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QOF Indicator OB005, Tirzepatide and the Commissioning Question

Calderdale LMC provides this analysis of QOF OB005 with a clear focus, confined to a single contractual question. It does not dispute the clinical value of obesity pharmacotherapy, nor the role of general practice in managing patients living with obesity, nor the fact that NHS England has placed funding for specified primary care activity into QOF. Throughout this analysis, every challenge and proposition is evidenced with clear referenced publications or attributable papers.

1.0 Setting the Ground and Context

These points are recorded at the outset so that the discussion remains focused on the key issue in dispute. The LMC is not challenging the existence of national QOF funding for OB005, nor the clear national policy intention to support delivery in primary care. The question requiring resolution is what contractual and commissioning consequences properly follow from that.

1.1 What the LMC Accepts without Argument

From the beginning, it is important to remove the arguments we are not making, as they could potentially obscure the analysis and positions that follow. For clarity, the LMC accepts:

- OB005 exists and forms part of the 2026/27 QOF.
- NHS England has purposefully chosen QOF as the national financial mechanism for the primary care activity described in the indicator. The FAQ states that OB005 provides a nationally funded QOF payment for practices delivering identification, assessment, initiation and ongoing management of eligible patients prescribed tirzepatide. (FAQ, Q9)
- The 2026/27 QOF cohort is small. NHS England anticipates an average of around sixteen eligible patients per practice. (FAQ, Q9)
- NHS England's intention to avoid a duplicate payment for a single episode of care. What the LMC does seek is set out in section 6.

Although the LMC has accepted the above as clear position statements from NHS England, the LMC does not agree with the specific assertion made in reference to the need for a Local Enhanced Service. Our position, developed in Section 6, is that the published FAQ does not address the key contractual question and that a local enhanced service is required with the LMC fully engaged in any negotiation. The reasons the FAQ does not settle that question are set out through the following analysis.

1.2 Status of the NHS England FAQ

The ICB appears to place significant reliance on the NHS England FAQ. Its status should therefore be clear.

The FAQ is guidance. It is not the GMS Regulations, the Statement of Financial Entitlements or the Standard GMS Contract, and it does not amend those instruments. Its purpose is to explain NHS England's intended operation of the 2026/27 QOF arrangements; it does not create additional contractual obligations for GMS contractors.

This distinction is important because the FAQ says only that:

"A separate LES is not required to reimburse practices for activity covered by OB005."

That is a statement about how this activity may be funded. It is not a statement that a LES is prohibited, nor that no further service needs to be commissioned. Indeed, in the same answer NHS England expressly states that OB005 does not replace the need for ICBs to commission *'the wider obesity pathway'*.

The LMC therefore regards the FAQ as relevant evidence of NHS England's policy and payment intention, but not as determining the separate questions of GMS contractual obligation or what wider services the ICB must commission.

1.3 The Single Contractual Question in Dispute

For Calderdale LMC, through understanding the position stated in the NHS England FAQ's, the primary question raised is:

1. Does the inclusion of tirzepatide activity within a voluntary QOF indicator, by itself, establish that every GMS contractor is contractually required to initiate, titrate and provide ongoing obesity pharmacotherapy within the practice?

2. If so, does it follow that the ICB is discharged of responsibility for commissioning a route for patients whose registered practice does not deliver OB005?

The above naturally leads to a consequential question:

- And if it does not, by what mechanism does the ICB intend to commission the work that falls outside the indicator?

1.4 Four Concepts that are being Treated as One

The difficulty in the current exchange is not disagreement about facts. It is that four separate questions are being answered with a single sentence - "it is in QOF". They are distinct questions with distinct legal and financial answers.

Question	What answers it
1. Is the activity clinically recommended?	NICE TA1026 and NG246. The clinical recommendation is not disputed.
2. How is the activity paid for when a practice delivers it?	QOF OB005. It is not disputed that activity leading to achievement results in QOF payment.
3. Is every GMS contractor contractually obliged to deliver it in-house?	The GMS Regulations and the Standard GMS Contract are the contractual requirements for general practice — not QOF or any published FAQ. This is the question the LMC says has not been answered.
4. Who is responsible for ensuring an eligible patient can access treatment irrespective of their practice's QOF participation?	The ICB's have a statutory duty to commission. NHS England says expressly that this duty survives OB005. (FAQ, Q6)

NHS England, and subsequently the ICB has answered Question 2. The concern is that this answer is then being treated as determining Questions 3 and 4, which clearly it does not.

A payment mechanism determines how activity is remunerated. It does not, by itself, determine who is contractually obliged to provide that activity or remove the need for an accessible commissioned pathway.

The LMC's position is therefore straightforward:

NHS England has determined how OB005 activity is funded when delivered through general practice. OB005 does not itself determine that every GMS contractor must provide that activity in-house.

2.0 OB005 Applies to a Narrowly Defined Cohort

OB005 applies only to patients included on the OBES2_REG register. The Business Rules define this as patients aged 18 years or over with a BMI, recorded within the preceding twelve months, of at least 35 kg/m² — or at least 32.5 kg/m² for patients of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background — who also have at least four of the following five criteria:

1. atherosclerotic cardiovascular disease;
2. unresolved hypertension;
3. dyslipidaemia;
4. obstructive sleep apnoea; and
5. unresolved type 2 diabetes.

(Business Rules v51.3, section 3.2.2)

This distinction matters. OBES2_REG defines the population relevant to the QOF indicator; it does not define the whole population eligible for obesity treatment, or the population for whom the ICB must commission services.

The existing Calderdale and Huddersfield Specialist Weight Management Service operates on different criteria. The information issued to practices in October 2025 specifies a BMI of 40 or more — 37.5 for the listed ethnic groups — together with at least four of five listed conditions. Set against a QOF register operating at 35 and 32.5, there is a band of patients who sit within the practice's QOF denominator but who, on the criteria last communicated to practices, cannot be referred to the commissioned specialist service for tirzepatide. The OB005 cohort and the commissioned specialist-service cohort are therefore not interchangeable.

This is consistent with NHS England's own FAQ, which states that ICBs '*remain responsible for commissioning the wider obesity pathway required to meet local population need, and not just the NICE Funding Variation priority cohorts eligible for assessment and treatment in Primary Care.'*

The significance is therefore not simply that OB005 covers a relatively small number of patients. It is that OB005 describes a defined QOF-funded primary-care cohort; it does not define, replace or exhaust the wider commissioned obesity pathway.

2.1 OB005 Requires Three Specific Recorded Components

For achievement, the OB005 numerator requires a qualifying BMI together with all three of the following within the reporting year:

- pharmacotherapy for obesity management;
- referral into a weight-management behavioural-support programme; and
- a recorded shared decision-making discussion.

(Business Rules v51.3, OB005 numerator)

The published coding is specific. The FAQ lists WTMGBSPREF_COD as "Referral to NHS obesity medication wraparound support pathway" and WTMGPHARM_COD as "NHS obesity medication pathway started".

This is narrower than OB004. For OB004, NHS England expressly recognises qualifying Tier 2 services including the NHS Digital Weight Management Programme and appropriate local-authority commissioned services. (FAQ, Q3)

For OB005, NHS England identifies the national BSOP pathway, or a locally commissioned equivalent meeting the requirements of the tirzepatide primary-care pathway. (FAQ, Q7)

The two indicators use different clusters, and a single referral does not serve both. A referral which qualifies for OB004 does not automatically satisfy the OB005 behavioural-support requirement. For OB005, NHS England identifies the national BSOP pathway or an appropriate locally commissioned equivalent.

The LMC would welcome written confirmation of which West Yorkshire services and coding arrangements currently satisfy this requirement.

The Business Rules also contain an exclusion which bears directly on the referral route**.** Denominator rule 2 rejects any patient who has a recorded tirzepatide prescription but no corresponding pharmacotherapy code (exclusion TIRZNOPH). Since the pharmacotherapy cluster contains a single concept - "National Health Service obesity medication pathway started" - a patient whose treatment was initiated by the commissioned specialist service will not carry that code, and is therefore excluded from the denominator altogether.

This is an exclusion rather than a personalised care adjustment, and it operates on the coding rather than on the care delivered. The consequence is that a practice which has identified, assessed, counselled and appropriately referred an eligible patient records no achievement for that patient, notwithstanding that the patient has received the treatment through a pathway the ICB itself commissions. The LMC asks the ICB to raise this with NHS England and to seek confirmation of how the rule is intended to apply to patients treated through a commissioned specialist pathway

2.2 The Business Rules Define QOF Achievement, not Contractual Obligation

NHS England describes the QOF Business Rules as technical specifications used to extract data from primary-care systems and to allocate rewards, including QOF points and payments. It states that the QOF registers are constructed “solely” to support practices, system suppliers and NHS England with the claims and audit requirements of the indicators.

The Rules also make clear that their purpose is technical rather than contractual. A patient may be removed from an indicator through a personalised care adjustment while remaining clinically eligible for care; NHS England expressly describes such removal as being “for payment purposes only.”

The Business Rules therefore answer:

> Has the practice achieved OB005 for QOF purposes?

They do not determine the separate question:

> What service is every GMS contractor contractually required to provide?

That question must be answered by the GMS Regulations and contractual framework, not by the technical rules used to calculate QOF achievement.

In short: the Business Rules determine QOF achievement and payment; they do not define the underlying scope of the GMS contract.

2.3 What the FAQ Says – and What it Does Not Say!

The NHS England FAQ is central to this issue and should be read precisely.

Q6 states that:

"A separate Local Enhanced Service (LES) for general practice is not required to reimburse practices for delivering tirzepatide (Mounjaro) prescribing and associated care covered by OB005, as these activities are now incorporated within the national Quality and Outcomes Framework (QOF)."

The LMC accepts that NHS England intends QOF to provide the national payment mechanism for OB005 activity where a practice delivers it. The LMC does not accept that this means a locally commissioned service is unnecessary.

The wording is specific: '*a LES is not required to reimburse the activity covered by OB005'*. It does not say that a LES is prohibited, nor that QOF itself commissions a complete and universally available tirzepatide service.

Indeed, the same answer immediately states:

'OB005 does not replace the need for ICBs to commission the wider obesity pathway…'

The two statements should therefore be read together:

QOF provides the national payment mechanism for defined OB005 achievement; the ICB remains responsible for commissioning the wider obesity pathway.

The FAQ does not say that OB005 is an essential service under GMS, that every contractor must initiate or titrate tirzepatide, that inclusion in QOF alters Regulation 17, or that a contractor which does not deliver OB005 has failed to meet a contractual requirement. Those propositions require a separate contractual basis and are not established by the FAQ.

Q9 in the FAQ's is also relevant. NHS England states that prescribing, dose titration, routine monitoring and follow-up may involve the wider primary-care multidisciplinary team*, 'supported by local commissioning arrangements where required.'*

The LMC's position is therefore that, if West Yorkshire wishes to secure a defined, consistent and sustainable primary-care tirzepatide service rather than rely on voluntary QOF participation alone, a locally commissioned arrangement is required to specify and support that service. This is not a request simply to duplicate the QOF achievement payment; it is a request to commission the infrastructure, capacity, responsibilities and access arrangements necessary to make the pathway deliverable and the indicator achievable.

3.0 The Contractual Position

The central issue is contractual. The question is not whether tirzepatide is clinically recommended or whether OB005 provides QOF funding. It is whether the GMS contract requires every contractor to initiate, titrate and manage tirzepatide within the practice rather than through an appropriate referral pathway.

3.1 QOF Participation is Voluntary

The 2026/27 Standard GMS Contract is explicit:

> *'Participation by contractors in the QOF is voluntary.'*

It describes participating contractors as undertaking specified tasks or achieving specified outcomes in return for payments measured against achievement.

The contractual difficulty is therefore straightforward:

A voluntary QOF indicator cannot, by itself, be the instrument by which mandatory provision has been secured from every GMS contractor.

If OB005 participation is voluntary, some practices may not deliver the OB005 route. If the ICB considers tirzepatide initiation and titration nevertheless mandatory under GMS, the contractual basis for that separate obligation needs to be explicitly identified.

3.2 Regulation 17 Expressly Permits Referral as Part of Clinical Management

The LMC does not dispute that obesity may fall within the management of chronic disease under Regulation 17. The issue is what "management" requires the contractor itself to provide.

Regulation 17(4) of the National Health Service (General Medical Services Contracts) Regulations 2015 requires services for patients suffering from chronic disease to be delivered:

'in the manner determined by the contractor's practice in discussion with the patient.'

Regulation 17(5) then defines management as including:

- offering consultation and, where appropriate, physical examination for the purposes of identifying the need, if any, for treatment or further investigation; and
- making available such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services under the Act and liaison with other health care professionals involved in the patient's treatment and care.

Regulation 17(6) likewise defines appropriate ongoing treatment and care as expressly including the referral of a patient for services under the Act.

The contractual distinction is therefore important:

The practice must assess the patient and identify the need for treatment. Regulation 17 does not say that every necessary treatment must then be delivered within the practice; it expressly recognises referral as part of management.

Regulation 17(6A) then lists the services which must be provided within the practice: cervical screening, child health surveillance, contraceptive services, maternity medical services, and vaccine and immunisation services. That list was inserted into the Regulations by amendment in 2021. Tirzepatide initiation, and obesity pharmacotherapy generally, is not on it.

The LMC's position can therefore be put simply:

Management of obesity may be core. It does not follow that every component of obesity treatment — including tirzepatide initiation and titration — must be provided in-house by every GMS contractor.

That further proposition requires a contractual basis.

(Regulation 17 as quoted above is taken from legislation.gov.uk, SI 2015/1862 as amended, Crown copyright, Open Government Licence v3.0. The corresponding provisions of the Standard GMS Contract 2026/27 give effect to it.)

3.3 This is Consistent with GPC England's Regulation 17 Position

This reading is not the LMC's own construction. GPC England has published Regulation 17 guidance, last updated 8 April 2025, which records that it was approached by a number of LMCs concerned about ICBs insisting that practices deliver services the practices were no longer able or willing to provide, and that it obtained expert legal advice on the position of practices working under a standard GMS contract.

That guidance sets out the same two-limb reading of Regulation 17(5): consultation, examination and diagnosis, which the practice must provide itself; and the making available of treatment or further investigation, which may be provided in-house or by referral. It states that individual practices have a choice as to which, and that beyond consultation, examination and diagnosis and the services listed at Regulation 17(6A), a practice may refer a patient to another NHS contracted provider.

It also frames the question in terms directly applicable here. The relevant question is not:

'Is obesity management an essential service?'

It is:

'Does the GMS contract require this particular treatment to be provided within the practice rather than through referral to another appropriate NHS provider?'

That is the question the LMC asks the ICB to address, and it is the question on which the national representative body has taken legal advice.

3.4 The ICB's interpretation does not itself determine the scope of the GMS contract

GPC England's Regulation 17 guidance, produced following legal advice, addresses circumstances in which commissioners assert that a particular service forms part of essential services. Its guidance states that such determinations are '*not within ICBs' powers.'*

The LMC relies on that advice. The ICB is of course entitled, as commissioner, to form a view on the meaning of the contract. Its interpretation does not, however, itself amend the GMS contract or create a requirement for a particular treatment to be provided in-house. The scope of the contractor's obligations must derive from the GMS Regulations and the contract made under them; where interpretation is disputed, the contract provides a formal dispute-resolution process.

Accordingly:

- A NICE recommendation does not, by itself, require every practice to provide the treatment in-house.
- Local formulary status does not amend the GMS contract.
- Inclusion within QOF does not, by itself, establish a mandatory essential service, particularly where the contract expressly states that QOF participation is voluntary.
- An ICB policy or interpretation does not, by itself, convert an activity into mandatory in-house GMS provision.

This is particularly relevant here because Regulation 17 expressly recognises referral to other NHS services as part of the management of patients and of appropriate ongoing care.

If the ICB considers that Regulation 17 nevertheless requires every GMS contractor to initiate and titrate tirzepatide within the practice, the LMC asks it to identify the specific contractual or regulatory provision on which that conclusion rests.

Where that interpretation is based on legal advice, we would welcome sight of the provisions relied upon so that they may be considered alongside GPC England's Regulation 17 advice.

4.0 Where the ICB Recognises the Same Distinction

The West Yorkshire ICB presentation, *Obesity Landscape and Other Metabolic Topics: Four Questions for the LMC*, was presented by Hannah Beba, Consultant Pharmacist for Diabetes and Clinical Lead for Obesity, and Sarah De Biase, Improving Population Health Senior Programme Manager. The copy held by the LMC is undated.

It is a candid document, and the LMC does not cite it to catch out its authors. It cites it because the presentation itself identifies the distinction at the heart of this paper:

> *'QOF is an incentive scheme, not a commissioning mechanism. It rewards achievement of an indicator; it does not fund the pathway required to achieve it. We all accept that, and we accept it is insufficient for the full pathway.' (Slide 5, speaker notes)*

The LMC agrees. The same presentation recognises that practice readiness varies, that some practices do not consider the work safely deliverable without additional infrastructure, and that '*both positions are legitimate.'* It also states that practices '*that wish to proceed can'* and identifies practice-by-practice choice as a potential source of inequity (slide 4).

Most importantly, the proposed model expressly requires:

> *'A route for every patient — including where a practice does not take part in QOF or any future local arrangement.' (Slide 11)*

The presentation also recognises that QOF expects referral into wraparound support but does not fund that support (slide 10) and describes implementation as a *'significant scope increase for general practice'* requiring education and infrastructure (slide 12).

These statements are difficult to reconcile with the proposition that OB005 has already secured universal provision from every GMS contractor. If some practices may not participate, an alternative route is required; if QOF is not a commissioning mechanism and is insufficient for the full pathway, the commissioning question remains to be resolved separately.

The LMC therefore asks that the distinction, already recognised in the ICB's own analysis is carried through into the final commissioning approach.

5.0 Operational Consequences in Calderdale

The contractual position above gives rise to three practical questions locally. Clear answers to these would resolve much of the current difficulty.

5.1 What is the Route Where a Practice Does Not Undertake OB005?

This is the central operational question, and it is the ICB's own. The presentation states that any future model should provide:

> *'A route for every patient — including where a practice does not take part in QOF or any future local arrangement.' (Slide 11)*

The LMC therefore asks:

- If an eligible patient is registered with a practice that does not undertake the OB005 prescribing route, where should that patient be referred for NHS assessment and treatment?
- If the answer is CHFT, the relevant eligibility criteria and capacity need to be confirmed.
- If the answer is another commissioned provider, that pathway needs to be identified and communicated to practices.
- If no alternative route currently exists, then the ICB's own requirement for "a route for every patient" has not yet been met.

This is the practical commissioning gap the LMC is asking the ICB to resolve.

5.2 The CHFT Specialist Pathway does not Currently Match the OB005 Cohort

Calderdale and Huddersfield already have a commissioned CHFT Specialist Weight Management Service providing a secondary-care MDT pathway, including weight-loss injections alongside specialist psychological and dietetic support.

The criteria last communicated to practices for access to Mounjaro through this pathway were BMI ≥40 — 37.5 for specified ethnic groups — plus at least four qualifying comorbidities.

OB005 includes patients from BMI ≥35 — 32.5 for specified ethnic groups — with the required comorbidities.

There are therefore a group of patients who fall within the OB005 QOF cohort but who, on the last criteria published to practices, cannot access the commissioned CHFT tirzepatide pathway. If those criteria have since been widened, the LMC would welcome confirmation, as practices are currently working to the October 2025 information.

The LMC asks the ICB to confirm:

- Has the CHFT eligibility criteria now been widened to align with the OB005 cohort and, if not, what commissioned treatment route exists for patients between the two thresholds?

NHS England also states that activity delivered through a Tier 3 Specialist Weight Management Service does not count towards OB005 achievement.

The LMC regards this as a QOF achievement rule, not a determination of the underlying GMS contractual position. As set out in Part C, Regulation 17 expressly recognises referral to another NHS service as part of patient management.

Accordingly, the fact that a referral to CHFT may not generate OB005 achievement does not, by itself, establish that referral is contractually inadequate.

Whether a referral earns OB005 QOF achievement, and whether referral is an appropriate means of discharging the contractor's underlying GMS responsibilities, are separate questions.

The former is determined by QOF rules. The latter must be determined by the GMS contractual framework.

5.3 Behavioural Support – Practices Need a Live Referral Route

The remaining question is administrative rather than contractual and should be the most easily resolved of the three.

OB005 requires, as part of achievement, a recorded referral into a suitable weight-management behavioural-support programme, alongside pharmacotherapy and shared decision-making.

NHS England states that the national Behavioural Support for Obesity Prescribing (BSOP) programme is available for patients whose prescribing has been initiated in general practice.

The issue for Calderdale practices is therefore not whether a national service exists, but how it is accessed locally. We are now more than four months into the 2026/27 QOF year, and practices require a clear operational pathway setting out:

- the West Yorkshire provider;
- how and where to refer;
- the referral form or template and required coding;
- eligibility requirements; and
- the route for queries, rejected referrals or access difficulties.

The LMC also seeks confirmation of which services satisfy the OB005 referral requirement. A service that qualifies for OB004 does not automatically qualify for OB005; the published OB005 coding specifically refers to referral into the NHS obesity medication wraparound-support pathway.

Practices cannot reasonably be expected to deliver and achieve OB005 without a clear and functioning route for one of its required components. This is a matter the ICB should be able to resolve quickly, and the LMC would welcome it being dealt with ahead of the wider questions above.

6.0 The Commissioning Choice

As clearly stated in section 1.1, the LMC accepts the ICB's principle that the same activity should not be paid for twice. We are clear that this paper is not seeking duplicate payment for OB005 achievement.

6.1 The Issue is Not Double Payment

The issue we are highlighting is different. OB005 is a voluntary, achievement-based incentive. It does not itself secure a universally available service. It does not require every practice to participate, nor does it provide an alternative route for patients registered with practices.

Regulation 17 is important here. The LMC accepts that obesity may fall within the management of chronic disease. However, Regulation 17 expressly provides that management includes making necessary and appropriate treatment available including through referral to another NHS service.

There are therefore two possible service models.

First, treatment may be provided within general practice. If the ICB wishes practices themselves to undertake tirzepatide initiation, titration, monitoring and follow-up as a defined and consistently available service, the LMC's position is that this should be commissioned through a Local Enhanced Service.

Second, treatment may be made available through referral. Where a practice does not provide tirzepatide initiation itself, an appropriately commissioned NHS specialist service can provide the treatment following referral. Referral is expressly recognised within Regulation 17 as part of management.

The commissioning question is therefore straightforward:

Either commission general practice to provide the in-practice tirzepatide service or ensure that every eligible patient has access to an appropriately commissioned NHS service to which their practice can refer.

What the LMC does not accept is a third position: that no commissioned referral route need exist because the treatment appears within voluntary QOF, and that the registered practice must therefore provide it in-house.

That is the proposition by NHS England for which the LMC is asking the ICB to identify a contractual basis.

6.2 Why the LMC Proposes a Local Enhanced Service

If West Yorkshire wishes to secure a defined, consistent and sustainable primary-care tirzepatide service, rather than rely upon practice-by-practice participation in QOF, a commissioning mechanism is required.

The NHS England FAQ does not prohibit such an arrangement. It states that a separate LES is not required to reimburse activity already covered by OB005. That is different from saying that a locally commissioned service cannot or should not be used to secure a defined service.

Indeed, NHS England also confirms that the ICB remains responsible for commissioning the wider obesity pathway and that prescribing, titration, monitoring and follow-up may be supported by local commissioning arrangements where required.

A LES could specify the participating providers, capacity, workforce, prescribing and monitoring responsibilities, specialist advice and escalation, arrangements for patients whose own practice does not participate, and the interface with CHFT and behavioural support.

The LMC's position is therefore not that NHS England mandates a LES, it is:

If the ICB wishes general practice itself to provide tirzepatide initiation, titration and ongoing management rather than make that treatment available through referral, the service should be expressly commissioned from general practice.

A LES is, in the LMC's view, the appropriate mechanism, and the LMC would welcome working with the ICB to develop a specification.

6.3 If There is no LES, There Must Be an Accessible Referral Route

Calderdale already has a commissioned specialist route through the CHFT Specialist Weight Management Service. This demonstrates that tirzepatide treatment can be provided through an NHS service following referral from general practice.

The issue is whether that route is available to all patients for whom treatment is required.

As set out at 5.2, the CHFT eligibility criteria last communicated to practices does not align with the OB005 cohort. There are therefore a group of patients who meet the primary-care Funding Variation criteria but who, on those

criteria, cannot access the existing specialist pathway. If the criteria have since been widened, the LMC would welcome confirmation, since practices are currently working to the October 2025 information.

This gap matters irrespective of QOF achievement.

If the ICB does not commission practices to provide the treatment themselves, it must identify the commissioned NHS pathway through which the treatment can be made available following referral.

The referral model also requires clarity at discharge. The October 2025 pathway anticipates patients returning to general practice after twelve months of injectable therapy. The LMC therefore asks the ICB to specify the intended responsibilities for continuation, maintenance, monitoring, de-escalation and management of weight regain following discharge. Those responsibilities should not be left to arise by default.

The fact that referral to a Tier 3 service may not generate OB005 achievement is a separate QOF matter. It does not, by itself, determine whether referral is an appropriate means of fulfilling the contractor's underlying management responsibilities under Regulation 17.

QOF achievement and the contractual adequacy of referral are separate questions.

6.4 The Immediate 2026/27 Operational Position

There is also an immediate issue for practices choosing to participate in OB005.

OB005 has applied since April 2026, and we are now in August. Achievement requires referral into appropriate behavioural wraparound support, yet practices need a clear and usable West Yorkshire referral route.

The LMC therefore asks that the operational BSOP pathway, as detailed in section 5.3 be communicated urgently.

Practices choosing to participate in OB005 should be enabled and supported to achieve it.

Equally, the existence of a voluntary QOF indicator should not be relied upon as establishing that a practice which does not provide tirzepatide in-house is thereby failing to meet a contractual requirement.

6.5 Questions Requiring a Written Response

The LMC asks the ICB to address five points.

<u>A. Contractual basis</u>
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, notwithstanding Regulation 17's express provision for referral.

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.

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

<u>C. CHFT pathway</u>
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.

<u>D. Behavioural support</u>
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.

E. 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?

6.6 Conclusion

The LMC accepts that NHS England has placed a financial incentive for defined primary-care activity into QOF through OB005.

The disagreement is about what follows from that.

QOF does not, by itself, establish that every GMS contractor must provide tirzepatide treatment in-house. Regulation 17 expressly recognises referral to another NHS service as part of patient management.

The LMC therefore asks the ICB to clarify which model it intends to commission.

If tirzepatide initiation, titration and ongoing management are to be provided within general practice, the LMC asks that an appropriate Local Enhanced Service be developed with general practice.

If that service is not to be commissioned from practices, the ICB should ensure that every eligible patient has access to an appropriate commissioned NHS service to which their practice can refer.

What the LMC does not accept is that the absence of a commissioned referral route can itself convert voluntary OB005 participation into a mandatory requirement for the registered practice to provide the treatment in-house.

This distinction is important beyond obesity. If inclusion of activity within voluntary QOF were sufficient, by itself, to establish universal in-house provision, the same reasoning could be applied whenever further activity is added to QOF and used to justify the withdrawal of commissioned services. For that reason, the respective roles of QOF, the GMS contract and local commissioning should be clearly established now, on a basis which will hold when the question next arises. For all the rationale detailed in this paper, QOF cannot be used as a mechanism by which services are commissioned.

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Sources

Statute

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