Introduction to NEL Obesity Management Clinical Policy – FAQ's

Programme Implementation and Timelines

1. **When can practices begin implementing the new GLP-1 weight management pathway?**

Following the publication of 2026/27 QOF obesity indicators in April 2026, alongside the NEL obesity management clinical policy, NEL practices can begin implementation as soon as it is practically feasible.

A phased approach is recommended to support practice capacity and as initial steps practices may wish to focus on:

- Undertaking relevant training (as outlined in the NEL GP Obesity Management Resource Pack) and becoming familiar with both QOF requirements and the NEL clinical policy
- Identifying eligible patients using available searches (refer to Q2 and also the NEL GP Obesity Management Resource Pack). Keep an eye on register, patients may be added throughout the year.
- Referral to tier 2 weight management programmes (refer to the NEL Clinical Policy)

2. **When will the QOF obesity searches and associated EMIS searches be available and updated?**

PrescQIPP has developed searches to support the identification of patients eligible for access to tirzepatide in line with the NICE funding variation. These can be accessed via the following link (registration required): Download tirzepatide cohort searches

This information has also been included in the NEL GP obesity management resource pack.

3. **When will the behavioural support service referral form be integrated into EMIS?**

The referral form for the NHSE commissioned behavioural support service for weight management (Healthier You) is now available within GP IT systems across NEL.

The name of the referral form is **(RP) Healthier You: NHS Behavioural support for weight management NEL CEG V1.**

4. **When will the supporting resources, templates, and guidance documents be available to practices?**

Nationally developed templates for GP IT systems are available free of charge. Further information on how to access these can be found via the following link: Templates.

The NEL GP Obesity Management Resource Pack is expected to be available in June 2026.

For further guidance refer to the NEL clinical policy and 2026/27 QOF.

5. **When will the planned drop-in support sessions commence?**

The weekly Obesity Management drop in sessions for primary care, commenced on 2nd June 2026.

Practice clinicians can join the weekly obesity management drop-in sessions with a Barts Health Consultant Physician in Diabetes and Obesity to discuss clinical queries. These sessions run every Tuesday from 1-2pm. You can join the session using the following link: Joining link

6. **When will the ICB commission a Tier 3 weight management service across NEL?**

NHSE has shifted funding for obesity management from specialist weight management services into primary care via QOF, with the introduction of 2 QOF obesity indicators to support access to tirzepatide in primary care.

Access to semaglutide remains available for eligible patients via a Right to Choose provider, such as Oviva, or through the Barts specialist weight management service (which accepts consultant-to-consultant referrals only). Both options are Tier 3 weight management services. The Barts specialist weight management service is in its pilot year with the aim to extend for future years.

Refer to the NEL Clinical Policy for further information.

Eligibility Criteria

8. **What are the eligibility criteria for tirzepatide prescribing under the new pathway?**

The eligibility criteria for tirzepatide follows the NICE funding variation, which is summarised below:

- Body Mass Index (BMI) of at least 35kg/m^2 (lower thresholds reduced by 2.5kg/m^2 required for some ethnic groups)
- At least 4 qualifying weight related comorbidities
- An initial face to face clinical assessment is required before initiation
- Patient commitment to Behavioural Support for Obesity Prescribing (BSOP) programme

Refer to the NEL clinical policy for further details.

9. **Is eligibility based on one obesity-related comorbidity or four comorbidities?**

NICE guidance recommends tirzepatide for adults with obesity with a BMI of at least 35kg/m2 (with lower thresholds for some ethnic groups) and at least 1 weight-related comorbidity.

However, within the NHS in England, access is being implemented through a phased roll out in line with the NICE funding variation. Initially eligibility is restricted to patients with 4 obesity related comorbidities. This approach enables ICBs to prioritise highest clinical risk groups while managing capacity and overall affordability in the system.

10. **If four comorbidities are required, how will practices realistically achieve the QOF targets?**

The requirement for four comorbidities (as set out in the NICE funding variation), rather than the single comorbidity threshold in NICE guidance, reflects the phased approach to implementation within the NHS.

In practice, this means that GPs should initially focus on identifying and managing patients who meet these higher-risk criteria, rather than the broader population described in NICE guidance.

This targeted approach is intended to support manageable workload, prioritise patients at highest clinical risk, and enable safe and sustainable implementation within primary care.

As QOF has been aligned to the NICE funding variation criteria, practices should focus on identifying and managing patients who meet these thresholds to meet QOF requirements.

11. **Can you provide a simple summary of who is eligible and who is not eligible for tirzepatide prescribing?**

A summary of eligibility criteria, including cautions and contraindications is provided within the NEL Clinical Policy. Practices should refer to this for full details when assessing patient suitability for tirzepatide prescribing.

12. **How should practices assess previous engagement with Tier 2 weight management services when determining eligibility?**

NEL ICB Medicines & Pharmacy Team is liaising with the local authorities as they commission tier 2 weight management programmes

13. **Will patients who are unable to access Tier 2 or lifestyle intervention programmes (for example, people with learning disabilities or severe mental illness) be prioritised for treatment?**

NEL ICB Medicines & Pharmacy Team is liaising with the local authorities as they commission tier 2 weight management programmes

Referral Pathways and Service Models

14. **What are the approved referral pathways for weight management and GLP-1 prescribing across NEL?**

Approved pathways in NEL depend on the intervention required. For QOF OB004, practices should refer eligible adults with obesity to an appropriate weight management programme in line with the local or national tier 2 service availability, these can be found on page 4 of the NEL clinical policy. For semaglutide (Wegovy®), access remains through NEL specialist weight management services, following local specialist referral routes or via a Right to Choose provider. For tirzepatide (Mounjaro®), the policy supports access within primary care for patients who meet the eligibility criteria, with prescribing linked to referral of the required wraparound (behavioural) support.

15. **Can practices continue referring eligible patients through Right to Choose providers such as Oviva for medication and wraparound support?**

Yes, a NEL resident can be referred to a Right to Choose provider, such as Oviva, to obtain Semaglutide and their associated wraparound support.

16. **What are the advantages of the NEL pathway compared with referral to providers such as Oviva, which offer prescribing, monitoring, and behavioural support within a single service?**

While a single-provider model may appear simpler, there will be differences relating to patient preference that will help determine which option may be more suitable. For example, overall treatment experience and outcomes may differ, and one important distinction is that tirzepatide does not currently have a defined time-limited stop point, whereas semaglutide is expected to be stopped after 2 years.

17. **Can NEL provide a one-page flowchart summarising referral pathways, eligibility criteria, comorbidities, Tier 2, Tier 3, bariatric services, and prescribing responsibilities?**

Yes. A one-page summary flowchart would be helpful and would be consistent with the policy's aim of supporting clear, standardised implementation across NEL. This will be incorporated into the NEL obesity management clinical policy once completed.

18. **What is the process for consultant-to-consultant referrals into weight management services?**

Consultant-to-consultant referral information is included on page 6 of the NEL Obesity Management Clinical Policy under *Additional NEL locally agreed criteria for phase 1 weight management pilot only*. Under this locally agreed pilot arrangement, patients may be referred consultant-to-consultant into the specialist weight management services at Bart's heath where they meet the relevant locally agreed criteria.

19. **Who is responsible for prescribing GLP-1 medications for patients receiving care within ELFT forensic mental health services, including Wolfson House and the John Howard Centre?**

NEL ICB Medicines & Pharmacy Team will liaise with the relevant mental health teams

Behavioural support for obesity prescribing

20. **What are the current waiting times for behavioural support programmes?**

The Healthier You: NHS Behavioural Support for Obesity Prescribing (BSOP) service is typically able to accept referred patients within 10 days, although this depends on patient availability. NHS England expects referral to successful contact, triage and booking onto a pathway to be completed within 30 operational days. If the provider is unable to contact the patient within 15 operational days, a letter is sent to both the patient and the GP. If there is still no response after a further 15 operational days, the patient is discharged from the service. Patients who are discharged in this way can be re-referred.

More information can be found here: BSOP programme

21. **What is the current capacity of behavioural support provider, and can they accommodate the anticipated volume of referrals?**

At present, the BSOP service has not reported any capacity concerns and is able to accommodate the anticipated volume of referrals. The service currently offers good appointment availability across daytime, evening and weekend sessions.

22. **Are practices expected to monitor whether patients engage with behavioural support services, or is referral alone sufficient?**

The BSOP service provides feedback to the prescriber at key points in the patient pathway. Practices are notified when a referral has been accepted, if a patient disengages from the programme, if a patient misses three sessions, and when the patient completes the programme. Where there are concerns arising from the sessions, these are also shared with the prescriber. If the prescriber has any queries or concerns, they can contact the service via the relevant mailbox: healthier.you@nhs.net

23. What happens if a patient declines referral to behavioural support?

NICE recommends that tirzepatide should be used alongside a behavioural support intervention that includes a reduced-calorie diet and increased physical activity. If a patient declines referral to the BSOP service, this should be taken into account by the prescriber when considering whether tirzepatide prescribing is appropriate. The BSOP service can notify the prescriber if a patient does not take up or engage with the service, but the decision to start or continue treatment remains a clinical decision for the prescriber.

24. Will practices still achieve QOF requirements if behavioural support has been offered but declined by the patient?

Yes. Practices can record the relevant QOF code for patients who decline referral to a weight management behavioural support programme, in line with the QOF business rules. This means the offer of referral can still be coded where the patient chooses not to proceed.

25. Will specific clinical codes be available to record patients who decline referral?

Yes. Relevant clinical codes are available for patients who decline referral, and there are also codes for patients for whom a weight management behavioural support programme is considered unsuitable.

26. What happens if a patient starts GLP-1 treatment but subsequently disengages from behavioural support services? Transparent that patient will be discharged back to GP, some ICBs approach is that no engagement no prescribing.

If a patient starts tirzepatide treatment for obesity management but later disengages from the BSOP service, the service will notify the prescriber at the relevant stages of the pathway. The decision on whether to continue prescribing remains a clinical decision for the prescriber, taking into account NICE recommendations, the patient's overall engagement, and whether treatment continues to be appropriate and safe.

27. How will compliance with wraparound support requirements be monitored and enforced?

Compliance with wraparound support is monitored through routine updates from the BSOP service to the prescriber. Practices are notified when a referral is accepted, if a patient disengages, if they miss three sessions, and when they complete the programme. The provider does not routinely issue detailed individual session reports, but it does share key pathway and discharge information to support clinical review and decision-making.

28. How do behavioural support programmes accommodate patients who do not speak English as their first language?

The BSOP service currently offers a range of access routes, including remote group sessions on Microsoft Teams and a digital app-based option, which helps support patients with different communication and access needs. The service indicates that support is available in a number of languages, including Microsoft Team sessions in English, Punjabi, Urdu, Hindi, Bengali and Gujarati. The digital app is also available in English, Urdu, Hindi, Arabic, Gujarati, Bengali, Tamil, Polish, Chinese, Punjabi and Welsh. Where a patient's first language is not English, practices should include this information on the referral form so the provider can consider the most appropriate support and communication approach.

If additional language or communication support is needed, this should be highlighted at referral so the provider can consider suitable adjustments on a case-by-case basis. Practices should include as much relevant information as possible in the referral form to support safe and equitable access.

29. **What reasonable adjustments will be made to ensure equitable access for patients with disabilities, mental illness, learning disabilities, or other barriers to engagement?**

The BSOP service is currently working with the Royal Association for Deaf people and aims to offer sessions for people who are deaf, hard of hearing, or use British Sign Language. Any learning disability, mental health need, sensory impairment, or other barrier to engagement should be clearly included on the referral form so that the triage team can consider appropriate adjustments and support.

Prescribing, Monitoring and Clinical Responsibility

31. What are the prescribing responsibilities for general practice once a patient starts tirzepatide?

Patients receiving tirzepatide should be reviewed regularly throughout treatment, with frequency aligned to dose titration, clinical response and NICE guidance. Practices are advised to ensure ongoing monitoring of treatment effectiveness, safety and treatment effectiveness and engagement with behavioural support.

The exact frequency should be individualised based on clinical need and patient factors, while supporting NEL clinical policy, NICE funding variation eligibility criteria and QOF delivery.

Please refer to Q33 for more information on treatment review recommendations.

32. Are practices expected to monitor patients' participation in behavioural support programmes?

Please section above, answer to questions 26 & 27.

33. How often should patients receiving tirzepatide be reviewed?

Patients receiving tirzepatide should be reviewed regularly, with monitoring undertaken throughout treatment.

NICE outlines that follow-up and monitoring should occur during both the dose titration and maintenance phases, to assess treatment response, tolerability and safety.

In practice, this means:

- Frequent review during dose titration* (e.g. monthly) and once on stable dose (e.g. 3 monthly), to support safe titration and assess tolerability.
- *Review during dose titration should align with dose escalation schedules (typically 4 week intervals)
- Ongoing periodic review during maintenance treatment to assess weight loss, adherence, adverse effects, any plans for pregnancy and overall clinical benefit
- Undertaking a treatment review at around 6 months on the highest tolerated dose to determine whether continuation is appropriate, taking into account the balance of benefits and risks

Review should also include reinforcement of dietary, physical activity and behavioural interventions, as medicines should be used alongside these measures.

The frequency should be individualised based on patient need and clinical judgement.

34. Will structured consultation templates be available within GP clinical systems?

Yes. National GPIT templates have been developed to support practices with implementation of the obesity management pathway and are available free of charge.

The template includes step-by-step prompts to support assessment against the NHS priority cohort criteria under the NICE funding variation for tirzepatide (Mounjaro®), including relevant assessment criteria, contraindications, and follow-up requirements. It is intended to support consistent documentation and alignment with evidence-based guidance as patients move through the treatment pathway.

EMIS practices are required to request access to the template by submitting an online form. For SystmOne practices, the template is available via an open access organisation group. Further information on how to access these templates can be found in the NEL GP Obesity Management Resource Pack.

Please note that this template is to support clinicians with assessing eligibility for treatment.

NICE has developed a range of checklists to support the initiation and ongoing review of tirzepatide treatment, alongside discussion aids to facilitate shared decision-making between clinicians and patients. Further details are available in the NEL GP Obesity Management Resource Pack.

35. Will structured review templates and shared decision-making documentation be provided?

Please refer to response above.

36. What training is available for GPs, nurses, healthcare assistants, and other staff supporting patients on GLP-1 therapies?

Suggested nationally available e-learning and training resources are available within the NEL GP Obesity Management Resource Pack.

Also practice clinicians can join the weekly obesity management drop-in sessions with a Barts Health Consultant Physician in Diabetes and Obesity to discuss clinical queries. These sessions run every Tuesday from 1-2pm. You can join the session using the following link: Joining link

37. Is guidance available on discontinuing tirzepatide once weight management goals have been achieved?

There are NICE recommendations on discontinuing tirzepatide that can be considered as part of routine clinical review and shared decision-making.

NICE provides information on follow up, monitoring and stopping treatment, via the following:

- The "Follow-up and monitoring checklist" supports clinicians to review treatment response, tolerability and ongoing need for therapy during titration and maintenance phases.
- NICE quality standards also highlight the importance of support after stopping weight management medicines, including advice on maintaining behavioural changes and ongoing lifestyle support.

In practice, discontinuation should be considered where:

- The patient has achieved agreed weight management goals

- There is insufficient clinical response despite optimal dosing (NICE criteria for discontinuation is if <5% of the initial weight has been lost after 6 months on the highest tolerated dose, the discontinuation should be considered)
- The patient experiences intolerable adverse effects
- There are changes in the patient's clinical circumstances (e.g. new contraindications)

For GP practices, key considerations include:

- Regular structured reviews (aligned with NICE and NEL policy) to assess response and ongoing benefit
- Use of shared decision-making to agree continuation versus stopping
- Providing clear advice and support on lifestyle measures to help maintain weight loss after discontinuation
- Signposting to local weight management or behavioural support services, where appropriate
- Any discontinuation plan should be individualised and clearly documented, including follow-up arrangements.

Refer to A guide for prescribing medicines to manage overweight and obesity for further information.

38. Can NEL ICB provide a prescribing protocol, clinical flowchart, and patient information leaflet outlining treatment expectations and patient responsibilities?

The NEL GP Obesity Management Resource Pack signposts to prescribing guidance and patient information. At present, NEL has not developed a standalone prescribing protocol.

NICE has also developed a discussion aid for tirzepatide to facilitate shared decision-making between clinicians and patients.

NEL ICB Medicines & Pharmacy Team will review the feasibility of developing a clinical flowchart as the pathway evolves.

Existing Services and Patients

39. Will the specialist weight management services provided by Barts Health and Homerton continue to accept referrals, or will these services be decommissioned?

The Barts Health specialist weight management service does not accept referrals directly from primary care. Access is limited to consultant-to-consultant referrals for patients eligible for semaglutide treatment.

The Homerton specialist weight management service continues to provide a bariatric surgery service but does not offer primary care referral for obesity pharmacotherapy.

40. What will happen to the existing City and Hackney Tier 3 weight management service?

The City and Hackney (Homerton) Tier 3 weight management service remains in place and provides a non-pharmacological treatment pathway. It also continues to provide a bariatric surgery service.

41. Patients who were referred to Barts Health or Homerton and commenced tirzepatide through specialist services—will they remain under specialist care or be transferred back to general practice?

Patients who have already started treatment with the Barts Health weight management service on behalf of primary care, will continue under this arrangement until next steps are understood.

The Homerton specialist weight management service did not initiate any patients on tirzepatide on behalf of primary care.

42. Under QOF OB004, would referral to a bariatric service or an existing Tier 3 lifestyle intervention service satisfy the referral requirement?

The QOF OB004 indicator requires that patients with a BMI ≥30 kg/m² (with lower thresholds for some ethnic groups) are referred to a weight management programme within 90 days of their BMI being recorded.

The QOF business rules do not specify the tier of service (e.g. Tier 2 or Tier 3). Patients would need to meet the relevant eligibility criteria for access to the service they were being referred into.

Refer to NEL Clinical Policy (page 4) and 2026/27 QOF business rules for further information.

QOF and Funding

43. What are the specific QOF requirements relating to obesity management and GLP-1 prescribing?

This information can be found in the Quality and Outcomes Framework (QOF) guidance for 2026/27 and the NEL obesity management clinical policy.

44. If a patient meets referral criteria but declines referral, will the practice still receive QOF credit?

If this is in relation to referral to the behavioural support programme, please see answers 24. and 25.

45. If a patient with a BMI above the referral threshold declines referral, will the practice be disadvantaged in relation to QOF performance?

Yes. Practices can record the relevant QOF code for patients who decline referral to a weight management programme, in line with the QOF business rules.

46. Given the significant workload associated with identifying, referring, reviewing, and monitoring patients, are there plans for additional funding beyond the current QOF allocation?

Currently there is no additional funding beyond the current QOF allocation.

Wider System and Strategic Questions

48. Is there sufficient system-wide capacity to manage the anticipated volume of referrals within the required timescales?

NEL recognises that system-wide capacity must be managed carefully as demand for obesity services and medicines is likely to exceed immediate service availability. The clinical policy describes a phased approach to implementation, aligned with NHS England interim commissioning guidance, with eligibility criteria and local referral arrangements intended to support safe, equitable and financially sustainable access.

49. What is the rationale for the current pathway, including the apparent distinction between referrals for semaglutide (Wegovy) and prescribing tirzepatide (Mounjaro) in primary care?

The rationale for the current pathway is set out in the clinical policy and reflects both national commissioning arrangements and local service design. In NEL, semaglutide (Wegovy®) remains available through specialist weight management services, including local specialist referral routes or a Right to Choose provider, whereas tirzepatide (Mounjaro®) is supported within primary care for patients who meet the policy's eligibility criteria, alongside referral to the required wraparound behavioural support. This distinction reflects the different commissioning and implementation arrangements currently in place for both medicines, which is reflected in their corresponding NICE guidance.

50. How will GLP-1 prescribing for obesity be balanced against ongoing demand for GLP-1 medicines for their original indication in Type 2 diabetes management?

The clinical policy is clear that it applies only to obesity management and is out of scope for people eligible for semaglutide or tirzepatide under the relevant NICE technology appraisals for type 2 diabetes. In practice, GLP-1 prescribing for obesity therefore needs to be managed separately from prescribing for diabetes, with treatment decisions remaining aligned to the relevant indication, national guidance, and local formulary and commissioning arrangements. This separation is intended to support appropriate clinical prioritisation and reduce the risk that obesity prescribing compromises access for patients who need these medicines for diabetes management.

51. Can NEL provide formal communication to secondary care providers clarifying referral expectations and reducing inappropriate requests for GPs to initiate obesity prescribing where this is not clinically or contractually appropriate?

Yes. Formal communication to secondary care providers would be helpful to reinforce the referral and prescribing arrangements set out in the NEL clinical policy and to reduce inappropriate requests for general practice to initiate obesity management medicines where this is not clinically or contractually appropriate. Where practices receive inappropriate requests from secondary care to initiate an obesity management medication, these can be forwarded to the NEL prescribing queries inbox at nelondonicb.prescribingqueries@nhs.net for review and support.