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AISMA Doctor Newsline

The heartbeat of medical finance

AISMA delivers its formula to even out Carr-Hill's financial peaks and troughs

The Association of Independent Specialist Medical Accountants (AISMA) presents the prescription it believes will lead to a successful outcome of the review into the controversial funding formula for GP practices

Leaders of AISMA believe the funding review should deliver three key results if it is to be judged a success for general practice:

They consider the outcome must:
1 bring additional investment in the global sum
2 have the backing of a data-led analysis of the problems deprivation causes in primary care, and
3 recognise that a separate funding mechanism is needed for rural and atypical practices.

They are also calling for any new formula to be tested rigorously to ensure it does not recreate unintended financial consequences for practices that could lead to GP partners leaving the profession. This requires it to be introduced on a planned, phased basis, they say.

The Carr-Hill formula

A six-month review of the 21-year-old Carr-Hill formula for funding distribution to GP practices was ordered in the government's *10 Year Health Plan* for England last October. It aims to bring about a fairer share of resources.

"Increased global funding will be needed if the government's goal of moving work from secondary to primary care is to be realised without taking funds away from existing practices"

AISMA leaders are adamant that, primarily, the overhauled funding formula must give practices certainty that their core funding will provide the financial baseline they need to operate.

AISMA chair Lizzy Lloyd considers it is essential the new formula for the global sum delivers enough money for all GP practices. She warned: 'If the output of the review is to simply redistribute existing money this won't work.'

AISMA board member Sue Beaton explained: 'Many practices are struggling, but some are struggling more than others. Increased global funding will be needed if the government's goal of moving work from secondary to primary care is to be realised without taking funds away from existing practices.'

She added that simply taking away money from the 'affluent' areas and giving it to the deprived areas would be neither sufficient nor fair.

The review should also be backed by a robust look at the causes of deprivation, AISMA believes.

Board member Pete Farrier has called for the setting up of a data-led model to analyse the problems resulting from deprivation in primary care, rather than just accepting deprived areas suffer more.

He said: 'What are the root causes? Which primary healthcare services can help solve these issues? The NHS should not be expected to sort out problems caused by poor housing and the lack of social care for elderly and disabled people.'

Turning to the Carr-Hill formula's outdated age and sex weightings, Mr Farrier said: 'The new formula must dispel the myth that GP practices with younger populations carry out less work and therefore require less funding. Likewise having an older list size does not necessarily equate to higher demand.'

Ms Lloyd pointed out how each population group has changed significantly since the Carr-Hill formula's introduction.

She said: 'Practice funding must reflect more accurately the support needed for children's mental health and mental health services more generally and other areas such as menopause.'

AISMA adviser Andy Pow revealed more of the thinking behind the Association's call for a separate funding mechanism for atypical practices, including rural practices with patient populations spread across large geographical areas.

He explained that these practices have higher operational costs, for example by needing to operate branch surgeries in rural areas.

'A universal funding formula will never work for practices that fall outside the norm, including many rural practices, those with a high percentage of patients who do not speak English as a first language, and practices with big student populations.'

Other considerations suggested by AISMA accountants for those carrying out the Carr-Hill review include implementing a more frequent review cycle to account for evolving health challenges.

They also say there should be a focus on the income practices receive for temporary residents which is based on historical data prior to 2004 and may not reflect today's demand.

Ms Lloyd expressed particular concern about three types of practices:

- those who have reverted from a PMS contract to GMS
- merged practices, and
- practices who have taken on new GMS-based contracts.

The AISMA chair pointed out: 'These practices receive no payments for temporary residents which simply isn't fair.'

AISMA is suggesting the review presents the opportunity to move away from a mainly capitation-based payment approach.

Board member Kieran Hancock said: 'If the government wants a GP workforce who can deliver appointments and keep patients out of hospital, perhaps now is the time to start paying practices for what they do, rather than by the number of patients on their list.

'This could mean practices being reimbursed for the number of appointments they deliver, the mix of staff used to deliver the appointments and the complexity of each case.'

Take a deep breath – this is going to hurt

GPs face a wide-reaching impact in 2026 from the last Budget's 'small' tax changes. **Morag Miller*** shows why

Nasty surprises were anticipated in November's 2025 Budget, with every potential UK taxpayer bracing themselves for what they felt would only be bad news.

There were no major changes to any area of tax, just small ones, meaning that the tax impact per individual and employer was lower, but the reach of those impacted far greater. The devil is in the details!

Fiscal drag continues

From April 2026 onwards, individuals will see several key differences – and also a lack of changes – which will impact how they are taxed.

The Chancellor extended the freeze on National Insurance and income tax bands by another three years, meaning the current thresholds, which have been frozen since 2021, now remain in place until 2031.

This will result in GPs across all categories - employees, those who are self-employed, and partners - paying more tax and National Insurance as their income increases over the coming years with inflation. Staff will also be affected.

Higher tax rates on dividends, savings and pension income

Those with dividend income, savings income and rental income will feel an extra pinch, with tax on these types of income increasing by 2% for basic rate and higher rate taxpayers (the additional rate remains unchanged). These rates will kick in from April 2026 for dividend income, and from April 2027 for savings and rental income.

For any companies holding a GMS or APMS contract, the new dividend rate may prompt practice owners to consider their remuneration strategy from the company.

But care should be taken when reviewing how funds are to be extracted from a business for a director/shareholder. There must be a

"Higher tax rates on property income may impact those receiving rental income from their medical practices, whether they own the premises in the partnership or a sole name"

commercial justification when swapping salary for dividends, or vice-versa.

Without this, HMRC may argue that any change in remuneration strategy is not allowable and consequently determine tax liabilities on drawings in their original form.

Higher tax rates on property income may impact those receiving rental income from their medical practices, whether they own the premises in the partnership or a sole name.

While not impacting current partners and notional rent receipts, higher tax rates on property income will impact those partners who own premises and have a lease in place with a practice, or former partners who continue to hold a share of the practice premises after retirement.

Rental income received by a company will be subject to corporation tax, the rate of which depends upon the level of taxable income within the period.

Making tax digital

All these tax changes are in addition to the complexities and costs that certain individuals (sole traders and landlords) are to face with the introduction of the government's plans for Making Tax Digital for Income Tax Self-Assessment (MTD ITSA), which will apply from 6 April 2026. This will require some self-employed individuals to submit some tax information digitally every quarter.

This is applicable where income from self-employment and property exceeds £50,000 (within the 2024-25 tax year). From 6 April 2027, the threshold will fall to £30,000 and then to £20,000 from 6 April 2028.

The government has said it is committed to introducing the digital system for partnerships. However, implementation has been stalled with no date assigned to the rollout.

Vehicle taxation and capital allowances

Owners of electric and plug-in hybrid vehicles were targeted in the Budget with the introduction of a new Electric Vehicle Excise Duty (eVED).

From April 2028, a charge will be imposed on both plug-in hybrid and fully electric vehicles, based on mileage: 3p for electric cars and 1.5p for plug-in hybrids.

On a positive note, the expensive car supplement will increase from £40,000 to £50,000 for 100% electric vehicles only. There are slight adjustments to 'company van' benefit in kind rates, and an easement on benefit in kind charges for plug-in hybrid vehicles.

Small changes to capital allowances will see an increase in first-year allowances for certain types of expenditure not covered by the Annual Investment Allowance (AIA). But there is a reduction to the standard writing down allowance from 18% to 14% for general pool items.

A new 'mansion tax'

A new 'mansion tax' is set to be introduced from April 2028. This will be an annual surcharge on properties valued over £2m, with rates ranging from £2,500 to £7,500. Properties will be valued by the Valuation Office Agency, reflecting market conditions based on the year 2026.

Working from home

The 'working from home' allowance is set to be withdrawn from employees - salaried doctors - from April 2026.

Pensions and savings

There have been no changes made to the annual allowance limit or the threshold and adjusted income levels used in determining the tapered annual allowance.

Earlier last November, it was also confirmed there will be no reduction in the tax-free pension Lump Sum Allowance which remains at £268,275.

The main pension announcement to affect both employers and employees is the capping of National Insurance contributions (NICs) relief on pension contributions, via salary sacrifice arrangements, to £2,000 per employee per tax year.

As salary sacrifice is not available for members of the NHS Pension Scheme, this will not impact many in this sector.

From April 2029, contributions above this will

"GP practices will face a further financial burden following the announced increases to the National Living Wage (NLW) and Minimum Wage (NMW) rates from 1 April 2026"

be subject to both employee and employer NICs, costing the employer an additional 15% in NICs. The NIC rate attributable to the employee will depend on their level of income.

These arrangements could give rise to a significant cost burden to many employers who have been used to not paying NICs on these payments for many years.

The annual Individual Savings Allowance (ISA) for individuals remains at £20,000 but from April 2027 there will be a new layer of complexity for savers to navigate. This is a throwback to the old ISA system.

In simple terms, you can put £20,000 into an ISA, but only £12,000 of that can be deposited into a cash ISA each year, and the remaining £8,000 of the allowance must be invested in stocks and shares. Over-65s can still invest the full £20,000 into a cash ISA.

Inheritance Tax

When it comes to Inheritance Tax (IHT) relief, the Budget announced the £1m Business Property Relief and Agricultural Property Relief combined allowance remains, but this could now be transferred between spouses and civil partners, meaning unused relief will not be lost on the first death.

But late last month the government said the level of the Agricultural and Business Property Reliefs threshold will be increased from £1m to £2.5m when introduced in April 2026, allowing spouses or civil partners to pass on up to £5m in qualifying agricultural or business assets between them before paying inheritance tax, on top of existing allowances.

The government explained it had listened to concerns of the farming community and businesses about its planned reforms and was going further to protect more farms and businesses 'while maintaining the core principle that the most valuable agricultural and business assets should not receive unlimited relief.'

Employment costs and rising wages

GP practices will face a further financial burden following the announced increases to the National Living Wage (NLW) and Minimum Wage

(NMW) rates from 1 April 2026.

The above-inflation increases of 6% and 8.5% to the respective rates for 16-17 and 18-20-year-olds will add considerable cost to employing younger workers from next year.

The rate for 21-year-olds and over is increasing by a lower 4.1%, but this will undoubtedly put pressure on employers to increase wages across the board to maintain the pay differential between starter roles and more experienced workers.

The government insists the uplift to these rates is to support workers and to help with the cost of living. Higher wages and salaries, however, inevitably lead to an increase in tax and NIC revenues, with the additional cost being borne by GP partners, not the government.

Further tax compliance activity on the horizon

HMRC is committed to eliminating tax evasion and avoidance, and it will pursue those deemed to owe tax. As part of the government's quest to narrow the tax gap, several new tax compliance initiatives are anticipated, including changes to behavioural tax penalties and tax errors.

Overall, it was a mixed budget. There will be relief to many that the numerous tax-hiking rumours did not materialise but the impact on what may initially be seen as small changes will still be felt by employers and individuals alike in the years to come.

ASK AISMA!

Partnership agreement questions from a longstanding senior partner 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**

WHY AGREEMENT UPDATES ARE INCREASINGLY ESSENTIAL

Q **Why do we need to keep paying to get our partnership agreement updated? When I joined we just had something drawn up by a local solicitor and never had any problems.**

A GP partnerships are very different now if you are comparing them to 30 years ago!

Incoming partners are not prepared to be controlled by the senior partner, and disputes can arise if matters are not fully considered. If you use a medical specialist solicitor, they will know the risk points and ensure you fully consider them in your partnership agreement.

As you are very aware, how income is earned changes regularly, more partners are involved in PCN work and spin off businesses.

How do you remunerate partners who do not spend all their time on practice business?

What if levels of outside work affect their performance in the practice?

What happens when there are adjustments long after someone leaves (like recent seniority adjustments)?

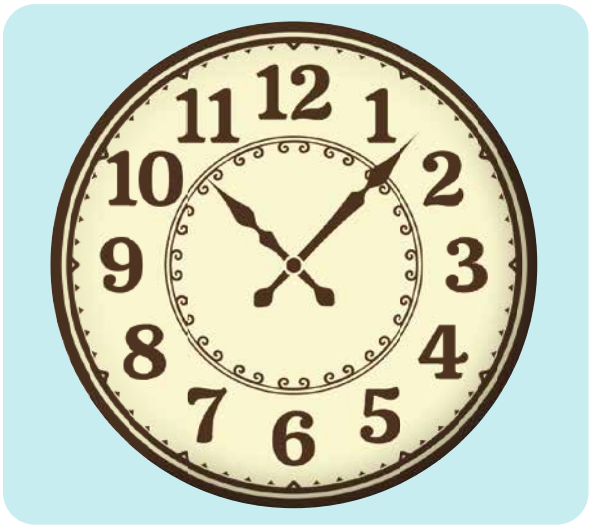
Every time there are changes in your practice, whether in relation to partners, sources of income, unexpected costs or premises, you need to think about whether it will affect what your partnership agreement says. Get it updated before there is any risk of disagreement.

The legal costs of sorting out a partnership dispute, on top of the stress it can cause, make the costs of a partnership agreement feel immaterial.

TREATING EVERY GP PARTNER FAIRLY

Q **How do I handle partners wanting to work part time? Can I treat partners who just want to work within school hours differently to a partner who has an outside appointment?**

A With the clinical pressures on GPs nowadays, many partners necessarily work less than 'full time.' What is full time anyway? Most practices tend to treat full time as eight sessions a week, which leaves a day in which



they may do something else.

There is no practical difference in someone wanting to work school hours and term times only and a 'full time' partner who chooses to do PCN work or other outside roles – although the practicality of fitting hours into patient facing sessions may be trickier.

To maintain fairness though, it is important to ensure that those working less than full time and being remunerated accordingly do not still have to do full time admin work or be available in the practice unpaid outside of their agreed hours.

It is much easier for the partner with an outside role to just say they are not available on Wednesdays, than it is to have to arrange meetings within school hours.

So yes, there can be a logistical difference between 'family care' and outside roles – it is just important to make sure there is fairness between different types of partners and that individuals are not ending up doing full time work with part time pay.

FLEXIBILITY NEEDED FOR PROFIT ALLOCATION

Q **Why can't we just share profits equally?**

A When partners all work full time and put the same amount of effort in for the benefit of the practice (whether fee earning or administrative), then sharing profits equally is fine.

However, with increasing numbers of part timers, and differences in roles, not to mention the ease of moving between partnerships and the need to encourage partner retention, flexibility in terms of profit allocation is important.

Partnerships need to decide if they are happy for partners to take on lucrative outside work and keep the proceeds personally (and potentially affect their commitment to the partnership), or whether all medical work should be included as partnership profits – albeit with an additional share going to that partner for work above and beyond what is expected from a partner.

New partners may need to concentrate on the clinical side initially and not take on their fair share of running the business – that may be reflected in profit shares – although that is rarely seen nowadays.

Some partners will do additional practice work in their own time, such as medical reports, and they should get a financial benefit for this.

Others may be prepared to leave more working capital in the practice so that others can withdraw most of theirs. That may be reflected by paying interest on capital.

Some partners may own a share in the practice premises while others do not. They should be remunerated for the capital invested and risk they take on, while of course bearing the cost of any practice loan in relation to premises purchase or improvements.

Normally the fairest way of sharing profits is to allocate 'pre-shares' of income or expenses, for additional work, responsibility and outside roles, or locum costs, for example. The balance, often referred to as the 'pool', is then split in a sessions ratio, commensurate with sessions committed or worked.

This all needs to be covered in the partnership agreement to ensure that there is no debate over what relates to whom and what is partnership income in the first place.

And of course, this means that the partnership agreement needs to be updated when there are material changes that could affect those shares.

Be sure your contract delivers what you want

Lawyers report a rise in cases where GP clients are not fully up to speed about fundamental aspects of contracts. **Justin Cumberlege** and **Sophie Birkbeck** run through the basics of making one – and what to consider when subcontracting

With GP federations and PCNs seeking more contracts and becoming involved in multi-neighbourhood providers and integrated health organisations, sub-contracting is set to be increasingly common.

Contracts do not have to be written agreements - they are also created verbally or by custom and practice. And be aware that existing contracts may be changed verbally and by custom and practice, sometimes inadvertently.

All that is required to create a binding contract is:

1 An offer – one party must make a clear offer to another, for example when one offers to buy a product or some services from another.

2 Acceptance – the party receiving the offer accepts it explicitly or by its actions.

3 Consideration – there must be an exchange of something of value, for example money is offered for the product or services.

4 Intention – the parties must intend the agreement to be legally binding. Courts presume this in commercial circumstances.

It is always best to have the agreement in writing so everyone understands their rights and obligations. This often makes people think through the service to be provided and 'what if' scenarios.

They may also decide to include a provision that contract terms may only be varied in writing, so there is no change by a verbal agreement or by custom and practice.

Contract terms should cover the price being paid, the term of the contract where a service is being provided, termination provisions, and the obligations of all the parties to the agreement.

Also consider an escalated dispute resolution procedure, requiring the parties to seek a resolution before starting expensive court or arbitration proceedings.

There are fundamental points to remember when entering into a contract. The key is – who is the contracting party? Is it a legal entity or an

"...it is important for partners to have a partnership deed clearly setting out the rules on entering into contracts"

unincorporated association of different people?

For example, a unit of an NHS Trust or a research project may want to contract with other parties to assist them, but neither a unit of an NHS Trust nor a research project are legal entities.

It is essential to identify the legal entity. A partnership is not one. It is a number of people carrying on a business together. A PCN is an unincorporated association usually made up of a number of GP partnerships.

Neither the partnership nor the PCN are separate legal entities, so technically they are unable to enter into contracts in their own name. Instead each partner is entering into the contract, even if the contract is signed by one partner as an agent for all of them.

Each partner is an agent of the whole partnership and they have the power to bind themselves and the other partners. Each partner also has unlimited liability. So if a contract is breached, each partner could be liable for the full contract value, even if they did not personally sign the contract.

This is why it is important for partners to have a partnership deed clearly setting out the rules on entering into contracts. For example, sometimes you will see there is a financial limit on the contract value any one partner can enter into without the consent of the others.

Unincorporated PCNs have a similar issue and could also potentially bind every partner of its member practices to the contract if one person, such as the clinical director, enters into a contract in the name of the unincorporated PCN. The network agreement should set out the rules.

As a result of this, PCNs often consider incorporating a service company. Not only does this limit their members' liability; a company is able to enter into a contract in its own name.

If contracting with a company, and the company breaches the contract, the liability of the shareholders of that defaulting company are limited to the amount they paid for their shares.

If the defaulting company is failing financially, you will have no recourse against the shareholders, or the directors (unless they have acted outside of their powers), so it is always important to check the value of the company to ensure that it is able to meet their obligations.

For this reason companies are required to publish their accounts by filing them at Companies House, where they are a historical record.

Subcontracting

Some contract tenders by 'head contractors' are for goods and services which a specific entity (the 'intermediate contractor') cannot provide itself under the head contract, so it needs to subcontract all or some elements to subcontractors.

But some head contracts prohibit subcontracting, or place certain conditions, such as obtaining the consent of the head contractor. So if you intend, as an intermediate contractor, to subcontract all or part of the contract, check the terms first or obtain consent at the outset.

When entering a subcontract consider:

- If the subcontract terms mirror those of the head contract. Do they make sense considering the circumstances of the intermediate contractor and the subcontractor? For example, should further subcontracting or alienation be prohibited?
- Will there be similar termination provisions? Should the termination provisions provide that the subcontract terminates upon the head contract's termination automatically? The subcontractor will want to ensure sufficient notice is given.
- Check the notice period for no-fault termination. Usually this would be less than the notice period required under the head contract so if the head contractor serves notice of termination, there is time to make the arrangements to serve notice on the sub-contractor.
- Should the subcontractor pay additional damages in the event of a breach to cover the losses of the intermediate contractor under the head contract?
- What services will be subcontracted? If it is not a complete pass through of all services or self-contained specific set of services, absolute clarity is needed about what services each party provides. Ensure there are no gaps.
- Consider the obligations on the intermediate contractor under the head contract, and which of them need placing on the subcontractor. For

example, are there any governance obligations? Are there mandatory policies noted in the head contract that must be adhered to by the subcontractor?

- How will the subcontractor be paid? Any payment to the subcontractor should be explicitly subject to the intermediate contractor receiving payment under the head contract first. If for any reason there is a payment delay under the head contract, should the intermediate contractor still be obliged to pay the subcontractor?
- Is the subcontractor required to report to the head contractor regarding the services being provided under the subcontract during the term of the agreement?
- Will any employees be transferred to the subcontractor? If so, you may need to consider the TUPE regulations before commencing the subcontract, and when it ends.

Other important clauses to consider, as with any other contract, include:

Data protection – will the parties be processing or controlling data? All sub-processing arrangements are prohibited unless the other party to the head contract (the data controller for UK GDPR purposes) has given its prior written general or specific consent.

The intermediate contractor must enter a sub-processing agreement with the subcontractor imposing the same data protection obligations on the subcontractor as are imposed on the intermediate contractor under the head contract.

This is essentially a requirement to 'flow down' the data processing terms in the main contract to the subcontractor.

The GDPR makes the head contractor fully responsible to the other party for the subcontractor's performance of its sub-processing obligations. There may be a need for a data sharing agreement between the head contractor and the sub-contractor.

Confidentiality – this should mirror the head contract's terms to ensure the subcontractor is subject to the same obligations.

The standard form of NHS contracts have standard forms of subcontract, but many of the issues need thinking through and reflecting in the schedules. If the subcontractor's staff are to benefit from NHS pensions, then the NHS standard forms will almost certainly be required.

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