate.
- Awareness that tirzepatide holds Black Triangle status (additional MHRA monitoring), that pancreatitis is a recognised risk, and that there are contraception and HRT considerations requiring counselling and follow-up.

The practical implication is that safe delivery and the monitoring it requires should not be constrained by what the funding happens to cover. If the two diverge, that is precisely the tension each practice needs to have considered in advance.

6. Suggested steps for practices

1. **Review the work and the funding for your own practice,** and consider whether the resources required to deliver OB005 are understood and sustainable in your own circumstances.

2. **Consider and document the practice's position.** Some practices may find it helpful to formally consider and record their position on participation in OB005, including the financial assessment, as this is a partnership business decision as well as a clinical one.
3. **Review the OB004 requirements.** Practices should review the requirements of OB004 — case finding, BMI recording, referral and coding — and determine locally how they wish to approach delivery.
4. **Factor in the longer term.** Consider how any prescribing you initiate would be resourced if QOF funding for this area were reduced or withdrawn in future years.
5. **Remember that QOF participation is voluntary.** There is no contractual requirement to pursue a QOF indicator and no sanction beyond the loss of the associated points. A reasoned decision not to pursue OB005 is not a breach of contract. Practices should ensure any decision is appropriately documented and supported by their own assessment of capacity, capability and sustainability.
6. **Contact AGMLMC if you would find it helpful.** We are happy to talk through the issues, and would be glad to hear of any variation you see between Places or any suggestion locally that this work is contractual.

This document is provided for information and guidance. Every practice remains free to reach its own decision, and AGMLMC is here to support you in doing so.