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2026–27 GP contract demands a funding and budgets review

Now the un-negotiated contract has arrived there is no time to lose in working through the implications.

Lizzy Lloyd* reports



The run up to the 2026-27 GP contract going live in April has been a protracted affair and left practices seeking clarity right up to the last few minutes.

NHS England (NHSE) set out the headline changes on 24 February, to apply from 1 April 2026, but at the time of writing we do not have all the financial details about implementation.

The *Statement of Financial Entitlements* (SFE) for 2026-27 was yet to be published although we did expect delivery before 1 April 2026.

For this year, we have seen a widening of the government's approach to delivering contract changes. This included talking to the RCGP, NHS Confederation, National Association of Primary Care, Healthwatch England and National Voices alongside the BMA's GPC England (GPCE).

GPCE has been unable to negotiate the contract with the government, as in prior years. As you will be aware, in a referendum about the



contract imposition, the changes, and how it impacts GPs, 98.9% of respondents voted to reject the contract. Collective action may follow, although the decision on this will not be made until 30 April following a meeting between the government and GPCE.

But despite the current lack of guidance, practices should now be reviewing their funding streams and updating their budgets for 2026-27

with the information we do have.

A longer-term vision and collaborative working will be required by practices and their PCNs, given the neighbourhood health framework implementation from 2027. Take advice at an early stage from both your AISMA accountant and a specialist healthcare solicitor.

For the year ahead, a big challenge will be the cessation of the Capacity and Access Payment (CAP) within the PCN DES. Practices should look with their PCNs at how that funding was used up until 1 April 2026.

The same-day access funding replacement will be paid directly to practices and relates to GP reimbursements alone. But it seems it will be paid in arrears and after the cost has been incurred, therefore adding to cash flow pressures for practices.

Existing PCN arrangements, such as community access hubs, may need to be unravelled or paid for out of other PCN income streams.

The core themes within the contract changes are consistent with previous messaging, the recently published neighbourhood health framework and the government's manifesto. These include:

- Reducing health inequalities
- Improving patient access and extra appointments
- Continuity of care - 'Bringing back the family doctor'
- Delivering patient care closer to home and

around communities

- Prevention of disease
- Reducing waiting lists, and
- Use of digital technology and data.

Headlines

GP contract investment will increase by £485m providing a 3.6% cash boost to cover the pay assumption, subject to The Review Body on Doctors' and Dentists' Remuneration (DDRB) recommendations, and to cover cost pressures.

This breaks down as £416m into the practice contract and £69m into the PCN DES.

The 3.6% cash injection, taking inflation into account, is considered to give a practice contract uplift of 1.4%.

The pay assumption incorporated is 2.5% for 2026-27. This is less than the recently published Agenda for Change uplift of 3.3%.

In recent years the DDRB reports have been published around June/July which has resulted in an uplift to global sum payments in September, backdated to April.

However, this was published earlier than expected and we now have the DDRB recommendation of 3.5% but are yet to find out if this will translate into a further uplift in global sum funding.

Global sum

The payment per weighted patient will be £128.69. This represents a £5.35 increase





“Possibly one of the biggest changes and challenges to the 2026–27 contract is the repurposing of capacity and access support and improvement funding...”

from the 2025-26 payment of £123.34, again subject to any further uplift following the DDRB recommendation.

For an average practice this represents additional global sum funding of around £55,000 under the current allocation formula and before the out-of-hours deduction.

The out-of-hours deduction will reduce from 4.75% to 4.7% to take account of the funding transferred from the Advice and Guidance DES which is not subject to an out-of-hours deduction.

But overall the cost of the out-of-hours deduction still increases, due to the rise in the global sum payment, by 19p per weighted patient. There will be no change to the weighting formula for 2026-27.

A six-month review of the Carr-Hill formula was instigated by the government in October 2025 and is being worked up from an academic perspective through the National Institute for Health and Care Research.

Repurposed capacity and access funding

Possibly one of the biggest changes and challenges to the 2026-27 contract is the repurposing of capacity and access support and improvement funding, valued at £292m and previously part of the PCN DES, into a new GP reimbursement scheme.

This enables practices to recruit new GPs or increase the number of sessions of GPs currently within the practice, to deliver same day access for clinically urgent appointments.

Access to the fund will need to be agreed with ICBs where practices have a high GP to patient ratio of over 3,000 patients.

As I write, few details are available on how this scheme will operate and whether partner time can be claimed. With CAP ceasing from 1 April it is unclear if the new reimbursement scheme will be in place in time.

Those support payments, representing 70% of the funding, have been paid unconditionally and monthly on the basis of £3.208 per adjusted patient.

Together with the 30% improvement payment

the total funding was likely to be worth around £47,000 to an average practice, as part of their PCN DES funding, for 2025-26.

Improving patient access

The contract has been amended to require patients identified as clinically urgent to be dealt with on the same day, as determined by the GP practice.

Non-clinically urgent patients are to be given an appropriate response by the end of the next working day.

NHSE has set out how practices need to record appointments for the clinically urgent and how they are mapped in line with national category guidance so the data can be captured.

It is expected that data will be collected across the following five indicators:

- % of clinically urgent seen on the same day
- % of non-clinically urgent seen within one week
- % of non-clinically urgent seen within two weeks
- Call waiting between 8am and 10am
- Call waiting in core hours.

Practices must not ask patients to call back another day and they cannot cap online consultations. Therefore, those consultations should operate in the same way as routine telephone/walk in appointments.

Advice and Guidance DES

Advice and Guidance was a new DES for 2025-26 worth £80m but is now moved within the core contract replacing the previous claiming of £20 per referral. There will be a requirement for it to be used and £82m of funding transferred to the global sum.

The aim, of course, is to reduce referrals into secondary care and therefore waiting lists.

With the payment now being part of the global sum, this will also remove some administrative time in practices and means it should be uplifted with future global sum uplifts. Conversely it will be paid in accordance with the weighted allocation formula so may not follow patient need.

Practices may want to review what income the Advice and Guidance DES generated for 2025/26 and whether that broadly equates to the funding transfer into the global sum.

Data will be captured to track the use of Advice and Guidance.

Quality and Outcomes Framework (QOF)

Changes are supported by 18 QOF points worth around £25m. The focus is on priority prevention areas including:

- Two new obesity targets to support referrals into weight management services. This will include delivering weight loss jobs. The previous Weight Management DES therefore ceases.
- Practices will be rewarded for progress made towards childhood vaccination

targets. Often practices in deprived areas struggle to meet the targets and miss out on earnings.

- The RSV vaccination programme is extended to all adults aged 80 and over and includes older adults in residential care homes.

- All eligible care home residents to be offered seasonal and routine vaccinations. PCNs,

although not necessarily carrying out the vaccinations, will be responsible for arrangements to encourage collaboration between practices.

The value of each QOF point is likely to rise by £2.46, before adjustment for disease prevalence and list size, to £227.95 per point. As in previous years, this rise will reflect the increase in practice list sizes so is not necessarily delivering additional income for the practice.

Additional roles reimbursement scheme (ARRS)

The GP ARRS scheme is expanded by removing the restriction that funding applies to recently qualified GPs, allowing employment of experienced GPs. This is subject to the GP

“Practices may want to review what income the Advice and Guidance DES generated for 2025/26...”

not having been “substantively” employed as a GP in a member practice of the PCN in the previous 12 months. Substantively is clarified as not relating to temporary employment or being engaged to cover, for example, maternity or sickness absence.

The maximum reimbursement PCNs can claim will rise to reflect their recruitment, being £152,900 including on-costs (£155,698 including London Weighting). For a GP in the NHS pension scheme this calculates as £118,759 plus on costs for a Whole Time Equivalent.

Where agreed with commissioners, PCNs will also be able to recruit a broader range of ARRS roles including non-direct patient care roles.

Continuity of care

A requirement of the PCN Network DES will be to identify and prioritise those patients for continuity of care and to build appropriate models for this.

PCN alignment

Neighbourhood health is part of the government’s wider agenda on local public service reform which will, with greater integration, change how public services are delivered.

So it is no surprise that the Network Contract DES will be amended to require PCNs to work with ICBs on alignment of PCN footprints and neighbourhoods.

Widespread reconfiguration of PCNs is not necessarily expected. The recent neighbourhood health framework confirms this ambition and that 2026-27 will be used to prepare for such reconfigurations and community working.

Reference material

The above relates to contracts in England only
<https://www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2026-27/>

<https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework>



Counting the cost of loose changes

OPINION

Lizzy Lloyd*
AISMA Chair

The publication of the *10 Year Health Plan for England* followed by the neighbourhood health framework means there has been plenty to keep abreast of during my first year as AISMA Chair.

But despite these documents there remains uncertainty about what is around the corner. Being unable to plan is now the biggest challenge ahead for our medical practice clients.

I have acted for practices when the 'Red Book' was the rulebook which governed how they were paid. Maybe I am looking back with rose tinted glasses but it clearly set out the basis of payments in mainly four ways.

Capitation fees

A patient basis payment broken down between three age groups and including target payments.

Item of service fees

Payment for specific activities such as night visits, temporary patients, contraception, and vaccinations and immunisations.

Allowances

A basic practice allowance and rurality, if applicable, together with seniority and a postgraduate education allowance.

Reimbursements

For staffing, personally administered drugs, rent and rates.

A new GMS contract was introduced in 2004 to share the funding more fairly depending on patient mix and to reduce the administrative burden of claiming for activity. The question is whether this is still being achieved?

The Carr-Hill formula was introduced as the weighting formula for patient demand to replace the capitation fees and allowances.

It would have left some practices unviable under the

proposed 2004 contract and so a concession decreed no one would be worse off. The Minimum Practice Income Guarantee (MPIG) funded the gap. This was then phased out from 2014 along with seniority.

The 22-year old formula is very much on the agenda for a revamp. It is based on old data and does not properly factor in deprivation. Levelling up health inequalities is clear in the *10 Year Health Plan for England*, and the 2026-27 contract changes.

But unless more money is put into the global sum then any change to the allocation formula will mean some practices will be worse off again. This is extremely reminiscent of where we were back in 2004 and no one wishes to see MPIG version 2.

Although the government is coming to the end of the academic reworking of the Carr-Hill formula, any change in funding allocation needs rigorous testing against all practice population demographics to ensure no practice or communities fall between the gaps.

Any suggestion this will be implemented in April 2027 seems ambitious, especially if it is part of a new national contract and the roll out of neighbourhoods.

GP practices face a lot of change in a short space of time. What any business needs is some stability because planning in times of constant change is exhausting and will not deliver the best strategies for the future. Practices need time to cost and plan how they will deliver the aims of the NHS plan.

The late announcement of contract changes, usually earlier in March before they are implemented on 1 April, makes planning for staffing, pay rises and future services hugely difficult.

Practices therefore end up making decisions without fully knowing what they need to deliver and how much they will be paid. This uncertainty can delay the start of new services and recruitment, hit partners' drawings and negatively affect cash flow.

That is not to say a contract review is not overdue. Looking back at the Red Book's funding streams, it is striking how similar it now looks to the 'new' GMS contract.

The list of enhanced services is now longer than the item of service fees GPs could claim then and although some of these are paid through automated extraction, subject to correct Read



coding, local enhanced services may have to be claimed - and often from a variety of places.

AISMA accountants work with their practices to check and benchmark this income to ensure claiming appears to be complete and correct.

Staff reimbursements have been replaced in recent years by ARRS claims via the PCN. Under the Red Book the reimbursements were paid monthly whereas the ARRS funds are claimed in arrears. Many changes to practice funding in recent years have resulted in negative cash flow for practices, making them feel worse off. Partners are paid last.

After six years of PCNs the ARRS funds would seem to have delivered additional services for patients and capacity. Whether this has reduced GP partner workload is debateable but there are other factors at play. The worry is the uncertainty over where this ARRS funding stream could sit within the new neighbourhood health framework.

The use of these resources varies across PCNs, with some being embedded in practices, employed by lead practices or shared across a PCN. It is a difficult problem to unravel and changes in structure would mean some transfer of people, incurring time and costs.

This brings us to the *10 Year Health Plan for England*, published in July 2025. PCNs did not happen overnight. It took time for practices to find the right colleagues, work across communities and roll out enhanced access and community services.

The 10 year plan could be seen as endangering PCNs or at least renaming them, replacing them with neighbourhoods. The recent framework lacks detail on how the neighbourhoods may be contracted, and crucially, funded at a time when there is clearly no new money.

Under the 10 year plan, the government's visions are set around these themes:

1 From hospital to community. Reduce waiting times and referrals to secondary care, which is repeated in the latest contract changes. Primary care is ready and able to take on services shifted into the community but more clarity is needed on what is to be delivered and at what price.

2 From analogue to digital. The collation of data to undertake pilots based on population needs will ensure resources are targeted in the right way. So long as that data is not then used as a performance indicator/target.

3 From sickness to prevention. Re-allocating funding to better reflect population needs is reflected in the review of the Carr-Hill formula along with the 2026-27 contract changes to the QOF points and PCN targets.

Primary care is clearly at the heart of delivering the 10 year plan, which is why it deserves to have the necessary information

to prepare and plan.

A follow-up paper published in mid-March gives a better idea of the hierarchy of the system and more details around population models of single neighbourhood providers (SNPs), multi-neighbourhood providers (MNPs) and integrated health organisations (IHOs).

But if patient-centred care and therefore primary care is at the heart of the delivery then why does it appear at the bottom of the hierarchical structure?

The framework document clarifies what is not changing, being GMS/PMS and APMS contracts which will continue and will be nationally determined.

Neighbourhoods are extra it would seem, albeit it is difficult to see how they would be funded. Indeed the framework document was light on the finance and what the contracts for SNPs/MNPs would look like. These are crucial for practices and PCNs to be ready for next April so they can start to consider how their neighbourhood may look.

Along with so many unknowns, GP practices and their AISMA accountants continue with a host of issues which cannot be overlooked:

- 1 Delivering the 2026-27 contract changes including same day access and changes in QOF points.
- 2 The impact of staff pay rises on their finances, given the increase in the national minimum wage (up 4% from April 2026) which often requires a review of the whole workforce.
- 3 Uncertainty of local enhanced services and funding from year to year.
- 4 Reduced drug margins on personally administered items including flu campaigns and on dispensing drug margins.
- 5 Historic service charge issues for those in NHS properties.
- 6 Making Tax Digital (MTD) for single-handed GPs.
- 7 Basis period reforms still unravelling and affecting partners' tax bills and pension costs.
- 8 McCloud pension remedy with many GPs still awaiting their remediable pension savings statements and the unknowns these may contain.
- 9 Pension tax charges continue to hit those who have built up larger pension pots over time and/or have outside earnings or wealth.

AISMA accountants are looking forward to our April conference where hundreds of us are enlightened by speakers, technical knowledge is updated, and we share and solve problems with our colleagues.

This annual event always helps us continue to assist our healthcare clients navigate another year of change.



ASK AISMA!



GP accounting issues are tackled here by [Abi Newbury](#)**

You can ask a question by contacting your AISMA accountant or messaging us through Bluesky @ [aismanewslines.bsky.social](#)

DON'T GET CAUGHT OUT BY THE NET TRAP

Q

Why is it important not to 'net off' expenses from income in your accounts?

A

'Netting off' occurs when a practice deducts an expense directly from a related income figure and shows only the net amount in the accounts.

For example, if a practice receives £10,000 of income and incurs £2,000 in related costs, netting off would mean showing only £8,000 as income and not showing the £2,000 expense separately.

At first glance this might seem harmless. However, it distorts the true picture of the practice's performance. The accounts no longer show the full level of income earned or the full level of expenses incurred. Total expenses appear lower than they really are and income is understated.

This can have practical consequences. Many practices use expense ratios when reviewing performance or considering efficiency.

If expenses are artificially reduced because they have been netted off, the practice may appear



more efficient than it truly is. Equally, it can mask areas where costs are rising or where better control is needed.

Where HMRC data is used for doctors' pay review purposes, understated expenses may result in new contracts that do not accurately reflect the true costs of running a practice.

Netting off also makes benchmarking difficult. AISMA benchmarking relies on consistent categorisation of income and expenditure across practices.

If one practice nets off certain costs and another shows them gross, the comparison is no longer meaningful. Clear, gross reporting ensures that like is compared with like across practices.

AISMA'S ACCOUNTING METHOD ADDS UP TO BIG BENEFITS FOR GPs

Q

Why don't AISMA accountants automatically recommend the cash basis of accounting?

A

The cash basis of accounting records income when it is received and expenses when they are paid. In contrast, the accruals basis records income when it is earned and expenses when they are



incurred, regardless of when the cash moves.

The cash basis can be simpler to understand and administer. However, simplicity does not always produce the most accurate picture of performance.

Under the cash basis, income or expenses can move between accounting periods simply because payment was delayed or brought forward. This can make one year appear unusually profitable and the next less so.

For benchmarking purposes, accruals accounting provides a more consistent and comparable basis. It reflects the true activity of the practice within the financial year to which that activity relates.

This is particularly important when comparing drawings, profitability and expense ratios across different practices. And if banks request sight of practice accounts for on-going or future borrowing they will most likely require these to be on a consistent accruals basis.

The most significant impact is on fairness between partners. Where there are changes in profit sharing ratios, new joiners or retiring partners, the timing differences under the cash basis can create material distortions.

A partner leaving just before a large payment is received may not share in income that was effectively generated during their time in the practice.

QOF is a good example. This income is earned by the partners during the accounting year, but the receipt of the achievement balance does not happen until the summer. With no timing adjustment made here to bring the income into the correct period, those entitled to that income may not share in it.

Conversely, a new partner could benefit from income earned before they joined. Profits can become open to manipulation and may give rise to costly disagreements between partners.

For these reasons, while the cash basis may be suitable in some circumstances such as single-handed practitioners or husband and wife

partnerships where the allocation of profits is less contentious, AISMA accountants will consider the wider implications before recommending it to the majority of GP practices.

MIXING DRUGS WON'T HELP YOUR RECOVERY

Q My accountant always nags us to separate reimbursable drugs from medical consumables. What is the benefit to us – they're all our costs aren't they?

A Reimbursable drugs are items for which the practice is reimbursed under specific NHS arrangements. Medical consumables, by contrast, are items used in the running of the practice and are not reimbursable.

If these categories are combined, it becomes much harder to see whether the practice is fully recovering what it is entitled to claim.

Separating them allows partners and managers to monitor margins and identify where money is being lost through under-claiming, incorrect coding or pricing issues, so that corrective action can be taken promptly.

By identifying those drug items where costs exceed reimbursement, practices can then also consider if it is commercial to continue to hold them, particularly where large cost items can be more risky to keep in stock.

From a benchmarking perspective, clear separation ensures that drug reimbursement levels and associated costs are comparable across practices. Inconsistent treatment can create misleading variations in expense ratios or apparent profitability.

Accurate analysis therefore supports better financial control, clearer performance monitoring and more reliable benchmarking within AISMA, which in turn benefits individual practices.





Get pay, benefits and financial entitlements right to support staff wellbeing and minimise legal risk

Check out **Mariam Jafri's** guide taking you through a potential minefield that can prove costly for a GP practice's money and morale

Discussions about workforce wellbeing often prioritise mental health, flexible working, and managing workplace pressures.

But an equally important, and sometimes overlooked, factor for practice owners is financial wellbeing and ensuring pay, benefits and sick pay are accurate, timely and clearly communicated.

Our experience advising GP partners and practice owners shows many workplace disputes and formal claims arise not from misconduct, but from uncertainty, inconsistency, or errors in administering pay and financial

entitlements.

These issues can undermine staff morale and negatively affect retention, if left unaddressed.

The key considerations GP employers should prioritise to get these fundamentals right, support workforce wellbeing, and reduce the risk of employment tribunal claims, are outlined below.

Payslips and pay accuracy: the foundation of financial wellbeing

Under section 8 of the Employment Rights Act 1996, employees have the statutory right to receive an itemised payslip on or before



“Any deduction – such as tax or National Insurance – must be authorised by statute, contractually permitted, or made with the employee’s prior written consent”

payday. Payslips must clearly set out gross pay, all deductions (including tax and National Insurance), and net pay.

We recently handled a case where a GP practice employed a practice nurse who worked variable hours alongside some overtime. Due to a payroll input error, her payslip showed incorrect gross pay, underpaying her for several overtime shifts.

Although the error was relatively modest, it meant her net pay was lower than expected, causing financial stress.

The nurse raised the issue with the practice manager. But because the practice did not routinely audit payroll and the error was not immediately identified, the problem continued for a second month.

Lack of clarity on the payslip made it difficult for her to see exactly where the error sat, undermining trust in the practice’s pay processes.

Frustrated by the delay and worried about ongoing underpayment, the nurse submitted a formal grievance. If the issue had remained unresolved, this could have escalated into a claim for unlawful deduction from wages under section 13 of the Employment Rights Act 1996, exposing the practice to legal costs, management time, and reputational damage.

Ensuring payslips are accurate and delivered promptly is critical. Even small errors or delays can cause significant financial anxiety for employees who rely on predictable income to manage household budgets and commitments.

Accurate payslips also reduce the risk of disputes escalating into formal grievances or employment tribunal claims. Regular audits and effective payroll systems can help employers ensure compliance with legal requirements and demonstrate a commitment to transparency.

Sick pay: clear rules and consistent application

Statutory Sick Pay (SSP) is governed by the Social Security Contributions and Benefits Act 1992 and sets the legal minimum entitlement for employees during periods of illness.

While many employers offer enhanced contractual sick pay schemes, it is essential that these are applied fairly, consistently, and in line with the agreed terms.

Inconsistent application of sick pay policies can give rise to disputes and, in some cases, may overlap with claims under the Equality Act 2010 where disability is a factor.

Effective management of sick pay entitlements therefore plays an important role in supporting both legal compliance and employee wellbeing.

Notice in lieu and pay on termination: getting it right

Pay in lieu of notice (PILON) and notice periods are often overlooked, yet they are critical areas for employers to manage carefully. The Employment Rights Act 1996 (sections 86 and 87) sets out statutory minimum notice periods, which can be superseded by contractual terms.

Whether an employee works their notice or is paid in lieu, it is essential that pay is calculated accurately, including any outstanding benefits or bonuses. Errors at this stage can give rise to claims for unlawful deduction of wages or breach of contract.

Practice owners should therefore have clear, well-understood policies on notice periods and PILON arrangements, ensuring both they and the practice manager understand the requirements and communicate clearly with departing employees.

This clarity helps manage expectations and reduces the risk of disputes at what is often a sensitive point in the employment relationship.

Deductions from wages: avoiding unauthorised deductions

Section 13 of the Employment Rights Act 1996 protects employees from unlawful deductions from wages. Any deduction - such as tax or National Insurance - must be authorised by statute, contractually permitted, or made with the employee’s prior written consent.

Common issues arise about deductions for overpayments, training costs, or adjustments to pay on termination. While practice owners may,



“Beyond legal compliance, getting pay, benefits, and financial entitlements right strengthens workforce stability and supports staff wellbeing”

in some circumstances, be entitled to recover certain sums, failing to follow the correct process or communicate clearly can expose the practice to formal complaints or claims.

To minimise risk, ensure policies on wage deductions are transparent, accessible, and applied consistently. Clear communication between partners, the practice manager and staff about when and why deductions are made can help maintain trust and support positive working relationships.

We advised a GP practice recently which employed a locum GP who left part way through the year. On termination, the practice deducted the cost of training from her final payslip, believing the clawback was permitted under her contract.

However, the deduction was not clearly itemised on the payslip, nor was the basis for it adequately explained.

The GP was surprised by the reduced final payment and contacted the practice to query the shortfall. A subsequent review of the contract revealed that, while repayment of training costs was conditional, the contractual conditions for making the deduction had not been met and the GP had not provided written consent.

As the deduction had already been processed through payroll, the practice faced a complaint that wages had been unlawfully deducted. The GP raised a formal grievance, requiring the practice to spend management time investigating the issue, reversing the deduction, and explaining the error.

The link between pay and wellbeing

Financial security is a fundamental component of employee wellbeing. For practice staff, who often operate under significant pressure and in demanding conditions, the certainty of receiving full and timely pay and benefits contributes significantly to their ability to manage work related stress.

When employees have confidence that their financial entitlements are handled accurately and transparently, it reduces anxiety and helps them focus on their roles. By contrast, uncertainty around pay can heighten stress and negatively

Practical steps for practice owners

Consider these practical measures to support workforce wellbeing and achieve legal compliance

- Ensure the practice manager regularly reviews payroll processes and systems to maintain payslip accuracy and timely delivery
- Provide training for practice managers on sick pay entitlements and the importance of applying policies consistently
- Develop clear policies on notice periods and pay in lieu, ensuring these are understood and applied consistently by practice managers
- Establish transparent policies on wage deductions, ensuring employees are informed and consulted where appropriate
- Encourage open dialogue between practice managers and staff around pay and benefits to address any concerns or misunderstandings promptly

affect morale.

Employers who prioritise accuracy and clarity in payroll and benefits administration send a clear message that they value and respect their staff, helping to foster trust and support a positive working environment.

At Hempsons, we advise practice owners to take a holistic approach, integrating precise payroll management, transparent communication, and consistent policies with broader health and wellbeing initiatives.

Complying with statutory obligations is fundamental. Beyond legal compliance, getting pay, benefits, and financial entitlements right strengthens workforce stability and supports staff wellbeing.

Mariam Jafri is a solicitor in Hempsons' employment law team



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 in the new financial year...

DEADLINE	ACTION
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6 April	<p>Tax: Making Tax Digital</p> <p>Making Tax Digital comes into effect for sole traders and landlords with income of more than £50,000 (based on 2024-2025 income). This means single-handed GP practices and individuals with property, or non-partnership self-employed income over the threshold, will need to report quarterly to HMRC.</p> <p>Those affected will need to keep digital records and submit information to HMRC using compatible software, which will be a significant change for those currently keeping paper records.</p> <p>Making Tax Digital does not currently apply to GP partnerships, unless any of the partners have property or self-employment income outside of the practice, in excess of the income threshold.</p> <p>If you are unsure if your practice or your GPs are affected by this change, please speak with your AISMA accountant.</p>
31 May	<p>Payroll: P60s</p> <p>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.</p>



31 May	Payroll: SD55 annual update <p>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.</p> <p>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.</p> <p>In Northern Ireland a GP55A year-end submission needs to be completed.</p>
6 July	Payroll: P11ds <p>P11d forms, detailing an employee's taxable benefits such as provision of a car or private health subscription, must be sent to HMRC (and copies to employees) by 6 July following the end of each tax year.</p>
31 July	Tax: 2nd payment of the year due <p>The second payment on account towards next year's tax liability must be paid by 31 July following the tax return submission deadline.</p>
31 July	Pensions: Scheme Pays Election <p>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.</p>
7 August	Tax: Making Tax Digital <p>The first Making Tax Digital submission is due to HMRC, reporting on the quarter 6 April 2026 to 5 July 2026. Subsequent submissions will be due on 7 November, 7 February and 7 May.</p>
5 October	Tax: Register for self-assessment <p>Anyone who meets the requirements for needing to complete a tax returnⁱ for the first time, must register for self-assessment by 5 October following the end of the tax year.</p>
31 October	Tax: Tax return filing deadline (paper) <p>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.</p>
31 January	Tax: Tax return filing deadline (online) <p>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.</p> <p>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.</p>
31 January	Tax: 1st payment of the year due <p>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.</p>
28 February	Pensions: superannuation certificates <p>Type 1 and Type 2 pension certificates reporting earnings for GP and non-GP partners, salaried GPs and any GP holding a qualified role must be submitted to regional pension administratorsⁱⁱ by 28 February.</p>

**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. Amendments can be submitted at any point in the 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. Payments 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.

Engage with the PCN to ensure monthly claims are sent to the PCN manager in good time, enabling any formal claim via the Primary Care Workforce Portal before any monthly cutoff date. This will help ensure efficient cashflows between PCNs and practices.



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*.

A version of this article first appeared in the Spring 2025 issue of AISMA Doctor Newsline

Reference material

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

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



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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.

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