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AISMA Doctor Newsline

The heartbeat of medical finance

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It's time for GPs to get some clarity on 10 Year Health Plan

We are now a quarter of a year on from the big policy document's arrival – but the Association of Independent Specialist Medical Accountants is concerned there still remain more questions than answers about the implications for GP practices

Leading medical accountants remain extremely uncertain about how their GP practice clients will benefit from the government's *10 Year Health Plan for England*.

Three months after the 'Fit For The Future' document was unveiled, members of the Association of Independent Specialist Medical Accountants (AISMA) are expressing concern at the continued absence of detail.

AISMA chair Lizzy Lloyd describes the lack of information as 'very worrying' because without knowing more it is difficult to see how the plan will be rolled out for general practice.

She says: 'The aspirations behind the plan are positive, but they need to be matched with detailed information, clear leadership and informed decision-making in preparation for the implementation of the new single neighbourhood and multi-neighbourhood contracts. Without this, the government will fail to unlock the potential these new contracts hold for general practice.'

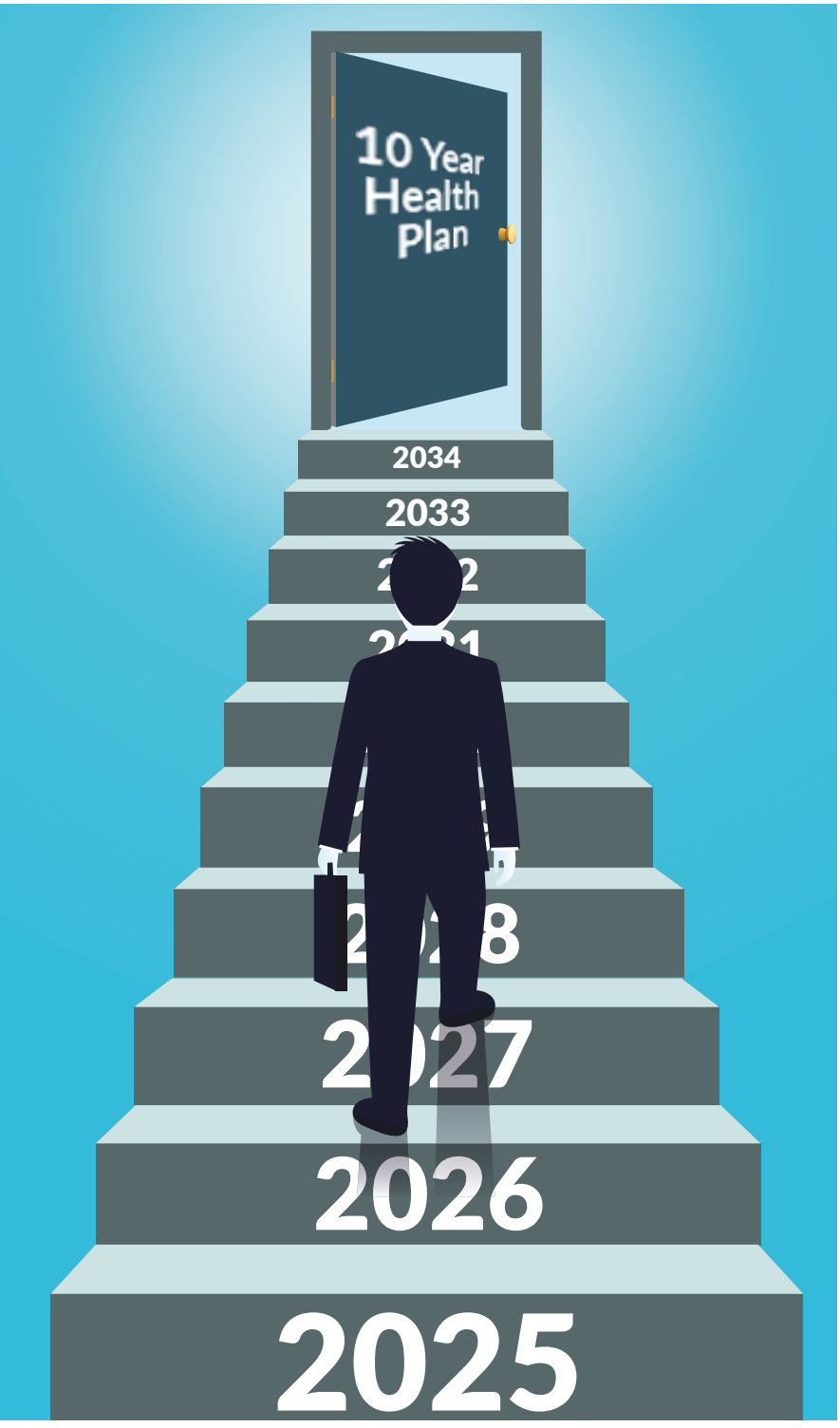
AISMA accountants have made clear that they are ready to contribute their expertise and share

learning, particularly from their experiences of helping to set up primary care networks (PCNs).

But AISMA's 'open door' offer back in the summer to contribute its expertise has yet to be taken up by those leading the implementation programme.

Meanwhile there is continued concern among the Association's leadership team about the level of risk involved for general practice posed by employment, premises and VAT issues.

It is calling for working capital and cashflow issues for the new organisations to be worked through and for there to be a continued focus on practice-level funding.



Increased risks through VAT, employment and premises issues

AISMA adviser Andy Pow warns it is vital for GP practices, PCNs and GP federations who are getting involved with the new contracts not to now jump to decisions without mitigating the risks.

And he is cautioning GP practices to regard specialist accountancy advice as essential. 'There are some highly technical tax considerations that need thinking through carefully', he explains.

'For example, VAT flows and VAT exemption rules need to be understood when it comes to employing and sharing clinical and administrative staff within the neighbourhood.'

Among employment issues he is concerned about is how staff will access the NHS Pension Scheme.

Those moving into these new organisations will need pension scheme access from the start of the new contracts, says Mr Pow, while organisations holding the new contracts must be set up as NHS employing authorities, and pension rules may need amending.

AISMA is also highlighting significant risks involved for GP partners becoming leaseholders for the proposed new neighbourhood health centres.

Limited liability partnerships could help mitigate risks for partners

While the new contracts open up potential new flows of money for general practice, the increased risks to GP partners are substantial, the Association believes. But accountants say these could be mitigated if practices were allowed to form limited liability partnerships.

Joint AISMA vice chair Jim Duggan says: 'GP partners could be about to take on a lot of new risks, in particular in relation to employment and premises.

'Business structure rules for GP practices need to change - and change quickly - so that practices are allowed to hold contracts and are able to access the NHS Pension Scheme through limited liability partnerships (LLPs).'

LLPs would provide the wrapper needed to protect the individual partners while allowing the business to work flexibly.

Working capital needed for new organisations

AISMA is calling for clarification on the initial investment required for working capital for the new organisations.

"For the new contracts to be successful quickly, serious consideration must be given to the funding of working capital, otherwise cashflow will be impossible to manage"

Mr Pow adds another concern: 'When primary care networks were first set up, they had to delay spending money on employing staff and providing services until they had built up enough working capital. However, there is no mention of working capital investment in the 10 year plan.

'For the new contracts to be successful quickly, serious consideration must be given to the funding of working capital, otherwise cashflow will be impossible to manage.'

He has been warning GPs to ensure they have a robust business plan dealing with working capital before they sign up to a neighbourhood contract. Commissioners will also need to consider this in how they support the newly formed organisations.

Questions over practice-level funding

According to AISMA the *10 Year Health Plan* does not address the core issues of funding at practice level.

Association chair Ms Lloyd points out: 'GP practices are the bedrock of the NHS, yet there is no mention of practice-level funding in the 10 year plan.

'I am concerned that PCN money or local enhanced service funding, which is currently used to support practices, will be diverted into the new neighbourhood contracts, leaving practices unsustainable. The money needs to stay where the core general practice service is delivered.'

She also highlights the risk to general practice of premises budgets being diverted to the new neighbourhood health centres.

'The existing primary care estate is no longer adequate and requires funding to bring premises up to the standard required to deal with the new ways of working demanded of GP practices, increased staff numbers and more patients. Many practices need to develop their existing premises and we hope the support will still be there for these smaller projects.'

Questions for PCNs and role for GP federations

AISMA reports one of the biggest concerns for PCNs is the impact of the *10 Year Health Plan* on the PCN model, and lack of real guidance on their future.

Board member Pete Farrier explains: 'PCNs were not necessarily set up geographically, and some have evolved from their initial inception into a very different model.

'How they are going to be potentially shoe-horned into the neighbourhood model remains to be seen. There is currently a lot of emphasis on a 50,000 population for single neighbourhood provider contracts, but smaller local communities, such as those in rural areas, will need to be protected.

'Single practice PCNs of a certain size and scale, and practices working together in strong, cohesive groups, could benefit most from these contracts.

'There may need to be a change, forced or otherwise, in the structure of PCNs to reflect neighbourhoods, but a lot of practices will want to wait and see. Our advice is not to jump too quickly but stay engaged and keep talking to your local area.'

GP federations are likely to be the only GP organisation of the size and scale big enough to hold a multi-neighbourhood provider contract.

Joint AISMA vice chair Abi Newbury says: 'It's going to be increasingly important for practices to have a strong federation representing their interests. For practices in areas without a federation, it will be essential to find one. Have conversations with your nearest federation about expanding its reach to include your area.

'Collaboration will be key when it comes to multi-neighbourhood provider contracts. It's vital that local providers, including councils, federations, voluntary organisations and hospital trusts, work together closely, not only to deliver the contract but to gain the wider benefits and opportunities the *10 Year Health Plan* has the potential to deliver.'

Paying the price of seniority adjustments

OPINION

Guy Vine*
AISMA board member

Too much of my year has been consumed by 2016-17 seniority adjustments - the contractual payment for GP partners based on length of service.

Seniority ended in 2019-20 with funding reallocated, so why am I talking about it in 2025?

Well, in each year it was running, seniority was paid quarterly 'on account', but a GP's entitlement to it could be partially abated or even lost.

To check entitlement, a GP's profits were tested against national average earnings ('final seniority factor'). If earning more than two thirds of the national average, then no abatement. Between one third and two thirds, entitlement was abated to 60%. Less than one third, then full abatement.

Once actual entitlement was calculated, this should have been compared to the payments on account and adjustments made as necessary.

This was quite a clunky system, and generally had some lag due to the need to compile the final seniority factor each year.

But that lag was a couple of years. Nine years was not normal. This is the result of a contract tendering process that went a bit wrong and the requirement to complete seniority reconciliations never making its way into the original Primary Care Support England contract drawn up by NHS England.

Who was most affected?

One of the problems with final seniority factors is that there is no concept of 'full time equivalent'. So, partners leading up to retirement and reducing sessions were most often the ones whose earnings drop to the levels where abatement can kick in.

Given the nine-year gap, most of those affected have long since retired from their practices. So getting hold of them to ask for a refund is not exactly simple. Some have not been contactable, some have left the country, and some have sadly died.

This was a point that must have been known beforehand, but the work was commissioned nevertheless.

There are four main categories I have seen:

The trivial

Minor adjustments of a few pounds in either direction for numerous GPs. I assume simply by virtue of a rounding difference in the formulae used.

A practice manager, copying me in when jesting with a former partner that the practice had decided to write off the £6 that was clawed back in their name, said: 'Perhaps you could just buy me a beer next time round'.

I quickly reminded them of the tax impact, so perhaps only half a pint was necessary.

The additional funding

There have been a few clients we have come across who have gained in this process, where the calculations now show they should have been entitled to seniority payments all along but did not receive anything.

I admit there was no complaint from GPs in this position.

The irrecoverable

We have seen some large clawbacks calculated (more than £10,000 each) for the partners of a practice that was ultimately failing and ended up handing back its contract a couple of years ago.

The former practice manager received a communication but could only respond with the fact the contract no longer existed.

I expect any chance of NHSE recovering funds here would require an expensive legal process. The cost would surely outweigh the benefit.

The disheartening

The majority of what we have seen has been in the 'trivial' category. However there have sadly been a few instances where this process has pitted current partners against a former partner, requiring practice managers to request funds from someone long into retirement and until that point, seemingly free from the concerns and stresses of their former profession.

Specific instances stick in my mind of GPs who are utterly outraged at what has happened. Some have forked out for legal advice and reviewed old partnership agreements to fully understand their position. It has left a seriously bitter taste for this group. On both sides.

I do not feel the decision to push ahead with these seniority reviews was a good one. With the current productivity crisis, my view is that most government decisions should be rooted in improving output. Yet the majority of what I have witnessed in this process has led to administrative burdens in a process that is being completed seven years after it should have been.

I would be very interested to see the net impact to the NHSE budget and whether the whole process has even recouped the cost of its implementation once the administrative cost to the practices has been included in the calculation.

Capital Gains Tax and property refinancing

Refinancing a GP practice property can be an effective way to manage partner retirements and buy-ins, restructure existing debts and release equity. But what do you need to consider when it comes to Capital Gains Tax? **Sarah Edwards**** reports

What is Capital Gains Tax?

Capital Gains Tax (CGT) is a tax on the profit or 'gain' when you sell or transfer an asset that has increased in value.

For GP partners this most commonly applies to a change in ownership of the surgery premises linked to the retirement of partners, new partners buying in or sometimes session changes.

What is refinancing?

Refinancing refers to taking out a new loan to pay off an old loan, to release equity or to facilitate partner retirements and buy-ins.

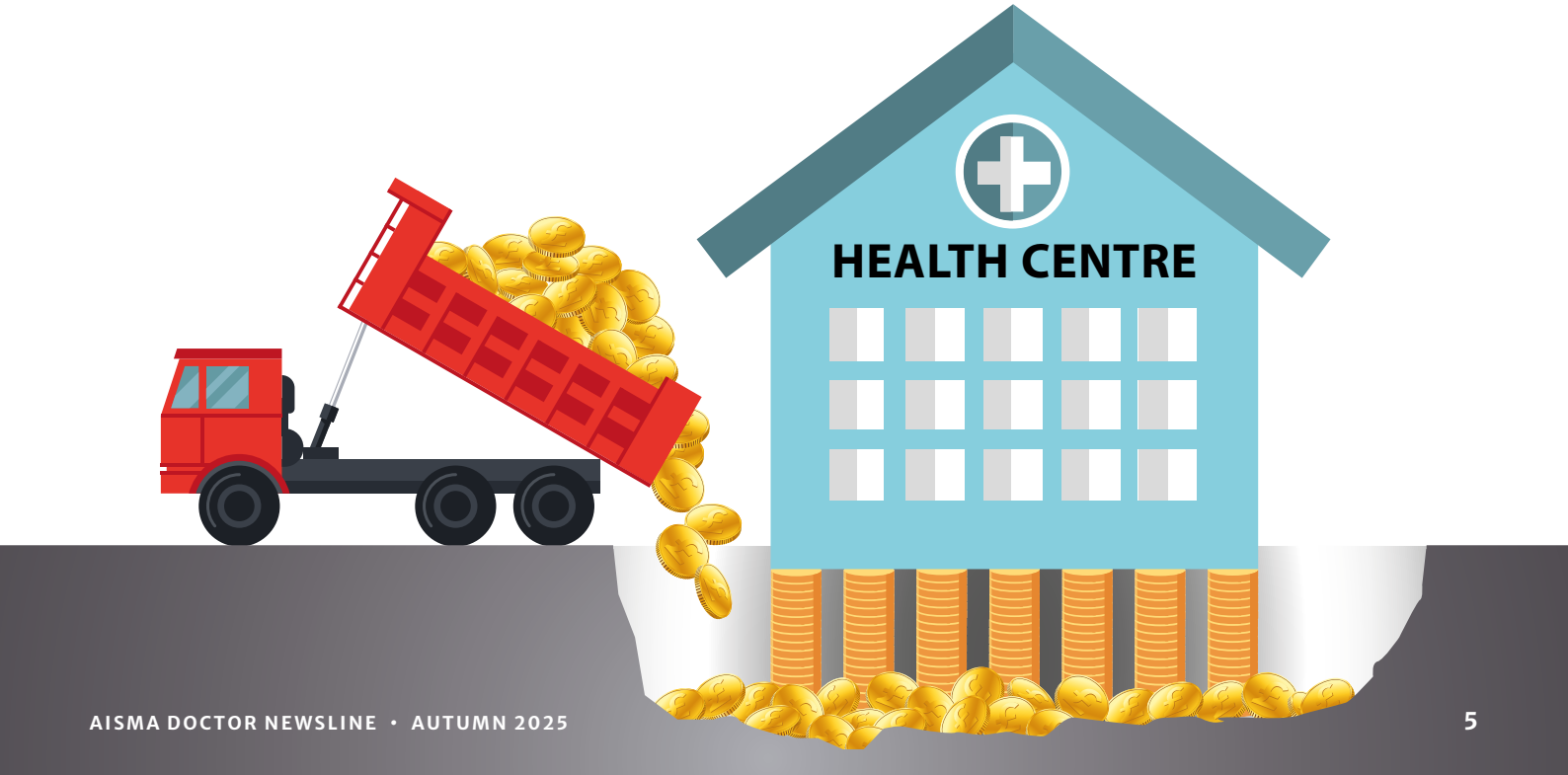
Does a refinance trigger a capital gain?

A refinance itself does not trigger a capital gain where there is no change in the ownership of an asset. If the refinance is to pay off existing loans or to release equity, then there is no sale or transfer of property ownership and therefore no capital gain.

So when do capital gains become relevant?

If the refinance is to facilitate a change of ownership, then the selling partners need to consider if they have a capital gain, for example:

- Retirements – if the refinance is to fund a partner retiring and selling their share of the property, the retiring partner needs to consider if the property's value has increased and if they have a capital gain.
- New partners buying in – if the refinance is for a new partner buying in then the partners selling an interest to the new partner will need to consider if they have a capital gain.
- Property ownership changes – if, as part of the refinance, a partner is decreasing their share of property ownership, maybe because they are reducing their sessions, then that partner will need to consider if they have a capital gain.



"Avoid nasty surprises and always talk to your AISMA accountant before refinancing the property"

Releasing equity now and selling later

Releasing equity in property is becoming more commonplace within GP partnerships for a number of reasons:

- Cash release – a refinance could release cash to invest or pay off tax inefficient debt.
- Better interest rate – a new loan might attract a lower interest rate than existing loans or secure fixed repayments at a low interest rate for a period.
- Higher drawings – a refinance could reduce the capital loan repayments. This might allow for higher drawings, rather than using profits to build up equity in the property for future extraction.
- Remove barriers for potential new partners - the higher the equity in the property, the more a new partner has to fund to buy in. Keeping the equity low could remove a barrier to new partners buying in.

But releasing the equity now could mean that on retirement there is a mismatch, with a capital gain on the sale of the property without any cash being paid out.

For example:

You own a GP surgery property worth £1m. Then you refinance and borrow against the full market value, extracting £1m in cash (minus any existing mortgage).

A few years later, you sell the property for £1m (same value), but your original purchase price was £300,000. The gain is £700,000 and CGT is due (potentially at 14%–24%, depending on your circumstances).

The problem

At the time of the refinance:

- You have released the equity in the property, the loan is now 100% of the value, and you take out the cash
- There is no capital gain because you have not sold or transferred an asset.
- You get to keep all the cash released.

At the time of sale a few years later:

- You owe CGT on the £700,000 gain.
- But you do not actually receive any new cash from the sale — it all goes to repaying the mortgage.
- This leaves you with a tax liability, but no cash released.

How to avoid this trap

1 Plan ahead before refinancing – consider refinancing to a loan less than 100% of the property value, leaving some equity for release on sale. Or plan to put aside funds to cover the capital gains tax when you subsequently retire.
2 Use a tax reserve – hold back the potential capital gains tax from the refinance proceeds in a tax reserve before distributing the balance. This reserve would release on retirement ensuring a cash distribution when the capital gain arises.
3 Stagger disposals - consider selling your share of the property in stages to spread the tax due.
4 Use reliefs – plan to make use of business asset disposal relief to reduce the capital gain.
5 Involve your accountant early – your AISMA accountant will flag this early and help you structure the refinance or property ownership to avoid nasty surprises later.

Other things to consider before refinancing

- The affordability of the new loan repayments and how that will change with base rate changes.
- How long you are tied into the loan and how the loan might impact future partner changes.
- Whether all the loan interest will be tax deductible. If the total borrowing is increased and cash is withdrawn by the partners, then unless the exercise is structured properly there is a risk it will not be.

Refinancing GP practice premises does not in itself trigger a capital gain. But CGT may apply if the refinancing is tied to a sale or ownership transfer.

Releasing all the equity in your GP practice property now may provide useful cash but you could be setting yourself up for a cash shortfall when you sell and face a CGT bill with no cash released to pay it.

Avoid nasty surprises and always talk to your AISMA accountant before refinancing the property.

ASK AISMA!

GPs' questions about budgets, profits and cost savings 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**

PRACTICE BUDGET TIPS

Q **We always produce a budget based on the past. How can we look at what we ought to be doing instead? Should we compare ourselves to other practices?**

A Historic data based on past financial accounts is often used when drawing up budgets and is definitely helpful in spotting trends and avoiding past mistakes.

However, looking back can be limiting in terms of aspiration and achievement and real financial planning needs to look forward.

Try looking at modelling the figures in a different way to encourage more strategic thinking, as well as realistic goals.

Start by asking: how much do you want to draw, and what level of profit is needed to support that?

Once you have a clear target, work backwards. What income would you need, and what costs are acceptable to get there?

This turns your budget from a passive record into a practical tool.

The annual AISMA survey is a valuable benchmarking resource but use it carefully with your accountant. No two practices are the same – list size, staffing levels, premises costs and clinical services vary widely. Use comparisons as a prompt for discussion, not as rigid goals.

ANALYSE NEW SERVICE COSTS

Q **My partners sign up for every new service that comes along. Is this the best way to increase our income or be more profitable?**

A It is tempting to take on new work when the opportunity arises; after all, that extra income will mean more profit won't it?

Unfortunately, it is not quite as simple as that, and a business decision should be made on a case-by-case basis.

This is because every opportunity comes at a cost. That cost may not be obvious, and sometimes it is simply 'partner' time – but time is your most limited resource.

How much time commitment is needed and from where? Will you need more staff time, admin support, or new equipment? Assess the direct costs of providing the service.

A new service may be poorly defined, with unclear funding or unreasonable reporting expectations.

Crucially, look at the net benefit. After tax, National Insurance and pension contributions, what will you actually take home?

Additional earnings could tip you into higher tax bands, create an annual allowance pension charge, reduce your personal allowance, or affect entitlement to tax-free childcare.

The net gain is often lower than expected and in some cases can actually be negative. So, before saying 'yes', weigh up whether saying 'no' might be better in some cases.

PRACTICE PROFIT BOOSTERS

Q **I have always been one for turning off lights to save costs – but what else can we do that actually makes a difference?**

A Turning off lights is good practice, and every little helps, but bigger savings lie in the areas where you spend most: staff and drugs.

Review and management can make a significant difference, and there are many elements within each spend that can be focused on to achieve results.

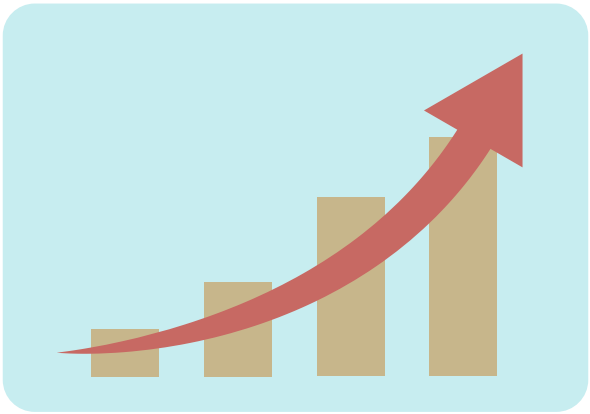
For staffing, look at rotas, overtime and skill mix. Are tasks being done by the most appropriate team member at the right cost level? Could there be more delegation between teams? Do you need to recruit if someone leaves or can it be covered with systems and streamlining?

For drugs, make sure you are being reimbursed correctly and not purchasing items for more than you recover. If your drug profit margin is lower than expected, it may be worth seeking professional input to identify the issues and improve the systems.

Keeping a close eye on recurring costs is also good practice. A contract calendar helps ensure you do not sleepwalk into renewals. Build in time to compare alternatives before committing.

And check that you are not still paying subscriptions for former staff – and equally that new team members are properly covered.

While smaller costs can seem insignificant, a rolling review can still yield results. Try assigning each team member an expense area – such as stationery, utilities or premises repairs – and ask them to identify savings over the year. This builds ownership and often leads to creative ideas.



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Make your space work for you!

New GMS premises costs directions signalled long-awaited changes to the funding system for surgery premises in England. Specialist primary care lawyer **Danielle Elmy-Liddiard** considers key alterations affecting GP practices

Effective use of surgery premises is increasingly in the spotlight as general practice continues to adapt to changing models of care.

For many GP practices who own or lease their premises it is no longer just a question of considering their own needs for clinical space but of strategic use to promote collaborative working with others to best serve their patients.

With more remote consultations, integrated teams and multidisciplinary approaches, many practices are looking at opportunities for sharing or subletting space to complimentary service providers, such as other healthcare professionals, charities, or Trusts.

This shift has prompted a more creative approach to property management. Flexibility and responsiveness are now key considerations for primary care estates. Subletting part of the practice premises or hiring out space for sessional use has become an attractive option.

Whether to house PCN staff, host community outreach teams or support neighbourhood health initiatives, sharing space can bring clinical and operational benefits. And it can also help offset rising estate costs.

Until recently, practices faced a difficult balancing act. By subletting they risked the permanent loss of NHS rent reimbursement for the affected areas, even when the space was being used for NHS-aligned purposes.

A new direction for reimbursement

Historically, the premises costs directions which underpin rent reimbursement took a strict approach to subletting. If a room was leased to another party, even if they were delivering NHS services, it was typically excluded from the rent reimbursement calculation.

The logic was that practices should not receive both rent from a subtenant and reimbursement from the NHS for the same space.

This approach potentially discouraged practices from supporting integrated working

or hosting additional NHS roles, purely because doing so could jeopardise their funding. As a result, valuable space could be left unused or informally occupied without any clear arrangement.

But the 2024 premises costs directions have helped ease this worry because they allow for reimbursement to 'continue or be reinstated' when the occupying party is delivering or supporting NHS services. This is as long as the use is properly documented and aligned with NHS objectives.

Importantly, Direction 5(3)(a) requires practices and commissioners to consider 'whether any opportunities exist for additional, multi-functional use of the premises.'

This is a significant development because it explicitly recognises that GP premises are no longer single-purpose spaces. The directions encourage use by a wider range of NHS-aligned teams and services, supporting the integration of care.

In practice, this means space can be shared with other complimentary service providers without the automatic loss of rent reimbursement. Under the previous directions, such arrangements could easily have triggered clawback, discouraging collaboration.

Help with costs

GPs can now for the first time seek reimbursement of costs for putting agreements in place with third parties with whom the premises may be shared. Direction 14(3) recognises that shared use often involves additional professional costs – for example, drafting or varying occupation agreements. It provides that 'a contractor may claim reimbursement of professional expenses 'where such expenses are incurred in relation to making premises available for additional NHS services and there is a written agreement with NHS England.'

This provision supports practices in setting up compliant sharing arrangements. The requirement for a written arrangement means that reimbursement is conditional on the arrangement being transparent and aligned with NHS objectives, not simply a commercial letting.

Recognising NHS aligned use

The directions are now more explicit in terms of discouraging double claims and requiring information sharing with the ICB.

Direction 49, for example, addresses contributions from third parties and makes clear this income must be disclosed but, in such circumstances, allows the ICB some discretion about whether to reduce reimbursement.

It will be interesting to see how this discretion is used in practice but one would expect it would be used sparingly if at all.

Importantly this enables ICBs to take a contextualised view and preserve entitlement

"Practices should take this opportunity to re-evaluate their premises. A careful review of how each area is used, by whom, and under what arrangements will be essential"

where NHS priorities are supported. In short, the directions do not create a new revenue stream but rather they safeguard existing entitlement where space contributes to NHS objectives.

GP practices should engage early with their ICB to clarify reimbursement eligibility, supply occupancy evidence and confirm any local processes or requirements.

These more pragmatic rules are likely to encourage collaboration between practices and other NHS organisations and help them with the costs of formalising agreements.

While the revised directions offer a more supportive framework, further clarity is still needed on sessional or hybrid use, and how non-NHS services (private physio or social care partners, for example) will be treated.

Structuring subletting arrangements

Practices should take this opportunity to re-evaluate their premises. A careful review of how each area is used, by whom, and under what arrangements will be essential.

If subletting or sharing has already occurred informally, for instance where occupation is based in the building without a legal agreement, it may now be sensible to regularise the position.

Clear documentation, such as a licence to occupy, can support reimbursement applications and help satisfy ICBs that the space is being used appropriately.

Practices should review lease or mortgage terms before entering into any agreement. Many leases restrict subletting or require landlord or lender consent, which may affect reimbursement eligibility.

Subletting must still be approached with care. The nature of the occupying party matters. Where the space is used by private providers offering non-NHS services, reimbursement will remain off the table and the replacement income generated is unlikely to be as reliable.

Similarly, informal arrangements that lack clarity may create risk or confusion about who is responsible for repairs, services or other liabilities.

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A shift from risk to opportunity

In this evolving environment, subletting is no longer a financial compromise, provided it supports NHS aims and is well-structured.

With the right professional support, practices can:

- unlock new funding streams
- strengthen their links with PCNs and ICBs, and
- make more sustainable use of their premises.

The 2024 directions give practices the policy backing to make practical, locally driven decisions about their buildings.

For GP partners and their advisers, this is an opportunity to rethink the role of the premises, not as a fixed overhead, but as a strategic asset that can flex to meet the changing needs of the NHS.

The directions provide reasons to be cheerful, particularly around the rules governing reimbursement. Directions 5 and 14 shift the focus from exclusion to facilitation.

Being able to seek reimbursement of costs will help but it seems clear there will be more formality and conditions attached, which GPs will need to consider carefully with the aid of specialist professional advice.

Time will tell if the new directions make a positive difference to primary care and help deliver premises fit for the future. With the government's *10 Year Health Plan for England* we may see more changes in the months and years ahead.