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AISMA Doctor Newsline

At the heart of medical finance...

GMS CONTRACT CHANGES 2022-23

As the 2022-23 financial year gets underway, practices must be fully aware of contract changes and the impact these could have on funding and workload. **Deborah Wood*** gives an expert round up and commentary

Doctors' representatives of the BMA's GPC had reached a stalemate in their negotiations with NHSE regarding the 2022-23 contract. On 1 March 2022 NHSE/I published a letter setting out the contract changes effective from 1 April 2022 which have not been agreed by the doctors' union.

The letter largely confirms arrangements in line with the previously agreed five-year framework published in 2019, together with some new proposals.

Doctors' leaders had hoped to see some of their proposals taken on board around resources pressure, long-term conditions, QOF reforms and a general overhaul of the contract, but this has not yet been brought to fruition.

TABLE 1	2019/20 £	2020/21 £	2021/22 £	2022/23 £	2023/24 £
Practice contract baseline	8,116m	8,323m	8,576m	8,792m	9,029m
Cumulative increase	109m	207m	253m	216m	237m
% annual increase	1.4%	2.6%	3.0%	2.5%	2.7%

As I write, the existing contract framework will end on 31 March 2024, with a default position for it to be then rolled over 'as is' unless any changes are negotiated in the meantime.

The main financial aspects of the contract, with specific reference to changes implemented for 2022-23, are:

Practice level funding

The practice contract baseline funding will increase by 2.5% based on predicted inflation rates in April 2019. Clearly current inflationary pressures are much greater at the current time. (see Table 1)

This means a 3% uplift to the global sum payment from £96.78 to £99.70 per weighted patient. The out of hours adjustment will remain at 4.75%.

The core global sum funding includes £20m rolled over for a further year to support workload costs for Subject Access Requests.

The £216m uplift to the contract is intended to cover pay rises at 2.1% for practice staff and GPs and practice expenses.

The weight management enhanced service introduced in 2021 has had a 97% take up from practices and will be continued into 2022-23 at an £11.50 referral payment. The overall funding for this has, however, been reduced from £20m in 2021-22 to £11.5m in 2022-23.

Additional Roles Reimbursement Scheme

The available funding will increase from £746m to £1,027m.

This will include the increase to two whole time equivalent mental health practitioners (previously one).

Overall the guaranteed investment in the scheme is shown in Table 2.

Quality and Outcomes Framework

There will be no changes to the content of the Quality and Outcomes Framework (QOF) beyond changing the topics for the Quality Improvement (QI) domain which will relate to optimising access and prescription drug dependency.

The QOF will be fully re-started from April 2022 with no further pandemic-linked protections.

The value of a QOF point will be adjusted in 2022-23 to reflect population growth and relative changes in average practice list size using data on 1 January 2022. The value of a QOF point will rise by 3.2% from £201.16 to £207.56.

Investment and Impact Fund

This is a reward for PCNs meeting the NHS Long Term Plan objectives and GP contract requirements. Money derived from the Investment and Impact Fund (IIF) must be used for workforce expansion and primary care services.

The IIF funding is increased from £150m to £260m, of which £75m was as previously planned and a further £35m is included for additional specific purposes. An IIF point has a value of £200.

NHSE published the IIF indicators in August 2021 for implementation from April 2022. These relate to Structured Medication Reviews and online consultations.

Three new indicators relating to oral anticoagulants, FIT testing and cancer referrals are introduced within the additional £35m funding.

TABLE 2	2019/20 £	2020/21 £	2021/22 £	2022/23 £	2023/24 £
Additional role reimbursements baseline	110m	257m	415m	634m	891m
Further funding		173m	331m	393m	521m
Total available	110m	430m	746m	1,027m	1,412m

"The BMA has reminded practices that they can opt out of the PCN DES and the opt out window is expected to be from 1 April 2022 to 30 April 2022"

Delivering PCN specifications

The total for the clinical director (CD) funding pot increases to £87m, including £43m for general leadership and management on top of the core £44m CD reimbursement. The additional £43m is also being provided for 2023-24.

Funding streams for PCN DES extended hours of £1.44 per patient and the CCG commissioned enhanced access of £6 per patient are being combined under the PCN DES into a nationally uniform access offer with updated requirements to be delivered by PCNs.

The transfer of the previous CCG element was deferred due to the pandemic and is now due to start from October 2022, with preparation from April 2022.

This will involve PCNs providing a range of practice services in the evenings and on a Saturday. The funding will be a total of £7.46 per weighted patient.

The early cancer diagnosis service will be simplified.

Planned implementation of the digitally enabled personalised care and support planning for care home residents is deferred with only preparatory work needed in 2022-23.

Other elements of the personalised care service are due to be delivered in 2022-23 (more details are given in the 1 March 2022 letter from NHSE/I).

The BMA has reminded practices that they can opt out of the PCN DES and the opt out window is expected to be from 1 April 2022 to 30 April 2022.

Vaccinations and immunisations

There are some changes to vaccinations and immunisations covering HPV and MMR.

- a move from a three-dose schedule to a two-dose schedule (with doses given at least six months apart), for both those aged 15 and over, and for the national HPV MSM vaccination programme.
- cessation of the 10 and 11-year-old catch-up programme along with practice participation in a national MMR campaign as per the current contractual requirement for practices to take part in one catch up campaign per year.

The MenACWY Freshers programme ceased at 31 March 2022.

Other 2022-23 changes

Online patient registration will see the removal of the need for wet signatures and hard copies.

The GP registration service (in development

via a pilot) will be made available to adopt on a voluntary basis. Alternative locally developed online solutions may be put in place.

Online appointment booking will see the removal of the 25% minimum. Directly bookable appointments that do not require triage will be made available, for example flu vaccination appointments.

Deceased patient records no longer have to be printed and sent to PCSE. Practices will have to process access requests. Practices can use PCSE to store physical records.

Health and Social Care (National Insurance) Levy

No specific funding has been made available within the contract to cover this additional 1.25% liability for staff and partners across 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.

NHS Pension Scheme Tiered Rate Contributions

While not directly related to the contract changes it is worth remembering that the proposed changes to the tiered rate contributions have been deferred from April 2022 to commence from 1 October 2022 and will be phased in over the period to March 2024 (see more about this on p12).

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

NHSE/I letter 1 March 2022
https://www.england.nhs.uk/publication/letter-general-practice-contract-arrangements-in-2022-23/

BMA GP contract Changes 2022-23
https://www.bma.org.uk/pay-and-contracts/contracts/gp-contract/gp-contract-changes-england-202223

NHS Pension Scheme Tiered Rates
https://www.gov.uk/government/consultations/nhs-pension-scheme-proposed-changes-to-member-contributions/outcome/nhs-pension-scheme-proposed-changes-to-member-contributions-consultation-response

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Tackle this squeeze with strict monitoring of your practice finances and performance

OPINION

Deborah Wood*
AISMA chairman

Spring is usually a time of renewal, a time to look ahead with optimism, but as I write this it is a little difficult to feel too sunny.

We have just started to emerge from the effects of a global pandemic, only to be confronted with a dreadful war on our European doorstep in Ukraine. This has brought with it misery for many and a knock-on effect financially to global markets, inflation and energy prices.

No doubt the GP practice clients that AISMA accountants serve are also seeing the impact of this turmoil, while at the same time finding that little progress has been made at home on their contract negotiations.

With continuing falling numbers of GPs across primary care, and below inflationary increases in contract sums and pay awards, I expect that many are unable to look ahead with confidence at the new financial year.

Practice finance will be squeezed in all directions. Below inflationary uplift in contract sums; increasing staff costs including the health and care levy; higher energy costs; rising finance costs; more pressure to deliver additional appointments while working more collaboratively across PCNs; not to mention working out how to fit into the new integrated care systems/partnerships (ICS/ICP) landscape.

AISMA accountants will soon be working with their clients to prepare the annual accounts for the year ended 31 March 2022 which may reflect additional one-off income streams relating to managing Covid-19 vaccination programmes.

The aligned services provided by general practice in addition to normal services, often out of hours and at weekends, will have had an impact on profitability and cashflow.

This has a knock-on effect to tax and pension payments which will fall due just as the funding issues noted above start to come into play for 2022-23.

For practices and GPs this will mean taking the opportunity for a review of finances, assessing what patients are going to need over the next 12 months and establishing staff capacity to safely deliver the priorities within the current year's contract and the NHS Long Term Plan.

All this while maintaining an appropriate profit stream for the practice partners who bear the risk of managing the business, meeting patient expectations and complying with their legal obligations.

Do put a realistic budget in place, understand the impact on cashflow, drawings, personal tax and pension contributions and keep monitoring performance regularly to make adjustments on a timely basis.

Collaboration across the PCN footprint and wider federations is ramping up again with more additional roles funded. Demand, particularly around the care home sector and requests to undertake work usually carried out in secondary care, are increasing. Practices need to ensure they are part of these plans.

AISMA continues to work with many organisations such as PCSE, NHS Pensions, NHSE/I, 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 on a timely and efficient basis.

There are still backlogs of unprocessed pension certificates, missing service, uncollected contributions, and unreconciled seniority payments. We do keep pressing for the expected improvements to systems to eventually start to make an impact.

Our member firms are also looking ahead to refreshing knowledge and sharing best practice at our annual conference in May, where we will no doubt be giving thought to how the proposed changes across Integrated Care Systems will develop and impact on our clients.

So whose business is this?

Whatever we face in the year ahead will be much easier if practices understand the dynamics of differing roles and responsibilities, says Fiona Dalziel

Thirty years ago, as something mysteriously entitled the 'New Contract' was being introduced, general practice was really beginning to embrace the concept of the role of practice manager.

In the early 1990s, GPs received little management or leadership training. They started as practice partners without much idea of what partnership meant, how to run a business or what their responsibilities were towards staff.

Many GPs who realised they needed to be able to concentrate on clinical work developed staff roles in the practice and employed a practice manager. The role was initially ill-defined and the range of responsibilities varied hugely from practice to practice across the country.

Over the years numerous practice management and health service organisations have tried to develop generic role descriptions, pay structures and training and accreditation programmes.

In many practices this is still the situation for both GPs and practice managers.

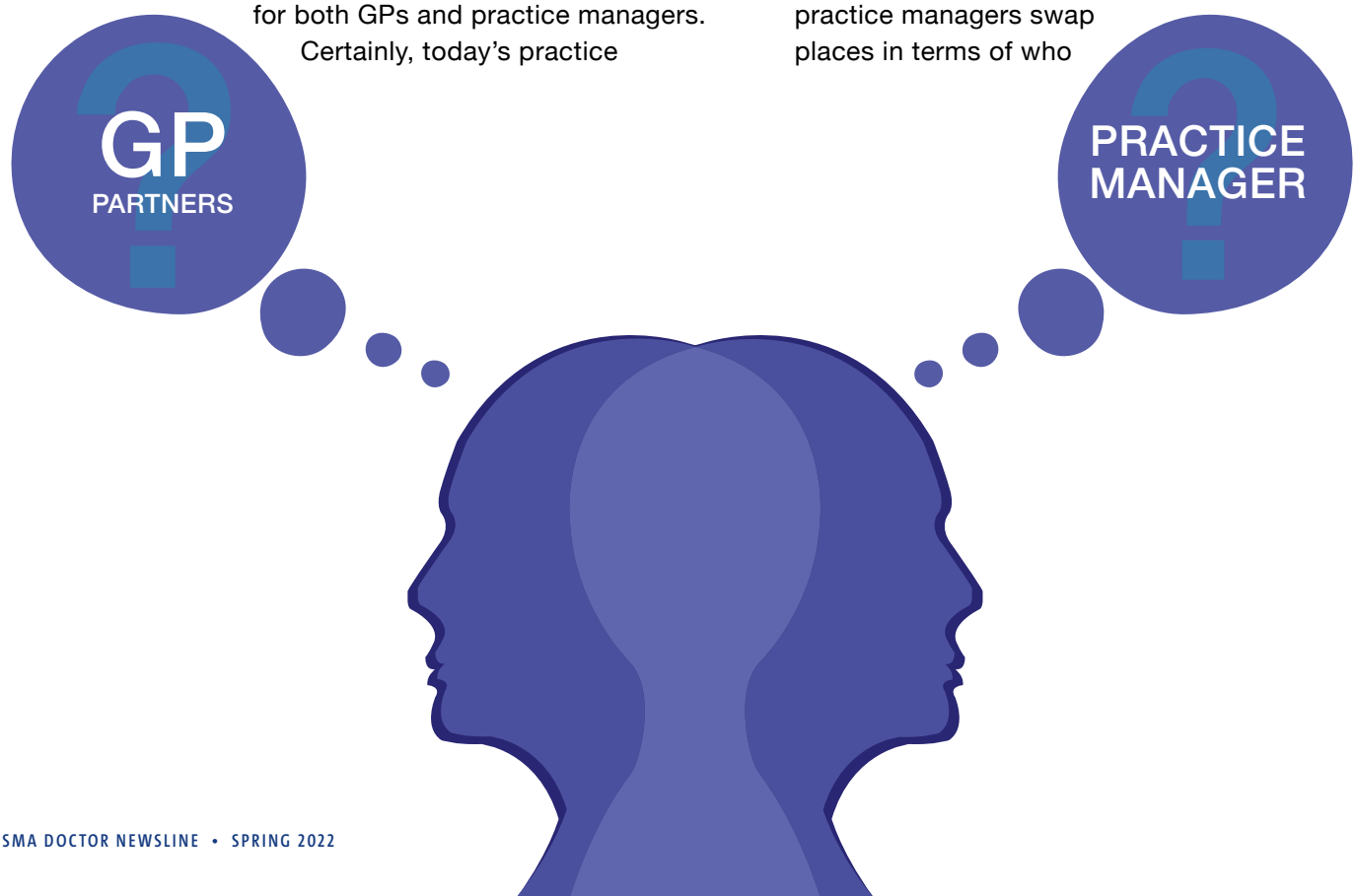
Certainly, today's practice management organisations are battling with similar issues to those of many years ago.

The Institute of General Practice Management's 2021 survey of practice managers found that 85% of respondents felt their profession had not had a voice in changes implemented in the sector.

What on earth is going on here? About half of the UK's GPs are in partnership and they employ many salaried or locum GPs. These partnerships are the GP partners' businesses and they are employers. Why does this cause an ongoing situation where practice managers are still struggling to be heard?

June Huntington, writing in her 1995 book *Managing the Practice: Whose Business?* explores the inherent conflict in the relationship between GP partners who own the business of the practice but are not its managers and practice managers who run the business but are not - with some exceptions - its owners.

She makes the point that, at numerous times during a working week, GP partners and practice managers swap places in terms of who



has authority over what is happening.

During the working day, GP partners as well as employed GPs are all 'workers' providing a service to patients and the practice manager is in charge of deploying this workforce to meet patient demand.

However, during a partnership meeting, the practice manager role changes. Although the practice manager may enter fully into decision-making processes and have a respected opinion, the bottom line is that this is not 'their business'. It's the partners' business and the practice manager is their employee.

Ultimately, this feeds right up to organisations such as the BMA which, along with its generous support to practice management bodies, at the end of the day protects the interests of its members, the GP partners.

Conversations about pay and drawings best illustrate this dilemma. Much as GP partners value their staff, there is a balance to be struck between paying your valued staff well and the conflicting pressures of partners paying school and university fees and installing that ground source heat pump.

Plainly, the current financial and geopolitical situations, not to mention the GP workforce crisis, are going to impact the situation.

What can GP partnerships and practice managers be doing to make sure everyone understands their own and the partnership's responsibilities and pressures?

Training

- Ensure all existing and, especially, new partners and practice managers understand the responsibilities of partnership. Include this in your induction training. Go through the elements of the partnership agreement with all partners and the manager.

This means that nobody has unrealistic expectations of the level of responsibility they are expected to take on.

- Make sure all partners understand how the practice's finances work. What are profit shares and parity? How are drawings calculated? What are the practice's biggest expenses and how do decisions on staff costs impact what a GP takes home at the month's end?

Policies

- Review how drawings are paid out. Some practices pay equal amounts each month and review the surplus at regular intervals, sometimes giving an additional pay-out.

Some clean out the 'kitty' and keep a reserve aside. What suits your practice best and what might work best if things get tighter financially because of inflation and rising fuel costs?

- Make sure staff are paid based on a consistent application of agreed pay scales. Think about how you agree pay awards each year and look ahead for what the impact of increasing inflation might be on both staff and partners.

How will the partnership deal with possible wage inflation? Better to think about this in advance than decide under pressure.

Finally, how can practices foster effectiveness between the responsibilities of partners and practice managers?

"Make sure staff are paid based on a consistent application of agreed pay scales"

Roles

Talk about how the dynamics between the partnership and the practice manager work – do not have a situation where your practice manager expects one level of decision-making autonomy and is given something quite different.

Power

Think hard about whether the amount of power you theoretically offer your practice manager accords with what actually happens. What exactly can s/he decide without referring back to the partnership?

Practice life is not going to 'settle down' or 'stop changing.' Handling whatever it is we are moving into will be much easier for practices where the dynamics of differing roles and responsibilities are understood.

https://igpm.org.uk/wp-content/uploads/2021/12/2021-Institute-of-General-Practice-Management-%E2%80%93-Survey-of-managers-in-general-practice-2021.pdf

Fiona Dalziel runs DL Practice Management Consultancy

Points to watch about PCN staff employment

Tread carefully. Alison Oliver sets out some legal considerations when using PCN companies to employ staff

A tricky issue for primary care networks (PCNs) has been how to go about employing their staff.

Some PCNs appoint a lead practice to employ staff on behalf of all practices. Others share employment responsibilities across all practices.

Many PCNs are forming companies to employ staff on their behalf. Some subcontract the employment to other organisations, such as GP federations.

Why can't PCNs employ staff themselves and how do practices get around this?

PCNs are unincorporated networks of practices. They are not legal entities in their own right. They cannot, therefore, employ staff themselves. This has resulted in a range of employment models emerging, including:

- Practices within a PCN sharing responsibility for employing PCN staff. So, for example, practice A might employ a clinical pharmacist and practice B might employ a social prescribing link worker, but those staff are shared between all the PCN practices
- A single lead practice employs all PCN staff on behalf of the PCN
- PCNs form a company to employ the staff on behalf of the PCN, and
- PCNs contract with other organisations, such as a local hospital trust or GP federation, to employ PCN staff.

Many PCNs are now forming their own companies as an employment vehicle and this is the model which is the main focus here.

Why form a PCN company as an employment vehicle?

One of the risks of PCN practices employing shared staff themselves is that they are not protected from arising employment liabilities. A limited company has its own legal personality and can enter contracts in its own right.

A company's shareholders are protected from the company's liabilities. By forming a company owned and controlled by themselves the practices can employ staff and ringfence those employment liabilities within the company while still retaining control over the employment vehicle.

What is the company role?

One issue to consider is whether the company is performing a managed service or is purely a supplier of staff to the PCN practices.

The practices in a PCN can delegate responsibility for all or a particular aspect of the network contract directed

enhanced service (DES) to the company.

In this scenario, the practices remain directly accountable to the commissioner for delivering the DES but pass on some of the responsibility to the company under a sub-contract or similar arrangement.

The company employs the staff, who work under the company's control and supervision to deliver the subcontracted services. As a clinical subcontractor, the company will be providing regulated activities and will need to be registered with the Care Quality Commission (CQC) as a provider of those activities.

If the company is purely acting as an employment vehicle, the practices retain responsibility for delivering the DES, but the company employs the staff and supplies them to the practices. In this model, the company could well be operating as an employment business.

What is an employment business?

The Employment Agencies Act 1973 defines an employment business as a business involved in 'supplying persons in the employment of the person carrying on the business, to act for, and under the control of, other persons in any capacity'.

The determining factor is who has predominant control over the staff member. If the PCN company manages the staff and has predominant control over what they do and how they do it while they are working for the PCN practices, then it is probably not acting as an employment business.

If, however, the PCN practices manage the staff and have predominant control over what they do, this looks more like the company is supplying staff to the practices and therefore acting as an employment business.

The fact that the supply of staff is not the core business of the supplier does not preclude them being an employment business. Interestingly, this means that a practice employing PCN staff and supplying them to other practices could also be caught by the Act.

What does it mean if the PCN company (or a practice) is an employment business?

An employment business must comply with the Conduct of Employment Agencies and Employment Businesses Regulations 2003. These set out various technical requirements, which include:

- Providing a 'Key Information Document' with certain prescribed information; and
- Various restrictions on fees and notice periods.

Other considerations

There are various other considerations for PCNs when considering their employment model, including:

- NHS Pension Scheme access – if the PCN staff are to be members of the NHS Pension Scheme, their employer must either be an employing authority (for example by virtue of holding a primary care contract) or apply for a special direction which confers temporary access for certain PCN staff;
- PCN staff contracts – the contracts with staff should make clear that they are required to work across various practices and make clear who has line management responsibility for the staff;
- VAT – the supply of staff (as opposed to a supply of medical services) is likely to be a standard rated VAT supply. PCNs should therefore take specialist tax advice on their structure;
- Sub-contracting requirements – PCNs must obtain consent from their commissioner before subcontracting any DES services and comply with the requirements of their primary care contracts when subcontracting any clinical services; and
- Risk and liability sharing – PCN practices should always have an agreement in place between themselves and with any organisation that employs staff on their behalf which makes clear how employment risks and liabilities will be shared.

Alison Oliver, a partner in the primary care team at Hempsons, advises GP practices, provider companies and PCNs on partnership and company law issues, NHS contracting, collaboration and governance arrangements. The company is a leading health and social care law firm ranked as one of the best specialist law firms in England and Wales in 2020

Disclaimer: this article is for information purposes only and should not be relied on as legal advice. Neither the author nor Hempsons will be liable for losses arising from reliance on the information in this article. The article is based on the law of England and there might be variations in other jurisdictions.

ASK AISMA!

Pay and pension matters dominate the topical questions from GPs answered here by Abi Newbury**

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

HELP US OVERCOME THE EFFECTS OF INFLATION

Q **My partners are worried about inflation and maintaining the real value of their drawings. How can I show them what we need to do to achieve this?**

A Most budgeting starts with looking at what you expect to earn and what you expect your costs to be, to arrive at a budgeted profit from which you can then calculate net-in-hand drawings.

If your initial budget is not showing enough profit to achieve this, you can tackle it from the other direction:

1 What 'take home' pay is required?
2 What is the gross equivalent of this after allowing for payments like tax, NIC, superannuation and student loan deductions
3 How far is this figure from the initial budget figure?
4 What do you need to do to achieve the necessary profits? It could be:

a) Reducing reliance on locums and taking on more work personally
b) Not replacing leaving staff and rearranging workload. But do not overdo this or you risk the rest of the staff crumbling under pressure.
c) Review other costs - not likely to make an enormous difference but every little helps.
d) Look at income levels – how many extra patients are needed to make up the excess? Is this feasible? Could the workload be handled without extra staff?

Can some work be moved downwards – doctors to nurse practitioners to nurses to healthcare assistants to admin for example – to free capacity at each level without paying for extra locum sessions?
e) What extra income-generating opportunities are available?
i. Are you maximising profit on Personally Administered Items - and ensuring no losses on high value items?

ii. Are there any enhanced services not currently done that would be financially viable?
iii. Are there any outside services or appointments that are financially lucrative? Services perhaps that other practices have dropped?
iv. Is now the time to restart a travel clinic?
v. Are there PCN led services you could be more involved in?

When looking at additional work, make sure you look at alternative uses of your time. Some fees may not be worth the additional efforts required. Also check if there are any hidden costs to providing that service.

Once you have looked at the potential opportunities, then consider if the suggestions are workable and whether all partners are on-board. Some partners may prefer lower drawings and a better work-life balance if the alternative is just even more unmanageable workload.

Showing others what they need to do to achieve inflation proof drawings may mean that, given the options, they will be more willing to accept less than inflation level increases to their drawings.

LOCUM PENSIONS ARE TOO BIG A HASSLE

Q **I can't be bothered with pension calculations – can I not just offer a flat fee to locums and they can choose whether to pension the income or not?**

A The simple answer is no! You are obliged to offer the NHS pension to locums who pension their income. Equally those who pension their income are obliged to pay that pension contribution over – it is not their money to keep.

However, you are not obliged to pay the same rate to every locum. You may choose to pay higher rates to specific locums you know well and offer good value for money, or you may be forced to pay higher rates to get someone at a specific time.

But the rate you agree is pre-pension contributions and you must add the contribution to that figure.

NEW PENSION TIERS ARE NOT MY PROBLEM

Q **I don't understand how the changes to pension tiers are my problem – surely, it's only the employee's problem?**

A Yes, it is the employee's liability – but there's no point in giving a pay increase when a pound or two less of that intended pay-rise would leave them with more money in their hands!

The proposed new pension tiers have been deferred until October (see page 12), but if you are looking at pay reviews from April you will need to take these into account because there are income levels when a tier increase could result in lower net income – more than wiping out the increased pay.

Check where each employee is on a pension tier banding. If they are at a level where a small increase will tip them up a tier, review the net effect.

For example, someone on £12,000 a year with an increase to £13,230 would be better off by £1,142 (before tax and National Insurance), whereas if the pay went to £13,232, they would only be £972 better off.

Or an increase from £26,823 to £27,779 is worth £554, add another £1 to £27,780 and the increase is worth only £139.

It is a very worthwhile exercise and your staff will appreciate you thinking of them.

This is not a worry at higher levels of income where rates are going down because they are likely to pay proportionately less.

From the practice's point of view, remember to factor in the 1.25% extra Health and Social Care Levy when looking at what the increases in salary are going to cost the practice. It may not sound a lot but all the little amounts keep adding up.

NHS Pension contribution rate changes now set for 1 October 2022

The last issue of *AISMA Doctor Newsline* reported on the consultation to change NHS Pension contribution rates for employees. James Gransby* outlines what happens now, what you need to do and how much this will cost - or save - your employees as a result**

Why was a change needed?

First, a reminder of why these changes came about. Within the 2015 Section of the NHS Pension Scheme, there was a switch from a final salary model to a model based on career average revalued earnings (CARE). The contribution rate changes were proposed to 'ensure that the costs and benefits of the scheme are more evenly shared' according to the consultation.

What changes are happening?

Following consultation, the Department of Health and Social Care (DHSC) intends to proceed with the proposals to:

- use actual annual rates of pensionable pay to determine members' contribution rates, instead of members' notional whole-time equivalent pay
- change the member contribution structure to the one proposed in the consultation document
- increase the thresholds within the member contribution structure in line with annual Agenda for Change (AfC) pay awards
- phase in the new member contribution structure, with the first phase to be implemented on 1 October 2022.

How did the final changes differ to the consultation?

Three changes were made to the final proposals, namely:

1. Aggregating multiple employments should be done at a later date in order to ensure the implementation is administratively robust

2. The position in relation to new bank posts needed to be clarified and that employers will determine the rate of contributions bank staff will pay in their first year, based on an estimate of their earnings

3. The changes will be postponed and the regulations, including amendments to give effect to the changes to the proposals, will be laid before Parliament and come into force on 1 October 2022.

Current tiers	Pensionable earnings (rounded down to nearest pound)	Current rate	Rate from 1 October 2022	Rate from 1 October 2023	Tiers
-	-	(WTE pay)	(Actual pay)	(Actual pay)	-
Tier 1	Up to £13,231	5.0%	5.1%	5.2%	Tier 1
Tier 1	£13,232 to £15,431	5.0%	5.7%	6.5%	Tier 2
Tier 2	£15,432 to £21,478	5.6%	6.1%	6.5%	Tier 2
Tier 3	£21,479 to £22,548	7.1%	6.8%	6.5%	Tier 2
Tier 3	£22,549 to £26,823	7.1%	7.7%	8.3%	Tier 3
Tier 4	£26,824 to £27,779	9.3%	8.8%	8.3%	Tier 3
Tier 4	£27,780 to £42,120	9.3%	9.8%	9.8%	Tier 4
Tier 4	£42,121 to £47,845	9.3%	10.0%	10.7%	Tier 5
Tier 5	£47,846 to £54,763	12.5%	11.6%	10.7%	Tier 5
Tier 5	£54,764 to £70,630	12.5%	12.5%	12.5%	Tier 6
Tier 6	£70,631 to £111,376	13.5%	13.5%	12.5%	Tier 6
Tier 7	£111,377 and above	14.5%	13.5%	12.5%	Tier 6
-	Expected yield	9.8%	9.8%	9.8%	-

What are the changes?

The table above shows the changes to the bandings and rates coming into force from 1 October 2022, and then subsequently next year.

Initially, the change was to take effect from 1 April 2022 but this has been delayed by six months. The reason cited for this was 'By postponing the reforms, the need to reform the member contribution structure is balanced against managing the impact on members' net income, particularly those who work full time on lower rates of annual pay.'

This does leave the rather unusual position of a mid-year change.

The issues with a mid-year change

The first obstacle has already been encountered, in the form of pensionable profit estimates.

This estimate document needed a re-design and the deadline for its completion was extended from 1 March 2022 to 31 March 2022.

If a staff member is due to join the surgery after 1 October 2022 then the new rates need to be entered. But for existing employees at that date the new tiers will be applied automatically without the need to enter them on the estimate form.

How this mid-year change is reflected on end of year Type 1 and Type 2 forms is yet to be seen and could lead to added complexity in some cases.

The changes are being made, so does that mean that the consultation was met with support?

The conclusion to the consultation states:

'Overall, the vast majority of respondents agreed with the proposals, and that where there was disagreement, this was largely due to competing interests of different parts of the diverse workforce, and the department has sought to adopt an approach which is proportionate to all of these views.'

However, one aspect where a majority disagreed, was to the question 'Do you agree or disagree with the proposed member contribution structure set out in this consultation?' 35% agreed, 52% disagreed and 14% did not know.

The report cited:

'The reasons for disagreeing with the proposal were varied, with many members saying that the increase in contributions for some members raised affordability concerns and that it was felt that higher earners were the main beneficiaries of reforming the member contribution structure.'

But this did not dissuade the DHSC from taking forward the proposals.

Difference between new contribution amount and current contribution amount for different proportions of a range of full-time pensionable earnings (negative = less to pay)

FTE pensionable earnings	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
£20,000	-£8	-£16	-£24	-£32	-£40	-£48	£126	£144	£162	£180
£30,000	-£123	-£246	-£369	-£492	-£420	-£504	-£588	-£240	-£270	£150
£40,000	-£164	-£328	-£492	-£448	-£560	-£240	£140	£160	£180	£200
£50,000	-£365	-£730	-£900	-£1,200	-£1,050	-£810	-£945	-£1,080	-£810	-£900
£60,000	-£438	-£876	-£1,080	-£1,008	-£810	-£972	-£1,134	-£864	-£972	£0

What else changes except the tiers and rates?

In addition to the rates changing, the contribution rate applicable will be based on actual annual pensionable pay rather than Whole Time Equivalent earnings, which will be fairer for those working part time.

The bands will also be linked to movements in AfC pay awards each year, which will help those members paid AfC rates avoid the 'cliff edge' situation where a small pay rise or bonus could lead to a reduction in net pay.

What effect does this have on your staff?

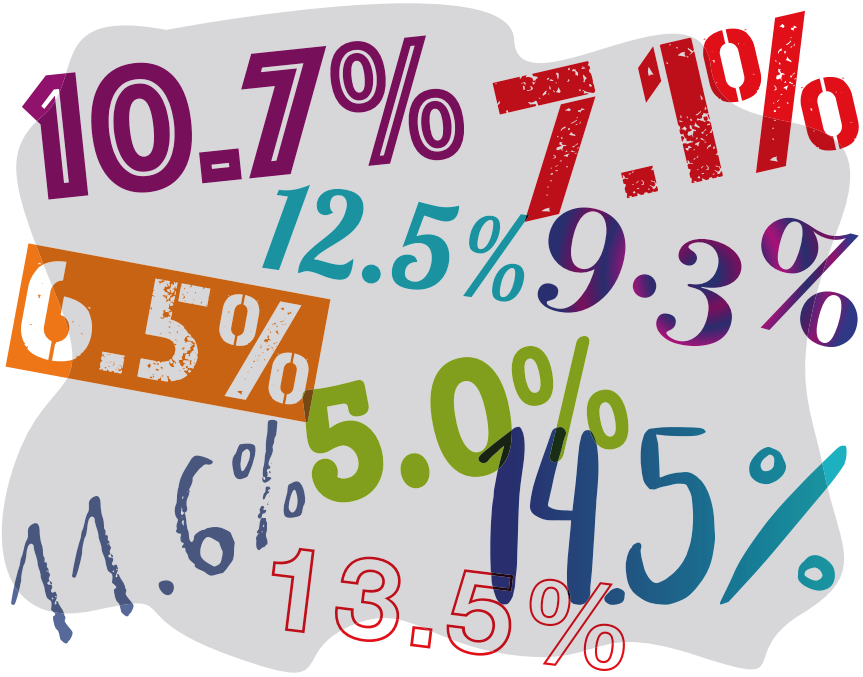
Approximately 40% of members will see their rates reduced as a result of the new member contribution structure. However, around 57% of members will see their contribution rates increased and around 3% of members will see their rates remain the same.

"around 57% of members will see their contribution rates increased"

The table above was released with the report and shows the complexity of how to explain to staff how they are affected personally. Showing them this table may be the easiest way to explain the changes based on their situation.

This demonstrates in the above examples that a member working 70% of £40,000 full-time equivalent would pay a higher contribution in the new structure than currently, whereas working 60% would mean paying a lower contribution under the new member contribution structure.

In summary, many working less than full time will benefit from the changes which will be welcome news for those individuals, while others working full time will be paying more in most cases.



What actions should I take for my practice?

In advance of your October payroll run you will need to make note of the change in rates and bands applicable at that time.

Specialist payroll providers will no doubt have this in hand, but those practices running their own payroll will need to make a note in their diary not to forget.

Communication with staff will also be important, not forgetting that for a number this will come as positive news.

It's payback time!

A new financial year heralds a year of change and more expense. Kieran Hancock**** gives a round-up of some of the effects

Many of us have become accustomed in recent years to receiving a small, albeit helpful, increase in net pay each April.

This has been due to annual increases in the tax-free personal allowance, which has risen substantially under the Conservative government, taking it from £6,475 back in 2010-11 to £12,570 from 2021-22 onwards. There have also been increases in the basic rate income tax band and National Insurance bands. When allowances go up, the tax and National Insurance paid goes down.

It was clear throughout the pandemic that the financial strain on the country has been huge and the support provided to individuals and businesses unprecedented.

We all knew this would come home to roost at some point and we would need to start contributing towards the vast increases in national debt. Well, we are already on that road and April 2022 was the date where further changes took effect.

In the 2021 Spring Budget, the Chancellor announced freezes on many bands and allowances for a period until 2025-26 and the 2022 Spring Statement didn't bring home any changes to these. A reminder of notable ones is shown in the table below.

As we return to the 'new normal', inflation is seemingly unstoppable and salaries and

Allowance	Limit	Comments
Pension annual allowance	£40,000	Has been at this level for many years and was not widely expected to be changed
Pension lifetime allowance	£1,073,100	Should have been increased by inflation each year. Would be £1,138,000 for 2022-23 assuming inflation would have been 3% for the previous two years
Tax-free personal allowance	£12,570	
Basic rate income tax band	£37,700	Combined with the personal allowance takes this to £50,270 before higher tax rates kick in

"Practices needs to consider the strains on their employees. Coupled with perhaps a further £70-£80 per month payable on energy bills, this could signal the start of a struggle for many"

earnings around the country are rising to keep up with increased competition, workloads and the lack of available candidates.

These increased earnings, without changes in bands and allowances, will result in the government collecting additional revenue. This will go some way to repay the pandemic debt, but not all the way and we must expect rises in various taxes over the coming years.

In addition to these freezes, there are further changes ahead.

National Insurance

In the 2021 Autumn Statement, the Chancellor highlighted the rising costs of social care and proposed raising more revenue to support reform by increasing National Insurance. From April 2022, National Insurance rates across the board will go up by 1.25%. This is for both employer and employee, as well as the self-employed.

A 1.25% increase may not seem an awful lot but it will impact on take-home pay for most of the country and increase the cost to employers.

To combat this increase, in the 2022 Spring Statement the Chancellor announced an increase in the primary earnings threshold/lower profits limit for National Insurance.

This sees the planned threshold of £9,880 for 2022-23 increasing to £12,570 from July 2022.

The increase will be welcome news for many as it will bring about an uplift in take-home pay. Compared with where people would have been had the thresholds not been increased, this works out at just under £30 a month. This means anyone under that level of earnings will not pay any tax or National Insurance.

Of course, there will be three months of pain until the change is implemented from July.

Looking at employers, the change in threshold will not impact on them and means that GP practices will see a substantial increase in their employer National Insurance contributions.

As well as additional charges for employees and employers, the government will also increase the dividend tax rates. The rates of 7.5%, 32.5% and 38.1% rose by 1.25% from April 2022.

From April 2023, the 1.25% increase in National Insurance will become a deduction and be rebadged as the Social Care Levy.

National Minimum Wage

Those at the lower end of the earnings scale and those who may be most susceptible to the National Insurance increase will have some reprieve, because the National Minimum Wage/ National Living Wage is substantially rising.

From April 2022 those over 25 will see an increase of 6.6% from £8.91 to £9.50 per hour. Looking at this annually, taking a 40-hour working week, this will result in an increase in an employee's wages of over £1,200 each year.

For the employer, this results in even further costs. A large part of workforces are paid based on minimum wage, be it the national minimum itself or a certain percentage above.

For the same practice with the wage bill of £700,000, if 30% of the workforce is paid at the National Minimum Wage, this would result in an almost £14,000 increase in staff costs each year. This will be compounded by the National Insurance increase shown above.

NHS Pension

Not linked to the government's plan to recoup some of the pandemic spending, but no doubt a change which will impact many, is the change in tier rates (see page 12) pushed back to 1 October 2022 because of the increased costs of living.

Practices needs to consider the strains on their employees. Coupled with perhaps a further £70-£80 per month payable on energy bills, this could signal the start of a struggle for many.

For the higher earners, it is clear there are some winners and losers and those with the highest earnings are more likely able to stomach the changes in monthly income.