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AISMA Doctor Newsline

The heartbeat of medical finance

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List cleansing: brush up to tackle the financial impact

Patient list cleansing sounds like an administrative exercise but right now it needs treating as a financial one too. **Daniel Tremain*** reports

At its heart, list cleansing is about making sure GP patient lists accurately reflect the people a practice is responsible for.

NHS England (NHSE) is currently validating lists to identify patients who may no longer be resident in England, checking registrations and, where appropriate, removing patients through the established FP69 process.

Such a huge increase in FP69 deductions now being processed by Primary Care Support England (PCSE) has left many to conclude that these have not been done for years. Some speculate this has not been addressed since PCSE launched in 2015.

Practices in areas with diverse and mobile populations are at most risk of patients being removed, typically practices in deprived areas or university practices.

As well as disruption to continuity of care for those with chronic conditions, the scale of the current exercise brings financial consequences.

According to recent reports, GP patient lists have reduced by 830,000 since the exercise began. AISMA estimates this could represent around £150m in lost funding (global sum, QOF and PCN) and is in discussion with NHSE and the BMA about the impact this is having on practices.

The fast shrinking patient list

The BMA has also raised concerns about the pace of deductions and what they could mean for practice finances. Patient numbers underpin important elements of practice earnings, so where funding is tied to list size, a fall in registered patients can translate directly into a drop in income.

If patient numbers fall faster, or by more than anticipated, the assumptions a practice has made around income, staffing and future investment can change with them.

And this impact should not be viewed in isolation. Changes in numbers can also have implications at PCN level, where elements of funding and service planning are linked to population size.

Ultimately, income may fall with list size, but salaries, premises and other fixed costs do not reduce at the same rate, potentially leaving an unexpected gap in the budget.

So, this is not solely a data exercise. Practices need to understand what is happening to their lists, whether deductions are appropriate and, most importantly, what those changes could mean for their finances before the impact is felt.

WHAT TO DO

1 Know what is happening to your list

If you do not have a clear picture of how numbers are changing it becomes difficult to forecast what that could mean for your income.

Practices should assign clear responsibility for monitoring FP69 notifications and patient deduction notices. This is usually another task for the practice manager or an admin team member.

These notifications are time-sensitive, so review proposed removals promptly rather than assuming every deduction is correct.

Where there is evidence that a patient remains eligible, practices should challenge the deduction through the appropriate PCSE or NHSE process within the required timescales.

Looking at the bigger picture is equally important. Rather than waiting for a fall in income to flag a problem, practices should compare their list size month-on-month and investigate any unusual spikes in deductions. A handful of removals may not materially affect the finances, but a sustained pattern could.

Where the numbers do not appear to add up, practices can also request formal list reconciliation through PCSE, which can help identify discrepancies affecting list size or capitation.

2 Remember: good data is now financial housekeeping

Good patient data has always mattered. The current exercise is a reminder that poor data can now carry a very visible financial consequence too.

To keep on top of this, use everyday interactions as an opportunity to check that addresses, telephone numbers and email addresses are correct to help avoid losing appropriate registrations.

Take care with patients who may be harder to reach or less likely to engage with routine communications, such as care home residents, those with learning disabilities, the homeless, students, people with limited English and the elderly.

NHSE says those identified for validation are contacted through available channels and given opportunities to confirm their details before the FP69 process progresses. But practices should still be alert to those who may need additional support.

Practices should also look at making their processes as straightforward as possible for eligible new patients to register, including - but not exclusively - through online routes.

"Start by re-forecasting the remainder of 2026-27 using updated assumptions around list size and income"

3 Do not wait for the next payment to model the impact

Practices should not wait for a change in their bank balance to understand the bigger financial impact. They should model multiple scenarios.

- What would a 1%, 2% or greater reduction in the registered patient list mean for the global sum - the core funding GPs receive - and other patient-based income?
- How would that feed through to monthly cash flow?
- And what commitments have already been made based on previous income assumptions?

GPs need to understand how much financial headroom they have if income changes. No expenses will change because of this, so these deductions directly impact the bottom line more quickly than their cost base can adjust.

The same impact can be seen at PCN level. If several member practices experience list reductions at the same time then patient-based network income, workforce or service delivery budgets will need to be revisited.

4 Build the impact into the wider financial plan

Once you understand the impact, it needs to feed into the wider financial plan. Start by re-forecasting the remainder of 2026-27 using updated assumptions around list size and income. Remember that for global sum funding the list size is calculated quarterly.

From there, look at cash flow. Reflect on whether you are feeling the impact of any reduction in funding. Costs, staffing and planned investments may need reviewing.

And it is also worth taking a fresh look at other income streams. Are you making full use of the funding and reimbursement opportunities the practice is eligible for? If one income source is under pressure, overlooking another becomes even more costly.

Also consider what revised profit expectations could mean for tax planning. The aim is to allow partners to make decisions with the full picture in front of them rather than dealing with each consequence as it arrives.

5 Work with the wider system

Where deductions appear disproportionate, or there are concerns about how the process is being applied, speak to your LMC and raise the issue with your ICB, particularly where there could be a significant local financial impact.

Practices within a PCN should also compare what they are seeing to understand whether deductions are isolated or part of a wider pattern across the network.

Throughout the process, keep clear records of deductions, any challenges made and the resulting financial impact.

The stronger the evidence, the easier it is to understand the scale of the issue, raise concerns where necessary around large-scale deductions and seek advice on challenging removals.

6 Treat list size as a live financial metric

For partners and PCN leaders, list size needs to be treated as a live financial metric. Review list size regularly to avoid the current focus becoming a one-off exercise again in the future. Understand how and why it is changing and challenge inappropriate deductions promptly.

The earlier you understand what a changing patient list means for your finances, the more options you have. The alternative is finding out when the money has already moved, and by then, your room to respond may be considerably smaller.

What remains unclear is whether the savings generated through these deductions will be reinvested back into general practice.

BMA and GP representatives have questioned where the funding released through list cleansing is going. They are calling for transparency, arguing that if patient-related funding is removed from practices then those resources should be recycled back into the global sum and primary care budgets so funding continues to follow patient need.

Meanwhile, if you need assistance with any of the above just ask your friendly neighbourhood AISMA accountant.

Have GPs ever faced such a lack of d*t*il?

OPINION

Sue Beaton**
AISMA board member

GP practices have, for many years, experienced various uncertainties about the framework they have to operate in and the associated financial costs and rewards of doing so.

However, I cannot recall any other time in recent years where there have been so many proposals and potentially radical changes announced but with so little solid detail.

There remains much uncertainty and unease among practices as to how they will be affected practically and financially in the future.

At the heart of this in England is the 10 Year Health Plan. The general ideology is now much publicised and generally welcomed, such as the intended shift from hospitals to the community/primary care, a focus on prevention rather than treatment and embracing digitalisation/smarter ways of engaging with patients and delivering results.

Yet so much is still unclear and the important details are still awaited.

Proposed Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contracts, a key feature of the Plan, leave much to be clarified.

A consultation period was launched by NHS England at the end of July, running to 10 September, with the aim of helping health service planners understand how the contracts would fit with current arrangements and also to better understand the benefits, risks, and implementation implications of each.

It is envisaged that feedback from the consultation would then be used to 'inform further, detailed consultation on firmer proposals' for both contract types later this year.

But this vague rhetoric currently leaves many practices uneasy and still unsure of how they will be affected, particularly with regard to delivery of and payment for enhanced services and the current roles and income sources presently achieved through PCN work.

There are also questions about premises and how or if they can be modernised to enable delivery of the envisaged wider service delivery.

This might entail moving, adaptations, co-habiting with other healthcare providers and/or new or amended leases, all of which take time and money to sort out.

Will increased costs be funded, will service charges (where applicable) be kept in check and properly managed, and who will be responsible for them?

Further uncertainty surrounds the workforce required to deliver the Plan. The Royal College of General Practitioners (RCGP) recently appealed to Health and Social Care Secretary

Yvette Cooper to publish the long-promised 10 Year Workforce Plan as soon as possible.

If the ideology of the overall Plan is to be delivered, then suitable funding and a suitable workforce has to follow. Recruitment, retention and support of GPs is vital to be able to stand a chance of delivering the expected rise in workload with the shift from secondary to primary care envisaged. Yet, once again, information is scant and more details are needed.

After so many years, GP practices are also still awaiting a much-needed overhaul of the outdated Carr-Hill formula, which has long been recognised as under-representative of the needs of practices and their varying demographics, with several practices struggling and at worst closing.

Simply redistributing existing money around the system is viewed by many as unfair and unworkable. One example of the feedback gathered during the consultation period(s) indicates that deprivation needs to be better represented and funded. But as yet, there is no major detail on how this will function.

The same applies to rural practices, whose very viability is at risk due to covering large geographic distances, with under-funding having a large impact and it is important they do not slip through the cracks when it comes to the formula review.

An updated and workable formula cannot come soon enough. It remains to be seen if there are any sensible amendments or proposals by 1 April 2027.

Added to the above challenges this year is the list cleansing exercise, (covered in more detail in AISMA Board member Daniel Tremain's front page piece), and this could also impact practices' finances going forward.

So, at this halfway point of 2026-27, whereas the usual concerns regarding staffing, funding, service delivery and profitability are still very much in evidence, a significant number of proposed radical new changes are being rolled out with likely wide-reaching consequences.

"The lack of clarity on fundamental details has created the fear that rapid roll out of some key contract proposals could lead to destabilisation unless and until operational definitions are clear"

Yet, at the moment, many are without sufficient detail and reassurance for those who have to deliver them, leaving many practices feeling anxious and unsettled.

Worries over levelling up and NHS capacity to properly and effectively deploy new technologies are adding to these concerns.

Despite a need for change and modernisation, there is evidence of a slowdown and pushback against any radical changes from, amongst other organisations, the RCGP. The lack of clarity on fundamental details has created the fear that rapid roll out of some key contract proposals could lead to destabilisation unless and until operational definitions are clear.

The recent change of Prime Minister and his appointment of a new Health and Social Care Secretary and Chancellor add to the uncertainty.

Moving into the second half of 2026-27, it can only be hoped that further clarity will begin to emerge, with suitable and workable delivery solutions for practices facing these multiple challenges.

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Take professional advice before acting on mounting Budget fever

Nerves are tingling for many business as we approach the autumn Budget. **Graeme Hills***** looks at key areas GP practices should watch

With the autumn Budget due on 28 October, speculation is building around changes to the taxation of capital, wealth, property and pensions.

For GP partners and practice owners, the important message is not to make irreversible decisions in response to headlines. But where a genuine transaction is already planned it is sensible to review the timetable now and understand whether bringing it forward could reduce uncertainty.

At this stage, most of the measures discussed below are proposals or informed speculation rather than government policy. The eventual detail and, crucially, the date from which any change takes effect may differ from the headlines.

Practices and individual doctors should therefore take advice based on their own circumstances before acting.

Capital gains tax: a likely area of attention

One of the most persistent suggestions is that capital gains tax (CGT) rates could rise, potentially moving closer to income tax rates.

For 2026-27, the main CGT rates are 18% for gains falling within the basic-rate band and 24% thereafter, while the individual annual exempt amount is £3,000.

Business Asset Disposal Relief is now charged at 18%, subject to its conditions and lifetime limit. A move towards income tax rates could therefore be material for higher- and additional-rate taxpayers.

For GPs, CGT may arise on the sale or transfer of an interest in practice premises, the disposal of shares in a company, a practice restructuring, or a partner's retirement or succession arrangements.

The tax outcome will depend on the legal

ownership, the nature of the asset, available reliefs and the terms of the transaction. Equalising CGT and income tax is not confirmed, and a rate increase could be accompanied by transitional rules or changes to reliefs.

It would be unwise to sell an asset solely because rates might rise. Transaction costs, commercial objectives, cash-flow needs and the risk that a deal does not complete before any effective date all matter.

Nevertheless, if a disposal is already at an advanced stage, now is the time to model the present rules against plausible alternatives, check whether relief conditions are met and ensure valuations and documentation are in order.

Could a wealth tax be introduced?

Discussion of a possible wealth tax is not confined to a single model. Proposals in the public debate have included a 2% annual charge on individual assets above £10m, as well as a more narrowly targeted 2% minimum tax on households with wealth above £100m.

Other variants could use a different threshold or rate, apply as a one-off levy rather than an annual charge, or focus on particular assets. None of these models has been confirmed as government policy, so the eventual scope, if any measure is introduced, remains highly uncertain.

For most doctors, the direct impact would depend heavily on where any threshold was set and how net wealth was calculated. A £10m threshold would bring more people into scope than a £100m threshold, particularly where wealth includes practice premises, other property, private company interests, investments, pension rights or assets held jointly or through trusts.

Valuation, debt deductions, exemptions, liquidity and interaction with existing taxes would all be central to the design. Until the government publishes a firm proposal, major changes to ownership or investment structures would be premature.

Those who may be close to a suggested threshold should instead assemble an up-to-date picture of their assets and liabilities and seek advice to ensure their estate plan is up to date.

Pensions: NHS benefits and private savings

Speculation has again focused on pension tax relief and the tax-free lump sum. The existing lump-sum allowance is generally £268,275, although protections and individual circumstances can alter the position.

Previous pre-Budget rumours prompted some savers to draw benefits early, only for the expected restriction not to materialise. Early access can create an unnecessary income tax charge, remove money from a tax-advantaged environment and disrupt a long-term retirement plan.

Many doctors' core NHS pension benefits are defined by pensionable pay and service under the relevant scheme rules, rather than by the market value of an individual investment pot.

That may make some forms of speculation about private pension 'pots' less directly relevant. It does not make pension changes irrelevant: tax relief, lump-sum choices, annual allowance exposure, retirement timing and any separate defined-contribution pension or SIPP may still require review.

A separate confirmed change is also approaching: from 6 April 2027, most unused pension funds and death benefits are due to be brought within the inheritance tax regime.

That is particularly relevant to doctors with substantial private pensions and estates, even though it is not a new Budget-day surprise. Existing nominations, wills and estate plans should be reviewed together rather than in isolation.

Note that NHS Pension Scheme benefits are not counted as an asset to be included in the inheritance tax estate.

Other areas worth watching

National Insurance for older earners:

The Institute for Public Policy Research (IPPR) has proposed extending a 2% National Insurance charge to people working beyond State Pension age. If adopted, this could affect some GP partners, salaried GPs and locums who remain in practice. It is currently a think-tank recommendation, not policy.

Property taxation:

The same IPPR work suggests replacing council tax and stamp duty with a proportional property tax of about 0.65%. Wider discussion has also included taxes based on current property or land values.

Practice premises may sit within complex ownership arrangements, so any proposal would need careful analysis before its effect on surgeries could be assessed.

"For GP practices, the proportionate response is to identify transactions already on the horizon...and take joined-up tax, legal, pension and financial advice"

Inheritance tax and social care:

Further estate-based funding has been discussed in connection with social care reform. Doctors with valuable homes, investment property, practice interests or private pensions should keep estate planning under review but should not make gifts or transfers merely in response to rumour.

Thresholds and investment income:

The Budget could raise revenue without changing headline rates by extending frozen thresholds or tightening the treatment of dividends, savings or property income. These measures could affect both personal cash flow and decisions about how income is extracted from incorporated businesses.

Plan, but do not panic

The weeks before a Budget often generate more noise than certainty. For GP practices, the proportionate response is to identify transactions already on the horizon, gather the information needed for a decision and take joined-up tax, legal, pension and financial advice.

Where commercial terms are settled and a transaction is genuinely ready, accelerating it may be worth considering. Where it is not, acting on speculation could create a worse outcome than waiting for the facts.

So what should GP practices and doctors do now?

1. Do not be spurred into action by speculation alone. A rushed pension withdrawal, property transfer or disposal can produce tax and commercial consequences that cannot easily be reversed.

2. Bring forward the review, but not automatically the transaction. If a sale, retirement, partnership change, incorporation, gift or pension decision is already planned, ask advisers now whether there is a credible benefit in completing before 28 October.

3. Model more than one outcome. Compare the current rules with reasonable alternatives, including a higher CGT rate, altered reliefs or a different effective date.

4. Check the practical dependencies. Obtain valuations, identify the beneficial owner, review partnership and property agreements, confirm lender or NHS-body consents, and allow enough time for legal completion.

5. Review the whole position. Tax planning should support the practice's succession, premises, retirement and cash-flow objectives, not drive them.

This article is based on information available at 4 September 2026 and is intended as a general overview. Budget measures remain speculative unless stated otherwise. It is not tax, legal, pension or investment advice; individual circumstances and scheme rules should be reviewed with an appropriate adviser

Defuse that dispute!

Disputes can destroy a GP practice but to prevent things becoming irretrievable there are some useful tools available to resolve the situation. **Sophie Kimber** and **Richard Nolan** reveal what is in the toolbox

Disagreements are an unfortunate reality in GP practices.

Whether they relate to finances, workload, decision-making, partnership obligations, retirement, or strategic direction, unresolved conflict can have significant consequences for the individuals involved and for the practice as a whole.

Disputes can impact staff morale, patient care, recruitment and retention, and long-term business stability.

But the good news is that court proceedings are rarely the only option.

In fact, there are a broad range of dispute resolution tools available and many of these can help parties reach a solution more quickly, cost-effectively, and with less damage to ongoing working relationships.

Understanding the different options can help practices choose the most appropriate route when a disagreement arises.

1 Negotiated settlement

Negotiation is often the first step parties explore when seeking to resolve a dispute.

This involves them discussing the issues directly, either themselves or through their professional advisers, with the aim of reaching a resolution. Negotiation can take place informally through conversations and meetings or more formally through correspondence.

The main advantages of negotiation are that it is generally quick, inexpensive, and confidential. Those involved retain control over both the process and the outcome, rather than having a solution imposed on them by a third party.

Many disputes can be resolved through effective negotiation before relationships deteriorate further. But success depends on all sides being willing to engage constructively and compromise where appropriate.

For this reason, it is not the appropriate mechanism for resolving a dispute in circumstances where the relationship between the parties has already deteriorated substantially or where a compromise is unlikely.

2 Facilitated meetings

A facilitated meeting can help bridge the gap between viewpoints where direct discussions have become difficult.

In the GP context, the parties can engage their LMC to assist. The LMC representative can help bring the parties together, ensure discussions remain productive, and encourage exploration of practical solutions.

They do not make decisions or determine who is right or wrong. Their role is simply to help the parties communicate more effectively and focus on resolving the issues.

Facilitated meetings can be particularly valuable where tensions have escalated due to misunderstandings, poor communication, or different expectations rather than fundamental legal disagreements.

3 Mediation

Mediation is a structured and popular form of alternative dispute resolution.

A trained, independent mediator works with the parties to help them identify issues, explore options, and negotiate a settlement. The mediator does not decide or impose an outcome. Instead, they facilitate discussions and help the parties find common ground.

One of the key benefits of mediation is flexibility. The process can be adapted to suit the nature of the dispute and may involve joint meetings, separate confidential discussions, or a combination of both.

Mediation is also confidential, which can be particularly important for GP practices wishing to avoid public disputes.

It is often quicker and less expensive than litigation and can help preserve professional relationships that may need to continue after the dispute has been resolved.

"Mediation...is often quicker and less expensive than litigation and can help preserve professional relationships..."

4 Expert determination

Some disputes centre on technical issues rather than broader relationship breakdowns.

Examples might include:

- disagreements about partnership accounts
- valuation of a departing partner's share
- profit allocations
- premises valuations, or
- other specialist financial matters.

In these circumstances, the parties may agree to appoint an independent expert to determine the issue. The expert is usually a professional with relevant technical expertise, such as an accountant, valuer, or surveyor.

The expert reviews the evidence and reaches a decision based on their specialist knowledge. Depending on the terms of the agreement between the parties, the determination may be binding.

Expert determination can be particularly attractive because it allows highly technical disputes to be resolved by someone with the appropriate expertise without the need for lengthy legal proceedings.

5 Arbitration

Arbitration is a more formal dispute resolution process but remains private and generally more flexible than court proceedings.

An independent arbitrator, often with legal or sector-specific expertise, hears evidence from both sides and then decides. Unlike mediation, the arbitrator's role is not to facilitate settlement but to determine the outcome of the dispute.

Many partnership agreements contain arbitration clauses requiring certain disputes to be referred to arbitration rather than the courts.

The resulting decision, known as an arbitral award, is usually legally binding and enforceable.

Arbitration can offer several advantages over litigation, including confidentiality, the ability to select a specialist decision-maker, and potentially faster resolution. But it can still involve significant time and expense depending on the complexity of the dispute.

"Obtaining advice from specialist medical accountants, solicitors, or other advisers can often prevent disputes from escalating"

6 Court proceedings

Court proceedings are generally considered the option of last resort.

Litigation may become necessary where other methods have failed, urgent action is required, or there are significant legal issues needing a judge's determination.

The court process involves formal pleadings, disclosure of documents, witness evidence, hearings, and ultimately a judgment. The parties are subject to strict procedural timelines, which can lead to serious consequences if not complied with.

While courts provide an authoritative and enforceable resolution, litigation can be expensive, time-consuming, stressful, and public. It can also further damage relationships between partners and colleagues.

For these reasons, parties are often encouraged to explore alternative dispute resolution methods before commencing proceedings, and throughout the litigation process itself.

7 Other options worth considering

In addition to the main dispute resolution routes, practices should be aware of several other approaches.

Early neutral evaluation

This involves an independent expert, often a senior lawyer or retired judge, providing a non-binding assessment of the strengths and weaknesses of each side's case. Such an evaluation can help parties understand litigation risks and encourage settlement.

Professional advice

Obtaining advice from specialist medical accountants, solicitors, or other advisers can often prevent disputes from escalating. An independent view of the financial, contractual, or regulatory position may help clarify misunderstandings and identify practical solutions.

Preventative measures

Although not strictly a dispute resolution tool, prevention is often the best approach. Well-drafted partnership agreements, clear governance arrangements, regular communication, and periodic reviews of financial and operational arrangements can significantly reduce the likelihood of disputes arising in the first place.

Sophie Kimber is a solicitor with Hempsons' corporate commercial team, and Richard Nolan a partner and head of health and social care dispute resolution.

***Hempsons' dedicated primary care and partnership dispute resolution team are available to provide expertise and support for any issue requiring your support**

Finding your way forward

When disputes arise in a GP practice there is no single solution that will suit every situation.

The appropriate route will depend on the nature of the disagreement, the relationship between the parties, the urgency of the issue, and the desired outcome.

In many cases, a negotiated settlement, facilitated discussion, or mediation can resolve matters efficiently while preserving important professional relationships.

Where technical expertise or a binding decision is required, expert determination or arbitration may be appropriate.

Court proceedings remain available when necessary but are often best viewed as a final option.

By understanding the range of dispute resolution tools available, practices can make informed decisions and increase the chances of reaching a constructive and lasting resolution.

In all cases it is advisable to obtain support from a specialist legal team at the earliest opportunity. This can often prevent the escalation of matters and will assist in identifying which route will help bring the dispute to a resolution in the most appropriate manner.