NHS
Lancashire and South Cumbria
Integrated Care Board

2025/26 Capitated LES Principles & End of Year FAQs – v.2 (29/04/2026)

This FAQ document has been developed to support practices in understanding the Capitated Local Enhanced Services (LES) end-of-year projections and reconciliation approach for 2025/26.

It provides further clarification on the methodology applied, how activity will be considered, and the approach to data quality, mitigation, and financial reconciliation.

If you have any further queries after reviewing this document, please contact your local Primary Care Team or lscicb.primarycareles@nhs.net

Projections & Methodology	
1. How are projections calculated?	Projections are based on average monthly delivery and are intended to provide an estimated year-end position using available activity data. Two delivery averages are calculated: • **Months 8–10 average** (reflecting recent delivery patterns) • **Months 2–10 average** (reflecting broader year-to-date delivery) The higher of the two averages is applied across the 11-month contract period to determine the projected position. *Projections are provided for indicative purposes only and do not replace the final reconciliation calculation, which will apply the full three-scenario reconciliation methodology outlined in the letter, once actual February and March activity is available.*
2. Why are averages used and why is cumulative activity also tested?	Delivery profiles vary across practices. Some practices mobilise gradually and increase delivery later in the year, while others may deliver higher volumes earlier. A single extrapolation method would not fairly represent all delivery patterns and could unintentionally under- or over-estimate likely year-end achievement.

	To ensure a fair and balanced approach: • Two delivery averages are calculated to reflect both recent and cumulative performance trends. • At year end, actual cumulative activity across May–March is also tested. At reconciliation, the methodology that produces the highest achievement figure for the practice will be applied. This ensures: • Full-year delivery is recognised • The timing of activity does not disadvantage practices • Achievement is not understated
3. Could projected achievement be lower than current year-to-date achievement?	The projection methodology is designed to ensure that projected achievement is at least in line with actual cumulative achievement at the point of reporting.
4. How will final year-end reconciliation be calculated?	At year end, three approaches will be tested: 1. Months 8–10 average (estimating May–January) plus actual February and March 2. Months 2–10 average (estimating May–January) plus actual February and March 3. Actual cumulative activity across May–March The **highest resulting achievement figure** will determine the final reconciled position. Where cumulative activity provides the strongest representation of achievement, this will be applied. This approach ensures that delivery across the year is appropriately reflected.

Data Quality & Coding	
5. What if a practice has a data query?	If a practice believes their reported activity does not accurately reflect delivery, they should: • Review their internal coding and activity records • Cross-check against the monthly BI extract • Raise any remaining data queries with **DQ**, in line with the process outlined in the 10th of March letter. Once practices have received their end-of-year reconciliation reports and accompanying letters, they will be required to submit mitigation for any necessary amendments.
6. What if activity has been coded late?	Practices are able to submit activity up to **three months after the end of the contract**, in line with contractual arrangements. However, practices have been advised to submit all activity by **10th April 2026** to support timely and accurate end-of-year reconciliation. Late coding submitted within the contractual timeframe will be included in reconciliation, but delayed submission may impact the timing of confirmation of the final position.
7. Can practices use anonymised patient lists or other evidence to demonstrate activity if this is not fully reflected in Data Quality (DQ) data?	The year-end position is based on activity that is identifiable through Data Quality (DQ) extracts, which rely on the correct clinical and associated administrative codes being recorded. Practices are expected, as far as possible, to ensure that the appropriate codes are used so that delivered activity is accurately captured within DQ. This applies equally where LESs are delivered via a subcontracted arrangement, in which case an appropriate administrative code should still be recorded at practice level. Where there are genuine and exceptional circumstances in which activity has been delivered but cannot be retrospectively coded, this may be raised separately through the mitigation process and will be considered on a case-by-case basis.

8. How is activity counted in LES reports?	Activity within the LES reports is measured on a per patient, per day basis. This is commonly referred to as a "contact". If a patient has multiple actions recorded on the same day, this is counted as one contact. Where the same patient is seen on different days, each day is counted as a separate contact.
9. Does the activity count include repeat attendances?	Yes. Repeat attendances are included **where they occur on different days**. Multiple actions delivered to the same patient on the **same day** are counted as a single contact.
10. What is included in the 'Possibles' column in BI reports?	The Data Quality (DQ) team have confirmed that the 'Possibles' column may include a range of consultation types, including: • non-Enterprise consultations • Activity delivered through subcontracted arrangements
11. How will 'Possibles' be treated for 2025/26 year-end reconciliation?	For 2025/26 only, activity identified within the 'Possibles' column will be **reviewed alongside 'Coded as Eligible' activity** to support a fair and proportionate end-of-year position. Where this activity can be reasonably demonstrated to relate to commissioned LES services, it will be considered as part of the year-end reconciliation. This approach recognises that some activity may not have been fully captured through coding, while maintaining the expectation that activity should be appropriately recorded.
12. What are practices expected to do from 2026/27 regarding 'Possibles'?	From 2026/27 onwards, practices should review activity recorded within the 'Possibles' column and ensure that consultations relating to LES services are coded using the relevant templates and codes. This will ensure activity is fully captured within the 'Coded as Eligible' totals.
13. How should activity delivered through subcontracting arrangements be recorded?	Where services are delivered through subcontracting arrangements, practices should ensure that activity is appropriately recorded and coded within the patient record.

14. What if subcontracted activity has been delivered but not coded?	For 2025/26, practices may submit reasonable evidence of delivery (e.g. summary reports or similar documentation) to demonstrate that the service has been delivered via mitigation. This will be considered as part of the year-end reconciliation.
15. What is expected from 2026/27 for subcontracted activity?	From 2026/27 onwards, all activity delivered through subcontracting arrangements is expected to be fully coded within patient records.
16. How are Enterprise consultations counted for LES activity?	Where consultations relating to LES services are delivered through Enterprise templates and recorded using the appropriate coding, they will be included within the 'Coded as Eligible' totals in BI reports.
17. What should practices do to ensure Enterprise activity is captured?	Practices should ensure that all Enterprise consultations relating to LES services are recorded using the appropriate templates and codes.
18. What if Enterprise activity is not fully reflected in reports?	Where practices believe that Enterprise activity relating to the commissioned service is not fully reflected, they may submit mitigation evidence as part of the year-end reconciliation process to demonstrate delivery.
Mitigation & Exceptions	
19. What if a practice raises exceptional circumstances?	Any exceptional circumstances should be considered in line with the mitigation guidance which will be shared with practices.
20. Can practices submit evidence where activity is not fully captured?	Yes. For 2025/26, where activity has been delivered but not fully captured through coding or reporting, practices may submit mitigation evidence to demonstrate delivery.
21. Will guidance be provided on submitting mitigation?	Guidance and a template for submitting mitigation evidence for both the LTC LES and the Capitated LESs are available on the 25/26 LES intranet page under mitigation and linked within this FAQ. In line with the mitigation timeline, mitigation will open from 30 April, once practices have received confirmation of their end-of-year achievement
Financial & Recovery	
22. Will financial recovery apply?	If, following final reconciliation, achievement remains below the agreed expected activity threshold, recovery will be applied in line with the contract principles previously shared. The adjusted 25% threshold already reflects the allowance built into the contract principles and will be applied consistently.
23. Can we arrange payment plans for recovery?	Where recovery is required, practices will be able to arrange a payment plan with Finance.

24. What if activity is significantly below 25%?	Where activity remains significantly below 25%, practices may wish to review: • How patients are accessing services locally • Whether activity is occurring through alternative providers or pathways
25. When will 25/26-year end figures be shared?	End-of-year confirmation letters will be sent to practices by 30 April. BI reports are expected to be available on the 25/26 LES intranet page by 20 April to allow practices to review them in advance. A timeline for the end-of-year process is also available on the intranet under the Resources section and was previously shared during the webinar on 18 March.
Activity & Calculations	
26. How were practice expected activity plans calculated?	Planned activity is derived from: Percentage of your practice's weighted population as a proportion of the LES budget. This figure is divided by the unit cost for each LES to generate planned activity numbers.
27. How have the tariffs been calculated?	A breakdown of the tariff for each LES is available on the 26/27 LES intranet page under the Resources section.
28. Will we receive expected activity levels for 26/27?	As phlebotomy is the only capitated LES with an expected activity level, an expected activity level and practice tracker for phlebotomy is available on the 26/27 LES intranet page under the Phlebotomy Resources section. The spreadsheet also includes a guidance tab for practices to review.
29. What year are the LES calculations based on for Agenda for Change?	LES calculations are calculated using 2024/25 Agenda for Change rates, including on-costs, at the top of the band.
30. Will the LTC LES for 26/27 be over 11 months as the specialty areas (Frailty or Diabetes) not been agreed yet?	The LTC LES will be delivered over a 12-month period, as practices are able to start on additional cohorts. Practices will receive their LTC LES activity plans and place-based cohort (Frailty or Diabetes) by 21 April.