CURATED AI RESEARCH

A free briefing series from Healthcare Acumen Ltd on how the NHS commissions, funds and pays for specialist medicines

Who Pays for a NICE-Approved Obesity Product?

Commissioning, funding pathways and tendering in England — and why a NICE recommendation stopped being the end of the argument

The question. A NICE-approved obesity medicine has a positive technology appraisal and a mandatory funding requirement behind it. So who actually pays for it, out of which budget, on whose signature — and why do eligible patients still wait?

Who this is for. Commercial, market access and medical teams preparing a launch, and anyone who has to explain an obesity funding pathway to a finance director.

Compiled. 15 September 2026. England only.

The short answer

Integrated care boards pay, out of a non-ring-fenced allocation calculated on local obesity prevalence rather than on the number of eligible patients. NICE granted a funding variation for tirzepatide, so the usual three-month funding requirement was replaced by a three-year phased rollout by cohort. Wraparound behavioural and dietetic support is mandated alongside the drug, which makes service capacity — not the appraisal — the rate-limiting step.

Obesity is, on current evidence, the clearest case in England of a positive NICE recommendation that did not convert into funded access. What follows is the machinery behind that, framework by framework, and where the leverage actually sits.

1. Why the usual rule does not apply

The standard logic of market access in England is that NICE recommends, and commissioners must then fund within three months. For obesity medicines that logic broke, and everything downstream follows from the break.

Table 1 — The three appraisals that define the obesity access environment

Appraisal	What it covers	Funding position
TA875 semaglutide (obesity)	Weight management via specialist weight management services; maximum two years of treatment	Standard funding requirement, constrained in practice by specialist service capacity
TA1026 tirzepatide (obesity)	Approximately 3.4 million eligible adults in England	Funding variation granted. 90 days for specialist services from 24 March 2025; 180 days for primary care from 23 June 2025; then a phased three-year rollout
TA1152 semaglutide (MACE reduction)	Established cardiovascular disease plus BMI of 27 kg/m² or above	Standard 90-day funding requirement, no phasing, no setting specified. Published 7 May 2026

Table 2 — The tirzepatide cohorts

Year	Cohort	BMI	Qualifying comorbidities
2025/26	I	40 or above	4 or more
2026/27	II	35 – 39.9	4 or more
2027/28 – 2028/29	III	40 or above	3 or more

Qualifying comorbidities: hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, type 2 diabetes. BMI thresholds are reduced by 2.5 kg/m² for South Asian, Chinese, other Asian, Middle Eastern, Black African and African-Caribbean populations. Around 220,000 patients are expected to be treated in the first phase, against an eligible population of roughly 3.4 million.

What follows from that

1. **The money follows prevalence, not patients.** Allocations were calculated on integrated care board obesity prevalence and are not ring-fenced. Access is therefore settled as a prioritisation decision inside a finance envelope, not as an entitlement decision at the point of care.
2. **Wraparound care is mandated, not optional.** There is no drug without nutritional and dietetic, physical activity and behavioural support — a minimum of nine months in primary care. NHS England funds a central wraparound offer for primary care; integrated care boards may commission their own instead.
3. **A cardiovascular indication is funded differently.** TA1152 carries the ordinary 90-day requirement, no phasing and no setting restriction. The same molecule reaches patients on different terms depending on which appraisal the prescription sits under.

> **What usually goes wrong**
>
> Launch plans built on the eligible population rather than the funded cohort. The gap between 3.4 million and 220,000 is not a forecasting error to be argued away; it is the policy.
>
> Value cases addressed to clinicians when the decision sits with a director of finance weighing a non-ring-fenced allocation against elective recovery and urgent care.

Pathway work that stops at the prescription. Where wraparound capacity does not exist, prescribing does not start, whatever the formulary says.

2. The eight frameworks that govern the money

Each of the following sets part of the answer to who pays. Taken together they describe the route a pound travels from the national settlement to a prescription, and the points at which it can stop.

2.1 NHS Payment Scheme 2026/27

What it is. The statutory rules for how commissioners pay providers, running 1 April 2026 to 31 March 2027. Four mechanisms apply: Aligned Payment and Incentive for NHS provider relationships above £1.5m; Low Volume Activity block payments below that; unit-price activity payment for non-NHS providers; and local payment arrangements elsewhere. The cost uplift for 2026/27 is 3.24% and the efficiency factor 2.0%.

Where obesity sits in it.

- High-cost drugs and devices are unbundled and excluded from national prices and settled by local agreement between commissioner and provider. Whether a product sits on that excluded list determines whether a trust is financially neutral on each prescription or carrying the cost itself.
- From 2026/27 certain high-cost homecare drugs moved into standard prices, changing who carries the cost of homecare delivery.
- Treatments tied to a NICE decision sit outside the Aligned Payment and Incentive rules and require locally agreed payment arrangements — the route CAR-T uses.
- Most obesity prescribing, however, never reaches a tariff conversation at all: it lands in the integrated care board primary care prescribing budget. Establishing which of the two worlds a given account is in is the first analytical step, and it is frequently skipped.
- Best practice tariffs and year-of-care tariffs are signalled for development. A year-of-care currency is the mechanism by which a wraparound-plus-drug pathway could eventually be funded as a single unit.

2.2 Strategic Commissioning Framework

What it is. Published November 2025, it sets out how integrated care boards operate as strategic commissioners and payors under the 10 Year Health Plan: a four-stage cycle of understanding context, developing long-term strategy, delivering through the payor function and evaluating impact. Integrated needs assessments and population health plans landed between January and March 2026, the development programme launched in April 2026, and adoption runs through the 2026/27 planning cycle. It requires a single system-wide approach to population health management, with segmentation and risk stratification through the NHS Federated Data Platform, and moves toward outcome-focused, value-based contracting, with shadow outcome measures piloted in 2026/27.

Alongside it. Integrated care board consolidation: 42 boards reducing to roughly 30 from 1 April 2026, comprising 12 approved mergers and one boundary change, with further mergers decided in summer 2026 for April 2027, and running costs squeezed to £19 per head of population.

Why it changes the commercial task. The customer base is becoming fewer, larger, more analytically driven and considerably thinner on staff. Decision-making concentrates in the payor function — chief medical officer, director of commissioning, chief pharmacist and medicines optimisation lead, director of finance — while place-based relationships built over years are reorganised away. A board operating on half its former running cost cannot build its own obesity cohort segmentation, which makes credible population-level analysis one of the few things industry can offer that a system actually lacks. And since outcome-based contracting is the stated direction, a product with cardiovascular, admission or remission outcome data is positioned for the next contracting generation in a way that weight loss alone is not.

2.3 NHS Standard Contract 2026/27

What it is. The mandated contract between commissioners and providers of NHS-funded services, published January 2026 with technical guidance republished in April 2026, in full-length and shorter-form versions. It carries the service conditions obliging providers to comply with NICE technology appraisals, sets quality requirements, and is the document into which service specifications, local quality requirements and variations are written.

Why it matters. This is where a pathway change becomes institutional rather than personal. A redesigned obesity pathway agreed with a clinical champion but never written into the service specification lasts exactly as long as that person stays in post. The durable asks are the wraparound offer, referral criteria, data reporting and review arrangements appearing in the specification itself. The contract is the award vehicle; the procurement rules sit separately, in the Provider Selection Regime.

2.4 Medium Term Planning Framework 2026/27 – 2028/29

What it is. Three-year revenue and four-year capital planning, published in autumn 2025. Revenue rises around 3% in real terms annually to £226bn by 2028/29. A minimum 2% annual productivity improvement is mandatory, and all organisations must reach balance or surplus without deficit support funding.

The obesity commitments it contains

- **2026/27:** deploy new obesity service models providing access to weight-loss medications and specialist provision.
- **By June 2028:** NICE-approved weight-loss treatments provided to approximately 220,000 eligible adults.
- **By March 2029:** 250,000 annual referrals to the NHS Digital Weight Management Programme.
- **Alongside:** a 25% reduction in premature cardiovascular mortality over ten years, neighbourhood health teams mandated from April 2026, and digital-by-default delivery.

Why it matters. These are published national commitments on a three-year clock, made under a binding productivity requirement. A proposition that helps a system hit a promise it has already made is a materially different conversation from one that asks it to start something new — and the productivity framing, covering avoided bariatric procedures, avoided admissions, downstream cardiovascular and diabetes cost and digital-first wraparound, is the language the plan is itself written in.

2.5 Better Care Fund 2026/27

Drawn from the published framework (Department of Health and Social Care and Ministry of Housing, Communities and Local Government, 17 February 2026) and the national planning data collection. Section 6 sets out what the returns show.

What it is. The mandatory pooled budget between integrated care boards and local authorities, planned jointly, agreed by health and wellbeing boards, and placed into one or more section 75 pooled funds under the NHS Act 2006. 2026/27 is the first year of Better Care Fund reform, aligning pooled funding with the neighbourhood health service set out in the 10 Year Health Plan.

Table 3 — Minimum contributions to the 2026/27 Better Care Fund

BCF funding contribution	Amount (£m)	Notes
Minimum NHS contribution	5,791	ICB allocations published 17 November 2025. The NHS minimum contribution to adult social care was uplifted 4.4%; the remaining ICB contribution 2.1%
Local Authority Better Care Grant	2,640	Allocations confirmed 9 February 2026; unchanged in cash terms from 2025/26
Disabled Facilities Grant	723	Allocations confirmed 17 February 2026; statutory grant limit currently £30,000 per adaptation
Total minimum	9,154	Ring-fenced by direction under section 223GA of the NHS Act 2006 and section 31 of the Local Government Act 2003

The three national conditions

1. **Effectively support the delivery of integrated and preventative care.** Joint plans agreed by health and wellbeing boards, explicitly linked to the integrated care board five-year strategic commissioning plan, setting out how funding develops the quality, efficiency and outcomes of intermediate care, and demonstrating value for money and improved productivity.
2. **Comply with expenditure and grant conditions.** Pool the designated minimum contributions into section 75 funds, maintain the NHS minimum contribution to adult social care — a 4.4% increase in every health and wellbeing board area — and comply with the Better Care Grant and Disabled Facilities Grant conditions. Pooling must be in place no later than 30 September 2026.
3. **Effective governance, reporting and engagement.** Joint governance with local accountability for outcomes, performance review against plan objectives and local goals, and engagement with oversight and support processes.

Assurance returns were due to the national Better Care Fund team and regional better care managers by 19 May 2026, signed off by named integrated care board and local authority chief executives and a named health and wellbeing board chair. NHS England may approve, place local conditions on a board, or decline to approve, and may ultimately withhold, recover or direct the use of the NHS minimum contribution.

The metrics it is judged on

Two local goals are mandatory, agreed with health and wellbeing boards, and a third is encouraged:

- **Non-elective hospital admissions for people aged 65 and over** per 100,000 population — mandatory.
- **Average length of discharge delay for all acute adult patients** — mandatory, derived from the proportion of patients discharged on their discharge ready date and, for those who are not, the mean days from that date to discharge.
- **Long-term admissions to residential and nursing care homes for people aged 65 and over** — encouraged, and monitored whether or not a local goal is set.

- Reablement outcomes are monitored separately: the proportion of people aged 65 and over discharged with reablement who remain in the community 12 weeks later.

Progress is visible to health and wellbeing boards on the Better Care Fund dashboard. The Discharge and Admissions Group, co-led by the Department of Health and Social Care and NHS England, works with the most challenged areas, and a national escalation process applies where conditions are at risk.

What changes from 2027/28

Indicative allocations for 2027/28 and 2028/29 have been issued. Government will consult on whether local areas should have more flexibility over the level of pooling, with any change to minimum contributions taking effect no earlier than 2027/28. The adult social care increases agreed at Spending Review 2025 will be preserved in whatever arrangements follow. If minimum pooling falls, the money stays within NHS and local authority budgets rather than disappearing — but the joint planning discipline attached to it weakens.

The honest position on the Better Care Fund

It will not fund an obesity medicine. There is no medicines line in the fund and no realistic route to one. Section 6 shows where every pound of the £10.8bn is planned to go, and none of it is pharmacotherapy. Claiming otherwise in front of a finance director is the fastest available way to lose the room.

What it is genuinely useful for:

First, it is the formal machinery where NHS and local authority commissioning meet. Tier 2 weight management is a local authority public health responsibility, so the health and wellbeing board and section 75 architecture is the route to joined-up tier 2 to tier 3 pathways, and to the voluntary and community sector that the framework names as a strategic partner.

Second, its two mandatory metrics — non-elective admissions in the over-65s, and discharge delay — are outcomes an obesity, frailty and cardiometabolic intervention can plausibly influence in older cohorts. That supplies an admissions-and-flow argument in systems where the medicines argument has stalled.

Third, national condition 1 requires Better Care Fund plans to be linked to the integrated care board five-year strategic commissioning plan, which means the same small group of people write both. A prevention proposition that reads across to both documents carries further than one addressed only to a medicines committee.

2.6 Quality and Outcomes Framework 2026/27

What it is. The GP contract incentive scheme. 2026/27 added 18 QOF points, worth approximately £25m, and modernised the register.

The obesity indicators

Indicator	Requirement	Points	Threshold
OB004	Referral to weight management programmes for adults with obesity	5	5 – 30%
OB005	Shared decision-making and pharmacotherapy indicator for obesity	13	50 – 80%

These replace the retiring Weight Management Enhanced Service, and the primary care management costs of tirzepatide delivery were folded into QOF for 2026/27 to support primary care as a new setting of care. The same round introduced blood pressure control indicators CD001 and CD002 in place of separate coronary heart disease and stroke indicators, heart failure indicators reflecting four-pillar therapy, and increased points for statin use in diabetes.

Why it matters. OB005, at 13 points with a 50–80% achievement threshold, is a direct payment to practices for identifying eligible patients and holding a structured pharmacotherapy conversation. It is case-finding and initiation, funded, at national scale, in the setting where the volume will arise. Of the eight frameworks in this briefing it is the one that moves fastest, and achievement data against OB004 and OB005 is a legitimate, non-promotional basis for a service support conversation.

2.7 NHS Oversight Framework 2026/27

What it is. Published 11 June 2026 and updated 29 July 2026. It segments organisations from 1 to 4, calculated quarterly in April, July, October and January, combined with capability ratings, and determining oversight intensity, intervention and earned freedoms. There are seven metric domains, the first being population health, prevention and reducing inequality.

The obesity metric. Integrated care boards are scored on the percentage of eligible people supported by obesity and long-term-conditions prevention programmes, with NHS England publishing quarterly management information against it.

Why it matters. Obesity performance is now measured, published, benchmarked against peers and consequential for board leadership. A system can decline to prioritise obesity, but it cannot do so invisibly. Set against the 220,000-patient commitment in the Medium Term Planning Framework, this is the clearest answer available to the question of why a system should act this year rather than next.

2.8 Modern Service Frameworks

What they are. The 10 Year Health Plan's successor to the National Service Frameworks: national outcome ambitions for major conditions, with evidence-based interventions, standards, measures and defined accountability. The cardiovascular disease framework was published on 7 July 2026 as the first. Serious mental illness and sepsis are the other initial frameworks, with dementia and frailty to follow.

Why the cardiovascular framework matters here. It reorganises care around a cardiovascular-kidney-metabolic model, managing blood pressure, cholesterol, blood glucose, obesity, chronic kidney disease, atrial fibrillation and smoking together rather than through separate pathways. It sets out to find the "missing millions" living with undiagnosed risk, targets a 25% reduction in premature cardiovascular mortality, carries 12 priorities each with a baseline, three-year target and ten-year ambition, attaches an equity metric to every standard, and aligns to

2026/27 incentive schemes including QOF and acute best practice tariffs — an explicit shift toward commissioning for outcomes rather than activity.

The consequence. Cardiovascular-kidney-metabolic clustering is the route out of a rationed obesity budget and into a funded cardiometabolic one. Placed next to TA1152, which carries the ordinary 90-day funding requirement and no setting restriction, an obesity product with cardiovascular outcomes data ceases to be a lifestyle spend and becomes a cardiovascular prevention intervention. That reframing is worth more than any argument conducted within the obesity budget itself.

3. Where the money actually sits

Route	Budget holder	What it funds	How it is unlocked
ICB prescribing and medicines allocation	ICB — non-ring-fenced, prevalence-based	The drug itself, in primary and secondary care	Formulary and area prescribing committee, medicines optimisation, cohort prioritisation
Centrally funded wraparound in primary care	NHS England	Behavioural, dietetic and physical activity support	Service design, digital delivery partners
QOF OB004 and OB005	GP contract, national	Case-finding, referral, pharmacotherapy conversations	Practice-level achievement support
Local enhanced services	ICB	Local delivery models beyond the core offer	ICB primary care commissioning team
Specialist tier 3 and tier 4 weight management	ICB — highly variable between systems	MDT assessment, specialist initiation, bariatric surgery	Service specification, capacity business case, competitive or direct award
Tier 2 weight management	Local authority public health	Community lifestyle services	Health and wellbeing board, Better Care Fund partnership architecture
Homecare and high-cost drug supply	Local ICB-to-trust agreement, with prior approval systems	Delivery, monitoring, prior approval control	Trust pharmacy, homecare provider contracting
NHS Digital Weight Management Programme	NHS England	Digital behavioural pathway; 250,000 referrals a year by March 2029	Referral pathway integration

Between the allocation and the prescription sit the approval layers: the integrated care board or system area prescribing committee or medicines optimisation committee; regional medicines optimisation groups; trust drug and therapeutics committees; shared care and prescribing-responsibility agreements, which become critical wherever initiation is specialist and continuation is in primary care; and prior approval systems where a system wants explicit cohort control. Each is a place where a funded product can still fail to reach a patient.

4. Tendering, local and regional

Weight management and obesity services are commissioned services procured under the Provider Selection Regime rather than general procurement law, with defined processes: direct award A, B and C, most suitable provider, and competitive. Digital weight management and specialist service contracts are being awarded and re-tendered now, and are visible on Find a Tender and on integrated care board procurement pages.

- Tender cycles are the moment a pathway is rewritten. Presence before the specification is drafted counts for more than a strong response after publication.
- Procurement pipelines, contract end dates and award notices are published by most systems, and belong in account planning as a standing input rather than an occasional check.

- Where a manufacturer provides or partners on service elements — digital wraparound, nurse-delivered initiation, remote monitoring — the boundary between a compliant joint working arrangement and an inducement needs settling early, with compliance and external affairs involved from the outset.
- Integrated care board mergers reset procurement timetables and standardise specifications across newly merged geographies. A pathway embedded in only one legacy board is exposed; one that becomes the template for the merged system is considerably strengthened.

5. What a launch team has to hold together

The funding pathway above crosses three internal functions, and the common failure is each working its own layer without a shared account plan.

Workstream	Function	Output
Value and budget impact at system level: prevalence-based allocation, cohort modelling, productivity case	Market access and health economics	System-specific budget impact and cohort prioritisation model
Clinical pathway, wraparound design, shared care	Medical	Pathway proposals, MDT capacity assessment, shared care templates
Formulary, area prescribing committee, drug and therapeutics committee, tender response	Market access	Formulary submissions and bid content
QOF achievement and primary care readiness	Commercial and medical	Practice-level support on OB004 and OB005
Policy positioning: cardiometabolic framing, prevention, inequality	External affairs	Positioning against the Oversight Framework and planning commitments
Health inequalities and equity: adjusted BMI thresholds, deprivation	All three	Equity narrative — every Modern Service Framework standard carries an equity metric

Measures that reflect this pathway rather than volume alone: formulary and committee position; systems with an agreed wraparound pathway; shared care agreement coverage; movement in the system's published obesity prevention metric; QOF OB004 and OB005 achievement in target primary care networks; cohort conversion against the system's own planning trajectory; and specification influence at tender.

6. What the 2026/27 planning returns show

Aggregated from the national Better Care Fund 2026/27 planning data collection: 7,417 individual schemes across 152 health and wellbeing boards. These are plans rather than outturn, and the publication itself records that data quality issues exist.

6.1 The pool is larger than the mandatory minimum

Source of funding	£m	% of pool
NHS minimum contribution	5,790.9	53.7%
Local Authority Better Care Grant	2,640.0	24.5%
Additional local authority contribution (voluntary)	954.8	8.9%
Disabled Facilities Grant	723.0	6.7%
Additional NHS contribution (voluntary)	673.8	6.2%
Total planned pooled spend 2026/27	10,782.7	100%

Local areas are voluntarily pooling £1.63bn above the £9.15bn mandatory minimum, around 15% of the fund, and roughly £6.4bn of the total is flagged as adult social care spend. Planned pooled spend grew from £5.36bn in 2015/16 to £11.26bn planned in 2025/26; the 2026/27 figure of £10.78bn sits below that, which points to reduced voluntary pooling rather than a cut to the minimum — worth watching, given the consultation on pooling flexibility from 2027/28.

6.2 Where it goes

Category of scheme	£m	% of pool
Intermediate care (all forms, home and bed-based)	2,013.1	18.7%
Long-term residential and nursing home care	1,518.3	14.1%
Long-term home-based social care services	1,272.3	11.8%
Discharge support and infrastructure	1,009.2	9.4%
Wider local support to promote prevention and independence	982.4	9.1%
Long-term home-based community health services	956.6	8.9%
Disabled Facilities Grant related schemes	689.9	6.4%
Assistive technologies and equipment	499.0	4.6%
Urgent community response	321.1	3.0%
Support to carers, including unpaid carers	201.7	1.9%
End of life care	94.1	0.9%

Categories have been consolidated where returns used different wording for the same scheme type. Remaining categories, including personalised budgeting, evaluation and enabling integration, housing and short-term social care, account for the balance.

There is no medicines spend anywhere in this fund. The nearest adjacency is the £982m recorded as wider local support to promote prevention and independence, which is directed overwhelmingly at frailty and older people rather than obesity pharmacotherapy, and the £2.0bn in intermediate care, which is where an obesity-related admissions or discharge argument would have to land.

6.3 Scale and variation

Measure	Value
Health and wellbeing boards submitting plans	152
Individual schemes in the returns	7,417
Median pooled budget per health and wellbeing board	£54.4m
Largest pooled budgets	Warwickshire £468.8m; Lincolnshire £365.2m; Birmingham £247.6m
Smallest pooled budgets	City of London £1.4m; Rutland £3.8m; Wokingham £15.7m

The spread reflects local pooling choices as much as population size — some areas pool whole community budgets, others only the minimum — so it indicates local appetite for joint commissioning rather than need.

6.4 The goals systems have set themselves

Planned metric for 2026/27	Mean	Median	Range
Non-elective admissions, 65 and over, per 100,000	1,681	1,682	1,142 – 2,558
Average length of discharge delay (days)	0.7	0.7	0.3 – 1.7

Reading the variation

Planned non-elective admission rates for the over-65s vary more than twofold between health and wellbeing boards. Systems at the upper end are under the greatest pressure on precisely the metric the Discharge and Admissions Group escalates against, and are correspondingly more receptive to a credible admissions-avoidance proposition.

It also indicates which conversation to open. In a high-admissions system, flow and admissions lead. In a system already performing well, the prevention metric in the Oversight Framework and the planning-framework cohort trajectory lead instead.

7. The answer, in six lines

1. **A NICE recommendation did not settle this.** TA1026 received a funding variation and a three-year phased cohort rollout. Access is being competed for inside a non-ring-fenced, prevalence-based allocation, alongside everything else on the planning grid.
2. **Service capacity is the binding constraint, not the medicine.** Wraparound care is mandated, and the systems that deliver are those that solved workforce and pathway first.
3. **Three published commitments give the timing argument.** 220,000 patients on NICE-approved weight-loss treatment by June 2028; a quarterly, published obesity prevention metric in the Oversight Framework; and the cardiovascular Modern Service Framework with its 25% premature mortality ambition.
4. **Cardiometabolic framing reaches different money.** TA1152 funds semaglutide for cardiovascular event reduction on the standard 90-day requirement with no setting restriction.
5. **The customer is changing shape.** 42 integrated care boards to about 30, £19 per head running costs, a formal strategic commissioning cycle, and shadow outcome measures in 2026/27. Fewer, larger, more data-driven systems with less capacity to analyse.
6. **The Better Care Fund is not the answer to this question.** It is a £10.8bn pooled fund with no medicines line. Its value here is architectural: mandatory metrics on admissions and discharge, national conditions tying it to the strategic commissioning plan, and a formal meeting point with the local authority public health function that owns tier 2 weight management.

Questions this briefing does not answer

- Which cohort a given product falls into, and whether the phasing applies to it.
- Whether the product is tariff-excluded, and where the cost is therefore carried.
- What wraparound offer exists locally, and who funds it.
- Whether cardiovascular or renal outcomes data exists, or is achievable.
- The primary care versus specialist initiation split, and whether shared care is in place.

8. Sources

Every material claim above is traceable to one of the following. Two were supplied directly rather than retrieved.

NICE

- NICE TA1026 — Tirzepatide for managing overweight and obesity
- NICE TA875 — Semaglutide for managing overweight and obesity
- NICE TA1152 — Semaglutide for reducing the risk of major adverse cardiovascular events (published 7 May 2026)

Obesity commissioning

- NHS England — Interim commissioning guidance: implementation of NICE TA1026 and the NICE funding variation for tirzepatide (Mounjaro) for the management of obesity
- NHS England Digital — Prescribing activity of tirzepatide in primary care for weight management

Payment, contracting and commissioning frameworks

- 2026/27 NHS Payment Scheme
- 2026/27 NHS Standard Contract

- NHS England — Strategic commissioning framework (November 2025)
- NHS England — Medium Term Planning Framework 2026/27 to 2028/29
- NHS England — NHS Oversight Framework 2026/27
- NHS England — Changes to the GP Contract in 2026/27
- NHS England — Provider Selection Regime: statutory guidance
- NHS England — Implementing integrated care board mergers and boundary changes, April 2026 and 2027
- DHSC and NHS England — Cardiovascular disease modern service framework (7 July 2026)

Better Care Fund

- DHSC and MHCLG — Better Care Fund framework 2026 to 2027 (17 February 2026; supplied)
- NHS England — Better Care Fund 2026/27 to 2027/28: minimum NHS contributions from integrated care boards
- Better Care Fund 2026/27 planning data collection — national aggregation of planning returns (supplied).

Points to check before relying on them

- The precise Standard Contract service condition numbering for NICE technology appraisal compliance in the 2026/27 edition.
- The final integrated care board count after the April 2027 merger wave, which was still being decided in summer 2026.
- Scheme category totals in section 6.2 involve some consolidation of near-duplicate labels in the returns; the source publication warns of data quality issues, so treat category-level figures as indicative.
- Historic planned spend figures in section 6.1 are drawn from successive planning rounds and are not adjusted for changes in reporting basis.

About this series

Curated AI Research is a free briefing series from Healthcare Acumen Ltd on how the NHS commissions, funds and pays for specialist medicines. Each briefing takes one question and answers it end to end: the named mechanism, the clause or fund it sits in, the people who sign it off, and what usually goes wrong.

AI does the retrieval and the first draft. Every material claim is traced to a primary source and linked. The framing, the judgement and the warnings are mine.

AI is very good at answering. It does not know what to ask.

Not advice — a map. Compiled 15 September 2026.