LMC POSITION STATEMENT

QOF OB005 — Tirzepatide (Mounjaro®): Warwickshire LMC's Position for Practices

2026/27 Contract Year | Issued August 2026 | Warwickshire LMC and Coventry LMC

1. NHS England's position

NHS England's position, set out in the 2026/27 QOF Guidance, Interim Commissioning Guidance (PRN01879), and OB005 FAQ (2026), is that **OB005 provides sufficient funding for practices to deliver tirzepatide initiation, titration, monitoring and ongoing management.** A separate Local Enhanced Service is "not required." NHS England estimates practices will manage an average of 16 eligible patients, implicitly assuming Cohort I was already initiated via a LES in 2025/26 and is now on maintenance, with only Cohort II being newly initiated in 2026/27. ICBs have adopted this position.

The ICB has since announced a non-recurrent funding package for Cohort I only, comprising: a fixed **mobilisation payment of £830 per practice** (payable automatically September 2026); and a **capped activity payment of £100 per patient** initiated on tirzepatide and referred to the Behavioural Support for Obesity Prescribing (BSOP) programme (payable following 2026/27 reconciliation). **No ICB funding has been offered for Cohort II.**

The ICB's current position is that **it does not intend to commission an alternative service for patients at practices that choose not to participate in OB005.** The ICB regards tirzepatide initiation as the responsibility of the registered practice. The LMC does not share this view and is actively challenging it. Practices that do not provide this service are therefore currently without a clear referral pathway for eligible patients, which is why the LMC is asking practices to formally request ICB guidance in writing — as set out in Section 5 below.

2. The LMC's position

The LMCs **do not share this view.** Our position rests on three grounds, set out below.

NHS England's position

- OB005 QOF payment provides sufficient reimbursement for tirzepatide initiation, titration, monitoring and management.
- A separate LES is not required.
- The 2026/27 cohort is compatible with existing LTC management workload.
- NHS England estimates 16 patients per practice on average.

The LMC's view

- The LMC's own cost analysis shows clinical staffing cost alone is £282 per patient in Year 1. In Coventry and Warwickshire, both Cohort I (~11 patients) and Cohort II (~13 patients) must be initiated from scratch, giving a total clinical cost of £6,761 for 24 patients.
- The total income available is £4,893 — comprising the maximum QOF payment (£2,963) plus the ICB package (£830 mobilisation + up to £1,100 activity for Cohort I). This leaves a shortfall of £1,868, and only if all 11 Cohort I patients are initiated and referred to BSOP.
- The ICB package does not fund Cohort II. NHS England's position is that QOF covers Cohort II, but this equates to only £228 per Cohort II patient (QOF max ÷ 13 patients) against a £282 initiation cost — a shortfall of £54 per patient before any other overhead.
- Safe initiation requires a minimum of 10 appointments per patient in Year 1 across GP, pharmacist and nurse. This is not embedded in existing LTC workflows.

3. What NHS England is doing — and why it matters

OB005 represents something qualitatively different from a standard QOF indicator. NHS England is using the QOF mechanism to commission a new specialist-adjacent clinical service — tirzepatide initiation, titration, monitoring and long-term management for a complex multimorbid population — without going through the normal commissioned service route. A service of this clinical complexity would ordinarily require a formally tendered and funded pathway, a service specification, agreed monitoring arrangements, clinical governance frameworks, and a tariff that reflects the true cost of delivery. Instead, it has been embedded in a voluntary quality framework at a point value that does not cover its costs, with the expectation that practices will absorb the gap.

This is not an accident of design. NHS England faces a genuine commissioning problem: 3.4 million people are eligible for tirzepatide, specialist weight management services lack the capacity to absorb them, and a formally commissioned pathway at scale would require investment and revenue commitment NHS England cannot currently make. QOF offers a workaround: a quality indicator that transfers the service into general practice without a specification, a cost-reflective tariff, or formal commissioning commitment. The financial risk moves to practices.

The mechanism works because QOF participation is nominally voluntary — but the framing obscures real pressure. Practices that decline lose income, face peer comparison, and — as the ICB's current position makes clear — are left without any alternative pathway for their patients, making participation the path of least resistance even where it is not financially viable. This is a fundamental misuse of the QOF framework. QOF was designed to incentivise measurable clinical outcomes, not to commission new clinical services. It lacks the safeguards proper commissioning requires: needs assessment, capacity planning, cost modelling, clinical governance, and a mechanism for practices to challenge the specification or negotiate the tariff.

This matters beyond OB005. If accepted without challenge, it creates a template for NHS England to embed other complex, underfunded services into general practice through voluntary QOF indicators at below-cost tariffs — a long-term structural threat to the financial sustainability of general practice and to the integrity of the QOF framework.

Where a service genuinely belongs in primary care, the appropriate route is a formally commissioned arrangement with a cost-reflective tariff, a service specification, clinical governance, and a negotiation mechanism. The LMC calls on NHS England and ICBs to develop such a model for obesity pharmacotherapy. Until they do, practices are entitled to decline OB005 participation and the LMC will actively support them.

4. A growing workload — and a greater burden in this area

Both Cohort I and Cohort II are eligible in 2026/27, giving an estimated denominator of **~24 patients per 10,000-patient list this year**, rising to ~39 with Cohort III from 2027/28. The LMC is not aware of any commitment from NHS England to increase OB005 funding in line with this growth. The ICB funding package is explicitly non-recurrent and covers Cohort I only.

Critically, no LES was commissioned in this ICB area for Cohort I in 2025/26. This means practices here face initiation costs for both Cohort I and Cohort II simultaneously. Even with the ICB non-recurrent package, our cost analysis shows a clinical workload shortfall of **£1,868** against total income. The LMC's preferred position is that tirzepatide prescribing should not sit in primary care at all, but if it does, a properly funded LES covering all current and future cohorts is the minimum acceptable arrangement.

QOF funding is not a growing pot. **The total value of the QOF framework has remained broadly constant in real terms.** When new indicators are introduced — as OB005 has been — the points and funding are redistributed from indicators that are retired or reduced elsewhere. The 13 points for OB005 did not represent new money; they were funded by withdrawing the Weight Management Enhanced Service and reallocating points from other areas. Any future increase in OB005 funding would similarly require reductions elsewhere in QOF. Practices that invest in building a tirzepatide service on the basis of current QOF income should not assume that income will increase in line with the growing workload.

The scale of this concern was acknowledged by NICE itself when publishing TA1026. The phased 12-year rollout was explicitly introduced to avoid displacing other NHS services — an acknowledgement that full funding of the eligible population at once was not viable. NICE's Chief Medical Officer stated:

> *"We have had to make this difficult decision in order to protect other vital NHS services and also to test ways of delivering this new generation of weight loss medications. We want to help NHS England carefully manage the roll out of tirzepatide to ensure that other services are not impacted in a disproportionate way."*
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> **— Professor Jonathan Benger, Chief Medical Officer, NICE (December 2024)**

NICE's own words confirm the LMC's position: embedding this service within QOF at current funding levels transfers the resource constraint to general practice without resolving it.

5. What practices are entitled to do

OB005 requires **actual prescribing** to achieve the numerator. The QOF business rules select patients who have been prescribed pharmacotherapy for obesity management within the reporting year alongside a recorded SDM discussion and behavioural support referral. A practice that holds the SDM conversation and makes a documented offer but where no medication is prescribed will not generate numerator patients and will not achieve the indicator threshold, unless appropriate exception codes are in place.

The BMA's position is that **the presence of OB005 in QOF does not make prescription of tirzepatide for obesity core General Practice work.** Practices that choose not to chase these QOF points will not be required to initiate these patients.

However, practices **still have a contractual duty to manage patients who present.** Where a patient appears eligible for tirzepatide, the practice should inform them of this, explain that the practice does not initiate the medication, and advise them that they have asked the ICB for a referral pathway. This is why the LMC is asking practices to **contact the ICB in writing, copying in the LMC,** to request referral pathway clarity. A template letter is available from the LMC office.

The RCGP was equally clear when TA1026 was published:

> *"Expanding the rollout of tirzepatide at the scale proposed will have significant practical and resource implications for the NHS and primary care. It's vital that general practice is resourced appropriately, and that GPs have the necessary training to safely take on any additional responsibility that comes their way."*
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> **— Professor Kamila Hawthorne, Chair, Royal College of General Practitioners (December 2024)**

That resourcing has not materialised. The LMC's position reflects theirs: redistributed QOF points are not adequate resourcing for a new clinical service of this complexity.

What OB005 requires for achievement

- A recorded SDM discussion.
- NICE-approved pharmacotherapy prescribed within the reporting year, or an appropriate exception code.
- Referral to behavioural support alongside prescribing.
- All three must be present for a patient to count in the numerator.

Practices that do not provide this service:

- Are not required to initiate tirzepatide.
- Forego the 13 OB005 QOF points.
- Must still manage patients who present and inform them of their eligibility.
- Should advise patients on the ICB referral pathway once confirmed.

QOF is a voluntary incentive scheme. Practices are **under no contractual obligation to participate in any individual indicator**, including OB005. The BMA's position is that declining to chase OB005 points does not mean practices are failing in their contractual duties. It means they are not providing an enhanced service that goes beyond core GMS. This is not a clinical failure or a breach of contract.

In summary: what this means for your practice

- The BMA's position is that **OB005 does not make tirzepatide prescribing core General Practice work.** Practices that choose not to chase these QOF points are not required to initiate patients. However, practices **do still have a contractual duty** to inform patients who present that they meet NHS criteria for tirzepatide, and to direct them to the ICB referral pathway.
- The ICB has offered a **non-recurrent funding package for Cohort I only**: a £830 mobilisation payment plus £100 per patient initiated and referred to BSOP (maximum £1,930 per practice). This brings income close to clinical cost for practices in areas that ran a prior LES (£28 shortfall). It does not fund Cohort II.
- In Coventry and Warwickshire, the clinical workload cost for 2026/27 is estimated at **£6,761 for ~24 patients** (both Cohort I and II to initiate) vs total income of £4,893 (QOF + ICB package) — a shortfall of **£1,868**. This shortfall exists even assuming all 11 Cohort I patients are initiated and referred to BSOP. See the Cost Analysis Appendix.
- The LMC's preferred position is that tirzepatide prescribing should not sit in primary care at all, but if it does, **a properly funded LES covering all current and future cohorts is the minimum acceptable arrangement.** The non-recurrent ICB package for Cohort I only is not adequate.
- Practices are **entitled to not prescribe tirzepatide and decline OB005.** There is no penalty beyond loss of 13 QOF points.
- The LMC is **engaging with GPCE on this** and pressing the ICB and NHS England for adequate commissioned pathway funding. We will update practices as positions develop.