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LMC Communication – Concerns for Practices R.E. QOF Indicator OB005

Context

You will be aware of the new QOF indicator OB005 as follows:

- **OB005** – Clinical management indicator *"Percentage of eligible patients… who have a recorded shared-care decision-making discussion… and are offered NICE-approved pharmacotherapy and behavioural support."* 13 points, 50–80% threshold. Focus: assessment, shared decision-making, prescribing, titration, monitoring, review.

Following the publication of the accompanying FAQs by NHSe in July, the LMC Chair has submitted a detailed analysis (available here) to the ICB focused on several contractual and regulatory issues with the position taken by NHSe and subsequently our own ICB. This communication is being sent to you as a key summary of the current ICB position and the concerns for our practices.

What Practices Must Delver to Achieve OB005

According to the published FAQs and subsequent confirmation to the LMC from our ICB, there is an expectation that practices are required to deliver all the following components:

- Identification of eligible cohorts
- Shared decision-making consultations
- Prescribing tirzepatide
- Dose titration
- Monitoring and review
- Referral to relevant behavioural support

Workload and Financial Risk Moving Forward

As the proposed cohorts increase, this could result in significant workload increases and consequential financial implications. Based on a practice of 10,000 patients, the workload and financial modelling demonstrate this concern:

- 2026/27: Cohort 2 (first year) - OB005 income: £2,964 Net position ranges from £1,499 to £64 profit, depending on GP/nurse mix.
- 2027/28: Cohort 3 plus Cohort 2 reviews - OB005 income: £2,964 Net position ranges from £4,766 to £910 loss.
- To note, each cohort is likely to remain in treatment for multiple years. At this stage, there is no reason to assume that QOF funding will increase in line with workload.

Practical Steps for Practices

Recommended actions:

- Run searches for cohorts 1–3
- Assess workforce skill mix (GP, nurse, other clinicians)
- Model financial viability before committing
- Remember: *"QOF is not compulsory… QOF is paid retrospectively and only if the target is met."*

LMC Concerns detailed to the ICB

In our detailed analysis submitted to the ICB, there are five key areas of concern for which we are asking for a detailed response. These are:

Contractual basis
Please identify the specific provision of the GMS Regulations or Standard GMS Contract relied upon for the proposition that every GMS contractor must initiate, titrate and provide ongoing tirzepatide treatment within the practice. Where a different interpretation is based on legal advice, please identify the contractual or regulatory provisions relied upon so that they may be considered alongside GPC England's Regulation 17 position.

Route for every patient
Where an eligible patient's registered practice does not undertake the OB005 prescribing route, what commissioned NHS pathway should that patient access?

CHFT pathway
Please confirm the current CHFT eligibility criteria and whether they now align with the OB005 cohort. If they do not, what commissioned treatment route exists for patients falling between the two thresholds? Please also confirm the intended arrangements for patients discharged from the service after twelve months of therapy.

Behavioural support
Please provide the operational West Yorkshire BSOP pathway, including provider, referral mechanism, coding and escalation arrangements, and confirm which services satisfy the OB005 behavioural-support requirement.

Commissioning mechanism
If the ICB wishes tirzepatide initiation, titration and ongoing management to be provided within general practice rather than through referral, will it enter discussions with the LMC to develop an appropriate Local Enhanced Service?

LMC Position and Advice to Practices

There are two key considerations we are asking practices to focus on until the ongoing discussions with the ICB bring clarity to the concerns outlined:

Inadequate Funding and Safety Risks

The LMC concludes:

- OB005 is not adequately funded for the workload required.
- Although there is a tier 3 service commissioned through CHFT, this is yet to be confirmed as inclusive of cohorts 2 and beyond.
- Practices could be expected to absorb complex obesity management without specialist support.

Risk of Work Becoming 'Core General Practice'

This is a major concern. If practices deliver tirzepatide for several years with an underfunded QOF incentive scheme being the only contracting mechanism, commissioners may argue that it has now become core general practice. Once normalised, work is difficult to hand back. It is our clear position that this work should be commissioned in general practice through a LES.

LMC Position

The LMC's view is that OB005, as currently funded, does not adequately resource the work it requires, and that the position worsens materially from 2027/28 as cohorts accumulate. That is our assessment of the indicator, and it is the basis on which we have gone to the ICB.

Whether to participate is a decision for each practice, based on its own list size, register, skill mix and capacity. We would ask that it is made deliberately, having looked at the modelling against your own numbers, rather than by default.

QOF participation is voluntary, and payment is retrospective and conditional on achievement. Practices which do participate should be supported to achieve, and we are pressing the ICB for the operational detail needed to do so.

Example Financial Modelling

The following is based on a practice list of 10,000 patients, with 10 identified patients per cohort and with appointment costs based on the current agreed rates for our existing LES agreements.

To Note:

Financial modelling for a 10,000-patient practice

- *OB005 requires complex modelling – practices must remember that each cohort will be treated for more than one year, so in the second year they will have new patient appointments for cohort 3 as well as review appointments for cohort 2, and so on in future years.*
- *Modelling for the first two years is given below, assuming a variety of types of service delivery.*
- *A GP-only model would make a loss from the start; a mixed model using suitably trained non-GP clinicians might break even or make a small profit in year one, but only on optimistic assumptions and only if the practice achieves all available QOF points.*
- *It is hard to see how any practice could deliver this safely at anything other than a loss from year two onwards.*
- *In future years, further cohorts are expected to widen eligibility. There is no reason to assume that QOF funding will increase in line with the workload.*

Cost to deliver with various appointment models

For these calculations a GP appointment is assumed to cost £48.25 and a nurse £23.60, based on current agreed costs for LES activity with Calderdale ICB.

2026/27 - cohort 2 first year

- *10 - Estimated patients per 10,000 patient practice.*
- *£2,964 - OB005 income, assuming £228 per QOF point.*

Appointment mix options and costs:

- *£2,900 for 6 GP appointments**.***
- *£2,195 for 3 GP and 3 nurse appointments.*
- *£2,515 for 7 appointments averaging a 50/50 split of GP/nurse.*
- *£1,465 for 6 nurse and 1 GP appointments.*

The net income then ranges from £1,499 to £64 profit depending on the kinds of appointments offered.

2027/28

- *£2,964 - OB005 income, assuming £228 per QOF point.*

2027/28 cohort 3 first year

- *20 - Estimated patients per 10,000 patient practice.*

Appointment mix options and costs:

- *£5,800 for 6 GP appointments.*
- *£4,390 for 3 GP and 3 nurse appointments.*
- *£5,030 for 7 appointments averaging a 50/50 split of GP/nurse.*
- *£2,930 for 6 and nurse and 1 GP appointments.*

2027/28 cohort 2 second year

- *10 - Estimated patients per 10,000 patient practice.*

Appointment mix options and costs:

- *£1,930 for 4 GP appointments.*
- *£1,444 for 2 GP and 2 nurse appointments.*
- *£944 for 4 nurse appointments.*

The net income for both 2027/28 cohorts then ranges from a loss of £4,766 to £910.