Enhanced Services 2026/27

Enhanced services provide a mechanism through which General Practice can deliver non-GMS services in response to local or national priorities. While a national budget is set for enhanced services, NHS Boards may supplement this funding to commission additional locally determined activity. For Boards, this offers flexibility to deliver services in a cost-effective and responsive manner. For practices, enhanced services have the potential to supplement core GMS income. For patients, they can support the delivery of care closer to home.

Income from enhanced services has historically formed an important component of practice funding. However, this has also created pressure on practices to take on additional activity, sometimes without sufficient consideration of whether the service represents fair value or is sustainably resourced. Over time, this dynamic risks drawing capacity away from core General Practice rather than strengthening it.

Looking ahead, enhanced services have the potential to deliver genuine mutual benefit for both NHS Boards and GP practices. To align with the BMA's position that "General Practice is open for business", it is essential that any new or continuing service represents good value for practices and is appropriately resourced.

Practices are therefore encouraged to carefully assess the business case for each of this year's enhanced services and to determine whether they remain viable to provide. The BMA business guidance offers a useful framework to support this assessment. While the impact on patients should remain an important consideration, it is equally important to recognise that inadequately funded services ultimately divert time, workforce, and resources away from core General Practice and may undermine its long-term sustainability.

We have attached a updated BMA enhanced service calculator to help practices assess the business case based upon their own practice processes.

Financial review

What follows is a breakdown of the 26-27 enhanced services for Lothian that details any significant changes from last year. We have used the service requirements to make an educated estimate of the time requirements and, through the BMA enhanced services calculator, taken a view on whether the service could represent value for money.

Any estimates are highly subjective and are greatly impacted by the way practices choose to deliver this work. We strongly encourage practices to calculate this based on their own approach. Such an understanding may help practices decide not to take on a service **OR** it may guide decisions over how they deliver a service.

CANCELLED ENHANCED SERVICES

None: We have continued to raise concerns regarding the cancellation of the diabetes LES last year. At the time, and still now, we believe this was a detrimental decision — for General Practice, for patient care, and for our secondary care colleagues.

The current Lothian diabetes guidance was developed and agreed at a time when a diabetes LES was in place. That LES provided the necessary resources to support staff training and safe patient care without adversely impacting other areas of GP work. Following the withdrawal of this funding, practices have been required to rebalance internal resources accordingly. It is therefore inevitable that practices are no longer able to deliver the same level of service, or adhere to the same guidance, that was achievable when the LES was funded.

Our persistence on this issue reflects the importance of maintaining clarity around the boundaries of GMS. Non-GMS work remains non-GMS work unless and until the GMS contract is formally amended. We cannot accept the premise that time-limited funding through an LES permanently redefines what does — or does not — constitute core GMS activity.

There is, of course, a wider and legitimate discussion to be had about how General Practice adapts to the evolving nature of medicine. This issue arises frequently and we fully recognise that clinical practice must change over time. However, such change is inherently subjective and must be progressed through agreement and negotiation, rather than by unilateral redefinition of contractual responsibility.

NO/MINIMAL CHANGE ENHANCED SERVICES

Care home lead practice: No change. List of homes updated. The LES estimates 1 session of time will be needed per week. It does not specify who should provide that time. A 60 person nursing home would result in a payment of: £2600 + 12,000(£200 per pt) = £14,600. Using the BMA ES calculator if that session was an even split between GP, PN and HCA time the funding looks reasonable but please look at how you deliver this service. **Value for money: OK - but depends on the home and practice approach**

Child health & wellbeing: No change. The demands of this service will vary across Lothian but are significant. Risk assessment of all families registering with the practice including an in person appointment if clinically appropriate, MDT meetings, and a designated Child protection lead. The funding is a share of a £478k pot based on the number of risk assessments performed. The variation makes analysis difficult but we do have concerns about the 'share of a fixed pot' model. **Value for money: Difficult to establish BUT clearly good practice**

Drug Dependence: Minimal change. Inclusion of disengagement plan and recovery plan - TBC. This is an area that is likely to be managed differently across Lothian. Minimum requirements are 2 appointments per year, prescriptions, education, planning, and audit. Payment is £560 per qualifying payment plus item of service payments for BBV testing and vaccinations. **Value for money: Fair**

Extended hours: No change. This DES is unchanged from last year. Practices must provide 30 minutes per 1000 patients. Payment is set at £3.01 per registered patient. £3001 for 30 minus of healthcare professional time each week for a year. As with other services value is dependant on how the service is provided. If exclusively GP appointments are used the service would run at a financial loss to practices. If exclusively PN appointments are used it would be in profit. A blend of the two would represent fair value and is permitted within the contract. **Value for money: Depends on setup**

Hepatitis C (BBV): No change. This service offers an item of service payment of £35 for carrying out BBV testing in targeted patient groups. Admin time to make the appointment, the blood test, and 5 minutes of GP time to review the result equates to a cost of ~£35 using the BMA calculator. Counselling prior to the test would not be covered by this payment so practices should consider how they approach this part of the work. **Value for money: Depends on setup**

High risk prescribing & monitoring: No change. This service contains two tiers of monitoring. £143 per patient for tier 1 and £114 per patient for tier 2 and warfarin. The monitoring of these drugs varies significantly depending on clinical factors. As such the cost to the practice can be variable. Taking a mid point of 4 bloods per year + 4x5min GP time to review results + 30 min admin time per patient per year (to maintain the recall lists) produces a BMA calculator estimate cost of £143. Tier 2 drugs and warfarin (if well controlled) may reflect the lower rate but may not fully cover the warfarin audit. **Value for money: OK - just - but depends on drugs/patients**

Minor Injuries: Essentially unchanged. The service represents **extremely poor value** for practices and is based on a flat fee structure. No payment for 0-19 patients. £382 in total for 20-49 patients. £760 in total for 50+ patients. A practice seeing 200 minor injuries a year would be doing so for just £3.80 per patient. With a clear alternative for minor injuries available via 111 we cannot recommend this service to practices. **Value for money: Extremely poor**

Minor Surgery: There is no longer a need to notify in advance the number of procedures expected. Payment will be made on the basis of data extraction so please ensure the correct codes are used. Funding was uplifted last year and those rates have continued this year: £54 for a joint injection and £107 for cutting surgery. There is also an expectation for an audit of the service. The BMA calculator would suggest these figures are slightly lower than delivery costs (£~63 for joint injection and ~£118 for cutting surgery) **without** including the cost of the audit. The additional cost of an audit would need to be incorporated on top of this but would vary significantly by the numbers of procedures done. **Value for money: Borderline low.**

Palliative care: Essentially unchanged. We remain concerned that there is insufficient investment in this area in both primary and secondary care. This service provides £68 per KIS under level 1 activity and a flat fee of £250 for infrastructure costs and £58 per reflective SEA. The demands of providing good palliative care is a separate issue and should be recognised and addressed through our funding. Looking at the specifics of the DES the funding for the KIS and the SEA are both low. A KIS will often need to be updated several times during a palliative care case to reflect the changing situation. A SEA can be time consuming to write and then discuss in an MDT. **Value for money: Low. BUT clearly good practice**

Phlebotomy (Domiciliary): Essentially unchanged. The funding is a pot of £320,000 for all of Lothian shared according to population distribution of >65 yr old patients. This is a static budget to cover a growing cohort of patients with increasingly complex needs and monitoring requirements. The ask is to provide domiciliary phlebotomy for any patients who need blood taken. This does NOT mean open access to all secondary care bloods - see below. **Value for money: Depends on local demand**

Phlebotomy (Practice based): This is essentially unchanged. The funding is a pot of £360,000 for all of Lothian distributed pro-rats based on the volume of bloods done in the previous year. This is insufficient to cover the bloods already agreed and emphasises the need to push back against additional unfunded phlebotomy from secondary care. The interface document on the LIG page (intranet) outlines the limited set of agreed secondary care bloods - the LES does not expand on that. The wider issue of secondary care bloods is a subject already being explored separately. **Value for money: Poor. However rated amber as there is no specific ask of the service and it is better to have a share of an inadequate pot than nothing.**

QI & Safety in Primary care: The project and impact requirements remain the same however there will a reduction in monitoring and training will no longer be mandatory. The funding may be adequate for a modest scale QI project. **Value for money: Small scale project- fair. Large scale project - poor**

VLARC: No change. Our analysis of the service suggests some services offer a little more than they may cost to deliver and others offer a little less. As so much of this analysis it is does depend on how practices do these procedures. **Value for money: Borderline**

PENDING ENHANCED SERVICES

The future of the following enhanced services remains unclear and will depend on decisions about national enhanced services currently in discussion. We felt given the timescales it would be helpful to get the services that are available out to practices as soon as possible.

Cardiovascular: The future of this enhanced service remains unclear at this stage

Frailty: The future of the LES remains unclear due to the potential for this to become a national DES. Our hope regardless if to keep the additional £1.19 million in General Practice perhaps by some extended work on frailty/admission prevention.

Pre-diabetes: The future of this LES remains to be decided.