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AISMA Doctor Newsline

The heartbeat of medical finance

How to get the best out of your AISMA accountant in a profit pressure environment

With GPs' financial challenges mounting there is one partner practices cannot afford to ignore. **Katie Collin*** shows the benefits of cementing strong relationships with your accountant

Primary care policy shifts are seemingly never-ending, and with financial changes continually forcing GPs and practice managers to re-evaluate their finances on an almost-daily basis, it is tricky to know where to start.

It is made even harder by the funding squeeze which is placing massive pressure on practices' profits.

When there is less money to spend, it becomes even more challenging to choose which accounting, forecasting, or financial planning jobs should come top of the list.

Building a collaborative, solid relationship with your AISMA accountant is vital. GPs now, more than ever, need a partner who has both their best interests at heart and a deep understanding of primary care evolution.

So here are five tips on how you can build those deep-rooted, reliable partnerships with your accountant, and how you can get the best from them.

1 Take a long-term view

Getting the most from your specialist medical accountant starts with taking a long-term view because we do our best work when we can keep practices' succession plans, workforce

ambitions, and premises' strategies at the forefront of our mind.

These big, overarching strategy conversations might not immediately be obvious when you first start working with your accountant. You might be more inclined to focus on year-end accounts and tax returns, for example.

But having visibility of the broader thinking about the direction the practice is moving in really helps inform our work. It means we can provide much more relevant, thorough advice.

It is especially relevant in the primary care sector, given that general practice is often shaped by frequent changes that do not follow a standard annual cycle.

You might think you are on top of a new contract, but in a few months further changes could force you to look at your plans in a whole new light.

So rather than thinking about how your AISMA accountant can help you navigate the new contract as an isolated event, think about how they can help you bring together every change to policy and funding flows over the several years ahead.

You will gain far more useful advice and insight into what the future might look like and what you need to do now to prepare for it.

2 Communicate regularly

Your AISMA accountant needs to be on top of all the changes your practice experiences to be able to support you with this long-term view.

That means if your financial circumstances suddenly change, or a new policy turns your staff costs upside down, we have everything we need to get to work immediately.

Your accountant can spring into action when they already have all the facts in front of them and then you can return to focusing on patients as soon as possible.

Open communication channels – at all times, not just at the year-end – really do make a difference. So share the cash flow numbers, staff costs, drawings, and income changes on a regular basis. It all helps your AISMA accountant provide speedy support when the sands shift.

3 See it, say it, sorted

Practices and GPs depend on other healthcare organisations getting their figures right. From the Department of Health and Social Care all the way through to NHS England (NHSE), ICBs, and trusts, and their organisational counterparts in Scotland, Northern Ireland and Wales, there are multiple steps where errors can creep in and complications can rear their ugly heads.

The most obvious example is NHS pension statements. I imagine every reader is painfully familiar with the havoc the 'McCloud' public service pension reforms have wrought over recent years. And we are not out of the woods yet.

Many NHS workers' pension records have

"Asking the simplest questions can sometimes trigger broader, transformative discussions that help you to see your practice's current trajectory in a new light"

missing information. I have seen lots of statements that are completely wrong. It is crucial these errors are spotted as early as possible, or they can have serious ramifications for your financial security.

So, if you see something that does not look quite right, the best course of action is to flag it right away – even if you are unsure if there is a problem. And that goes for all financial statements and forecasts, not just those related to pensions.

Sitting on any financial mismatches always exacerbates the issue, and your accountant can usually find a solution if they know about the issue sooner rather than later.

4 There are no silly questions

It is also important to know there are no silly questions you can ask an accountant.

Most funding updates are accompanied by reams of long documents and complex calculations, and it is your AISMA accountant's job to help you digest that information.

This stuff is a minefield and you should never hesitate to ask a question on something that does not quite make sense at first glance. Confusion can end up being expensive. So ask away, even if you think it is a daft question.

Asking the simplest questions can sometimes trigger broader, transformative discussions that help you to see your practice's current trajectory in a new light.

They often open up dialogues that allow your accountant to deliver incredibly useful, targeted advice, providing invaluable guidance on an area you might not have considered before.

The complex funding landscape of 2026 means specialist medical accountants must act as advisors, not just auditors or compliance monitors.

5 Ask for the ugly truth

As well as being aware of the benefits of a certain policy, funding change, or internal strategy shift, you also need a firm grasp of the risks.

A prime example of a policy shift that will affect all English and Welsh practices in 2027 is the upcoming review of the Carr-Hill formula. We remain in the dark over what a new formula might look like, but it is likely to mean big changes.

Accountants are already modelling what changes in weighted list size could look like for practices, even though it will still be some time before publication, to give clients an insight into what their future weighted income might look like.

Even if the changes to the formula are scrapped, which is highly unlikely, practices need to know the risks and factor them into their planning now.

I recommend asking your AISMA accountant for the harsh reality, even if it is not pretty. Ask for models to help you visualise where resources might end up, and for an outline of the greatest risks to consider. That way, you will be in receipt of all the facts with plenty of time to prepare.

To sum up

The relationship between GP practices and their accountants has shifted in recent years to account for the highly complex funding structures and changes we face.

Funding flows are more complicated, with money sitting at multiple levels and tied to tricky-to-navigate conditions.

There is growing ambiguity over the legal structures in which this funding sits, with neighbourhood health plans in England set to muddy the waters further.

GPs face more financial challenges than perhaps ever before and amidst the madness they need accountants to be dependable, knowledgeable, and insightful extensions of their practices.

By asking the right questions of their AISMA accountant, providing regular updates, and sharing insight on wider strategy discussions, GPs and practice managers will have the partners they need to navigate the chaos.

GP contingent decisions – you can have your cake (with a cherry on top) and eat it

OPINION

Guy Vine[**]
AISMA board member

The 'McCloud remedy' continues to shape our NHS pension discussions with GP partners. For those impacted, the topic should be contingent decisions.

In summary, if you opted out of the pension scheme at any point between 1 April 2015 and 31 March 2022, because of the move to the 2015 scheme, then you can now choose to reverse that decision and 'buy back' the lost service.

The original 2015 reforms were found to be discriminatory, so at face value this seems a sensible correction. The remedy aims to put scheme members back into the position they would otherwise have been in.

But we should pause here. That is not quite what is happening in all scenarios.

What is a contingent decision?

Per NHS Business Service Authority: 'A contingent decision is a decision you made or did not make because of actual or perceived implications of the 2015 Scheme reforms.'

In simple terms, it answers a single question: would you have behaved differently if you knew you would remain in your legacy scheme until 2022?

For GPs, the most common example was opting out - often done to manage annual allowance exposure or contribution costs at a time of uncertainty.

The remedy now allows those decisions to be revisited. This is where the story becomes more interesting and where two familiar idioms collide to form the intentional malaphor[1] in this Opinion's title.

You can have your cake and eat it

The member's decision is being made with the rather significant benefit of hindsight.

It is a complex scheme and not always well understood by its members. For many who never opted out, the period between 2015 and 2022 included changes to tax legislation which both reduced the available annual allowance and brought in tapering for high earners.

A typical year in this period for a large number of partners was filled with unknown variables such as pensionable profits, CPI, all the other intricacies of the scheme and their impact on scheme growth.

These elements, all mixed together, often lead to an annual ritual of dread and anxiety inducing tax discussions for GPs.

Those who opted out to avoid it all and make life simpler at the time, arguably have it simpler now too. The unknown variables of the past have now been replaced by facts.

The unknown tax liabilities are replaced with known figures (and a choice over whether to commit to incurring them), and the unknown benefit growth is now being reliably projected and understood with specialist advisors whose fee is likely reimbursable.

With this full knowledge of the outcome on all fronts, the GP also has an added bonus of being able to structure their period of membership further, to get the 'best bang for your buck' throughout the remedy period.

No member who remained active between the period of 2015 and 2022 has been afforded such a luxury.

To say this is not an improvement on the original position that the partner would have otherwise been in, for me, is not factually correct.

Cherry on top

For many GPs, the process itself, and the ability to have all the detail and the facts laid bare is compelling enough to review their position.

The final perk to GP partners in all this is the cost. The buy back process (which is the same for all including GP partners) involves the member repaying the employee contributions due, plus interest.

When first coming across this, I had to re-read and went on to check with other industry experts too. No, I was not wrong, GP partners only have to pay employee contributions plus interest. No employer's!

That almost halves the cost for those impacted but affords the same benefit uplift.

Tax relief will follow on the employee's contributions paid, and these can potentially be structured to ensure maximum tax relief is gained.

There is even talk that if a member is unable to get full tax relief then a claim could be made to the compensation scheme to make good, although I have not seen evidence of this just yet.

Any drawbacks?

You could point to the interest as a drawback and yes, late payment interest such as this does not attract tax relief. That is simply a cost that must be borne but the saving on the employer's contributions more than makes up for that cost.

And note the interest applied has been aligned with NS&I saver rates rather than commercial borrowing rates. At the time of writing the rate is 0.3% lower than the Bank of England Base Rate.

I do not see the interest in this process as a detrimental factor considering the GP has had the ability to freely deploy that cash elsewhere during the last decade or so.

Is this really restoring fairness?

The purpose of the 'McCloud remedy' was clear. To remove discrimination and restore fairness.

Yet the contingent decision framework goes further than this for impacted GP partners.

It improves the position and for me it creates a clear divergence from those members who remained in the scheme, who do not have the ability to revisit those decisions.

Putting it all together

Any GP partner who opted out during the remedy period absolutely must have this on their agenda to look at. I for one will certainly be talking to my clients who have not yet investigated this option.

They should of course still seek financial advice when the results are known, and it still may not be the right decision to take. But, the variables are removed, certainty is in, and the cost is nearly halved.

Talk to your AISMA accountant about the next steps because for those impacted, the process means you can have your cake, admire the cherry on top, and then decide afterwards whether you would like to eat it or not.

[1] Malaphors: "It's as easy as falling off a piece of cake"

2026–27 GP contract update: what practices should do now

Lizzy Lloyd*** provides a catch-up on important changes

The 2026-27 GP contract details have trickled out in stages with the Statement of Financial Entitlements (SFE), amended guidance and the Network Contract DES variation all published after the *AISMA Doctor Newsline* spring issue.

Practices have consequently found it difficult to plan and now need to consider the practical effect on income, staffing, cash flow, and primary care network (PCN) arrangements.

Key points for practices

- The global sum has increased to £130.07 per weighted patient, a £6.73 uplift on 2025-26, but practices should not assume the full increase drops through to profit.
- The Capacity and Access element of the PCN DES has ceased, with funding repurposed into a practice-level GP reimbursement scheme, capped at £4.57 per adjusted patient.
- The GP reimbursement scheme can support additional or maintain salaried GP sessions.
- Same day access, open online access, not asking patients to call back another day and provision of detailed access data will need to be delivered alongside the usual QOF, enhanced services, and long-term condition monitoring.
- Local Variation Arrangements (LVAs) point towards greater ICB influence over PCN services and neighbourhood working.
- PMS and APMS practices receive the same uplift but should check the impact of the out-of-hours deduction and local contract variations.

Recommended actions now

- Calculate the broad impact of the contract changes for an illustration of the effect on practice income.
- Update 2026-27 practice budgets and monitor these regularly.
- PCNs should have already reviewed the effect of the loss of Capacity and Access funding against how it was spent. Identify whether any costs now need to sit with member practices or GP reimbursement funding transferred to PCNs.
- Model the GP reimbursement scheme, recognising that claims will be in arrears and only where the eligibility conditions are met.

- Consider opportunities to maximise the GP reimbursement scheme to free up time.
- Review staffing mix and delivery of care to ensure same day access is delivered without materially affecting other work.
- Re-cost local enhanced services (LESs) and other non-core income streams to ensure these remain profitable.
- Consider where delivery of LESs may change through PCN arrangements.
- Engage early with the ICB and PCN leadership about LVAs, neighbourhood working and any proposed changes to funding flows.
- Take advice on risk, governance, legal structure, pension treatment, and tax before taking on additional services through your PCN.
- Be 'Neighbourhood ready.'

Why these matter

The table (below) illustrates the funding impact for a GP practice with 11,000 weighted patients in 2026-27. Figures are before staffing increases and other operational changes and so are not a substitute for a practice-specific budget.

The effect will vary depending on list profile, 2025-26 Advice and Guidance earnings, weight management, and QOF achievements.

The PCN Capacity and Access support and performance payments have ceased. But practices can make a claim for this funding under a GP reimbursement scheme up to a maximum of £4.57 per adjusted patient (details below).

This funding pot could be around £50,000 for this practice. This does not represent additional earnings for the practice, as it can only be claimed when spent.

While the headline uplifts to global sum funding may appear significant, the practical position is more complicated. Many practices already spend a large proportion, if not all of their global sum, on staffing and so are reliant on QOF, enhanced services and local income streams for partners' earnings.

With funding moving out of Advice and Guidance and weight management, the possibility of LVAs and the uncertain nature of local funding, practices need to understand not just the income headline but the inflationary pressures, staffing costs and timing of payments on their bottom line and cash flow.

If clinical and administrative time is diverted towards access metrics, there is a risk of achieving less in other areas unless practices actively plan their workforce and workflow.

GP reimbursement scheme

The scheme allows practices to claim reimbursement for costs incurred in increasing or maintaining GP sessions, with the aim of improving patient access.

Although the operational detail was not available until late May, the SFE confirms that the scheme applies from 1 April 2026 to 31 March 2027.

The later explanatory note confirms that the funding for this scheme will remain within the core GP contract on a recurrent basis, beyond

Global sum	**£6.73 increase per weighted patient (based on 1 April 2026)**	**£74,030**
Out of hours deduction	**Reduced to 4.70% from 4.75% from 1 April 2026**	**(£2,800)**
Advice and guidance income	**Funding reinvested to global sum from 1 April 2026**	**(£10,320)**
Cessation of weight management	**Funding reinvested to global sum**	**(£1,208)**
QOF income	**18 additional points**	**£5,000**
Effect on profit before staffing increases and other changes		**£64,702**

"PCN member practices can transfer their funding entitlement to each other, subject to confirmation from the ICB"

31 March 2027 and will not transfer back to PCNs. But there is no confirmation that a GP reimbursement scheme will continue.

Under the scheme practices may be able to claim for:

- the employment of a new salaried GP providing additional sessions, where the GP has not been employed by the practice in the previous 12 months, subject to limited exceptions.
- extra sessions from an existing salaried GP at the practice.
- continuation of a salaried GP post previously funded through PCN Capacity and Access or PCN Test Sites programme. PCN member practices can transfer their funding entitlement to each other, subject to confirmation from the ICB.

Crucially the GPs for whom practices wish to make a claim do need to hold an employment contract.

Practices with more than 3,500 patients per GP need to contact their ICB before accessing the scheme for the ICB to understand their GP to patient ratio.

The scheme is subject to additionality conditions and practices should confirm they are not already claiming a reimbursement for the same costs.

The amount claimable is capped at £4.57 multiplied by the practice adjusted population (as of 1 January 2026), claimed via the Calculating Quality Reporting Service (CQRS) within three months.

The claim amount is the actual amount incurred by the practice, including on costs for employer's national insurance and pension.

But this is subject to a maximum of £152,900 (or £155,698 including London weighting) for new employed GPs a year. For additional sessions from existing salaried GPs, the claim is limited to £78.41 an hour (£79.84 where London weighting applies). Please note that these hourly rates were revised downwards in yet a further SFE amendment published on 24 June 2026 due to an error in the previous calculation. The maximum claims include on-costs. For an existing salaried GP who is a member of the NHS pension scheme, this equates to a gross hourly rate of £60.60 (£61.71 including London weighting).

Note that a practice can only ever make an annual claim up to its overall funding pot of £4.57 per adjusted patient.

Local Variation Arrangements (LVAs)

This flexibility was in the contract variation to the Network Contract DES and was effective from 1 May 2026.

It allows ICBs to request local variations to the PCN DES. It does not amount to a full neighbourhood contract structure, but it is a clear signal that practices and PCNs should be preparing for localised service redesign and potentially funding flowing away from their core contract.

"The potential of LVAs underlines the need for practices to understand which income streams are secure and which are locally determined..."

Practices will need to work closely with their PCNs, federations and other primary care providers.

LVAs would allow workforce funding and enhanced services to be redirected into PCNs along with any other local funding. This is likely to be redirection rather than new money. The core contract cannot be varied.

There has long been concern over LESs because they can form a significant part of practice funding but are 'bolt on' services and income which can change year on year.

The potential of LVAs underlines the need for practices to understand which income streams are secure and which are locally determined and may be reshaped through LVAs or future neighbourhood working.

PCNs should therefore be considering their own structure, not just in relation to LVAs but also future neighbourhood changes where services may move from secondary to primary care - the 'left shift.'

We assume this potential for a quiet reshaping of local services to start developing neighbourhood services (through the PCN) is separate from the proposed Multi Neighbourhood Provider and Single Neighbourhood Provider contracts, for which we await further guidance. However, the direction of travel is clear for practices and PCNs to start preparing.

Supporting publication timeline

- **31 March 2026:** the 2026 Statement of Financial Entitlements was published, confirming the global sum payment of £130.07 per weighted patient.
- **30 April 2026:** an amended SFE clarified locum reimbursement sums and included details of the GP reimbursement scheme. ***General Medical Services Statement of Financial Entitlements Directions 2026***
- **30 April 2026:** a contractual variation to the Network Contract DES was published, effective from 1 May 2026. ***NHS England » Primary Care Networks: Network Contract Directed Enhanced Service from May 2026***
- **1 May 2026:** operational guidance was published for implementing the 2026-27 contract changes for PMS and APMS practices.
- **20 May 2026 (updated 29 May 2026):** explanatory guidance for clarity on the GP reimbursement scheme, claims process and contract monitoring. ***NHS England » Supplementary information to support changes to the 2026/27 GP contract***
- **24 June 2026:** amendment to the SFE in respect of the GP reimbursement scheme hourly rate claims

At the time of writing, no further detail has been published on the long-awaited Carr-Hill formula review.

ASK AISMA!

GP accounting issues are tackled here by Abi Newbury****

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

TAX ADMINISTRATION REQUIREMENTS ARE CHANGING

Q **Am I affected by Making Tax Digital, or can I ignore it?**

A We are increasingly being asked by GP partners whether Making Tax Digital (MTD) applies to them, or whether it can safely be ignored.

Making Tax Digital for Income Tax (MTD ITSA) does not currently apply to GP partnerships. So if all your income comes through the partnership, you are not affected at present.

However, MTD applies to individuals, and that is where it becomes relevant.

Your partnership profit share is ignored but you may be brought into MTD if you personally have rental income (including premises held outside the partnership), a separate sole trade or any other self-employed income.

MTD is being introduced in stages:

- From April 2026 – income over £50,000
- From April 2027 – over £30,000
- From April 2028 – over £20,000.

This 'qualifying income' is based on gross income from property and self-employment combined, not profit. So, for example, a GP partner with £35,000 of rental income would be brought into MTD from April 2027, even if their main earnings come from the practice.

If you are affected, you will need to keep digital records, submit quarterly updates to HMRC and complete a final year-end declaration - effectively moving from annual to more regular reporting.

So can you ignore it? Yes, if your only income is from the partnership. Otherwise, probably not.

The key is to look at your own income position, not just the practice, and to take advice early so there are no surprises. The rules are being phased in but the first affected taxpayers need to start keeping digital records from 6 April 2026, with quarterly submissions required to be sent to HMRC from 7 August 2026.

DO WE NEED TO GET INVOLVED WITH NEIGHBOURHOOD HEALTH?

Q **Our practice is already under pressure and some partners ask why we need to get involved with wider neighbourhood working. Can we not just carry on providing general medical services to our own patients as we always have done?**

A It is an understandable question. Most practices are already dealing with rising demand, workforce pressures, premises issues and increasing administration. Anything that looks like another meeting or another system initiative can feel like a distraction from the day job.

However, neighbourhood working is now clearly part of the direction of travel for the NHS. The aim is to move more care closer to patients, with general practice, community services, social care, mental health teams, voluntary organisations and other local providers working more collaboratively.

The issue for practices is not whether change is coming. It is whether you are involved early enough to influence it.

There are potential benefits for patients. Better links with community, social care and voluntary services may help with frailty, long-term conditions, mental health, safeguarding, hospital discharge and wider support needs.

These are all issues that often land in general practice, even where the solution is not purely medical.

There may also be benefits for the practice. Stronger local relationships can make it easier to know who to contact, where to refer, and how to solve problems that otherwise keep coming back to the GP or practice manager. Good neighbourhood working should reduce duplication, not add to it.

There is also a commercial point. Future service developments, premises opportunities and local funding are likely to follow the neighbourhood agenda.

Practices who engage early are more likely to understand what is coming, shape the model and protect their own position. Early adopters often benefit because they are at the table while decisions are still being made.

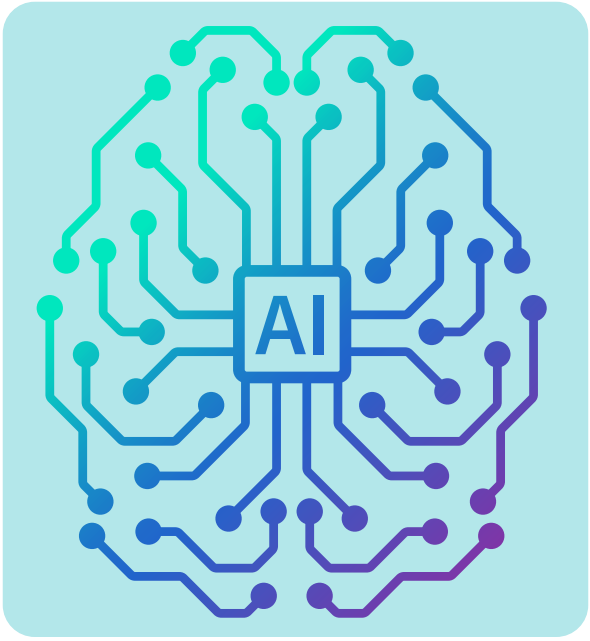
That does not mean signing up to everything. Practices should be clear about workload, funding, staffing, governance and clinical responsibility. If you are asked to take on new work, you should ask who is paying, who is accountable and what support is available.

The best approach is to engage positively, but practically. Ask what problem is being solved, what the benefit is for patients, what the impact will be on the practice and whether the proposal is properly resourced.

General practice should remain at the heart of patient care. The opportunity is to make sure neighbourhood working supports that role, rather than allowing decisions to be made around practices without their input.

CAN AI HELP OUR PRACTICE OR IS IT TOO RISKY?

Q **I recently joined a fairly 'old school' practice and am keen to update how we work, including using AI to help with routine tasks. Some partners are nervous about this and worry that AI is risky, unsafe or a threat to traditional general practice. How can I explain the benefits and suggest a sensible way forward?**



A Your partners are right to be cautious, but caution does not have to mean doing nothing.

AI should not be used as a substitute for clinical judgement, but if used carefully then AI may help reduce some administrative pressure that makes traditional ways of working harder to sustain.

The best starting point is to focus on low-risk, practical uses. For example, AI can help draft meeting notes, prepare patient newsletter text, simplify patient information, summarise non-confidential guidance, produce first drafts of policies, or help structure agendas and action lists. These tasks still need human checking, but they can save time and reduce duplication.

Practices may also later want to consider more specialist tools, such as approved systems for document handling, inbox triage or consultation scribing. These need proper review before use, including data protection, consent, information governance, clinical safety and supplier assurance.

The discussion with partners should not be about using AI because it is fashionable. It should be about whether the practice can use modern tools safely to free up staff time, improve communication and reduce avoidable workload.

A sensible approach would be to agree some basic rules: no identifiable patient data in unapproved tools; no AI-generated patient communication without review; no clinical decisions made by AI; and no new system introduced without practice approval.

Then start small. Choose one administrative task, test whether AI genuinely helps, review the output and decide whether to continue.

The safest practices are unlikely to be those that ignore AI completely. They will be the practices that understand the risks, set clear boundaries and use AI only where it supports staff and patients.

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Stay in control and avoid costly last-minute surprises

Premises' repair, maintenance and dilapidations liabilities are easily overlooked but your obligations can pose significant financial risks, particularly at lease expiry. Rachel Croft and Stephanie Trompeter provide practical steps to help you manage and save money

GP practices typically occupy surgery premises or health centres under a lease and are often responsible for the full cost of repair and maintenance even where they do not own the building.

In most cases, the lease for what is one of your most valuable and costly assets will be held by GP partners or a company, who bear liability for compliance.

If your obligations are unmet then the landlord may bring a claim for dilapidations - damages for breach of lease covenants relating to the state and condition of the premises - usually at or shortly after lease expiry.

So it is important to understand the extent of your repairing obligations as early as possible. Here are five practical steps to help you plan ahead and limit your exposure to claims.

1 Plan ahead

Well in advance of lease expiry, review the tenant obligations about the condition in which the premises must be returned. These typically include obligations as to repair, decoration and reinstatement.

Key questions to consider include:

- Are you required to keep the premises in 'good repair', or only in no worse condition than evidenced by a schedule of condition?
- What statutory compliance obligations apply, for example, fire safety, gas and electrical safety, and water hygiene?
- Have you carried out alterations which may need to be removed at the lease-end, such as accessibility adaptations or internal reconfigurations?

You should also locate all documents supplemental to the lease, such as licences for alterations, deed of variation and any schedule of condition. A schedule of condition can significantly

reduce dilapidations liability but is often difficult to locate many years after completion, weakening your negotiating position.

2 Seek early input if you plan to do the work

Consider instructing a chartered building surveyor to advise on the works required to comply with your lease obligations at term-end.

Carrying out works requires time and planning. You will need to allow time to procure contractors, obtain quotes and complete the works before lease expiry.

Doing the works gives you greater control over cost and quality. But there is a risk you do things the landlord would not ultimately have required, or which do not materially affect the level of a dilapidations claim.

The alternative approach is to wait until lease expiry and respond to a terminal schedule of dilapidations. In that scenario, you are no longer doing physical works to the premises but engaging in a financial negotiation to settle the landlord's claim for damages.

This shifts the focus from carrying out repairs to assessing the validity, scope and value of the landlord's claim, often with the benefit of legal and valuation arguments.

This distinction is important because a landlord's claim is ultimately limited, by statute, to the diminution in value of its interest in the property, which may be significantly less than the cost of carrying out the works.

3 Budget for repairs

Practices should ideally set aside funds on an ongoing basis throughout the lease term to meet repair obligations. This helps spread the financial burden and avoids a large, unexpected liability at lease expiry.

Financial planning should begin at least one year before lease expiry. Without adequate preparation, practices - particularly partner-led practices - may face substantial and potentially unaffordable liabilities at lease end.

Note that agreeing a new lease of the same premises, whether by renewal under the Landlord and Tenant Act 1954 or otherwise, does not eliminate existing dilapidations liability.

That liability is instead typically deferred and may continue to accrue, ultimately crystallising at the expiry of the new lease. As a result, entering into a renewal lease without addressing the condition of the premises can simply postpone, rather than resolve, the issue.

Where a lease renewal is being negotiated, practices should consider seeking to agree a schedule of condition to be attached to the new lease.

This can limit future repairing obligations by reference to the documented state of the premises at the start of the new term, helping to manage long-term exposure.

4 Seek specialist advice

A terminal schedule of dilapidations is often served shortly before, or after, lease expiry. Once received, it should be reviewed by a specialist solicitor

working alongside a chartered building surveyor.

Specialist advice can often significantly reduce the level of a landlord's claim. Landlords may seek to include:

- Improvements or upgrades rather than repairs, for example the replacement of items not yet beyond economic life
- Items falling outside the tenant's legal obligations, and
- Inflated costs or claims which do not reflect the landlord's actual loss.

It is also important to consider valuation evidence. In some cases the diminution in value of the landlord's interest may be significantly lower than the cost of the works, and the claim may be reduced substantially, potentially to nil.

Practices should also consider if any liability can be passed on to third parties, such as undertenants or occupiers.

5 Find out the landlord's intentions

The landlord's intentions for the premises after lease expiry are highly relevant to the value of any dilapidations claim.

For example, if the landlord intends to redevelop the property, carry out substantial refurbishment, or grant a new lease to a third party, then the value of its claim may be significantly reduced.

Practices should monitor planning applications, review any notices served and, where appropriate, make inquiries through local agents.

It may be possible to negotiate an early settlement with the landlord. A pragmatic and collaborative approach can help crystallise liability sooner and reduce ongoing professional costs. But be cautious and take legal advice to avoid the risk of overpayment.

Rachel Croft and Stephanie Trompeter are real estate litigation specialists at Hempsons

Some other key lease considerations for GP practices

Be aware of other important landlord and tenant issues. These include:

- rent review provisions, which may lead to significant increases in rent over time
- service charge obligations, particularly in multi-occupied health centres where costs can be substantial and difficult to challenge
- restrictions on assignment or underletting, which may limit flexibility if the practice structure changes, and
- break clauses, which may contain strict conditions to be operative.

Practices should review alienation and sharing provisions carefully, especially in light of PCN arrangements and the increasing use of space by third-party clinicians.

And do not forget security of tenure under the Landlord and Tenant Act 1954, because it affects your renewal rights and negotiating position at lease-end.