First published June 2026

BMA England

Focus on...the obesity indicator set in the Quality and Outcomes Framework (QOF)

Introduction

This guidance document invites practices to carefully consider the potential benefits and disadvantages of seeking to achieve the obesity indicator target OB005 (pages 70-71) within the public health domain of the QOF for 2026/27. These amount to a total of 18 points worth a maximum of £4,103.10.

Use of finite resources, and the limited incentive money on offer, means that attempting to achieve these points is highly unlikely to be cost-effective for your practice, given the additional workload that it requires.

Policy and contractual context

As part of the imposed contract changes for 2026/27, NHSE England introduced OB004 and OB005 in order to implement NICE guidance TA1026 (NICE recommendations on the use of tirzepatide for managing overweight and obesity in adults) and 'support referrals into structured weight management programmes and medicines optimisation'. At the same time, the existing weight management Enhanced Service was retired. Implementation in 'Primary Care' had been proposed in 3 cohorts:

Funding Variation Years	Estimated Cohort Duration	Cohorts	Cohort Access Groups	
			Comorbidities	BMI
Year 1 (2025/26)	12 months	Cohort I	≥4 'qualifying' comorbidities hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes mellitus	≥ 40
Year 2 (2026/27)	9 months	Cohort II	≥4 'qualifying' comorbidities hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes mellitus	35 – 39.9

Year 3 (2027/28 and 2028/29)	15 months	Cohort III	3 'qualifying comorbidities hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes mellitus	≥ 40

These three cohorts are expected to cover approximately 220,00 patients over the three years.

The current changes to QOF implement from 'year 2' and so for the current contractual year covers both cohorts 1 and 2, with cohort 3 covered if retained for 2027/28. It is the position of GPC England that this is an entirely inappropriate approach towards implementing this and will have a negative impact for practices and patients, especially as the proposed phased expansion of cohorts will potentially increase the associated costs and workload considerably in future years.

QOF is a voluntary incentive program designed to reward quality of care. It is not a commissioning route and should not be used as such. A far more effective approach, for both practices and patients, would be to provide a suitably resourced enhanced service, as had occurred locally in numerous areas of England.

During the 2026/27 GMS contract 'consultation', GPC England raised concerns that this would likely impact these locally commissioned services for the prescribing and monitoring of tirzepatide, as ICBs may look to utilise these indicators as an alternative form of provision, allowing them to cut commissioning costs.

We understand from LMC intelligence that this has now happened in several ICB footprints and the number is growing.

The legal basis for QOF being voluntary

Despite what some ICBs have recently told LMCs and or practices, QOF is voluntary rather than contractual.

The core legislation, the (General Medical Services Contracts) Regulations sets out mandatory contractual services and define what *must* be provided under the contract. There is no provision in the Regulations requiring a contractor to participate in QOF, nor any breach/sanction regime for 'non-participation', or for not attempting to achieve particular indicators, apart from the loss of the associated points/funding.

Workload and funding implications

Workload implications

Delivering this work is likely to require a material level of clinical input that is not fully reflected in the headline value of the available QOF points. In practice, prescribing responsibility will still need to sit with a GP or other appropriately qualified independent prescriber, even where elements of review and follow-up are undertaken by other members

of the practice team. The contact assumptions used in this modelling should therefore be treated as a minimum estimate only, given the clinical complexity of this cohort and the need for safe prescribing, monitoring, and follow-up.

The NICE TA1026 also effectively mandates provision of wrap-around care alongside the prescribing of tirzepatide for all patients receiving tirzepatide, regardless of their setting of care, as acknowledged by NHS England commissioning guidance.

These estimates are also likely to understate the true operational burden on practices. They do not include the additional time and cost associated with training, administrative processing, clinical supervision, patient recall systems, coding, medicines optimisation activity, or the wider infrastructure needed to deliver a safe and sustainable service. As a result, the true cost to practices may be higher than the figures set out below.

Financial implications

Year 1: At best, practices may approach cost neutrality only under highly constrained conditions with optimised workforce models

Year 2+: Cohort 3 onwards will see eligible patients more than doubling with no inherent matched QOF funding. The resulting rapidly escalating workload with a static income ceiling will lead to an increasing financial deficit over time.

Practices with higher clinical engagement may be financially penalised due to increased workload, as greater patient uptake directly increases unfunded activity without corresponding increases in income.

What practices need to do

Given there are several costed and formally ICB (integrated care board)-commissioned obesity services across England, your practice should consider whether it is financially viable for practices to deliver the voluntary QOF indicator incentive target OB005.

Where you determine it is not financially viable, GPCE recommends that practices do not overtly attempt to chase the points available for QOF indicator OB005 and calls for NHS England to ensure that a properly costed and commissioned service is available in every ICB area to resource the associated workload.

July 2026