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Issue 71
Spring 2025
@aismanewsline.bsky.social
@AISMANewsline
www.aisma.org.uk

AISMA Doctor Newsline

The heartbeat of medical finance

Your guide to the GMS contract changes 2025–26

With the 2025–26 financial year upon us, practices must be fully aware of contract changes and the impact these could have on funding and workload. **Deborah Wood*** gives an expert round up and commentary

A letter setting out the GP contract arrangements in England effective from 1 April 2025 was issued by NHSE on 28 February 2025.

This year the content of the proposals followed constructive consultation with the GPCE and was agreed in principle by the BMA provided the government agrees to renegotiate a completely new national contract within its term.

The NHSE letter explained the background to the contract changes in the context of improving patient access to GP services and the Department of Health and Social Care continuing to listen to the profession. The aims of the contract are to:

- continue to move care into the community
- focus on prevention, and
- move to a digital way of working.

Greater freedom for GPs has also been recognised with removal of red tape.

The main financial aspects of the core contract, with specific reference to changes implemented for 2025-26 are:

Practice level funding

Overall investment will increase by £889m of new funding for the core contract and the PCN DES. PCNs will have a challenge because, excluding the additional investment in GPs, there is a meagre uplift and in some cases no uplift at all.

The total contract value is increased from £12,287m in 2024-25 to £13,176m. This funding for general practice has grown at a faster rate than overall NHS funding, a 7.2% rise.

This is intended to enable practices to cover a 2.8% uplift in pay for staff, continued employment of GPs via ARRS, general cost pressures from premises and population growth, increased activity levels and complexity.

£70.4m of the retired QOF points is reinvested into the global sum allocation.

A further uplift may be made once the response to the DDRB pay review is known.

The uplift to the global sum payment from £112.50 per weighted patient will be £9.29 to £121.79 and the updated Statement of Financial Entitlements (SFE) has confirmed there are no changes to the out of hours adjustment, remaining at 4.75%. £743m is allocated to the global sum.

An adjustment to global sum payments for care home patients only applies to CQC registered nursing and residential homes.

The funding announced as part of the contract deal is expected to cover the extra costs resulting from the changes to National Insurance contributions (NICs) and National Living Wage, which kick in from April.

A House of Lords' favourable vote recently to extend the exemption from the NICs rise to NHS general practices failed to get any further.

Enhanced services

Practices will be able to take part in a new enhanced service for advice and guidance to support the move from secondary care to primary care, worth up to £80m. The advice and guidance specification also refers to the need for areas to probably cap claims.

The enhanced service will incentivise closer working between general practice and secondary care and will help to ensure that patients receive care in the right place at the right time via the use of specialist advice and guidance, while also supporting elective recovery.

Practices will be able to claim (subject to eligibility criteria set out in the enhanced service specification) a £20 item of service (IoS) for pre-referral requests.

The Weight Management Enhanced Service will continue in 2025-26. Practices will receive £11.50 per referral with total funding of £7.2m for the enhanced service.

The Additional Roles Reimbursement Scheme (ARRS)

The scheme will be more flexible in the coming year to allow PCNs to respond to local workforce requirements. The current two pots of ARRS funding will be combined into a single fund for reimbursement of patient facing staff costs without restriction on numbers or type of staff (including GPs).

The salary element of the maximum reimbursement amount that PCNs can claim for eligible GPs will be increased from £73,113 in 2024-25 (the bottom of the salaried GP pay range) to £82,418.

That is an uplift of £9,305 representing the lower quartile of the salaried GP pay range, reflecting that some GPs will be entering their second year in the scheme. Proportionate employer on-costs

will also be included within the overall maximum reimbursement amount which PCNs will be able to claim. The criterion for eligible GPs remains the same.

Practice nurses will be added to the above scheme provided they have not held a post within the PCN or its member practices within the last 12 months

£174m of increased funding is provided overall.

The Capacity and Access Payment (CAP)

The Capacity and Access Payment (CAP) will continue in 2025-26 and is worth £87.6m, the same as in 2024-25. It will change to two domains instead of three, one for modern general practice access (£58.4m) and the other £29.2m to support PCNs to risk stratify patients according to need, particularly those who would benefit from continuity of care.

The Capacity and Access Support Payment (CASP) worth £204m (same as 2024-25) will continue and remains unconditional.

PCN Network DES arrangements

£41m of additional funding is provided.

Quality and Outcomes Framework (QOF)

To respond to requests to reduce bureaucracy, the 32 indicators that were income protected in 2024-25, will be permanently retired. These indicators account for 212 points worth £298m.

£100m of this is reinvested into the global sum, IoS fees and locum reimbursements.

The balance of £198m attaching to 141 points will be redistributed across nine CVD prevention indicators, with the upper achievement thresholds increased. The aim is to reduce premature mortality from heart disease and stroke by 25%.

There will also be a small number of technical changes to QOF indicators that will bring indicators into alignment with NICE guidelines.

Personally administered vaccines

Claims for high-volume vaccines will be available via the new digital portal as well as the current postal system.

Vaccinations and immunisations

IoS fees for routine childhood vaccinations will increase from £10.06 to £12.06. This is funded by a £17.8m reallocation of retired QOF points. There will be an evaluation during 2025-26 of the effect that these changes have on activity, uptake and inequalities in uptake.

The increase only applies to childhood routine vaccines in Table 1 of the SFE, plus Hep B immunisations at birth/four weeks and 12 months, and MMR for those aged six and over. All other IoS payments remain the same.

Following recommendations by The Joint Committee on Vaccination and Immunisations (JCVI), the following changes will be made to the routine childhood and adult schedules in 2025–26:

- two changes to the childhood vaccination schedule, driven by the discontinuation of the Menitorix (Hib/MenC) vaccine, including:
- an additional dose of Hib-containing multivalent (six in one) vaccine, offered at a new immunisation visit at 18 months of age.
- the second dose of MMR vaccine brought forwards from three years four months to the new immunisation visit at 18 months of age to improve coverage.
- the exchange of MenB and PCV vaccines within the childhood schedule (subject to final ministerial agreement).
- a change to the adult shingles programme, reflecting new evidence on the effectiveness of the vaccination for a broader severely immunosuppressed (SIS) cohort.
- the potential introduction of a varicella vaccine, subject to final ministerial agreement, in quarter two of 2025-26.
- an amendment to the requirement to record the dried blood spot test for at risk babies, allowing that recording to take place between 12 and 18 months.

All changes to both the childhood and adult

"From 1 October 2025 practices will be required to keep their online consultation tool open for the duration of core hours for non-urgent appointment requests, medication queries and admin requests"

routine schedules are included in the amended version of the SFE for 2025-26, which also addresses inconsistencies in the treatment of patients that move practice.

It makes clear that the receiving practice will be paid for the intervention. This is consistent with the approach to payments for departing patients taken elsewhere in the GP contract.

Accessibility

The contract will look to ensure that patients can contact their practice, by phone, online or by walking in, and for people to have an equitable experience across these access modes.

From 1 October 2025 practices will be required to keep their online consultation tool open for the duration of core hours for non-urgent appointment requests, medication queries and admin requests.

This will be subject to necessary safeguards in place to avoid urgent clinical requests being erroneously submitted online. Guidance will be displayed on practice websites and reflected in the wording of the patient charter

By 1 October 2025 practices will be required to ensure the functionality in GP Connect is enabled to allow read only access to patients' care records. This will apply to other NHS commissioned providers for direct patient care and to providers of private healthcare where the private provider obtains explicit permission from the patient to access their NHS GP care record, and they are providing direct care to the patient.

The system will also allow community pharmacy registered professionals to send consultation summaries into the GP practice workflow – which will reduce administrative burden for general practice teams.

A patient charter will be published via the practice website, to set out the standards that can be expected from the practice regarding its core contractual requirements.

Locum reimbursement

£12m is reallocated from the retired QOF points to increase the amounts available for locum reimbursements via the SFE, covering parental leave, sickness absence, prolonged study leave, and suspended doctors.

This follows an increase of 6% in line with the DDRB uplift for 2024-25 and will update for the effect of previous year's pay awards when the SFE was not increased, expected to be between 15.9% and 17.1%.

Patient safety and out of area patients

In 2025-26 GP practices will be required to have regard to the patient safety strategy and register for an administrator account (unless their local risk management system is already connected) with the 'learn from patient safety events service' (LFPSE) for the purposes of:

- recording patient safety events at the practice about the services delivered by the practice, thereby contributing to the national NHS-wide data source to support learning, improvement and learning culture.
- enabling the practice to record patient safety events occurring in other health care settings (for instance if a GP practice wished to record an unsafe discharge from hospital).
- individuals recording patient safety events being able to download a copy of the record for purposes of supporting appraisal and revalidation.

There will be a contractual requirement that GP contractors work collaboratively with commissioners to implement out of area registration. This will provide safeguards when practice lists are expanding rapidly with the registration of out of area patients.

Contractors will need to seek approval of their plans to enable commissioner oversight of the safety and effectiveness of the arrangements so patients can access the full range of primary medical services.

At the point that such an application is required and made, the contractor's patient list should be closed to new out of area registrations until the commissioner is assured of the arrangements the contractor has in place.

In making the decision, the commissioner should always seek to enable and maintain patient choice of GP practice.

Partnerships

The GP contract regulations will be amended to make it clear that GMS contracts can be terminated where there is no clear successor when a partnership dissolves.

Violent patients

NHS England and DHSC support GP practices to immediately remove from their patient lists patients who commit acts of violence and threatening behaviour towards practice staff.

The process for patient removal will be made clearer in the GP contract regulations, in a way that protects the right of practices to immediately remove violent patients, whilst ensuring patient choice is retained when patients have not been immediately removed from their previous practice.

The changes will also reinforce the importance of practices processing the immediate removal of violent and threatening patients alongside reporting this to the police within the period set out in regulations.

It will also be made clear that police reports made after this period should not necessarily affect patient choice of alternative provider and should not necessarily mean that the patient requires allocation through the Special Allocation Scheme.

Managing patient lists

Amendments will be made to the GP contract regulations to enable NHSE to contact a patient digitally (as opposed to in writing) when it becomes aware that a patient has moved from the practice area.

This will allow additional routes for NHSE to advise the patient to either obtain the contractor's agreement to remain on the contractor's list of patients or to apply for registration with another provider of essential services.

The notice timeframe for deregistration will be reduced from six to three months when a patient is no longer known to NHSE.

Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS)

Any changes announced to the core GMS contract are expected to be mirrored via PMS and APMS.

Please note: all the above information relates to contracts in England only.
Northern Ireland/Scotland/Wales: Information can be obtained from your local AISMA accountant.

What to look out for

As I write, the government is due to publish its 10-year plan for the NHS and has already announced that it will be abolishing NHSE. The BMA is pushing for substantial contract reform during the current Parliament.

There is much to keep abreast of in the coming weeks including the finer details of the new GP contract for 2025-26 and the updated SFE.

As ever practices must be fully aware of these changes and their impact on practice funding and workload.

It follows that practices need to take a careful look at future strategy and work on finding the best and most profitable way of using time and resources.

Collaboration across networks will continue to be fundamental and advice should be taken at an early stage regarding how best to make the network arrangements work for your practice.

Reference material

The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2025

NHS England
Changes to the GP Contract in 2025/26

BMA
GP contract 2025/26 changes

Celebrating AISMA's 30 years of enabling GPs to stay ahead of change

OPINION

Deborah Wood*
Chairman, AISMA

The Association of Independent Specialist Medical Accountants (AISMA) first formed as an organisation of like-minded professional advisers to the sector in 1994.

I have been privileged to serve the Association from its inception with various roles culminating in the position of chairman until I step down at our forthcoming AGM at the end of April.

So, I thought it might be appropriate to use this piece to reflect over the past 30 years of providing accountancy/tax/NHS pension and other advisory services to our clients in the primary and secondary care sectors.

This seems to be particularly appropriate given the government's recent announcement to abolish NHS England and the need to give thought to what that might mean when looking ahead for the life of this Parliament and maybe beyond to the next 30 years.

Both the healthcare and accountancy professions have undergone significant change during this period and will no doubt continue to do so. One of the main aims of AISMA has been to stay abreast of those changes and facilitate best practice and technical guidance across its membership and for the benefit of the clients of those member firms.

It may not seem surprising that the evolution of the sector repeats many of the intentions currently on the table, each change with its own political twist depending on the colour of the government of the day. The table below outlines a potted history (focused on England) and the impact of some of those changes.

AISMA continues to work with many organisations throughout the UK, including PCSE, NHS Pensions, NHSE, SPPA, NHS Scotland, the BMA, Department of Health and Social Care and HMRC to try to ensure GPs and practices are receiving relevant and up to date information to assist them to manage their affairs on a timely and efficient basis.

This will be of particular importance during the months ahead as the impact of the government's plans for the NHS become clearer.

As noted in the table, history tells us that much of what is to come is likely to just be a variation on what has been before and that inevitably there will be yet further change down the line.

Our member firms are looking forward to refreshing knowledge and sharing best practice at our annual conference later in April where we will be giving thought to how we can best support our clients to fully understand how they can remain sustainable whilst meeting their contractual obligations amidst further politically motivated upheaval.

I sincerely hope the indications shown by the outcome of the recent GPCE and NHSE contract consultations give way to a brighter economic outlook that recognises the value of appropriate levels of investment needed for general practice, primary care and integrated care to not only survive, but to thrive again.

AISMA – Seeing you through three decades of change

THE FIRST 10 YEARS

1994 **NHS reorganisation to reduce the number of regional health authorities to eight.**

1996 **The White Paper, *Primary Care; Delivering the Future* is published.**

This outlines a programme for action both nationally and locally. It considers developing partnerships in primary care, and between primary and secondary care and local authorities.

Proposals are made for the fairer distribution of resources and their effective use, including an extra £65m in general medical services cash limited funds and £32m of new funds for health authorities specifically for community and primary care service improvements.

Workforce planning and employment opportunities, together with plans for improvements in primary care premises are discussed and the final section considers the better organisation of primary care by linking practices together, improved management support, and increased use of information technology.

1997 **The NHS (Primary Care) Act 1997 and the NHS Pensions Act 1995 come into force.**

These enable new possibilities for delivering primary care such as personal medical services which started as pilots in 1998 and adopted permanently in 2004.

GP practices are encouraged to increase flexibility and choice.

The White Paper, *The New NHS: Modern, Dependable* is published. This aims to replace the internal market and GP fundholding with a more co-operative, integrated system.

NHS Pension Scheme opens to all members of GP practice staff on NHS contracts.

CONTINUED >

1998 The National Institute for Health and Clinical Excellence (NICE) and NHS Direct are established.

1999 The White Paper *Our Healthier Nation* is published.

This targets public health improvement, health inequalities, socio-environmental causes of ill-health and looks to narrow the health gap and increase healthy life expectancy.

GP fundholding is abolished, and new primary care groups (PCGs) are formed.

Scotland, Wales and Northern Ireland given devolved powers for health.

2000 The NHS Plan: a 10-year modernisation programme.

- This provides a strategy for more doctors/nurses/beds/ hospital building schemes
- Performance targets to focus on reducing waiting times
- Involvement of the Private Finance Initiative (PFI)
- Walk-in centres are introduced.

2001 The Health and Social Care Act 2001 formalises The NHS Plan.

2002 District Health Authorities are replaced by Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) and the four-hour target for A&E is brought in.

2003 New contracts for GPs and hospital consultants are agreed and Agenda for Change standardises pay and conditions for most NHS staff.

THE SECOND 10 YEARS

2004 The White Paper Choosing Health is published The first ten Foundation Trusts are set up.

The Practice Based Commissioning policy is outlined. A new GMS contract is agreed.

2006 The White Paper *Our Health, Our Care, Our Say* is published. This encourages patient choice and the movement of services from secondary to community care.

2008 Lord Darzi leads the NHS next stage review and the 2008 section of the NHS Pension Scheme comes into force.

2009 The NHS Constitution is published; the Care Quality Commission (CQC) is created, and large-scale efficiency savings are sought by 2014 of up to £20bn.

2010 The White Paper *Equity and Excellence: Liberating the NHS* is published. This involves moving responsibility for purchasing care to groups of GPs.

Healthy Lives, Healthy People is published and proposes the return of public health back to local authorities.

2012 The Health and Social Care Act 2012 is passed, and the BMA takes action to strike over changes to the NHS Pension Scheme.

2013: The New NHS.

- PCTs and SHAs are abolished and NHSE is created.
- 211 Clinical Commissioning Groups (CCGs) are set up.
- Health Education England (HEE) becomes responsible for education, training and workforce development
- Public Health England is established to improve health and wellbeing.

THE THIRD 10 YEARS

2014 NHSE publishes *The Five Year Forward View* and £2bn is added to the NHS budget.

2015 *The 10-year Plan for Health and Care* is presented and the new 2015 NHS Pension Scheme goes live.

2016 Junior doctors vote to strike, their new contract is agreed in May 2016, and Sustainability and Transformation Plans (STPs) are published.

2017 *Next Steps on the Five Year Forward View* is published.

2018 Funding settlement announced as the NHS turns 70, with the NHS to receive average annual real term increase of 3.4% for five years.

2019 *The Long-Term Plan* is published.

A new GP contract is agreed with the BMA, aiming to enable GPs to build primary care networks (PCNs), develop multi-disciplinary teams and deliver a wider range of services locally.

2020 Covid-19 arrives bringing an urgent search for a vaccine.

Vaccination programme and ongoing lock downs follow.

NHS is the first health system globally to commit to become carbon net zero.

2022 Health and Care Act 2022.

Development of Integrated Care Systems.

NHS is awarded the George Cross for services during the pandemic.

2023 *Long Term Workforce Plan* launched, and the McCloud Remedy for NHS pensions starts to come into force.

Get on top of these vital dates to keep your finances in order

Are you a slave to the treadmill of financial deadlines? If so, **Sarah Faulconbridge**** offers this handy guide to key submission dates so you can keep on track at the start of the new financial year

DEADLINE	ACTION
30 April	**GP pay transparency** For practices in England, the GMS/PMS regulations contractually oblige GPs to self-declare their NHS earnings if above the threshold for the relevant financial year. The deadline for submission is 30 April.
31 May	**Payroll: P60s** P60 forms, containing an employee's annual earnings and tax deductions, must be issued to employees by 31 May following the end of each tax year.
31 May	**Payroll: SD55 Annual Update** Information regarding annual pay, contributions and part time hours worked must be submitted to NHS Pensions annually to update a member's record. This is a mandatory requirement for practices in England and Wales, with a specific deadline of 31 May following the end of each tax year. In Scotland this information is submitted via the NSR03 form and the deadline for submission is the 31 May following the end of each tax year. On a monthly basis, the SPPA also needs to be updated of any changes between part-time and full-time via the NSR04 Service Change form. In Northern Ireland a GP55A year-end submission needs to be completed.

31 July

Tax: 2nd payment of the year due

The second payment on account towards next year's tax liability must be paid by 31 July following the tax return submission deadline.

31 July

Pensions: Scheme Pays elections

Any member of the NHS Pension Scheme with an annual allowance tax charge can elect for the pension scheme to pay these charges, instead of paying them personally. The election deadline is 31 July following the January in which the charge must be declared on their tax return.

5 October

Tax: Register for self-assessment

Anyone who meets the requirements for needing to complete a tax return[i] for the first time, must register for self-assessment by 5 October following the end of the tax year.

31 October

Tax: Tax return filing deadline (paper)

Paper self-assessment tax returns must be submitted by 31 October following the end of the tax year. There is a late filing penalty of £100 for returns filed after this date.

31 January

Tax: Tax return filing deadline (online)

Online self-assessment tax returns must be submitted by 31 January following the end of the tax year. There is a late filing penalty of £100 for returns filed after this date.

Note: Partnership tax returns have the same filing deadlines as self-assessment tax returns (paper 31 October, online 31 January). Late filing penalties apply to each partner.

31 January

Tax: 1st payment of the year due

Any balancing tax charge, together with the first payment on account towards next year's tax liability, must be paid by 31 January following the end of the tax year.

28 February

Pensions: superannuation certificates

Type 1 and Type 2 pension certificates reporting earnings for GP and non-GP partners, salaried GPs and locums must be submitted to regional pension administrators[ii] by 28 February.

28 February

Pensions: Estimates of Pensionable Profits

Practices in England and Wales must submit Estimates of Pensionable Profits for the upcoming tax year, for both partners and salaried GPs, to PCSE by 28 February before the start of the new financial year.

In Scotland a Notification of Estimated Pensionable Profits (NEOPP) form can be submitted at any point during the year. Note that if a practice wishes to submit an NOEPP to amend pension contributions, it must be sent to Practitioner Services by the 12th of the month for contributions to be included on that month's health board statement.

In Northern Ireland Estimated Payment on Account (POA) forms must be submitted on or around 31 March preceding the financial year ahead.

31 March

GP earnings

GP practices in England are required to publish a summary of GP net earnings on the practice website, along with the number of full and part time GPs in the practice. This should be published on the website by 31 March following the end of the financial year.

MONTHLY TASKS

PPA claims

Claims for personally administered items should be made no later than the fifth day of the month after prescriptions were issued. Late claims can be accepted for up to six years after, but this must be highlighted separately when making the claim. Payment for claims are received by the practice two months in arrears.

Review CQRS national data extract

For practices in England, vaccinations, immunisations, learning disability and QOF data, extracted from the clinical system using the GP extraction service, needs to be reviewed using the Calculating Quality Reporting Service (CQRS) for accuracy and declared monthly (annually for QOF). Payment will be received in the next available GMS/PMS payment run.

Note: Check with your local commissioner for deadlines relating to other local enhanced services.

PAYE

Monthly payroll deductions, such as PAYE and National Insurance contributions, are reported using a P32, which must be paid to HMRC by the 22nd of each month following the month end if paid by BACS. If paid by cheque, it must reach HMRC by the 19th of each month following the month end.

Pensions

For practices in England and Wales, staff pension contributions, both employee and employer, are paid over to NHS Pensions using a GP1 form. The GP1 must be submitted to Pensions Online by the 19th of each month following the month end to be paid via direct debit.

In Scotland pension contributions should be paid by the 19th of the month following deduction from members' pay. Employers or payroll providers should log onto the online portal (https://pensions.gov.scot/login-register) provided by the SPPA to record contributions each month.

For Northern Ireland the GP1 form must be submitted to HSCNI before the 6th of the following month.

Additional Roles Reimbursement Scheme claims

For practices in England, a monthly claim should be submitted to the PCN for any Additional Roles Reimbursement Scheme (ARRS) staff employed on the practice payroll to recover the cost.

AGREE THESE DEADLINES WITH YOUR ACCOUNTANT

Personal expenses

Expenses paid for personally by a partner that are wholly and exclusively for their role in the partnership should be included in either the practice accounts or the partnership tax return. Deadlines for providing receipts and invoices should be agreed with the practice accountant.

Year-end accounts information

Practices should undertake and reconcile their bookkeeping on a monthly basis. Following the practice year end, complete the bookkeeping for at least another two months to allow time for any debtors or creditors to become apparent before handing the records over to the practice accountant to prepare the year end accounts.

Year-end accounts meeting

The accounts meeting will take place yearly between the partners and the accountant to discuss the year end accounts. Agree timescales before your accountant starts work on preparing the accounts.

For more help on understanding pensions and accounts, ask your AISMA accountant for the AISMA guides *Explaining the NHS Pension Scheme and Understanding the practice accounts.*

[i] https://www.gov.uk/self-assessment-tax-returns/who-must-send-a-tax-return

[ii] England: PCSE; Wales: Local Health Boards; Scotland: Scottish Public Pensions Agency; Northern Ireland: HSC Pension Service

ASK AISMA!

GPs' questions about puzzling superannuation issues are tackled here by Abi Newbury***

You can ask a question by contacting your AISMA accountant or messaging us through X @AISMANewsline or Bluesky @aismanewsline.bsky.social

PENSION ESTIMATES ARE SUCH A PAIN

Q **As usual we've had to provide estimates of pensionable pay. It's a pain keeping this in mind every time we have a partner or session change; why can't we leave it until the end of the year to sort out?**

A Primary Care Support England (PCSE) use estimates of pensionable pay to deduct an estimated amount of superannuation (NHS pension contributions) from the practice's monthly income.

These amounts taken on account are then set against the final liability for the year when your pension certificate is completed, with a balancing adjustment then to either be paid or refunded.

If there has been a major change during the year for which no interim update has been made, that could leave a large adjustment at the end of the year.

For example – if you are full time on 1 April 2025 but then drop to half time from 1 May and you fail to make the adjustment in good time, you will hugely overpay during the year but will not get the money back until the pension certificates are completed in February 2027. Moreover, the additional contributions you paid will not gain you any tax relief!

If the scenario was the other way round, so that deductions are insufficient (perhaps you went from part-time to full-time), then you will not get the tax relief for the top-up amount until you physically pay over the superannuation balance – that could be in another tax year when you are in a different tax band.

If someone joins the practice in the year but no deductions are made because the estimates have not been provided to PCSE, they could have a much higher tax liability than they were expecting because they cannot claim relief on superannuation contributions due, only on what has been paid.

So, in general, it really is best practice to update the estimate of pensionable pay whenever there has been a major change - such as sessional shares - to try to get deductions to match actual pensionable pay as closely as possible.

DO I NEED TO STUDY MY PENSION RECORD?

Q **Some of my colleagues say they have had problems with their pension record. I've never looked at mine – should I? How? What should I look for?**

A You should certainly review your pension record annually. Your pension benefits on retirement could be adversely affected if you do not.

If an error is discovered promptly, it is much easier to correct. If you do not discover issues for several years, or worse still on retirement, it is much harder to distinguish between what has happened versus what should have happened.

Did you know that if one year's certificate is missing or has not been processed, then subsequent ones won't be either? Do not ignore any messages from PCSE, Practitioner Services (PSD) in Scotland or HSC Pension Service in Northern Ireland querying pension certificates! **So really there are two main things to look at:**

1 Total Rewards Statement

The Total Rewards Statement (Annual Benefit Statement in Scotland and Northern Ireland) shows pension earned to date. Ask yourself if it looks reasonable. You can ask NHS Pensions, the SPPA in Scotland or HSC Pension Service in Northern Ireland.

This will give you detailed information for each year and will make it easier to spot missing years or typos in pensionable income. You would be surprised how many errors there can be.

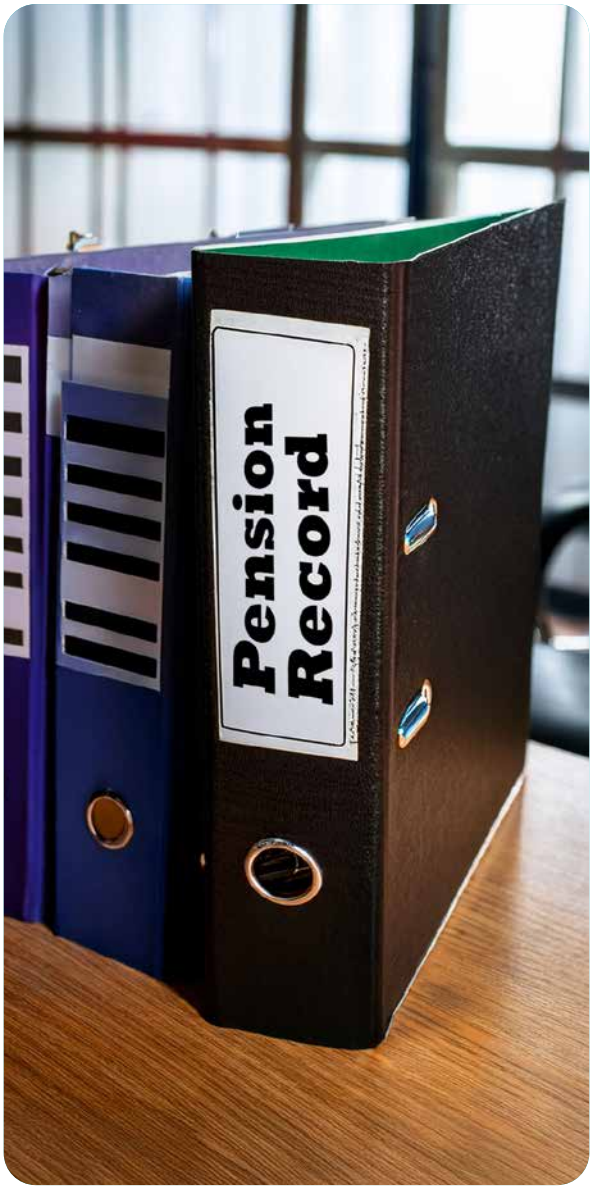
Pension records in England and Wales are being migrated to the My NHS Pension platform so watch out for information on accessing this. The new platform will contain a lot more information to help you check your record.

Your accountant should be able to help you if you do not know what to look at or you need assistance in understanding the information.

2 PCSE records

In England you can go to PCSE Online and see what has been accounted for within each pension year. If you have worked additional locum sessions which have been pensioned, you should find these logged on your employee contribution statement.

If you cannot see them then this could be an indication that PCSE has been unable to match your pension payment to the correct month or that the submission has been rejected.



In Scotland, members can view their pension information via the SPPA My Pension Online Member Service. There is a time delay on the uploading of the ABS and the records can be up to two years out of date. There will be a delay in ABS for recent years showing online due to the issuance of RPSS which is currently underway.

In Northern Ireland you can log onto the HSC Member Self Service website within HSC Pensions which will allow you to view available Annual Benefit Statements, Annual Allowance Statements and RPSS statements. To obtain details of pensionable income included within your records you may need to contact HSC Pensions directly.

The take-away from this should be that you need to check for errors, and if you discover them, while it can be a time-consuming task to get them corrected, the earlier you catch them the easier it will be.

DON'T OVERLOOK UNPAID/OVERPAID PENSION DEDUCTIONS

Q **I'm planning to retire next March – so what happens with unpaid or overpaid pension deductions?**

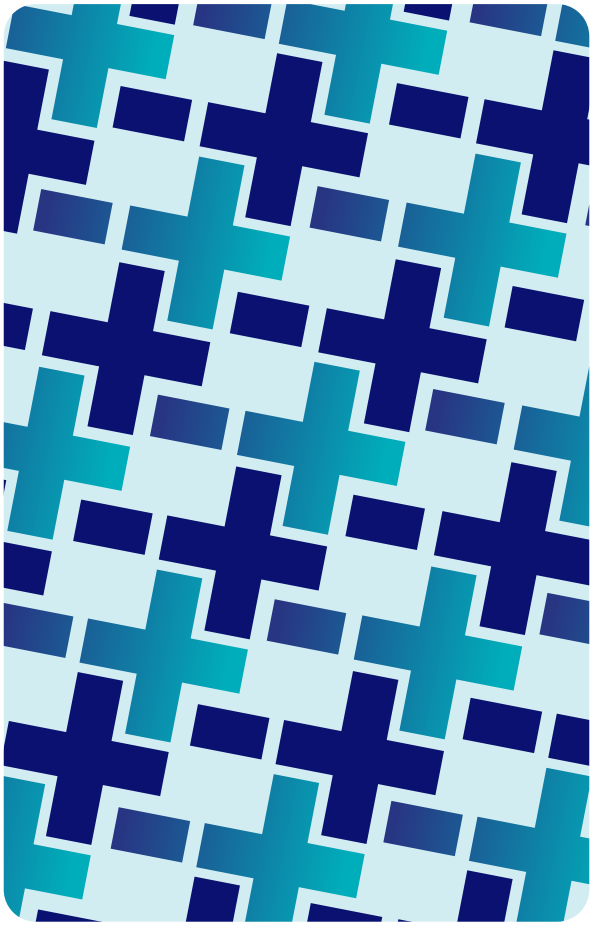
A This is something easily overlooked. As a partner in your practice, superannuation is deducted from the practice's monthly income. The practice's accountants will normally include a 'provision' for outstanding amounts at the year end, so that you are not lulled into a false sense of security with more money left in your current account than is available to draw when you leave.

But for tax purposes you can only get tax relief against pensionable income. So imagine you retire fully in March and the balance is not paid until a year later. If, in that year, you do not have any earned income (broadly earned income – pension does not count) then you cannot claim any tax relief.

If a partner is planning to retire during the year it is important to estimate the pension situation in advance and make a 'payment on account' of pension contributions due before the end of the tax year to ensure you get the tax relief correctly.

What can you do if you have not made a payment on account? Well, you could do a bit of locum work (or any employed or self-employed work) in the following tax year up to the level of the pension contributions and then offset them against each other so no tax is payable.

Or you could defer your retirement into the next tax year so that you have sufficient earnings to cover the contributions.



The key is to ensure that your accountant is aware of the planned changes, and your plans for the following tax year, and that they have the practice's authority to perform calculations as necessary if the practice is to pay for it.

Then they can advise you where you stand so you do not lose out due to the timing rules around tax relief on pension contributions.

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AISMA Doctor Newsline is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK.
www.aisma.org.uk

AISMA Doctor Newsline is edited by Robin Stride, a medical journalist. robin@robinstride.co.uk

***Deborah Wood is healthcare services partner at MHA Preston and chairman of AISMA**
****Sarah Faulconbridge is a medical accounts senior at The Rowleys Partnership Ltd and a member of AISMA NextGen.**
*****Abi Newbury is managing director at Honey Barrett and an AISMA board member**
****** Kieran Hancock is a director of Forvis Mazars and an AISMA board member**

Taxing times – and it could get a lot worse

How much will the Chancellor's 2025 Spring Statement impact doctors? **Kieran Hancock****** gives an overview

It has been a worrying period for many GP partners and practices since last October's Budget announcements.

Increases to the employer's national insurance rate and a lowering of its starting threshold, plus the increase in the minimum wage, meant all practices have been looking ahead to understand the financial impact. Funding uncertainties prompted affordability fears.

Many were still reeling from the Chancellor's autumn announcements and the Spring Statement on 26 March crept up without much notice.

Well, the good news is that Rachel Reeves announced nothing fundamental affecting taxes or costs – for now. But these are not ruled out for the annual Autumn Budget. The bad news is that the cost rises mentioned above remain and start affecting practices from April.

There were some key announcements affecting the medical profession:

Debt collection

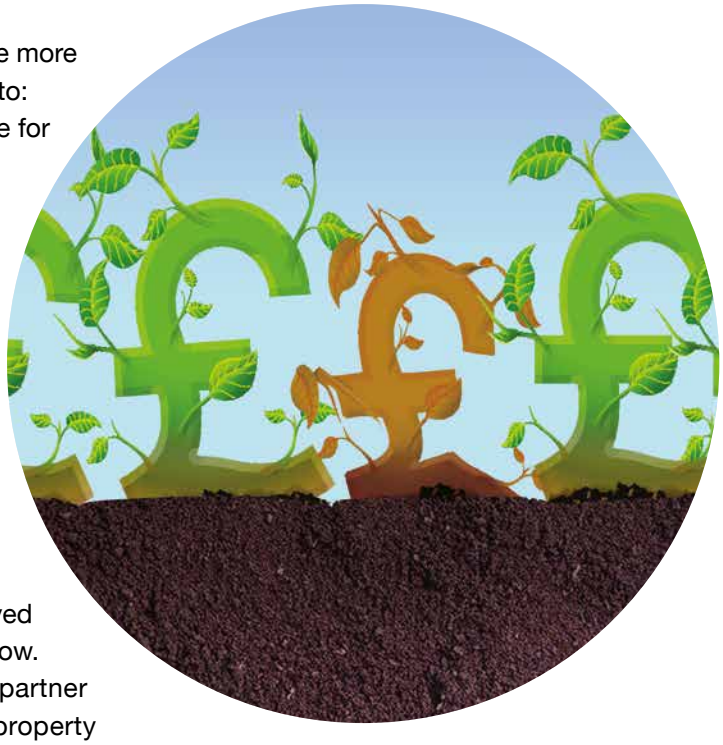
We are promised substantial investment in tax office staff over the next five years to chase outstanding debts and a strengthening of partnerships with private debt collectors. So if you have a debt with HMRC then it is important to be proactive and agree a repayment plan.

Late payment penalties

On joining Making Tax Digital (MTD) – see more below – late payments will be subjected to:

- 3% of the tax outstanding which is due for more than 15 days
- another 3% where it is due for more than 30 days, and
- 10% a year where it is due for more than 31 days.

Late payment penalties currently start at 5% of the January balancing payment outstanding for more than 30 days.



Making Tax Digital

Digital reporting to HMRC on a quarterly basis will be rolled out to the self-employed and landlords as outlined in the table below.

This is a key issue for locum GPs, or partner GPs who have other self-employed or property income and they will each need to consider how to report to HMRC.

AISMA accountants will be crucial in supporting locums to report correctly and efficiently to HMRC. There is no set date for the introduction of this to partnerships. That may be a relief to many practices.

Practices should move towards real-time reporting to improve their own financial systems and ensure they are well positioned for the eventual implementation.

MAKING TAX DIGITAL ROLLOUT

- April 2026: Self-employed or property income of more than £50,000
- April 2027: Self-employed or property income of more than £30,000
- April 2028: Self-employed or property income of more than £20,000.

Child benefit

From summer 2025, a new service to report any High Income Child Benefit Charges will be launched, meaning this can be paid through PAYE and avoids the need to submit a tax return.

This should help many employed medical professionals. Anyone whose sole income stream is taxed through PAYE will not be required to submit a tax return, regardless of the level of income. This will also take many out of self-assessment.

Benefits

There were several changes to the benefits system to reduce the amounts paid overall and create cost savings for the government. This may not affect GPs or other medical professionals but it is important they consider the impact on their patients who may require further support from social prescribers or other similar roles.

As ever, speak regularly with your AISMA accountant to understand the impact of these changes on you and your practice. The need to budget, look ahead and forecast earnings is more important than ever. GP finances continue to be increasingly complex, and support is needed to navigate these effectively and efficiently.

Lastly, here is a reminder of previously announced changes effective from April 2025:

National insurance (employers) - rate increased from 13.8% to 15%; threshold where this becomes payable reduced from £9,100 to £5,000

Minimum wage - over 21: £12.21 per hour, up from £11.44; 18 to 20: £10 per hour, up from £8.60.

Capital Gains Tax - rate on the disposal of business assets/property increased to 14%, up from 10%. Further increase from April 2026 to 18%.

And do not forget from April 2027 - inheritance tax (IHT) changes. Pensions (not the NHS Pension/defined benefit pensions) will be included in an individual's estate for the first time.

This will be a significant change and could bring many within the scope of IHT for the first time.

Act now to deal with disputes between practices in your PCN

Damaging network disagreements are increasing – **Robert McCartney** shows how to navigate them and outlines your options for reaching resolutions

The introduction to the Mandatory Network Agreement for Primary Care Networks (PCNs) states that they 'will require strong relationships and the creation of an environment of trust, collaboration and innovation.'

But unfortunately this is not always possible and the number of disputes have been rising. PCN finance and decision-making issues are often the cause.

PCNs are not a legal entity. They may have incorporated a provider vehicle for their use and have a dedicated management team, but fundamentally they are collaborative groupings of practices which themselves are a group of partners.

Disputes are consequently either arguments between neighbouring practices or they are between the practices and the PCN management workforce - including the clinical director - and may be driven by one or two partners.

Here I will focus on disputes between the practices. Workforce related matters should be considered according to Schedule 5 of the network agreement and the individual employment contracts.

Managing disputes

It is important to identify the key individuals and understand the legal and personal

"Accountants should be instructed to produce an analysis of the current financial position, and a review made of the decision-making processes to determine how the current position materialised without full agreement"

relationships between them.

Resolution is normally found in utilising one or both of these factors; for example re-enforcing a legal term that underpins their relationship or seeking to repair the personal relationship between them.

A PCN's legal relationship is governed by the network agreement and disputes should be resolved in accordance with clauses 92 and 93 of the mandatory terms. They describe two stages:

Stage One:
Holding a meeting 'in accordance with Schedule 1' with the 'aim to discuss the dispute with a view to finding a resolution.'

Stage Two:
A member practice may 'refer the dispute to our Local Medical Committee (LMC). If the LMC agrees to hear our dispute, we will work with the LMC to agree a process for hearing a dispute.'

These two stages are limited in detail as many Schedule 1s failed to provide any structure to the meetings and the second stage is fully dependant on whether the LMC can assist.

Clause 94 states that alternative dispute resolution procedures can be included in Schedule 2. Many early examples of network agreement schedules did not include suitable procedures and consequently it is necessary to agree and then implement a suitable process.

This will ensure that it is managed in an agreed way and will often take some of the tension out of the situation.

Schedule 2 should subsequently be updated to provide clarity as to how future issues should be resolved.

Concerns about funding

Understanding the problem

Issues have arisen due to the financial pressure facing many practices. Concerns about cash being 'locked up' in PCNs and questions about how the funds can be accessed are a recurring theme of disputes, especially if partners have to pay tax on money they never got.

Partnership changes, especially retirements, spark questions about whether partners are entitled to money in a PCN account and how this should be accounted for. Are these funds invested for future PCN use, or will they eventually be released to the practices? Did tax returns appropriately reflect this position and have they been accounted for?

Finding solutions

The best cure is prevention. Schedule 4 of the PCN's network agreement should cover financial arrangements. In 2019 these were relatively simple models and did not recognise the complexities of the subsequent financial structures.

Schedule 4 should be updated to provide detailed information about how the PCN's finances will be managed and most importantly should include good financial governance - the obligation for an agreed form of record keeping, preparation of management accounts, transparency to the member practices and how to manage fund allocation disagreements.

If there is already a dispute then resolution will require the practices and the PCN's management team to engage in a reconciliation process of the accounts.

Accountants should be instructed to produce an analysis of the current financial position, and a review made of the decision-making processes to determine how the current position materialised without full agreement.

Only by addressing these concerns openly with appropriate professional advice will this type of dispute be resolved.

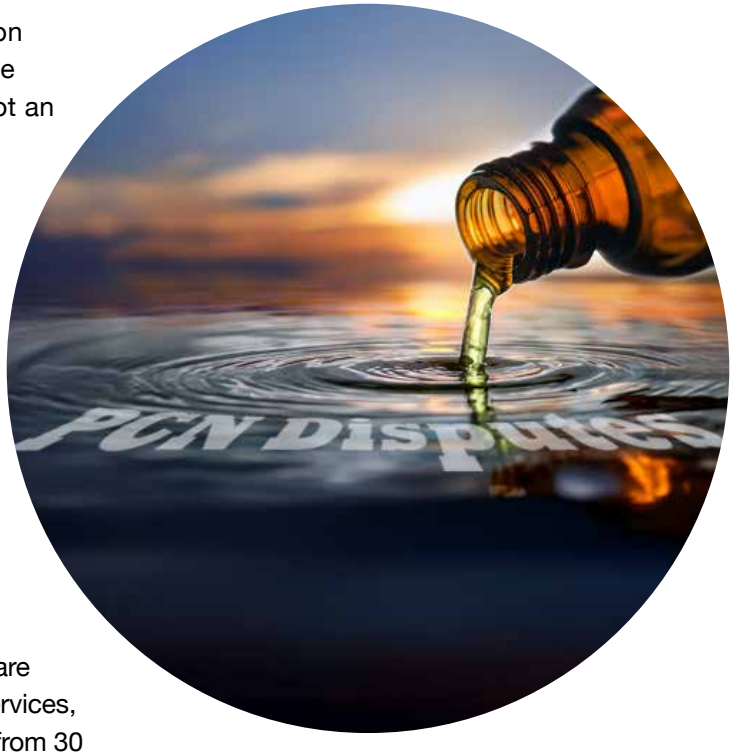
Financial disputes are often the most emotional within a business, but it is rare for there to be any genuine underhanded or inappropriate actions. Most matters are resolved by improving the understanding of the current position.

Some unfortunate serious financial mismanagement cases may require action against those responsible. This could include legal action and even involving the NHS

Counter Fraud Authority. While litigation should be avoided by agreeing suitable settlement terms, sometimes this is not an option, or agreement is not found.

It is advisable to review Schedule 4 to ensure it reflects the current arrangements, or puts in place suitable ones, to avoid future problems.

The best time to agree your financial governance is while everyone is working well together but unfortunately then is when people think it is least necessary.



Decision making disputes

Understanding the problem

PCNs are complex arrangements. They are required to co-ordinate the delivery of services, the management of workforces ranging from 30 to over 100 people, and they are expected to lead on developing the local area's integrated care.

Management resources have risen over the years and the current PCN Designated Enhanced Service Specifications have given PCNs the ability to appoint a management team of their own design.

Practice representatives in some PCNs historically formed highly functioning management boards. In others the PCN struggled to secure consistent engagement with practices who were content to leave the decisions to the clinical director and network administrator.

This has resulted in many PCNs being unable to demonstrate how and when key decisions were made and the evidence is missing when they subsequently seek clarity.

Practices may then think they were excluded from decisions and question if there has been a fair and equitable allocation of PCN resources:

- Have the practices shared responsibility when problems arose?
- Was there full engagement even when some practices were not involved with the matter under discussion?
- Did the clinical director make all the decisions, without consultation, possibly because no one else showed any interest?

A bad case of communication

Communication is one of the most important elements to resolve disputes. In one recent case a practice of 10 partners insisted it was excluded from decisions about how and where enhanced access clinics would be based and accessed.

One partner was a PCN representative who went to the planning meetings and was on the panel making the final decision. Unbeknown to the PCN team, these partners had a strained relationship and the GP failed to inform his partners.

The PCN could not show a fully documented decision-making process as it had relied on the representatives to feedback and to act on behalf of their practices, as stated in Schedule 1 of their network agreement.

But it was reasonable to show to the practice that, as their representative had been in attendance and approved the decision-making, things had been approved on their behalf.

The PCN team changed their communications and reporting processes. They ensured the partners in all the practices were aware of the powers they were delegating to their representatives, created minutes of all meetings, produced a record of decisions and increased the frequency of practice engagement events.

Their PCN must therefore ensure Schedules 1 and 2 are up to date, that they have agreed clear lines of communication, and everyone involved understands their roles and responsibility within the team.

"My advice is to always raise issues at the earliest opportunity and directly address them to reduce the risk of escalation"

Finding solutions

Schedule 1 of the network agreement should include details about the PCN's management and decision-making procedures. The requirements have become more complex since 2019 but many PCNs have not updated this Schedule to reflect changes in how they operate.

To avoid disputes PCNs need to be able to evidence how, where, why and when decisions were made. This would include a clear understanding of :

1 What powers are delegated to the clinical director and the management team?
2 What are the limits on this delegation?
3 Which matters require the input and decision of the practices, or an accountable board?
4 Where are decisions made: are there frequent, fixed meetings as opposed to ad hoc arrangements?
5 Are there standing instructions from the practices delegating powers to a board and defining the issues which must be decided by a wider membership of partners?
6 How is this information documented and communicated between the practices? Is the detail encapsulated in the network agreement or does a corporate handbook set out the details?

Robert McCartney is an associate at law firm Hempsons

Unable to resolve the dispute

In extreme circumstances of disputes between practices they may determine the relationship between members is irreparable and may elect to expel a member.

Section 4.9.7(ii) of the PCN DES Specification states that where *'there has been an irreparable breakdown in the relationship or expulsion'* this may give grounds for a practice to leave a PCN.

Neither the specification nor the mandatory agreement is conclusive that a practice may be expelled without agreement of all parties and it is important that the Schedules are specific about circumstances where expulsions may be made.

Section 6.7 governs the removal of practices following an irreparable breakdown in relationships and includes a process of notification to the ICB who will *'consider the matter, including holding discussions with all practices within the PCN.'*

In effect this becomes the final stage of the dispute resolution procedure although it will focus on the impact on the practice's patients if a PCN exit happens.

Under section 6.7.4 the ICB has the final determination about whether it consents to a PCN membership changes. So it therefore can prevent a practice from leaving.

When this happens the practices are left with a difficult decision. They may review the relationship, re-engage with each other and seek to resolve the dispute knowing that they must work together, or they may opt out of the delivery of the PCN DES.

But this last option is rarely advisable given the financial impact and loss of control over key services.

If a PCN exit is approved then the practice will need to join another and engage with its systems and processes. It will need to adapt and learn to avoid future problems.

My advice is to always raise issues at the earliest opportunity and directly address them to reduce the risk of escalation.

Well drafted schedules to the network agreement are important to avoid and resolve disputes. It is essential for Schedule 2 to set out a clear procedure for managing under performance and other common dispute issues - and contain a fair and practical dispute resolution procedure.

Regular engagement between the practices, and good communications, will significantly reduce problems.