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AISMA Doctor Newsline

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Flu vaccines are still profitable – if managed carefully

GP practices' flu campaigns are a valuable income stream – but with reduced profit margins, they need increased diligence. **Harriet Hole** shares some vital tips

The flu season offers GP practices a key opportunity to support public health and generate income.

For prescribing-only practices, flu vaccinations can account for up to half of annual drugs income, and even for dispensing practices they are the drug with the highest value.

But with rising vaccine costs and tighter margins, extra care is needed to ensure they remain profitable.

The flus that are recommended for use are reviewed annually, and the vaccines to be used this autumn are different to previous years. Unfortunately, these come with increased costs. Using the Seqirus Over 65s vaccine as an example, the numbers have changed as follows:

- NHS Basic Price has increased from £13.50 to £17.55 (+30%)
- Vaccine cost has also gone up, from around £11.20 to £15.25 (+36%)
- This brings the drugs gross profit margin down from around 23% to 16%. A few years ago it was over 40%.

There is further bad news as the Item of Service payment for adult flus has remained unchanged

at £10.06, even though it has been increased to £12.06 for childhood vaccines.

Despite these challenges, the annual flu campaign is still worthwhile. However, there is less margin for error, and so careful management is essential to ensure profitability.

Common pitfalls include wastage, payment errors, or claiming for the wrong vaccine. Here are my tips to avoid these errors and ensure a profitable flu campaign.

Planning: September

Vaccine orders for next year usually need to be placed in early autumn, so it is helpful to start planning while the current campaign is still underway.

To determine how many to order, review:

- How many vaccines were reimbursed last year? (check ePACT2)
- What was delivered vs. used vs. returned?
- How many enhanced service payments were made, and how does this compare to the ePACT reimbursement?

Ordering early ensures the best price can be negotiated with suppliers. And always ask for the highest possible sale or return deal. 10% is typical. When comparing different supplier options, calculate your own profit rather than relying on supplier forecasts.

Even more important than profit, though, is supplier reliability. Regardless of margin, practices should ensure their supplier is reliable to minimise the risk of late deliveries.

Delivery: September – November

Wastage from unused doses is one of the biggest reasons practices see reduced profits from flu. Over the years, we have seen a steady decline in patient uptake of flus as a result of the eligible cohort reducing and increased competition from other providers such as pharmacies.

Uptake can be encouraged by communicating with eligible patients. Use multiple channels, including personalised messages - for example: 'Mr Jones, we've ordered your flu vaccine, which will be ready for you at the beginning of October.'

Practices could consider a joint promotion with other local practices – by organising flu clinics on the same day and sharing the cost of a local radio or newspaper advert.

Make it as easy as possible for patients to receive a vaccine at any time that suits them, for example offer online bookings and walk-in appointments.

To maximise efficiency, consider combining flu vaccines with other services like blood pressure checks or other vaccinations to support QOF targets. Anecdotally, practices offering both flu and Covid vaccines have seen less dramatic declines in flu uptake, suggesting patients prefer a one-stop shop.

Involve the whole team. Encourage receptionists and clinicians to prompt patients to book their flu vaccine at every opportunity.

Through the season, monitor progress of uptake using:

- Vaccines given (clinical system) vs. stock held
- Claims submitted vs. payments received, and
- Uptake by patient group.

A simple spreadsheet, updated monthly, can help flag early issues like low uptake in certain cohorts or missed claims.

Claim accurately: September – March

As flu vaccines are ordered in large volumes but typically delivered just once or twice per season, practices should run a simple year-end reconciliation: compare the number of doses purchased with the number claimed.

While this approach is not practical for most drugs, with flu it is straightforward - and if the numbers match, it is a strong indicator that no claims have been missed.

For 2025-26, the change in flu vaccine being delivered means it is vital that the correct vaccine is claimed this year, not just the one that was claimed last year. Our advice is: when completing the claim for the first time each season, get hold of a box the vaccine came in and copy exactly what is written on the box onto the FP34-Appendix form.

To optimise dispensing fees, aim to distribute the vaccines across your GPs. Once the number of items prescribed by any GP exceeds 472, the dispensing fee for all items for that GP in that month reduces.

Check payments: November – May

Once claims are submitted, it is important to check that all payments have been made accurately. One tool which can support in verifying this is ePACT2 data, which tells practices every drug that they have been paid for. You should check both the quantity paid, and also that the correct vaccine has been paid because the NHS Basic Price is different for

different brands of vaccine.

You should also review the CQRS Annual Activity Summary Report, which shows the number of Items of Service reimbursed. This figure should roughly match the number of flu vaccines claimed.

In summary

Flu campaigns remain a valuable income stream - but with reduced profit margins, they require close attention to detail. Efficient delivery, early planning, and accurate claiming are all essential. Where possible, combine delivery with other services to spread costs and increase uptake.

Harriet Hole is head of finance and operations at Ash Lane Consulting

Delivering flu vaccines as a PCN

Delivering flu vaccines at a PCN level can offer significant benefits, particularly when aligned with Covid vaccination delivery.

By coordinating orders, practices within the PCN can secure the same batch numbers - crucial for maintaining eligibility for sale or return agreements, typically set at 10%.

This allows vaccines to be redistributed between practices if one site has higher uptake, supporting overall efficiency and reducing wastage. Additional advantages include the ability to market to a larger patient group, combine resources such as staff and venues, and streamline Covid vaccination alongside flu.

However, success depends on having a clear, written agreement in place from the outset.

The agreement should cover:

- How stock will be shared if demand is uneven
- How vaccines will be claimed and reimbursed, and
- What happens if a practice overorders or uptake is lower than expected.

To mitigate risks, practices should:

- Retain a 10% reserve of purchased stock
- Clearly document which practice is claiming which vaccines, and
- Maintain a shared, monthly PCN flu report.

Also note this: flu vaccines delivered via a PCN may not be automatically recorded in a practice's clinical system. These should be entered manually to ensure accurate claims.

When coordinated properly, a PCN-led flu campaign can be both clinically effective and financially successful.

The big challenge is coming up with the right numbers

OPINION

Sue Beaton*
AISMA board member

AISMA's recent annual national conference, attended by 200 specialist medical accountants, highlighted the constant changes affecting the NHS, and particularly GP practices in all four UK countries.

Not only are there continuing issues from past years to contend with, but also considerable new challenges. Provision and delivery of primary care services is ever-changing.

Rob Day, head of primary care at law firm Mills & Reeve, summed this up at our event by highlighting three expected shifts in the delivery of care arising from the government's 10 Year Health Plan - published as *AISMA Doctor Newsline* went to press on 3 July. These shifts are from hospital to the community; from treatment to prevention; and from analogue to digital.

Some efforts and incentives have already started this process such as the General Practice Requests for Advice and Guidance Enhanced Service and the roll out of the telephony programme, but considerably more change is expected and needed in these areas.

Primary care is expected to play a hugely important role assuming a varied core contract for the provision of wider community services and interacting with Trusts.

The BMA's Julius Parker, deputy chair of the GPC England and CEO of Surrey and Sussex LMCs, gave our conference audience an overview of the current 2025-26 contract's background and content.

It was heartening to hear that, unlike prior years, the most recent talks were more conciliatory than previous years' negotiations. He cited political engagement with the process, leading to concessions and an eventual agreement.

Talks were forward-looking and recognised with increasing awareness that negotiations need to look beyond nGMS 2004 and the PCN DES.

In England there is a continuing uplift in the global sum, with further shifts out of QOF (questioning its future?) and a loosening of the ARRS constraints.

85% of the GPC in England voted to support but this was contingent on a new contract negotiation (GMS2).

But this begs the question, how should GMS2 be financed? We shall wait and see but it would seem likely to be a mix of capitation (most likely under a new formula, but learning lessons from Carr-Hill), incentives, items of service, shared working with PCNs, federations, and third parties.

GP practices in all regions have continuing, worrying issues affecting the funding of staff pay. In Northern Ireland GPs are angry and frustrated after what the BMA council chair has called an 'astonishing imposition' of an 'unworkable' settlement that 99.6% of them voted against.

Prof Philip Banfield told the BMA's annual representative meeting in June that the settlement alleviated none of the pressures but instead threatened the very existence of general practice in Northern Ireland. In Scotland and Wales, concerns also remain about continued underfunding of contracts.

There is another worrying and pressing new issue facing the NHS and not one that has been seen to this extent before. It is the growing GP unemployment crisis, which is expected to hit harder when GP registrars qualify in August.

This work scarcity has been seen with locums in recent years but it is evidently now a wider problem.

> *"Ultimately, without adequate numbers of highly skilled and suitably rewarded GP clinicians, the service delivery, no matter what the contract looks like, will be a challenge"*

Dr Cheska Ball and Dr Vicki McKay, co-chairs of the BMA's GP registrars committee, have pointed out that the few roles available to new GPs are incredibly competitive and even if someone manages to get a placement, these are often fixed term 'and not conducive to what being a family doctor means.'

The BMA wants ring-fenced, direct funding for practices to be used solely for hiring more GPs. Dr Katie Bramall-Stainer, chair of GPC England, has called for government action now to retain these GPs and give patients more appointments.

Primary care is currently seeing great change, with a shift in emphasis on how and where patient care should take place.

Funding, as ever, continues to be a key factor in delivery but recruitment and retention of key staff and in particular GPs is also fundamental.

Ultimately, without adequate numbers of highly skilled and suitably rewarded GP clinicians, the service delivery, no matter what the contract looks like, will be a challenge.

ASK AISMA!

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

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

HEFTY EXPENSE CLAIMS CAN PROVE TOO COSTLY

Q **I'd like to claim lots of personal expenses to reduce my tax – but I am worried HMRC might question it. What is sensible?**

A The golden rule is that salaried doctors can only claim expenses 'wholly, exclusively and necessarily' incurred in the performance of your duties.

You may be able to claim:

- GMC and other professional subscriptions plus indemnity subscriptions (if not reimbursed by the practice)
- Exam fees, where directly required for your current role (but generally not training costs unless you are in a specific training role under a formal training contract)
- Home working costs (only if required by your employer), and
- Motor expenses for visits and specific work-related travel (but not commuting).

GP partners and self-employed locums have wider scope under self-assessment – they do not need to prove that expenses are necessarily incurred but they must still be wholly and exclusively for the purposes of the business. Additional allowable claims could include:

- Business use of home (such as admin and bookkeeping)
- Mobile phone use for work
- Mileage for work-related travel (not commuting), and
- Courses and CPD where relevant to your clinical role, but not for formal extra qualifications generally - that would be treated as 'capital.'

Keep records and receipts for every claim. HMRC is increasingly requesting evidence, sometimes years later.

Do not try to claim huge amounts of expenses that are not directly related to your work. That is just asking for an HMRC inquiry which could extend to the partnership too.

Remember that deliberately claiming incorrectly is fraud and HMRC can go right back to the beginning in many cases to collect the tax due on incorrect claims, plus interest and penalties at the same level as the tax. These can add up to huge amounts before you even factor in professional fees incurred in accountants trying to correct everything for you.

IT PAYS TO REPORT YOUR MOVEMENTS

Q **I've moved house and changed job – which organisations do I need to notify?**

A We are talking here about financial and tax-related updates - although of course you should also notify the GMC, banks, insurers, and the DVLA.

Make sure you inform:

- HMRC – via your personal tax account or through your accountant. A wrong address can mean missed notifications which could lead to interest and penalties.
- Your accountant – we cannot speak to HMRC on your behalf if our records do not match theirs. We may need more than an email address to contact you!
- NHS Pensions and PCSE – so you do not miss important updates like Total Reward Statements or RPSS letters which can have deadlines.
- Medical defence insurance/indemnity provider – they need your current details to maintain cover.
- Your employer – for those with salaried or employed roles.

It is a small admin task but not doing it can cause big problems.

Similarly, do not forget to advise people appropriately when you change an email address or a mobile phone number.

PLAN EARLY TO AVOID PUTTING SURGERY OWNERSHIP AT RISK

Q **There has been a change in our partnership and the property is now owned by a former partner. How can we protect ourselves?**

A This situation is more common than you might think, and too frequently we find this has happened without any planning.

Does your existing partnership agreement force continuing partners to buy the property?

If not, and you plan or are obligated under your partnership agreement to let the former partner continue to own, then this definitely needs formalising.

Check and update, or create:

- Lease or licence – the partnership must have legal rights to use the building, and clear terms. Is the rent to match funding received or how is it calculated? A new lease or changes to an existing lease must be approved by the ICB. You should also take advice on potential tax consequences.
- Service charges and dilapidations – clarify who is responsible, when, and how arrears are handled. Can the landlord demand backdated charges?
- Maintenance and insurance – document responsibility for ongoing costs, not just major works.
- Payment – set out clearly how this will work and when, to minimise the risk of overpayment, particularly if large repairs are expected.

There are other considerations, such as what happens if the former partner sells their premises share or passes away and leaves their share of the practice premises to someone else.

Protect yourself now to avoid costly surprises later. We recommend reviewing both legal and financial aspects together.

A message from AISMA's new chair

Newly appointed AISMA chair **Lizzy Lloyd***** explains why she will advocate for the next generation of specialist medical accountants to share in the experiences and professional networks that proved so critical to her own career development

Lizzy Lloyd, casting an eye to the future

AISMA members act for over 45% of medical practices across the UK and it was an honour to be nominated and voted in as chair at the Association's annual conference last April.

As I settle into my new role I am all too aware that I have big shoes to fill and any such appointment comes with much to keep one busy.

I attended my first AISMA conference in the late 1990s where, in truth, a fair proportion of the content went over my head. But as a keen young accountant at the start of my career, I was immediately welcomed into an association committed to making a tangible difference to doctors and medical practices.

Over the years, I have always valued the chance to chat with colleagues and share experiences about the financial issues faced by our clients in the medical sector. This makes the annual conference a 'must attend' event. It is the specialist medical accountant's Glastonbury - but with less mud!

It is important to me that our next generation of accountants who are passionate about this particular niche can share the same experiences and build the professional networks that have proved invaluable to my own career. I shall work hard to encourage this during my time as AISMA chair.

Over the last ten years I have been lucky enough to be part of the AISMA board and have witnessed the hard work that goes into fulfilling the Association's position as a trusted and respected organisation.

In the Spring issue of *AISMA Doctor Newsline*, past chair Deborah Wood documented the relentless changes faced by the medical sector in the three decades since AISMA's formation.

While AISMA members have kept abreast of these changes to help their medical clients navigate the choppy waters of constant NHS re-organisation, they have also had to maintain their own highly technical tax and accounting knowledge.

If you search for 'AISMA' on a web browser you might find an eclectic array of international organisations, from Advanced Information Security Management and Applications, to the Alliance for 14.0 and Smart Manufacturing in Africa and the All India Station Masters' Association.

But in the UK the term 'AISMA' is synonymous with providing the highest standards of service, both technical and advisory, to the medical practices, primary care organisations, GP partners and sessional GPs our members act for.

All AISMA accountants must reach a certain standard of technical experience and act for a minimum number of medical clients to qualify for membership. We have periodic peer reviews to ensure this standard is maintained and members must agree to and abide by the AISMA service charter.

Our members can access a wealth of information to help them deliver a truly specialist service. Most AISMA accountants will have

"So the need for practices to engage an accountancy firm which properly understands the sector is vital for GP practices"

horror stories of GP practices they have come across where the accounts were ill-prepared, the tax computations were underclaiming reliefs or pensionable pay was mis-recorded. The latter is so important, given it will form the basis of a GP's ultimate pension.

So the need for practices to engage an accountancy firm which properly understands the sector is vital for GP practices. A firm bearing the AISMA standard will ensure this.

The level of work and technical complexity our members are now involved with has changed enormously and continues evolving.

Currently your AISMA accountant may be preparing GP practice annual accounts, working on PCN accounts, and reviewing and benchmarking your financial results.

They will also be checking any seniority clawbacks and calculating GPs' tax and exposure to the annual allowance tax charge.

On top of this they will be advising partners and practice managers on contract changes, together with the impact of increased employer National Insurance contributions and DDRB uplift, all while advising on the continuing technical challenges posed by the McCloud pension remedy.

And, of course, we are all considering the impact of the newly published 10-year plan for the NHS in England and anticipating a GP contract change in this parliament.

As AISMA chair I shall lead work to ensure our members have all the information and support they need to enable them to complete the tasks listed above.

Many of us with years of broad experience have seen many changes and ideas return time and again, slightly tweaked and with a different acronym. Our member forum is a vital tool for us to access each other's experience and share and seek advice.

Yes, our role as specialist medical accountants is to prepare practice accounts, tax returns and pension certificates. But we understand the value of an adviser who can assist with interpreting results with an eye to the future.

GPs and their practice management team are extremely busy and AISMA accountants work with their clients to deliver timely advice so that practices can continue serving their patients and keep primary care thriving.

As we act for nearly half of GP medical practices across the UK, many organisations and policy makers do – or should – want to talk to us. Whether they take our suggestions forward is another thing.

Rest assured, AISMA will continue to encourage these conversations, put forward our clients' experience and lobby at the highest level to support primary care as it anticipates yet another period of substantive change.

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NHS pension update: what you should know

Get to grips with NHS pension issues affecting you. **Kieran Hancock**[****] sets out eight key points – with 'nudges' for action – to be aware of

The NHS pension is extremely complex and consequently results in different levels of understanding among its members.

But with the impact of the 'McCloud remedy,' covered in previous *AISMA Doctor Newsline* editions, and the move to the 2015 Scheme on 1 April 2022, it is important GPs are aware of some ongoing issues impacting their financial future.

1 – The Remediable Pensions Savings Statement (RPSS)

These began being issued to pension scheme members affected by the 'McCloud remedy' from October 2024. They set out pension growth for several years, previously calculated under the 2015 rules, and compare that to the 1995/2008 rules. Differences in pension growth may result in increased or decreased annual allowance tax charges.

You must establish if you need to make a full submission to HMRC using its digital service and you can do this by completing a 'triage' process. The full submission reports any increased or decreased tax charges to HMRC, to allow payment or refunds to be processed. If you have received an RPSS you need to take action.

There is a three-month deadline from the date of the RPSS to make a submission to HMRC, if required. But late submissions are unlikely to be penalised.

If you have not received an RPSS and you expect to receive one then you can ask NHS Pensions to generate one for you. It has released a 'self-identify' form to do this. Please ask your AISMA accountant for details.

2 – Pension record

Many NHS Pension Scheme members, mostly GPs, have missing information from their pension record. This will stop an RPSS from being produced and will also prevent you from having an up-to-date view of your pension benefits and any tax implications.

If you have missing information then it is likely that your pension certificates have not been processed by PCSE. Your AISMA accountant can provide guidance on what to do.

3 – Annual allowance

It is important to assess if you have breached the annual allowance in a given tax year. Depending on the type of pension, the annual allowance is the amount you can either contribute to, or for your pension to grow by, in a tax year without incurring tax charges. This annual allowance is currently £60,000.

If you have breached it, then it may mean you have additional tax to pay to HMRC.

Any unused amounts from the previous three years can be used to offset any excess of the allowance for the current year. The remainder is taxed at your highest rate.

HMRC guidance states that any annual allowance tax charges should be reported via a self-assessment tax return each year. Estimated tax charges can be used where an actual figure cannot be established. Your AISMA accountant can help.

4 – Tapering

Where your pre-tax income exceeds £200,000 a year you may be subject to a 'tapering' of your annual allowance. If you are over this limit then you need to consider your pension growth (for NHS Pension Scheme members the movement in value of your pension benefits between the start and end of the tax year) on top.

If the combination of these two exceeds £260,000, then your annual allowance will be

reduced by £1 for every £2 over. The minimum annual allowance is £10,000 when the combined figures exceed £360,000. If you believe you will breach the £200,000 threshold then it is important to consider how you can keep below it.

Doing this may reduce your tax charges by many thousands of pounds. These are all questions to think about: Can you control your income? Are there additional expenses to claim? Can you make further personal pension payments or payments to a charity?

5 – 'Scheme pays' elections

Tax charges mentioned above arising from your NHS pension growth can be paid by your NHS Pension Scheme instead of you making these payments personally. This is known as a scheme pays election. Opting for this approach will reduce your pension benefits in the long term so talking to your financial adviser to understand the impact is recommended.

To make a scheme pays election you need to apply to NHS Pensions. If you cannot establish if there are charges to pay then you can make provisional elections to ensure you do not miss any deadlines.

These can be amended later. You should always take financial advice to understand an election's impact on you.

There are key submission deadlines to be aware of:

- Years 2019-20 to 2022-23 (the in scope 'McCloud remedy' years): 6 July 2025
- Year of 2023-24: 31 July 25.

As I write it is not yet clear how the 6 July 2025 deadline will affect anyone receiving an RPSS before or after that date. For anyone receiving the RPSS before, NHS Pensions may look at the date of the RPSS, given the suggested three-month submission deadline (see point 1 above).

Anyone receiving the RPSS after the deadline, should seek their AISMA accountant's support to determine the impact and advise them what to do.

6 – 2019-20 compensation

If a clinician had an annual allowance tax charge for the 2019-20 year, then the government will cover this charge for you, using a compensation scheme.

To do that, you need to:

- make an application using scheme pays and
- complete a compensation scheme claim form.

The standard deadlines for this have long passed, but you may still be able to access it if McCloud affects you.

7 – Contingent decisions

If you are affected by the 'McCloud remedy' and you opted out of the NHS Pension Scheme between 1 April 2015 and 31 March 2022 then you can buy back that missing service to reinstate it.

With the original move to the 2015 pension scheme on 1 April 2015, many pension members opted out because of annual allowance tax charges. As the move to the 2015 pension scheme was pushed back to 1 April 2022 due to McCloud, that period can be re-assessed.

NHS Pensions has issued calculators to establish the cost of opting back in (at any point and for any length) and the additional pension benefits that will create. These calculators are not yet optimised for GPs.

You should always seek financial advice when making decisions on your pension benefits. Your AISMA accountant will be able to point you to the right place.

8 – Incorrect pension growth

As the NHS Pension Scheme is based on earnings and not contributions, the growth in your pension scheme can vary substantially year on year. With the 1995/2008 scheme being a final salary scheme for non-GPs in your practice, large pay rises can create significant growth figures.

Those growth figures may cause tax charges. Any periods of part-time working can often cause issues with pension growth. This is likely to be where employers wrongly record part-time pay as whole-time.

You should review any periods of part-time work to ensure it is recorded correctly.

Also, many pension members often receive pay arrears due to pay increases. These increases should be allocated to the relevant years, and not the year of receipt. Your employer, alongside NHS Pensions, should be able to correct this for you.

AISMA accountants are well-placed to support with all of the points above. Please contact your local specialist if you need assistance.

Act fast if you receive a remedial or breach notice

Robert McCartney presents a quick guide to help save your contract

Growing pressures on GP practices are leading to an increase in concerns raised by patients, the CQC and whistleblowers.

When these are investigated, commissioners have the authority to act against the contractor, including issuing remedial and breach notices.

These notices are becoming more common, cause significant stress, and may result in serious consequences for practices.

So, let us explore the procedure which is followed, how to respond to the notices, and the available options for challenging them.

Similar procedures apply to GMS contracts and PMS agreements. I will specifically refer to the former, but it is crucial to consult your LMC and legal advisors immediately if a notice is received under any primary care contract.

What are remedial and breach notices?

Remedial and breach notices are outlined in clause 26.13 of the contract. Although often used interchangeably, they serve different purposes. A breach notice is issued when a breach cannot be rectified and is not serious enough to warrant immediate termination - typically linked to a specific past incident.

A remedial notice is appropriate when the breach can be corrected. It serves as a serious warning but also as an opportunity to implement corrective actions and prevent future issues. Depending on the situation, both types of notices may be issued.

A remedial notice must include the breach details, the steps required to remedy it 'to the satisfaction of the Commissioner,' and a timeframe - usually 28 days. However, this period can be shortened if there are concerns about patient safety or significant financial loss.

The consequences of receiving a notice

Failure to comply with a remedial notice may result in the termination of the contract by the commissioner, and if the breach is remedied but then repeated, it may result in a termination.

Alternatively the commissioners may consider contractual sanctions in accordance with clause 26.16. These include withholding or deducting money payable under the contract.

"... early understanding of the breach being complained of and establishing clear communications with the ICB primary care team is critical"

It is therefore essential that a practice receiving a remedial or breach notice should take immediate action.

What to do if you receive a remedial or breach notice

In both scenarios the first step is to identify the alleged breach and ascertain whether this can be challenged. An investigation should have been completed by the commissioner, and under clause 26.19 of the contract, the commissioner must consult the LMC before issuing a notice. The contractor should therefore be aware of the issues and the notice should not be a surprise.

If the contractor disagrees with the breach determination, legal advice is recommended to help challenge the decision. Even if the breach is acknowledged, the contractor may dispute the procedure or details within the notice. It is important to engage constructively with the commissioner and address the underlying issues.

Breach notice

If a breach is served it may be challenged on the basis that the breach could be remedied, and so a remedial notice would be the appropriate one.

While this would place an increased obligation on the contractor to take remedial steps this procedural challenge could provide the time and opportunity for the contractor to find a solution to the problems it faces and avoid a further notice being served.

Remedial notice

For remedial notices, the contractor must assess whether the notice complies with the contract's requirements. It should provide clear, actionable steps.

Vague or open-ended instructions are inappropriate, as they can lead to prolonged and unnecessary action being taken or in a worst case scenario, set the contractor up to fail.

Both parties are obligated to act in 'good faith' and 'reasonably' under clauses 2.1.4 and 2.1.5. An inadequate notice may breach these obligations.

If there are concerns about the notice, legal advice is advisable, but it is also important to submit a factual response and seek clarification.

Given the tight timeframes and potentially significant workload, early understanding of the breach being complained of and establishing clear communications with the ICB primary care team is critical.

"Most disputes are resolved through communication and meetings, though some may escalate to board or committee levels"

How can notices be challenged?

While clause 26.18 outlines a process for challenging termination notices, there is no specific procedure for challenging remedial or breach notices. These fall under the dispute resolution process in part 25 of the contract.

This begins with a local resolution procedure, which must be exhausted before escalating further. The local procedure in clause 25.1, requires both parties to '*make reasonable efforts to communicate and co-operate with each other with a view to resolving any dispute.*' Commissioners typically have a local policy outlining escalation steps.

At this stage, the contractor must present a strong case to ensure their challenge is understood. While lawyers may be asked to help, anyone can submit a challenge.

It is important to consider that this is likely to be the basis of any later submissions to the court or to NHS Resolution, and it may not consider matters that were not raised at this initial stage.

Concerns about impartiality and fairness are common but must be substantiated. Personal attacks should be avoided. Most disputes are resolved through communication and meetings, though some may escalate to board or committee levels, where the contractor may not be permitted to attend. The LMC may participate in these discussions.

If the issue remains unresolved, the contractor must decide whether to escalate further and first needs to determine whether the contract is an NHS contract. Clause 3.1 should state this.

If the contract is an NHS contract, the dispute must be referred to NHS Resolution in accordance with the NHS dispute resolution procedure, which represents the Secretary of State and is able to make determinations.

Most cases are decided on paper, although complex matters may involve hearings. Contractors must decide whether to represent themselves or appoint legal advisers, potentially including a barrister.

NHS Resolution's decisions are final and binding, although they may be challenged by seeking a judicial review on specific grounds, as established in the Court of Appeal decision in *R (Shashikanth) v NHS Litigation Authority [2024] EWCA Civ 1477*. While judicial review is beyond this article's scope, it remains a potential final recourse.

If the contract is not an NHS contract, the contractor may still use the NHS dispute resolution procedure or pursue a claim in the courts. The appropriate legal route depends on the dispute's nature. Court proceedings are both expensive and lengthy but may be suitable for severe, complex legal issues requiring judicial input.

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Don't forget the patients!

Most disputes are resolved using the local procedure and only the most serious matters escalate further. Every challenge must be assessed on a case-by-case basis.

At all times, the contractors must remember that their core focus must be on the delivery of services to their patients.

Working with the commissioner's requirements, and liaising with them, is likely to be more beneficial in the long run.

Relationships become very fraught but a beneficial outcome is often achieved by engaging with the procedure, and resolving matters, rather than to challenge on technicalities.

However, this cannot simply be achieved; and it is important that you obtain the support from appropriate experts at the earliest opportunity to avoid the worst-case scenarios of facing sanctions or potentially losing your contract and your livelihood as a GP partner.