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AISMA Doctor Newsline

The heartbeat of medical finance

It's going to be a bumpy ride

Could it really be as bad this year as we first thought? **Kieran Hancock*** reflects on the autumn Budget and concludes the answer for GPs and their practices is a very big 'YES!'

STOP PRESS

Practices are advised to contact their AISMA accountant for latest advice in the wake of the government's new £889 million general practice funding pledge.

Speculation was rife about what would happen in the first budget of the new government. Following the '£22 billion black hole' findings it was clear taxes needed raising to ensure future financial stability.

With Labour promising to avoid income tax, National Insurance and VAT, this left certain other taxes clearly needing a review.

The Budget brought positive news about a proposed investment in the NHS, but many areas will adversely affect GPs, and in particular GP partners.

Employer National Insurance

There were significant changes to employer National Insurance contributions (NICs), paid by employers for their employees:

1 The rate payable was increased from 13.8% to 15% with effect from April 2025.

2 The income threshold where employer NICs apply was reduced from an annual income of £9,100 to £5,000.

These changes increase the number of employees where employer NICs are payable, and introduce a higher rate to be applied. As an example, an employee earning £30,000 will generate a rise in employer NICs of £866 a year.

The government protected smaller businesses

"Practices and PCNs therefore need to look ahead to work out how much additional cost they will face from April 2025 when these changes come into effect"

with an increase to the employment allowance, which is available to offset employer NICs. Previously this was £5,000, increasing to £10,500 from April 2025.

But, as GPs are now well aware, the employment allowance does not apply to general practice, nor to any organisation that has more than 50% of their business in the public sector.

National Insurance is a UK-wide cost so all four countries will be affected.

Minimum wage

The National Minimum Wage (NMW) is also due to increase in April 2025 from £11.44 to £12.21 an hour. This 6.7% rise applies to employees aged 21 and over.

For employees aged 18 to 20, the increase is £8.60 to £10 an hour, with a view to aligning this with the full adult rate in future years.

Practices employing staff will therefore need to ensure they are compliant with minimum wage legislation and budget for the rise in costs from April – a yearly increase of £1,600 per 40-hour, full time worker.

While both changes apply to all businesses including GP practices, this will be particularly challenging in general practice where the ability to increase income is limited by the contracts available.

The 2025-26 contract reviews will therefore be critical, and it is hoped that funding will flow through the contracts to compensate for some of the costs, although no information is yet available.

Practices and PCNs therefore need to look ahead to work out how much additional cost they will face from April 2025 when these changes come into effect. It is likely to be significant.

Pensions

One of the subjects experts were speculating about in the weeks leading up to the Budget was pensions. Changes to the annual allowance, lifetime allowance and tax-free lump sum were all discussed.

There is some comfort that none of the above were targeted. But this does not mean that the tax issues have gone away. There are problems that we will continue to see for many high earners in the years ahead.

Beyond the Budget, we must not forget that the NHS Pension Scheme/s are in the process of updating pension records to reflect the McCloud judgment.

As part of this there may be a requirement to

review annual allowance tax declarations for the eight years from 2015-16 to 2022-23. Many doctors have been receiving a remedial pension saving statement (RPSS) letter, which will need action.

Capital Gains Tax

Changes were predicted to Capital Gains Tax (CGT), including an alignment to income tax rates, or the abolishment of preferential tax rates. In the event, the changes were not anywhere near that bad, but what was changed will affect some GP partners.

This includes Business Asset Disposal Relief (BADR). This is currently a 10% tax rate payable on the disposal of business assets where conditions have been met.

GP partners would usually see this on exit from a practice and the sale of their property share. From 20 April 2025, the rate will be increased to 14%. And then from April 2026, it will be increased further to 18%. These increases will affect leaving/retiring partners, so forward planning is key.

The main CGT rates were previously 10% and 20%, depending on income levels. Effective from 30 October 2024, these rates have been increased to 18% and 24% respectively and will be aligned to those applicable to residential property. These rates now apply to all disposals, unless covered by BADR.

Inheritance tax

Inheritance tax (IHT) was another feared area. The changes announced in the Budget will largely affect those outside general practice. Changes to business property reliefs mean those with qualifying assets in excess of £1m will no longer be free of tax and will gain only 50% relief over that limit.

"Changes to business property reliefs mean those with qualifying assets in excess of £1m will no longer be free of tax and will gain only 50% relief over that limit"

It is unlikely that GP partners or others in the medical profession will have business assets above the threshold but it is possible in some cases.

The main change was to the treatment of pensions. Historically, pensions sat outside the IHT estate and were usually free of any tax, unless you were aged 75 or over, in which case income tax was paid on the inheritance.

But from April 2027, private pension funds (not defined benefit/NHS schemes) will be brought within the scope of IHT.

This means they will add to the overall value of the estate, resulting in many more people being subject to IHT. Any GPs building private funds outside the NHS will need to consider the impact of this.

Other points

- Corporation tax rates will remain the same
- Income tax thresholds will remain at the same levels until at least 2027-28
- Stamp Duty Land Tax (SDLT) will increase from 3% to 5% on purchases of second properties.

Looking ahead

The finance function of GP practices has historically been backward looking. But it is now more important than ever for practices to have robust processes, to forecast forward, identify what costs will impact them and consider how they can deal with those pressures.

Your AISMA accountants will be able to guide you through this and advise you how the Budget impacts you directly.

General practice – the great betrayal

OPINION

Jim Duggan**
AISMA board member

We have become all too familiar in recent months with the words 'The NHS is broken', a phrase that has been bandied about as if it were a surprise revelation.

In fact, it merely reiterates what everyone working in the NHS has repeatedly reported for some time.

Unfortunately, though that is where the similarities end.

You might be forgiven for thinking this is a throwback to the pandemic, but the current crisis goes back much further, to the 2004-05 contract.

This contract received widespread approval within general practice. GPs would finally be rewarded for all the unpaid work they did to safeguard the nation's health.

But since its implementation there has been a concerted effort to subvert general practice and the partnership model as a vehicle for delivering the contract.

No sooner was the ink dry on the contract than we saw material changes appear in the funding.

This was closely followed by a public campaign that reported misleading figures of GP incomes, which we can only surmise was an attempt to justify the funding reductions and drive a wedge between patients and their doctor.

We all thought this misleading reporting around GP finance was a thing of the past, so it was far from encouraging to see similar misleading patterns resurfacing.

More recently we have had a five-year plan that limited growth in funding for general practice. This was so inflexible that primary care finances had to bear the full impact of a period of high inflation with little more than a sticking plaster for support.

In addition, a move to providing more income through the core contract has reduced the transparency of funding for primary care, making it virtually impossible to know if proper payment is being received for the treatment provided.

We have seen this recently when it came to the reimbursement of the enforced pay rises (9.8% for the National Living Wage and 6% for all other workers).

Under the old GMS contract, staff reimbursements were in the region of 70% but when it came to the reimbursement for 2023-24 that had reduced to 44% for PMS practices and 48% for GMS practices. This was a clear indication that income going into core contract funding does not keep pace with reality.

It is not surprising that the impact of the inevitable financial pressures has resulted in a recruitment and retention crisis in general practice.

The brunt of this is being borne by general practice partners going that extra mile to ensure patients can see a medical professional. This has resulted in partners working long hours, possibly to levels that could be considered unsafe, to keep the surgery doors open.

Imposing the transparency reporting before resolving this crisis is yet another attack on GP partners, particularly as it only applies to general practice. In some circles this would be classed as discrimination.

It is clear that, despite rhetoric to the contrary, the partnership model is not favoured in certain quarters. To those challenging it I would remind them that a review was carried out by Dr Nigel Watson in 2019.

It concluded that the partnership model provided the best structure for delivering primary care services within the NHS.

If there was any doubt about the partnership model, we only need to remember the Covid vaccination program and more recently record numbers of GP appointments being made available to patients.

These successes have only been made possible because GP partners have taken responsibility for their delivery and because decisions could be taken at a local level.

To those who continue to cast doubt over the partnership model I would say that the question has now been asked and answered and it is time to move on and support general practice, rather than undermine it hoping to drive a different agenda.

We will all be familiar with the phrase 'you get what you pay for.' How, then, can we expect an underfunded NHS to continue to provide the gold standard of treatment we have come to expect?

The NHS may be broken and adequate funding the first step to reinvigorating it, but it is only one step, albeit a very important one.

Decisions and actions taken during the past 20 years have resulted in an erosion of trust across the NHS. This trust is vital if we want the NHS to remain the beacon of excellence we have come to rely on.

In my opinion enough is enough. The time has come to take the first steps to rebuild that trust if we want to see general practice fulfil its true potential.

AISMA members are ideally placed to support clients at every step of the way as they work hard to deliver a service that could offer so much more with the right conditions.

Seeking cures for GPs' thorny financial challenges

2024 was a busy year at AISMA and its representatives continue to work behind the scenes with organisations and policymakers on general practice finance and pension issues. Andrew Pow* reports**

The change in government in the summer brought the opportunity to raise a range of important issues about GP funding.

Since then, we have met with the BMA for one of our regular catch-up sessions and twice with NHS England and the Department of Health and Social Care.

These meetings allow us to raise our concerns over the status of NHS general practice and PCN finances, as well as allowing them to check in with us on pressing current issues.

Right now, the issue of the employer National Insurance contributions (NICs) and the National Minimum Wage rise from April 2025 is by far the biggest problem practices are talking about to our member firms. These will stay high on the agenda until some resourcing clarity is given for all of the four nations.

It is worth remembering that health budgets are devolved and while these tax decisions were made in Westminster, it will be down to the individual countries to decide how and if funding flows to GP organisations to meet these costs.

AISMA representatives also meet regularly with officials from NHS Pensions and Primary Care Support England (PCSE). We have proposed improvements to their systems for the submission of the Type 1 pension returns and, although these were broadly accepted, for various reasons they will unfortunately not be brought into place in 2025.

We therefore continue to press them for changes that will make the process of submitting and processing forms more efficient for accountants, practice managers and GPs. For now, watch out for another round of pension returns soon.

Throughout 2024 AISMA appeared regularly in the medical press commenting on relevant issues arising for general practice.

Topics included the funding uplift following the Review Body on Doctors' and Dentists' Remuneration (DDRB) recommendations, the creation of a new funding stream for GPs within PCNs, McCloud and the correction of pensions, and - not least - the Budget.

The Budget brought a flurry of interest from the national press asking AISMA to comment on conflicting information coming out from HM Treasury.

We also assisted with comment on an investigative article in the British Medical Journal

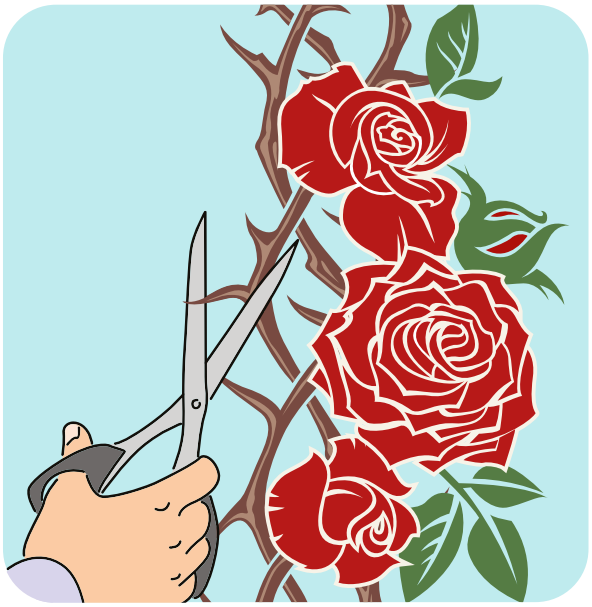
on the current issues around the funding of a local enhanced services (https://www.bmj.com/content/386/bmj.q2068).

In Scotland our representatives also met regularly with their respective official organisations to discuss issues specific to Scottish general practice.

There have also been some notable developments within AISMA. Our 2024 annual conference had the highest attendance ever, allowing our accounting experts to meet, learn and exchange views in an open forum.

It may not be at Glastonbury levels, but it quickly sells out and confirms the desire of our network to continue learning.

We have also invested in a community online platform which allows our accounting network to interact throughout the year and keep fully abreast of the full range of issues affecting our GP clients. This ensures your AISMA accountant has access to the best and most up to date technical expertise available.



"...This ensures your AISMA accountant has access to the best and most up to date technical expertise available"

This article would also be amiss if it did not deal with the big headache of the day for accountants - the impact of the 'McCloud remedy' on NHS pensions.

Following years of legal wrangling, the government has now had to roll back pension records into the old legacy public pension schemes. Many GPs have to resubmit tax data for eight years to HMRC to correct annual allowance calculations. But many have still not received the information they need to do this.

AISMA ran a special training session in the autumn to brief members on this and it remains the number one topic in our online community.

Alongside our colleagues at the Institute of Chartered Accountants in England and Wales we have lobbied for the easing of deadlines set in legislation. The work required on this is on top of an already busy schedule so we are having a hectic start to the new year.

2025 will bring us all many challenges but rest assured, AISMA will remain the heartbeat of medical finance. Will 2025 bring renewed and much needed investment in general practice? We shall have to wait and see.

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ASK AISMA!

GPs' questions about a variety of issues around Capital Gains Tax 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

TAXING SITUATION OF BUY TO LETS

Q **I am selling my buy to let flat, and I've heard that the Budget hasn't changed my tax rate. However, I haven't made a gain – because I am only getting the same out of it as I put in after I've repaid the mortgage – so presumably I won't need to pay any tax?**

A If you're selling a buy-to-let flat and the proceeds are just enough to cover your mortgage and initial investment, it might seem as if you haven't made a gain. But, unfortunately, that's not how it works for Capital Gains Tax (CGT).

HMRC calculates the taxable gain based on the difference between the purchase and sale prices of the property – mortgages do not come into the calculation at all.

So, if your property has increased in value since you bought it, this increase (minus allowable costs, such as legal fees) is treated as a gain subject to CGT. The difference can be exaggerated if the property is situated overseas – because you need to use the different exchange rates at purchase and sale dates.

CGT rates for property sales were unchanged in the autumn Budget. If you're a higher-rate taxpayer the CGT rate is 24% (if you have a low-income year, then it's 18% up to the higher rate threshold then 24% on the excess).

The annual exempt amount has reduced in recent years, so only the first £3,000 of any gains in a tax year will be tax-free.

Remember, any CGT due on property sales must be reported within 60 days of the sale or penalties and interest will become payable.

PARTNERS CAN'T AFFORD TO BUY OUT RETIRING GP

Q **I am retiring from my practice after 30 years and the value of my share in the practice property has increased considerably. My partners say that they cannot afford to buy me out. What are my options?**

A Firstly, look at your partnership agreement: does it force your partners to buy you out? If so it is down to them to find a way to raise the funds.

Do you want to sell your share of the property, or would you prefer to receive rent from it?

If you sell at retirement or shortly after, you should be able to claim Business Asset Disposal Relief (BADR) which would reduce the rate of tax that you would have to pay on the capital gain from 24% (as a higher rate taxpayer) down to 10% in the current tax year (although this is increasing to 14% from April 2025 and 18% from April 2026).

You could potentially sell your property share on retirement but agree that the proceeds are paid over a specific period of years. This would not diminish the immediate tax due (so upfront payments would have to be enough to cover this) and it would put you at risk if the partners did not pay as promised.

You could retain a charge on the property to help protect you, although if there is still a mortgage on the property the lender would have the first charge. So you would still potentially have a risk (particularly important if they don't stay in the premises and the bricks and mortar value is a lot less than the market value as a GP practice).

You could retain ownership of the property and lease it to the partners. Ideally the lease would leave all repairs – structural or otherwise – as the practice's responsibility. This would provide you with steady income for a period, which would be taxable at your marginal rate and the chance of capital growth.

The gain on the eventual sale of the property would be subject to the normal CGT rate (24% for higher rate taxpayers) – or on current legislation would disappear on death if you still owned the property at that stage. The full value would be included in your estate for IHT purposes and so potentially subject to tax there.

Another alternative would be to sell to an external investor so that you get the BADR benefits and the practice does not have to stump up cash. However, having an external investor may not be best for the practice, although it may encourage them to find ways of financing the purchase themselves.

SHARE INHERITANCE WORRIES

Q **My father had a large share portfolio and died six months ago. My three siblings and I are inheriting these shares equally. What capital gains will I pay? Can I use the losses that have arisen?**

A When inheriting a share portfolio along with siblings, a key consideration is whether to distribute the shares or sell them within the estate. This choice can have implications for CGT and the use of losses, especially if the portfolio's value fluctuates.

So, it is important to distinguish between the effects of the estate selling the shares and distributing the proceeds, and the estate distributing the shares and the beneficiaries selling them.

Selling within the estate: If the estate sells the shares before distribution the gain is the difference between probate value and the value at which the shares are sold, with only one CGT annual exemption regardless of the number of beneficiaries or the number of other assets sold.

All gains will be charged at the higher CGT rate of 24% from 29 October 2024. If there are losses in excess of other taxable gains, these losses cannot be passed on to the beneficiaries and so are effectively wasted.

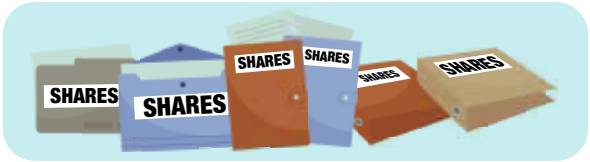
Distributing shares to beneficiaries: Shares can be transferred directly to beneficiaries based on the probate valuation. If you then sell these shares at a gain, CGT applies to any increase over this value.

This approach allows each beneficiary to use their individual CGT exemption (£3,000 each for 2024-2025), potentially reducing the tax bill.

If losses are arising that are not covered by other taxable gains then they can be carried forwards to use against future gains.

Taking the shares rather than the cash proceeds from the estate will also allow the beneficiaries to determine when, or if, to sell the shares. This may be different for each beneficiary.

Careful timing of sales can maximise losses to carry forward or can put gains into a tax year when other income is low to minimise the CGT rate or enable the spreading of disposals over some years to maximise annual exemptions.



Time to get INTo these new neighbourhood teams

GPs are in a strong position to lead the move to more integration in primary care – so become involved and ensure you get what you wish for. **Justin Cumberlege** and **Robert McCartney** set out the way ahead

What are Integrated Neighbourhood Teams (INTs)?

The concept of the INT, originally introduced in the influential report by Dr Claire Fuller called 'Next Steps for Integrating Primary Care', was to look at ways of breaking down traditional barriers within health, social care and other public services.

This aimed to create a single function creating solutions that addressed all the needs of the individual within any given community. The concept has gained traction and been adopted by the Labour government.

But the role of general practice within the INTs is yet to be fully defined or understood. It is important for GPs to be involved in this change and that it is not imposed on them.

Before Dr Fuller's report the primary care networks (PCNs) were expected to undertake some of this integration. Schedule 7 of the PCN Network Agreement required details of the terms of engaging with third parties.

It was expected that PCNs would expand to encompass a wider range of members beyond the core GP practices. In most cases this did not happen because PCNs became focused on becoming service delivery vehicles offering services at scale as required under the Primary Care Network Directed Enhanced Service (DES).

How can general practice secure its position within the INTs?

GPs are in a prime position to be central in INTs. As the most consistent part of the wider primary care structure for many patients, they may unite the other elements of healthcare, and give primary care a collective voice at 'place level'.

This would generally need a population of over 200,000, which would require getting together with other PCNs.

By joining together with other primary care providers, such as the providers of 111, out of hours, community pharmacy, optometry and dentistry, primary care will have a voice which is counted by the Integrated Care System.

This would make them equal to acute trusts, community providers, mental health providers, social services, education, other council run services and third sector providers across the area.

While 200,000 is a large scale it would be built on the foundations of each neighbourhood which can advise and influence policy based on the experiences in their areas while creating INTs.

Creating an organisation of primary care services - although not necessarily providing them - to ensure the patient pathway through primary care is efficient and effective, and only accesses secondary care at the appropriate time, if necessary, is an objective cited by Lord Darzi's report *Independent Investigation of the National Health Service in England*.

How can this structure be co-ordinated?

Once there is a willingness for the primary healthcare providers to come together, there is a question as to how it will be co-ordinated.

Memorandum of Understanding

At the least a Memorandum of Understanding (MoU) will assist in setting out some non-contractual objectives, and how the parties will work together to implement them.

This document will be aspirational, while proposing objectives and commitments by different parties to perform certain tasks. However, as a non-contractual document, commitment may be low, and it could become a talking shop which may not be of value. Also, it is unlikely that any bid for funding is going to be successful based on an MoU.

Collaboration agreement

A step beyond that is a collaboration agreement, where the parties agree what each will provide for the services, and the organisation of them, much the same as an MoU, except there are usually certain matters which are agreed contractually as there is a deeper involvement of the parties.

This is normally in response to a

commissioner's request for certain services to be provided. A group may come together in a geographical area with the objective of submitting a joint bid and to manage the delivery of this service.

The first step is to agree who is required to participate in the bid, and what their roles will be. For example, one party might agree to provide premises and arrange appointments, while another provides a service and a third another service.

Also, the parties would agree how they will fund the bid and establishment costs. This needs a commitment by all participating parties to ensure the bid is written and a commitment to their roles if it is successful.

Within the wider context of the INT this structure would be a unified voice built primarily around the service on which it was focused. There is no reason why this type of agreement could not be expanded to bring in other partners from the INT.

An emergency paediatric dental service could, for example, include the local 111 provider, dental practices, GPs, mental health provider, education services and social services to provide a unique and integrated pathway for service users.

While this would be service-specific the lessons and experience of building this collaboration could be expanded into a wider range of INT services.

Contractual agreement

If there is a vision to create a movement which will have an impact, and which needs a longer-term commitment from the participants, then a contractual agreement would be advantageous.

"The legal entity would typically be a company where all the participants are members"

This would require the parties to co-ordinate their actions, resource the activities, and appoint a leadership team to speak for the group and perhaps carry out certain actions.

There could be restrictions on the participants to protect the activities of other participants. Consideration does need to be given to the anti-competition regulations if there is a competitive market. Restrictions effectively prevent that competition in certain areas.

For GP practices, contractual arrangements could be somewhat problematic, as each individual GP partner is a participating party, and would also carry personal liability for any breach.

This is similar to the network agreements, but on a much larger scale, and could involve areas on which they are not familiar and have little control.

Joint venture company

Mitigating the effects of the risk of incurring a large liability is often achieved by incorporating a company. This would be the next step for participants – to form a joint venture company, a separate legal entity.

The legal entity would typically be a company where all the participants are members. A board is appointed to run it and ensure it achieves intended objectives.

The directors would also participate in the integrated care system, promoting the effective provision of healthcare services by company members, whose numbers could be expanded to include all parties providing primary, social and healthcare.

A separate legal entity has many advantages. It has the sole objective of pursuing its business objectives and the directors' primary responsibility is to do what is best for the company.

The company can employ people in its own right, so they are not being seconded from other businesses, although they could be part time for this business.

Data sharing issues are made easier by one company being the organisation receiving, processing and controlling it.

The company would be a place where integrated care is organised. It can draw from the knowledge and experiences of members, directors and management team. They should know what is possible and what the ICB's priorities for the area are.

It would need to be resourced, initially by the members, and then by any provider contracts it takes on.

CQC registration would be required if it is a provider, and staff access to NHS pensions would require an NHS contract (or sub-contract) to provide healthcare services. By careful planning, exemptions should be applicable which reduce or remove the risk of VAT being applied.

A large advantage for the GPs is that there is no personal liability for the organisation's activities other than the duty to perform the role of a director.

How to get started

There is no need to begin from the ground if there is a GP federation already owned by the practices and which has CQC and NHS employer status.

It may be a matter of introducing members from different providers, and/or having them on the board, and perhaps forming a sub-committee to co-ordinate the integrated service.

You face a cultural challenge. The care sector is governed by local authorities, the GPs are subject to a very rigid NHS contract and the NHS commissioners often prefer a public sector (NHS Trust) option if available, even if that is a company owned by an NHS contractor and has been set up as a community interest company (CIC).

But the government push to integrated care, the current dominance of primary health care by the private sector (traditional GP partnerships) and the cost effectiveness of that sector, all provide advantages for integration to happen.

GPs are in a strong position to lead this change and building those relationships with the local primary care providers is an excellent starting point.

A unified primary care voice will be more persuasive than individual PCNs representing GPs.

Justin Cumberlege is a partner and Robert McCartney is an associate in the primary healthcare team at healthcare specialist law firm, Hempsons