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AISMA Doctor Newsline

At the heart of medical finance...

GMS contract changes 2024-25

As the 2024-25 financial year gets underway, practices must be fully aware of contract changes and the impact these could have on funding and workload. **Deborah Wood*** provides an expert round-up and commentary

NHS England's letter setting out the arrangements for the GP contract in England was rejected by the BMA, who put it to a referendum of its GP and GP registrar members in England which closed on 27 March.

While the referendum result did not prevent the government from imposing the 2024-25 contract from 1 April, it sends a strong and powerful signal expressing the profession's views about the contract offer and will inform potential collective next steps.

NHSE's letter explains the background to the contract changes in the context of simplification and flexibility with a view to freeing up practice time and improving patient access.

BMA leaders had hoped to see some additional investment to assist with practices' ongoing inflationary pressures, particularly linked to increasing practice staff costs, and believe the lack of support for this will mean more practices risk discontinuing.

The last GP contract framework ended on

31 March 2024. Despite NHSE committing 12 months ago to work with the BMA's General Practitioners Committee in England to develop a contract the BMA wanted to see, this has clearly not been achieved collaboratively.

The main financial aspects of the core contract, with specific reference to changes implemented for 2024-25, are as follows:

Practice level funding

Overall contract investment will increase by £259m to £11,864m, £215m of which is for the core contract and £44m for the PCN DES.

This is intended to enable practices to cover a 2% uplift in pay for staff including ARRS, salaried GPs and contractor GP partners. The global sum is increased to reflect an inflation uplift of 1.68% (£24m) and 0.38% population growth (£35m). £64m is allocated to GP contractors, with £91m to practice staff and salaried GPs.

There is scope for elements of the funding relating to GP pay to be increased once the Doctors and Dentists Review Body (DDRB) has made its report, scheduled for May 2024.

The uplift to the global sum payment from £104.73 per weighted patient will be £2.84 to £107.57 and the out of hours adjustment is expected to remain at 4.75%.

The Additional Roles Reimbursement Scheme (ARRS)

The following changes are intended to increase the scheme's flexibility by widening the reimbursable roles and removing role restrictions where possible:

- Enhanced practice nurses will be included in the roles eligible for reimbursement. This will allow nurses working at an enhanced level of practice, and holding a level seven or above postgraduate certification or diploma in one or more specialist areas of care, to be recruited via ARRS.

As a new role, this will initially be capped at one per PCN (two where the list size is 100,000 or over).

- PCNs will be able to recruit other direct patient care non-nurse and non-doctor roles, if agreed with their ICB.
- Where PCNs already have one mental health practitioner (MHP) in place, 50:50 funded by the PCN and the mental health provider, funding arrangements for subsequent MHP roles will be for agreement between the PCN and the mental health provider, subject to ICB approval.

This could include additional MHPs being up to 100% funded through the ARRS. All mental health practitioners will continue to be employed or engaged by the mental health provider.

- Caps on advanced practitioners will be removed.
- PCNs will be able to claim reimbursement for the time personalised care roles spend out of practice undertaking training or apprenticeships to obtain a level three occupational standard.

The mechanism which allows commissioners to redistribute unclaimed ARRS funding between PCNs will be removed from the Network Contract DES.

TABLE A	
MGPA priority domain	**All PCN practices to have following components in place and these continue to remain in place**
1) Better digital telephony	**Digital telephony solution implemented, including call back functionality; and each practice has agreed to comply with the Data Provision Notice so that data can be provided by the supplier to NHS England.** **Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.**
2) Simpler online requests	**Online consultation (OC) is available for patients to make administrative and clinical requests at least for the duration of core hours.** **Practices have agreed to the relevant data provision notice (DPN) so that data can be provided by the supplier to NHS England as part of the 'submissions via online consultation systems in general practice' publication.**
3) Faster care navigation, assessment, and response	**Consistent approach to care navigation and triage so there is parity between online, face-to-face and telephone access, including collection of structured information for walk-in and telephone requests.** **Approach includes asking patients their preference to wait for a preferred clinician if appropriate, for continuity.**

The Capacity and Access Payment (CAP)

The Capacity and Access Payment (CAP) will continue in 2024-25. The overall amount of funding allocated to the CAP will increase by £46m to £292m.

70% of funding will be paid to PCNs via the Capacity and Access Support Payment (CASP) without reporting requirements, proportionate to their adjusted population, in 12 equal payments.

The remaining 30% of funding will be available to PCNs via the Capacity and Access Improvement Payment (CAIP). This will be paid to PCNs in monthly instalments over the remainder of the financial year (or in April 2025) once all practices within a network have put in place the components of the Modern General Practice Access (MGPA) model (see Table A above).

Each PCN clinical director will need to provide assurance of this to their ICB. These conditions can be met at any point during the year and PCNs will receive payment in-year once they are met.

Investment and Impact Fund (IIF)

The number of IIF indicators will be reduced further from five to two (retaining the indicators on learning disability health checks and FIT testing). Funding from the other three indicators (flu and access) will be redirected into the Capacity and Access Payment (CAP). This will leave approximately £13m worth of funding within IIF for 2024-25.

PCN clinical directors' requirements and funding

The PCN clinical director role description will be simplified and refocused. It will focus on the following key responsibilities: co-ordination of service delivery, allocation of resources, supporting transformation towards Modern General Practice and supporting the PCN role in Integrated Neighbourhood Teams.

A more flexible funding pool will also be created for PCNs by rolling the clinical director payment and PCN leadership and management funding (£89m combined) into core PCN funding to give £183m in total.

The Network Contract DES service requirements

Until now there were nine service requirements detailed in the Network Contract DES. Some of these are supported by non-contractually binding guidance documents.

Eight of the PCN service specifications are now replaced by one simple overarching specification with a greater focus on outcomes. The new overarching specification focuses on supporting resilience and care delivery, improving health outcomes, reducing health inequalities, and targeting resources to deliver proactive care.

The Enhanced Access specification remains as a separate specification with the arrangements unchanged in 2024-25.

Quality and Outcomes Framework (QOF)

In an effort to respond to requests to reduce bureaucracy, 32 indicators (out of the total 76) are income protected in 2024-25. These

TABLE B		
Clinical/policy area	**ID**	**QOF points**
Mental Health	MH021	6
Depression	DEP004	10
Asthma	AST008	6
Register Indicators x 19 covering a range of clinical areas	CAN001, CKD005, CHD001, HF001, HYP001, PAD001, STIA001, DEM001, DM017, EP001, LD004, MH001, OB003, OST004, PC001, AF001, AST005, COPD015, RA001	81
QI indicators x 6	All	74
COPD	COPD014	2
Smoking	SMOK005	25
Cancer	CAN004	6
Cancer	CAN005	2

indicators account for 212 of the 635 points that can be earned through the QOF scheme.

For the income protected indicators, practices will be awarded QOF points based on their performance in previous years, while points for the remaining live indicators remain conditional on their performance in 2024-25.

The 32 indicators which will be income protected include the indicators protected in 2023-24 (see Table B above).

Recognising the need to support practice cashflow, QOF aspiration payments are increased from 70% to 80% in 2024-25.

Vaccinations and immunisations

Practices are required to:

- share vaccination status (both vaccinated and unvaccinated) with the local Child Health Information Services (CHIS), and any other system nationally required, and support CHIS data cleansing.
- improve data recording of vaccination status for all patients, including where they have arrived from overseas and where there is an unknown or incomplete history to offer vaccinations in line with the UK Schedule and Green Book.
- improve data quality for vaccination events, with this being supported through a rationalisation of SNOMED codes used for vaccination event recording.
- ensure they are using the relevant codes within their clinical system templates; and
- maintain accurate and up-to-date patient vaccination records, including correcting vaccination records as and when they are made aware of any errors.

Weight Management Enhanced Service

The Weight Management Enhanced Service continues. Practices will receive £11.50 per referral with total funding of £7.2m for the enhanced service.

Digital telephony

From October 2024, the GP contract relating to digital telephony will be amended to require practices to provide data on eight metrics through a national data extraction.

The eight metrics are:

- call volumes
- calls abandoned
- call times to answer
- missed call volumes
- wait time before call abandoned
- call backs requested
- call backs made, and
- average call length time.

This data will be used by ICBs and NHSE England to support service improvement and planning and will be available for PCN use to:

- gain better insight into patient demand and access trends which systems can use to support understanding of operational pressure in general practice, and
- gain better understanding of patterns of demand and periods of surge activity to inform commissioning of local services.

"...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"

Employing doctors

Flexibilities similar to those brought in to assist with the Covid-19 pandemic will be made permanent.

This means that doctors employed or registered with bodies designated by the Medical Profession (Responsible Officers) Regulations 2010 (Schedule, Part 1 only) will be able to deliver primary care services without being on the Medical Performers List (MPL).

A corresponding change to the GP contract regulations allows GP practices and PCNs to employ doctors who are already employed, for example, by an NHS trust, NHS foundation trust or health board without the requirement for the doctor to also be registered on the MPL.

Patient registrations

NHSE has co-developed a new registration solution with patients and practices to make registering with a GP easier, simpler, and standardised. Practices will be contractually required to adopt and offer both formats, to be in place by October 2024.

Continuity of care

The provisions in the GP contract regulations will be amended to explicitly require continuity of care to be considered when determining the appropriate response when a patient contacts their practice.

Workforce data

Practices and PCNs will be required to submit workforce information on a quarterly basis to the National Workforce Reporting Service (NWRS).

Armed forces veterans

Practices must have due regard for the requirements, needs and circumstances of armed forces veterans when offering services and making onward referrals.

Looking ahead

The DHSC will build on the engagement with the Expert Advisory Group to convene a taskforce on the future of general practice over the Spring and Summer.

This will be a key opportunity for the Department and NHSE to hear from stakeholders about priorities for change, including through the 2025-26 contract.

Additionally, there is continued support for people currently on the Fellowship Scheme, throughout 2024-25 and NHSE is considering the future of recruitment and retention schemes to best support general practice.

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.

Conclusion

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

NHS England

https://www.england.nhs.uk/long-read/arrangements-for-the-gp-contract-in-2024-25/

BMA

https://www.bma.org.uk/pay-and-contracts/contracts/gp-contract/gp-investment-in-england

GPs turn to AISMA as they battle the imposition

OPINION **Deborah Wood*** AISMA chairman

April sees the start of another financial year and now is the time when your AISMA accountants begin planning with you for the new cycle of services relating to the accounts year just ended.

Budgets, estimates of pensionable pay, drawings levels and staff pay awards are all being considered but once again this is against the backdrop of another imposed contract update.

In preparation for this article, I looked back at the one I wrote in Spring 2023 and unfortunately things have not changed a great deal with failures to recognise the cost of inflationary pressures that continue to impact primary care services.

Clients are seeking advice from their AISMA accountants on business cashflow crises and sustainability issues, looking for help with forecasts and trying to understand where the resources are to meet patients' needs.

The GPs who are responsible for their practices and their patient care are deliberating about how much they might need to reduce their own drawings by before the balance of workload and reward is eroded completely, leading to handing back of contracts.

Looking back over the previous five-year funding deal, the increased investment via PCNs does not appear to have fully reached the coal face of general practice, and the 26,000 additional healthcare professionals employed via ARRS money do not seem to be reducing GP workload or increasing patient access.

Cost of living pressures continue in the wider economy which means that the small increases included in the contract towards pay awards will not match the uplifts needed for minimum wage and staff retention.

Collaboration across the PCN footprint is vital to maximise the benefits of the available resources. Practices need to ensure they are part of plans and have control over, and access to, the funding deployed centrally to benefit their own patients, practice staff and resources to deliver contract requirements.

AISMA accountants will soon be working with you to prepare annual accounts for the year ended 31 March 2024.

That is nothing new for practices who have traditionally had a March year end but for the first time we will also be preparing accounts for a shorter period to 31 March 2024 for many practices who have previously had other year ends such as June or September.

This is due to the basis period tax reforms and could well lead to some workload demand pressures across our member firms.

AISMA continues to work with many organisations throughout the UK, including PCSE, NHS Pensions, NHS England, Scottish Public Pensions Agency, NHS Scotland, the BMA and HMRC to try to ensure GPs and practices are receiving relevant and up to date information to assist them to manage their affairs in a timely and efficient basis.

"AISMA accountants will soon be working with you to prepare annual accounts for the year ended 31 March 2024"

This will be of particular importance during the months ahead as the impact of the McCloud Remedy becomes clearer and our clients start to receive their remediable pension savings statements and consider what action to take via the HMRC Digital Service.

Our member firms are looking forward to refreshing their knowledge and sharing best practice at our annual conference later in April, when we will no doubt be giving thought as to how best we can support our clients to fully understand and check the information they will receive.

I sincerely hope that the current political uncertainty, industrial action, and resourcing issues start to give way to a brighter economic outlook that recognises the value of appropriate levels of investment needed for general practice to not only survive, but to thrive again.

We're all going on a summer holiday...

but not all at the same time!

With a bit of smart thinking, your staff, GPs, and the practice can look forward to hassle free annual breaks, says **Fiona Dalziel**

When managing a practice, one of the very most fundamental tasks - and most stressful - is making sure there are enough staff present to provide the service.

Some absences are difficult to plan for; we have all experienced urgently searching for cover for illness, bereavement leave or accidents. This is impossible to plan for and we do not have spare team members sitting waiting for a call.

But what measures can we consider when planning for expected absences? Let's look at annual leave.

Planning for staff annual leave

Many practices work a system where the holiday year of all employed staff runs from the beginning of April to the end of March. Some staff are keen to plan their holidays in advance to ensure availability of dates. However, many are not.

The result of this is that we experience an annual logjam of people who are trying to take leave in the same few weeks at the end of the holiday year.

These staff want to make sure that they are granted all their annual leave. Payment in lieu of holidays or carrying them forward into the next holiday year are not common practice.

Despite reminders and cajoling, the impact on the office or nursing team of several simultaneous holiday absences can be very difficult, especially if unexpected absences then happen as well.

"Sit down together. This meeting may require some actual negotiation and compromise"

Well, it is possible to minimise the risk of this happening with a bit of system change. What can you do? Let's look at staggered holiday year ends.

Firstly, think everything through in advance so that you have a proposal for staff to consider. Secondly, consult with staff.

This is not a change to their terms and conditions – you are not changing the amount of their holiday allowance – but consultation before introducing the change will help identify concerns and may bring up good suggestions.

You may wish to clarify what the change will be in writing by producing a new annual leave protocol.

All staff can be allocated a different month for the start of their new holiday year. During the introductory year of the new system, staff should be allocated a new starting month and then a pro rata number of days' leave they can take during the months between the end of their 'old' holiday year and the start of their 'new' year.

At this time you may need to be flexible with the pro rata/part year allocation in the case of someone having a special event, such as a wedding in Australia for which they need more days. The watchwords here are 'fairness' and 'consistency'.

New-start staff will simply be allocated their start date as the beginning of their holiday year.

Update your annual leave tracking system to take into account the variety of holiday year ends you now have.

The introductory year will require careful monitoring, listening and flexibility but the end result should help avoid the staff March log jam.

Planning GP annual leave

It may make sense to work a similar varied year end system for GP partners too. Alternatively, consider an annual holiday planning meeting well in advance so that the major pressure points are covered.

The main pressure points are the school holidays for partners with family. Again, fairness and consistency really matter. Give the partners plenty notice of the holiday planning meeting and hold it in roughly September for a holiday year starting in January (or earlier if you can get everyone together).

Check out in advance which partners need the school holidays next year and have a note ready of who had which dates in previous years. In some practices, it will work well to rotate the choice of Easter versus October. Partners' needs will vary depending on the age of their families.

Sit down together. This meeting may require some actual negotiation and compromise. It cannot be done successfully by email.

It is not vital to agree every individual week of all partners' holiday allowances. However, having major holidays agreed in advance when nobody is under pressure can be a huge advantage.

Public holidays

We have all experienced the intense four-day week engendered by a Monday public holiday. On occasion, there are additional public holidays tagged onto planned ones and we are even more pressurised.

We don't actually have to close on a public holiday. Add up the public holiday days and add them to each member of staff's annual leave allowance.

Identify 'fixed' and 'flexible' public holiday days. Normally, the Christmas and New Year days will be 'fixed' and Easter, May, and the others can be 'flexible'.

On a 'fixed' day, the practice will close and staff will keep days aside for this. On a 'flexible' day, the practice will open and staff who want to take the day off can apply to have it as a day's annual leave or will just work as normal.

The practice can now stay open on the public holiday. As with the other changes, consult widely with the team before implementing anything so that you are well-prepared and are able to be as fair as possible.

Fiona Dalziel is a practice management consultant

Could you soon be paying less interest on healthcare sector loans?

Ian Crompton looks at recent changes in the Bank of England base rate – and pointers to where it may go in the next few years

One of the most frequent questions I am asked is what is going to happen to interest rates. Obviously, I cannot answer for certain, but I can comment on the trend, forward market rates, and forecasts.

You will be aware that in the last two years, the base rate has increased from an all-time low of 0.1% to – as I write - 5.25%. I often hear people complain about 'high' rates but the average rate since the Bank of England was formed in 1694 is 5.9%, and over the last 100 years, it is 8.3%.

Rates have been increased to help curb inflation, which is now falling, and the general view is that it will continue to do so. It may not get back to the 2% target, or stay there, but it is back to reasonable levels following the economic shocks of the government's Covid spending-spree, and the impact of the war in Ukraine.

The Bank of England sets the base rate, and many bank loans are linked to it. The rate also influences other 'managed' rates such as residential mortgages which, as a rule, will rise and fall in a comparable way.

There is however a 'market' in which banks and financial institutions lend to each other, either 'overnight' or for agreed terms. These 'market' rates can provide an indication of the future trend in base rate.

Longer term 'market' rates are based on the expectation of where the base rate will go in the future. I like to look at the rate offered as the 'cost of funds' by a bank for five-year and 25-year fixed rate loans. Base rate linked loans are at a bank margin, for example 2.5%, above base rate. Fixed rate loans are effectively a bank margin over the market cost of funds for the appropriate term, say five years.

The table (below) shows the Bank of England base rate quarterly since December 2021, when it was 0.1%. The lines show the 'market' rates for five-year fixed and 25-year fixed at the same dates.

Simplistically, to illustrate how these rates work, in September 2022 a base rate linked loan with a 2.5% margin would be 2.5% + 1.75% = 4.25%. A 25-year fixed rate loan would be 2.5% + 3.53% = 6.03%.

	12/21	3/22	6/22	9/22	12/22	3/23	6/23	9/23	12/23	3/24
Base Rate	0.10%	0.50%	1.00%	1.75%	3.50%	4.00%	4.50%	5.25%	5.25%	5.25%
5-year	1.17%	1.54%	3.05%	4.22%	4.32%	4.53%	5.53%	5.44%	4.86%	4.61%
25-year	1.41%	1.41%	2.79%	3.53%	3.70%	3.90%	4.78%	4.93%	4.71%	4.45%

NB: the five and 25-year rates shown are illustrations of rates applicable on one day at the start of that month. The rates vary daily unlike base rates which only move following Bank of England's Monetary Policy Committee meetings which are typically every two months.

In September 2022 therefore, the markets would only lend for 25-years at a rate higher than base rate, because it was expected that base rate would increase. You will also see that to lend for five-year fixed, banks would expect an even higher rate (4.22% + 2.5% = 6.72%) because they expected the average rate over five-years to be higher than the average over 25 years.

So, looking at the trend and forward market rates, the cells highlighted in pink show increasing rates, those in green reducing. Base rate has stopped increasing (orange), and five and 10-year market rates are reducing and below base rate. Overall, this suggests the financial markets expect, and are 'pricing in' a fall in base rate. Beware - markets can be wrong!

As an example of what the rates' difference can make in real terms, monthly repayments on a base rate linked loan of £1m at say 2.5% over base rate, at the rates shown in the table for March 2024 are illustrated below.

- 25-year base rate linked at 2.5% OBR would be 2.5%+5.25% = 7.75% and annual repayments of £90,639.
- 25-year fixed rate loan would be 2.5% + 4.45% = 6.95% with annual repayments of £84,431.

Clearly the fixed rate loan option would not benefit from any base rate falls, but a client can potentially 'lock-in' at what may be a much more affordable rate.

"...the Bank of England 'will not hesitate to increase rates if inflation proves to be persistent' "

We have looked at what the market rates and trends may tell us, so now onto the forecasts by the experts. The current consensus suggests the base rate will fall to 5.0% in July 2024, be 4.5% by January 2025, 3.75% in January 2026 and 3.5% at the start of 2027.

But no one can be sure. Whatever the trends and forecasts, note the statement from the Bank of England, that it 'will not hesitate to increase rates if inflation proves to be persistent'.

- *Any comments are my personal views and should not be considered as advice or recommendation. Rates shown and quoted are real, but for illustration only. Some banks may use different terminology for certain rates, but the principles are the same.*

Ian Crompton runs PrimaryCare Finance Consultancy Ltd

The Budget – what it means for you now

As 2024 will almost certainly be an election year, Chancellor Jeremy Hunt's Spring Budget arrived with much anticipation. **Kieran Hancock**** gives a quick round-up on what it means for GPs and their practices

My Autumn Statement report in the last issue of *AISMA Doctor Newsline* commented on the cost-of-living crisis and the impact of inflation on GP practices.

Inflation continues to fall and is, at the time of writing, 3.4% meaning general costs should become more manageable. But, and as shown in more detail below, staff costs continue to rise due to the National Living Wage increase.

The government has again imposed the GP contract on practices for 2024-25 and the BMA has rejected this. There is speculation that the miniscule funding increase will lead to industrial action later this year.

Those in primary care hoped for a rescue package in the Chancellor's announcements and while additional NHS funding was announced there was nothing to improve GP practices' finances.

The Spring Budget brought some expected changes but also surprises. Some changes will benefit the medical profession but these will not make up for the continued increase in pressure all partner professionals feel, and the continued erosion of their funding.

Practices continue to hold out for the government to see sense and offer the much-needed additional funding. But as I write it seems unlikely anything further will happen until the next general election.

Here are the Chancellor's most notable announcements and a recap on other upcoming changes.

National Insurance Contributions (NICs)

Self-employed

Class 2 NICs will be abolished from 6 April 2024. This is paid by all self-employed individuals, where profits exceed £12,570 a year, at the rate of £3.45 a week, which was due to increase to £3.70 a week from 6 April 2024. For the 2024-25 tax year, this will give an annual £192.40 saving.

Where profits are below £6,725, voluntary contributions can still be made at the rate of £3.45 a week. This amount will be retained at previous levels to achieve a qualifying year for state pension benefits.

For profits between £6,725 and £12,570, an automatic state pension credit will be given.

Class 4 NICs are also paid on profits over £12,570. There will be a further 2% cut in NICs

"Make pension contributions – employer schemes or personal pension contributions will reduce taxable income"

from 6 April 2024. This is in addition to the 1% cut in the Autumn Statement. Class 4 NICs between £12,570 and £50,270 will be paid at just 6% from 6 April 2024.

Income over £50,270 will continue to be subject to 2% NICs.

The savings on Class 2 and 4 will be £1,323.40 for anyone earning more than £50,270. It is a saving not to be sniffed at.

But unfortunately, the self-employed won't feel these savings until January 2026, when tax payments for profits generated after 6 April 2024 will be due.

Employed

Class 1 primary NICs are paid by employees where income exceeds £12,570 a year.

NICs were cut from 12% to 10% from 6 January 2024 on income between £12,570 and £50,270. Where income exceeds £50,270, 2% continues to be paid on the excess.

A further cut to Class 1 primary NICs will come in from 6 April 2024, reducing the 10% above to just 8%.

For an employee earning over £50,270 a year, the combined savings from the recent changes will be £1,131 a year.

High-Income Child Benefit Charge (HICBC)

Where Child Benefit is received by an individual, or their spouse/co-habitant, a clawback of this benefit (by way of a tax charge) can occur.

Until 6 April 2024, where taxable income exceeded £50,000, there was a clawback of 1% of the Child Benefit received for every £100 of income over the limit occurred. When income exceeded £60,000 the benefit was fully repayable to HMRC.

This meant a couple earning £50,000 each (£100,000 joint), would be able to secure Child Benefit in full. But where one person earned £60,000 and the other nothing (£60,000 joint), the benefit would be clawed back fully.

As an example, an individual (or their spouse/co-habitant) who received Child Benefit for two children in the 2023-24 tax year had an effective tax rate of 62.75% between the upper and lower income limits.

From 6 April 2024 the lower limit was increased to £60,000 and the upper to £80,000. This means that 1% of Child Benefit will be clawed back for every £200 of income over the lower threshold. This will reduce the effective tax rate to 53.1%, using the same example as above.

You may wonder what you can do to avoid or reduce the charge. You could:

- Make pension contributions – employer schemes or personal pension contributions will reduce taxable income.
- Make gifts to charity via Gift Aid. These will have the same effect as the pension contributions above.

Claiming Child Benefit can provide additional earnings for mortgage purposes, as well as qualify as income for state pension purposes, so it is worth considering before opting out!

Taxes

Unlike the Autumn Statement, there was a flurry of announced changes in the Spring Budget. These are:

Residential property gains

Capital gains generated on the sale of residential property will be taxed at 24% (down from 28%) from 6 April 2024. This comes in as an incentive to liven up the housing market.

Furnished Holiday Lets (FHLs)

Rules currently provide tax reliefs on qualifying lets of furnished holiday accommodation. The reliefs cover income, capital gains and inheritance taxes. The government feels this is incentivising short-term accommodation, rather than long-term lets.

From April 2025, the FHL rules will be abolished, and income from letting all property will be treated the same. This is a substantial change and means property income and gains for many property owners will change substantially.

Non-domiciled tax status

Rishi Sunak's wife has claimed a preferential tax treatment, due to the fact she is not 'domiciled' in the UK, and the media has covered this heavily.

Where an individual is resident in the UK, but not domiciled, you have flexibility about how you are taxed. In short, you can a) be taxed on worldwide income or b) claim for the 'remittance basis' and be taxed on UK income, plus any 'remitted' worldwide income or gains.

Where individuals have been resident for several years, there is a tax charge that needs to be paid each year, to apply this treatment.

For the very wealthy, the tax charge is relatively small in relation to the tax that would arise. This enables overseas income and gains to be sheltered from UK tax, provided it is not brought into the UK.

From April 2025, the government plans to abolish this and introduce a new scheme based on residence in the UK.

Broadly, individuals will not pay UK tax on foreign income or gains in their first four years of tax residency, providing they have been non-resident for the previous 10 years.

If this affects you, I recommend you seek specialist advice as soon as possible!

Multiple Dwellings Relief (MDR)

It is not likely to be a well-known relief but the Stamp Duty Land Tax (SDLT) liability on the purchase of property can be reduced in certain cases.

Broadly, if you purchase a single 'site', which is made up of more than one 'dwelling', your SDLT liability could be calculated by applying the relevant rates to those individual dwellings. This is likely to reduce your SDLT liability.

SDLT rates increase with the value of the property, and unlike income tax, the higher rates apply to the full purchase price, not amounts over relevant thresholds.

Again, if this affects you or you are intending to buy property with multiple dwellings soon, I suggest you get specialist advice.

A reminder of previous announcements:

- Capital Gains Tax annual exemption reduces to £3,000 for 2024-25 (down from £6,000 in 2023-24).
- The tax-free dividend allowance drops to £500 for 2024-25 (down from £1,000 in 2023-2024).
- Corporation tax continues at 25% on profits above £250,000 and 19% on profits below £50,000, with a marginal rate in between. Directors need to consider any 'associated' companies, as these will reduce the thresholds and change the overall tax payable.
- The personal allowance continues at £12,570, along with the basic rate band at £50,270.
- The National Living Wage (NLW) increased to £11.44 an hour from 6 April 2024. The NLW will apply to employees aged 21 and over (previously 23). There are other notable rises for under 21s.
- The Lifetime Allowance (LTA) will be fully removed from 6 April 2024. For the 2023-24 tax year, the LTA remained, but the LTA tax charge was removed.

  This continues to be a key focus for the medical profession, considering what many predict will be a likely government change this year.
- The Annual Allowance (AA) continues at £60,000. The higher limit and removal of the misalignment of inflationary uplifts of pension benefits now means most pension members will not exceed the limit. Hurrah!
- Self-assessment for individuals whose income is solely received through PAYE will have no requirement to complete a tax return from 2024-25, regardless of the level of their income. This goes over and above the £150,000 limit in place for 2023-24.
- Full expensing allowances on relevant plant and machinery for companies became a permanent relief. This does not apply to partnerships or sole traders, but they are still able to benefit from the £1m Annual Investment Allowance.

Our big fight for your pension form clarity

It's not been a case of many happy returns for GPs' annual pension forms – and AISMA has been working tirelessly behind the scenes to sort things out. **Andy Pow***** reports

As we move into Spring, accountants across the country are putting away their spreadsheets for another year after dealing with the increasing complexities of the pension return filing season.

Every year GPs and non GP partners are required to submit an annual Type 1 form (for partners) or Type 2 form (sessional and salaried GPs) to ensure that superannuation payments taken from the practice for the previous pension year are adjusted at the right pension tier level.

These forms are also the methodology to notify your pensions agency of the annual pensionable income.

Without them being processed correctly, pension records for GPs and non-GP partners will not be updated.

There is a further requirement for practices to submit an estimate of income form for their partners and salaried GPs to ensure contributions are correctly taken each month going forward into the new financial year.

But there are some common issues which may delay the processing of forms. Working with your AISMA accountant can help you navigate the problems. These include, but are not limited to:

1 New joiners need setting up on the pension system or returns will not be able to be processed nor contributions be collected promptly.

However, it is more than that because the most common issue we see is where a salaried GP moves into a partner role. Practices are often unaware that the status needs updating on the pension record.

If you do not do that the pension forms cannot be processed. Equally, leavers need reporting to ensure pension contributions cease being taken from the practice.

2 Differences can exist between the contributions paid per the GP records and those held by PCSE in England and its counterpart in Wales.

Most commonly this happens when there are backdated adjustments taken after the accounting year end, often following a late update of a joiner or leaver.

Differences in GP solo contributions recorded for out of hours and appraisal work can also happen.

If the contributions paid shown on the form do not match those on the system then that form

will not be processed and an investigation will be needed, therefore delaying the updating of the pension record.

3 Pension records will not be updated until all previous years have been processed. If you have previously had a role as a salaried GP or partner, you need to ensure all previous forms have been submitted and, most importantly, processed. If not, then you will need to take steps to fill in the gap years.

AISMA works actively every year with pension organisations to talk through the issues. Most recently we have been in discussion with primary care support organisations in England and Wales, and the Scottish Public Pensions Agency (SPPA) in Scotland, about changes to processes in future years.

Our requests cover various areas but four important changes are needed:

1 There is a useful document available online in England and Wales called the Employee Contribution Statement. This shows what has been recorded for the contributions already paid by the individual.

Currently this can only be accessed by individuals, so neither accountants nor practice managers can get into it on behalf of their practice. We have requested a change in the system to allow accountants access, subject to data protection rules.

If that can be achieved then accountants will be able to match contributions paid and identify differences at an earlier stage prior to the end of year forms being submitted.

2 One of the issues with the end of year mad rush is the fact that the forms are issued very late in the cycle. This year was later than ever in England and Wales, which led to a delay in the submission date by a month.

AISMA accountants also identified errors in the online system because pension organisations did not leave enough time to robustly test the system.

If accountants can have access to the final forms much earlier in the year then these can be processed at the point the accounts and tax returns are prepared. That would be a far smoother process for all.

3 Simplification of the processing is needed. We currently have the situation where forms are completed and then must be either entered into an online system manually or uploaded manually.

This often creates significant work for practice managers and also delays processing because it requires manual input at the pension processing end.

We hope our discussions can make progress with moving to an alternative option to allow bulk uploads from accountants into the system ready for client approval.

4 Finally, the Type 2 pension form for salaried doctors is being looked at to ensure it provides a reconciliation not just back to the pension agency records but also the payroll to ensure clarity for both GPs and practices about who any liability for pension adjustments rests with.

Things often change slowly in the NHS world, as we know, especially when it comes to IT system developments. All AISMA can do is continue our active dialogue to try and make things better for our clients.

For now though, the pension season is behind us for another year, allowing a small break before the challenges of a new accounting period.

Never has it been more important to have a specialist advisor working alongside you to deal with the many challenges ahead.

ASK AISMA!

The need for increased drawings, higher profits, and tip top practice systems bring in a wide range of questions from GPs – answered here by **Abi Newbury******

You can ask a question by contacting your local AISMA accountant or messaging us through X @AISMANewsline

HELP ME EXPLAIN TO PARTNERS WHAT IT TAKES TO GET HIGHER DRAWINGS

Q **The partners are wanting more drawings – but where from? How do I make them understand how the finances work?**

A Drawings are those amounts paid out to partners on account of the profit the practice business is making.

They don't just come in the form of bank payments directly to each partner. Pension contributions are drawings, as are other 'bonuses' taken during the year on account of the profits made. If your practice pays tax on your behalf then this is also a drawing.

So, the question here is whether there is enough profit available to enable drawings to increase. And if not, how to generate the extra income to enable that.

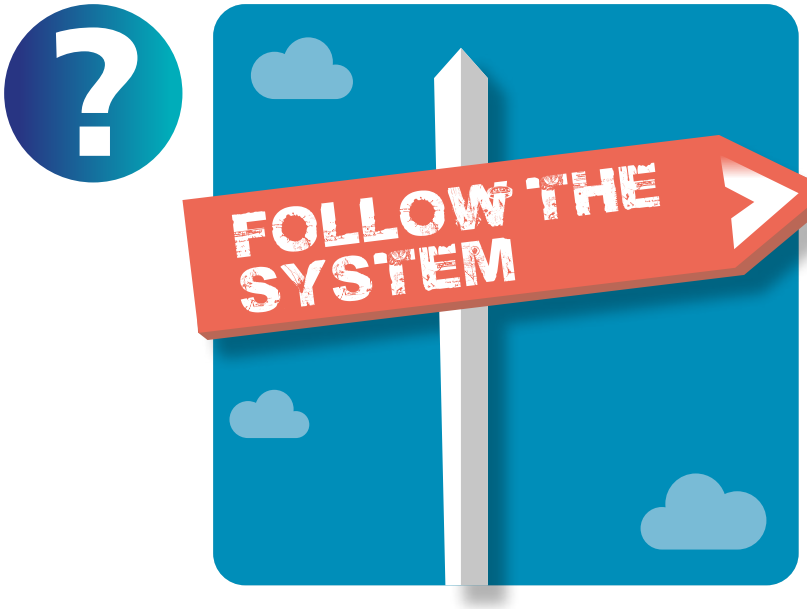
The starting point is a forward-looking budget: enter the detailed income and expenses as you expect them to be, based on what you know to date, to see what profit that gives.

Then work in the other direction: what drawings are they realistically wanting, and what profit levels must you get to achieve that?

There are only really two options – reduce expenses or increase income. To make material differences it usually comes down to staffing costs, patient numbers and services offered.

If the increased profit required means, for example, more work by partners and reduced locum costs then they can choose whether they want profit over quality of life.

This is not to forget the smaller tweaks that can be made that will all add up to greater change, but it's a starting point.



WE DON'T WANT TO WORK EVEN HARDER–BUT WE DO WANT MUCH HIGHER PROFITS

Q **How can we maximise profitability without increasing the partners' workload?**

A Systems are key. They can ensure you:

- get paid for everything you do
- do not forget to make claims for things that still need claiming for
- do not waste drugs through poor stock control, and
- do not allow bad debts to accumulate.

Every process should have a written system. It should not be dependent on a partner or an individual staff member.

The practice should be able to be run regardless of the individuals involved. That is not to say that staff are not valuable. The practice would not function without them.

But it cannot depend on a small number of people doing everything their way, with no contingency plans if someone leaves or goes on long term leave for any reason.

Ensure everyone in the practice knows the systems and follows them. This includes locums. Every practice is different. Don't just assume they know how yours work. And don't let a 'we've always done it this way' partner buck the system and lose you money!

Where systems are clear, you can ensure the work is carried out most efficiently – so that the more expensive people can delegate to less expensive people.

Delegation is the second key. No-one should be doing anything that a more economical person can do just as efficiently.

This should free up doctor and management time to enable more fee earning work to be carried out within the same hours.

WE NEED TO BE CONFIDENT WE ARE NOT ON SHAKY GROUND

Q **How do we trust our systems are working?**

A There are plenty of reports available from in-house systems and from PCSE. The point here is to ensure they are reviewed regularly.

Is everything as expected? Is anything missing? Does it indicate specific work needs doing? What can be done to make a change?

Action is needed. There is no point producing and glancing at reports but not looking critically enough to determine what needs to be done and then taking measures to ensure it happens.

If you are not hitting targets – why not? Are follow up systems not working? Are there staff shortages? Are people not coding things properly? Are the systems being communicated effectively?

There is always scope for improving systems – what worked a couple of years ago may not be relevant now. Keep everything under review.

As contract needs change, as patient numbers change, as the balance of doctors versus other professionals changes, all these things will affect how the practice needs to be run and the systems needed to maximise financial benefits and minimise clinical risks.

Systems work. A systemised business will fare much better than one without the means to control and determine what happens within that business. But to trust those systems there is the need to review and test them regularly.

Explained: the Provider Selection Regime for primary care services

The Provider Selection Regime (PSR) replaces the Public Procurement Regulations for the award of health care services contracts in England by commissioners. **Justin Cumberlege** explores the detail

Behind the PSR is this concept: freed from European Union restraints, English commissioners of health services can award contracts without having to go through the lengthy and resource intensive competitive tenders every time.

It came into force on 1 January 2024 and is set out in the Health Care Services (Provider Selection Regime) Regulations 2023.

At one extreme, the PSR permits a contract to be awarded to an organisation:

- without any tender process, and
- where the commissioner considers only that organisation is able to deliver the contract, only a notice being published that the contract has been awarded.

At the other extreme, a competitive tender process is followed, as previously.

Commissioners are referred to as the 'relevant authorities' which include a number of public bodies who commission health services. For primary care it is most commonly going to be the Integrated Care Board (ICB) for the relevant area.

The selection process will partly depend on whether it is an existing contract which is to be renewed, or a new contract, whether there is one or multiple potential providers, their past performance and their ability to deliver the contract.

In each case it will be the particular commissioner which decides the suitable process to follow

"The most suitable provider process allows the contract to be awarded without running a competitive process..."

depending on the service and the contractual requirements.

Processes

There are three possible provider selection processes:

1 Direct award processes of which there are three: A, B and C
2 Most suitable provider process
3 Competitive process.

It is possible that the commissioner's decision about which process will be followed could be challenged. To assist both the commissioners and potential providers statutory guidance has also been issued (The Provider Selection Regime (PSR) statutory guidance). Annex C of this guidance is devoted to primary care services.

The NHS has also produced a toolkit*.

Regulation 6 sets out which process is to be followed in the given circumstances and slide 12 of NHS England's Policy slide deck on the toolkit page summarises it.

Our understanding is Direct Award Process A will not be appropriate for primary care contracts.

It is intended for services which can only be provided by the existing provider due to the nature of the service, for example accident and emergency departments within the local hospital and the ambulance services.

Direct Award Process B equates to the 'any willing provider' award, meaning any provider who has shown that they meet the required criteria for a service in which there is patient choice as to who they can use, may be awarded the contract.

This means there may be any number of providers in the area who can provide the services, and patients may choose which one they go to.

Direct Award Process C will be used where the contract is being renewed. So, if a provider has an APMS contract to provide essential services from a surgery, and that contract term has to come to an end, the commissioner may decide to award a new contract on the same terms to the same provider, without inviting others to bid for it.

A 'considerable modification' to a contract is not allowed although there are some exceptions which are deemed 'permitted modifications':

- the contractor is the same entity but for a corporate change due to takeover, merger acquisition
- it does not materially alter the character of the contract
- the lifetime value of the renewed contract is worth no more than £500,000 more than the lifetime value of the existing contract; and
- the lifetime value is worth no more than 25% of the total of the existing contract.

If the modification is greater than this, then one of the other two processes must be followed.

The most suitable provider process allows the contract to be awarded without running a competitive process because the commissioner has identified the most suitable provider.

For any contract there will be specified 'basic selection criteria' to be met and each provider will be considered against 'key criteria'.

Upon considering this information the commissioner may decide which of the providers meets these criteria and therefore may award the contract to them. This could be open to challenge by others who consider that they meet the criteria and should have been given the opportunity to bid.

The 'basic selection criteria' are set out in the regulations and the commissioner will need to be persuaded of the provider's suitability to pursue a particular activity, economic and financial standing, and technical and professional ability.

These should be objective.

In addition, there are the 'key criteria' which will be stated by the commissioner for the contract. These may be weighted for the contract. Again, they are set out in the regulations, but they are much less determinable, and may vary considerably between contracts, and commissioners. The key criteria are to assess in respect of the provider's offering for:

- quality and innovation
- value
- integration, collaboration and service sustainability
- improving access, reducing health inequalities and facilitating choice, and
- social value.

The competitive process is the equivalent of the public procurement procedure we have had for a considerable time, with the commissioner providing details of the contract that parties are then invited to bid for and one provider being successful and being awarded the contract.

Having won the contract the provider will then hope that, at the end of the contract term, it will be awarded the contract under a direct award process C. Therefore, once a provider has a contract they need to position themselves to ensure they are able to retain it.

Decision making

Regardless of which process is selected the commissioner must ensure decision making is fair and transparent. The regulations set out the procedure (see regulation 6) and notices which must be published which are set out in the schedules.

Records must be kept of the decision, and the intentions of the commissioner made clear. Providers must know what the key criteria are, how the assessment will be made, and the importance of each criteria (its weighting).

The chart on slide 13 of NHS England's Policy slide deck** on the toolkit page sets out the decision tree for the commissioner to follow.

There will also be the standstill period for direct award process C, for the most suitable provider process, and the competitive process, during which the provider selection decisions may be reviewed. This could be by a panel to be set up to oversee PSR to be called the Independent Patient Choice and Procurement Panel.

Primary care

Annex C of the Statutory Guidance is dedicated to primary care contracts, being for services which are primary medical care, community pharmacy, primary dental care, and primary eye care services.

While many contracts are in perpetuity, there are times when new contracts have to be awarded, in particular if they are APMS or Personal Dental Services contracts which have a defined term.

As stated above, if a number of providers are able to provide the service (for example dermatology services) then selection process B may be appropriate, where any GP practice, or PCN (subject to it having an appropriate legal entity to hold the contract), or GP federation or NHS Trust with the required expertise and resources could be awarded the contract, and then patients will be able to decide which provider to receive the service from.

If it is a renewal of an APMS contract providing essential services, then it may be appropriate for a direct award under process C.

Providers will need to be wary of additional services being added onto the contract, as this may amount to a material modification (see above) resulting in the contract being a new contract, and therefore not qualifying for a direct award.

"The risk of contract awards being biased is foreseen, and hence the emphasis on fairness and transparency"

In such circumstances it would be advisable for the provider to request these additional services are in a separate contract, to secure the existing one.

Note that the guidance states that where there is a merger of practices, the merging of the contracts is a permitted modification, and so would continue with the new merged entity.

If the partnership running the practice has dissolved, then the commissioner will have to decide what the most appropriate selection regime is, which may be dependent on the attitude of the previous partners.

For example, if a partnership at will was dissolved due to a dispute with one partner, and the other partners wish to continue, the commissioner may choose to award the other partners a new contract as the most suitable provider.

The previous ability for the commissioner to award contracts in an emergency, remains. So, if a sole practitioner were to die, and it was not considered in the best interests of patients to disperse the list, a caretaker contract may be awarded for up to a year while it is decided whether to select the new provider by using the most suitable provider process or the competitive process for a new permanent contract.

Reference is made to the guidance in the Primary Medical Care Policy and Guidance Manual (PGM), but this is yet to be updated at the time of writing to include the PSR.

Planning

Those wanting to bid for contracts which are anticipated, either as new contracts, or as contract renewals, should ensure the commissioner is aware of their ability to perform the contracts and their interest.

Either this is to ensure the existing contract is awarded to them again, or to ensure there is not a direct award to the existing provider without proper consideration being given to them.

The risk of contract awards being biased is foreseen, and hence the emphasis on fairness and transparency.

For a provider it is much better to be close to the ICB and knowing the intentions of the ICB, so as to pre-empt an undesired process being followed, than having to challenge it once the contract is awarded.

Justin Cumberlege (J.Cumberlege@hempsons.co.uk) is a partner in the corporate primary healthcare team at the law firm Hempsons

Reference material:

**NHS England's Provider Selection Regime toolkit page: NHS England » Provider Selection Regime toolkit products*

***NHS England's Policy slide deck: PRN00853-Provider-Selection-Regime-policy-slides-4-January-2024.pptx (live.com)*

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