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association of independent specialist medical accountants

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AISMA Doctor Newsline

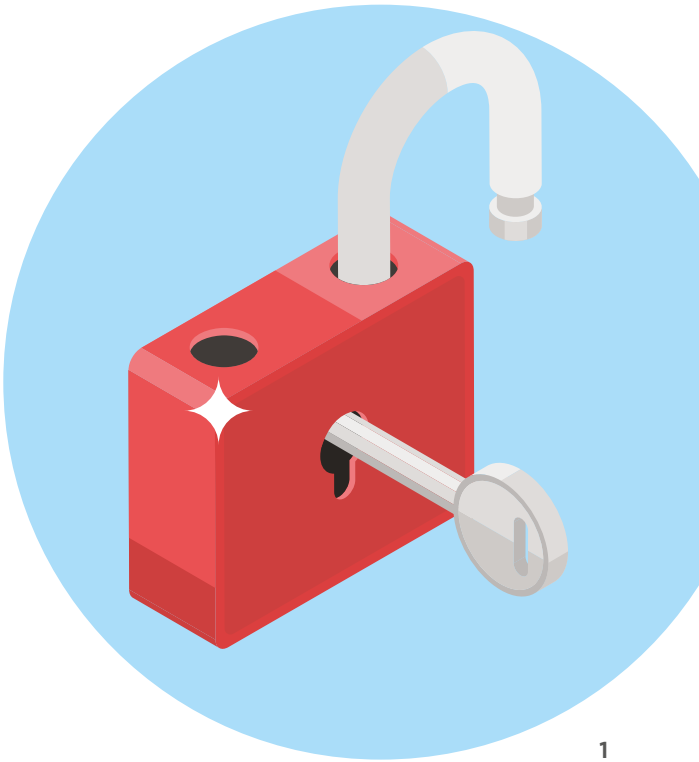
At the heart of medical finance...

Check these tips to aid your practice's recovery

As practices emerge from the pandemic, **James Gransby*** sets out some key financial tips to consider now

Many lessons have been learnt by GP practices in these last few testing months and the profession will benefit from huge progress made in clinical delivery.

As lockdown eases practices might wish to put thought to the following financial considerations:



Looking back

The Government announced financial assistance at a blistering pace and it would be easy to have missed what was available or made some mistakes along the way, so here are the main points and some actions you may need to take now.

1 SSP reclaim

At the outset of lockdown there was the ability to make claims under what was called the Coronavirus Statutory Sick Pay Rebate Scheme for most employers with under 250 staff who

experienced employees taking time off sick because of Covid-19.

Did your practice qualify for a claim and has it now made it? There are more details here:

https://www.gov.uk/guidance/claim-back-statutory-sick-pay-paid-to-employees-due-to-coronavirus-covid-19

2 Furlough

There have been mixed messages on this topic from the Government and it is still a slightly grey area.

GP practices were excluded from claiming furlough payments and NHSE also released guidance notes confirming this since practices are being reimbursed for Covid-19 related expenditure.

However, there are certain classes of employee whose services were no longer needed during lockdown and whose salaries cannot be claimed for as a reimbursement, and some practices may have made a claim in respect to those employees.

This is an area where practices should seek further guidance to consider carefully whether to repay any money claimed because the Government is looking to write to people who have done this incorrectly.

3 Cost of equipment

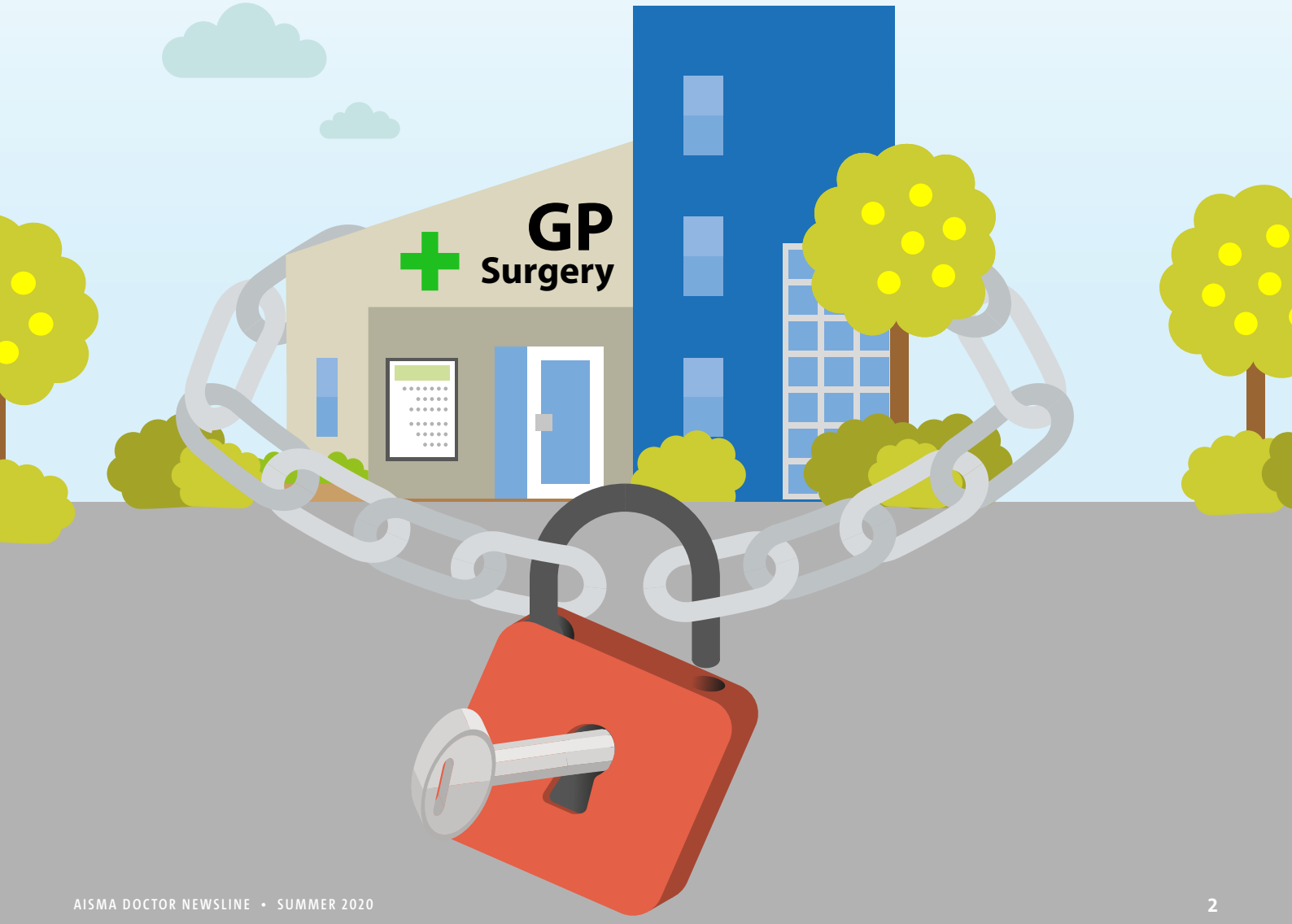
For PPE there is a specific claim form, developed jointly by the BMA and AISMA, which can be found here:

https://www.aisma.org.uk/claiming-additional-costs-covid-19/ .

In the pressure of frontline working it would have been easy to miss potential claims and so looking back over expenses to see if any were missed, including the reimbursement for Bank Holiday working, could prove to be time well spent.

4 Financial housekeeping

- NHSE has made some pledges during Covid-19 including: 'That means that we will be



"Practices are now experiencing a strong increase in patients, perhaps having not presented with conditions which have now deteriorated, and so when this increased workload comes through the locum GPs may be in extremely high demand again for a period"

continuing to pay global sum at the rate agreed in 2021, there will be arrangements for continuing to pay QOF, DSQS in dispensing practices, and then around some of the DESs.'

Practices should review income received from the NHS to ensure payments have indeed been received in line with these proposals.

- Some enhanced services will have taken a back seat during lockdown, for example minor surgery procedures. So now is the time to consider how you will prioritise what the practice does over the next few months, balancing up those which are most lucrative financially against those most critical for patient care.

- Other aspects of financial housekeeping would involve checking that the partners' 2018-19 superannuation certificate adjustments have been processed (usually in March) as this could have either a positive or negative cashflow effect depending on whether there was a net refund or net shortfall position. This could be more important this year if cashflow is tighter than previously.

The present

Many practices now aim to boost their remote consultation technology and some are considering reconfiguring their practice space.

Investment in infrastructure changes, whether that is reconfiguring a building or investing in technology, requires money.

Things to consider here are:

- Watching tax relief in relation to the Annual Investment Allowance (AIA).

Currently up to £1m of eligible expenditure is given 100% tax relief in the year of expenditure. But this is dropping to £200,000 from 1 January 2021.

While you may consider that £200,000 is sufficient, be aware that the introduction of the lower allowance is pro-rated and so for those with a March 2021 year end there is only a £50,000 allowance in the three months January 2021 to March 2021 (3/12ths x £200k).

Therefore expenditure above that £50,000 level should be incurred before 31 December or after 1 April 2021 for 31 March year ends.

- Will your GPs look to find money for capital expenditure from their own money, say, by reducing drawings or injecting personal funds, or would they prefer to obtain finance for this equipment while interest rates are low?

This should be a consideration well in advance of the expenditure being incurred as specific finance can only be sought then and not after.

- Partners who are due to retire soon may have less of an appetite to part with their money and profits to spend on projects which they will not see the benefit from. This is an understandable viewpoint and so building up a separate capital reserve could be considered. For many this could be the first time they have thought about this.

Other operational measures to look at now could include:

- Frontline general practice does not look the way it used to and so ensure your workforce mix is correct for any changes in the way you are now working. An example is staff overtime. If you have been able to cut staff overtime costs during the lockdown, keep an eye on this creeping back up. Is all overtime necessary?

- Locum use has been lighter during lockdown due to changes in working practices and fewer patients presenting.

Practices are now experiencing a strong increase in patients, perhaps having not presented with conditions which have now deteriorated, and so when this increased workload comes through the locum GPs may be

in extremely high demand again for a period.

A GP practice should ensure it has the financial capacity to pay for these extra locum sessions when they are needed and locums themselves may wish to prepare for the workload increase.

Similarly, if you have reduced locum costs during lockdown, are you able to maintain this saving in future?

Locum fees are one area where costs can swiftly get out of control. Are you able to maintain a similar pattern of working post lockdown rather than simply reverting to how things were before? This will take some careful thought about meeting patient need while 'retraining' patients into accepting more efficient and effective ways of working.

- Drug and instrument costs may have risen significantly due to demand. It may now be the time to think of ways to mitigate these costs such as joining a buying group or collective purchasing via the PCN or buying generic rather than branded items.

Are actual stocks being checked before an order is placed? And could it be that several people in the same practice are ordering the same item separately rather than coming together to order in bulk?

"If you are planning on incurring the cost of very deep cleans of Covid-19 areas in due course then make sure this cost is claimed back where you can "

- Reviewing indemnity/insurance renewal prices can sometimes lead to a reduced cost as some are still high. One factor may be down to partners still doing significant 'outside' work but if this has dropped then the annual charge should be negotiated.

- If you are planning on incurring the cost of very deep cleans of Covid-19 areas in due course then make sure this cost is claimed back where you can.

- If some staff members have performed above and beyond during the crisis then perhaps reward them with a financial bonus, or additional time in lieu, if resources permit.

The Future

Some things to look out for on the horizon could include:

- Make the most of pensions relaxations while they are in place. The 24-hour retirement rules were relaxed as part of the Coronavirus Act meaning that the 16-hour working restriction does not need to be adhered to for those retiring from the 1995 section of the NHS Pension Scheme.

If this were something that would have been an inconvenience to you and the practice then perhaps consider if you can benefit from this relaxation while it is available.

- If you need to defer your 31 July 2020 tax payment due to being hit financially as a result of Covid-19, then ensure you save up enough by 31 January 2021 as the tax which you have deferred will become payable by then at the latest.

- For those who own their surgery it could be time to look at re-financing while bank interest rates are so low.

This could free up some equity locked in the building or reduce monthly outgoings in the form of mortgage repayments. This is a complex area and the existence of early repayment charges would need consideration. But it may now be a good time to turn attention to this if it has not been looked at in recent years.

- One item which can often be put on the backburner during a crisis is updating your partnership agreement, particularly if this has not been updated to reflect the practice's involvement in the PCN or if there have been partner changes.

But it may now be a good time to revisit this. For example does it cover the scenario of who pays the tax charge in the event of Final Pay Controls being charged?

There will be many aspects to consider and while this certainly is not an exhaustive checklist of points, hopefully some issues raised here have been useful to you in your practice.

Safeguarding your future

OPINION

Deborah Wood
AISMA chairman

Since our last edition I have taken over as AISMA chairman from Bob Senior and AISMA has celebrated (albeit in a subdued way) its 25th anniversary. Little did I think that my first opinion piece in my new role would be written following 15 weeks of pandemic enforced lockdown arrangements.

It has been an exceptional time of accelerated change to deliver emergency services across the NHS and for those of us not on the frontline, but supporting our clients in general practice, we too have had to quickly adapt to the changes needed to maintain business as usual.

This has meant moving into a working world where everyday use of virtual technology has become commonplace, has benefited patient and staff safety, has created flexibility and saved time.

The rapid introduction of these new approaches will no doubt be built on further over coming months, notwithstanding the need to be vigilant around data protection - as Babylon can attest to.

A short word of warning to those medical professionals returning to support the NHS during this crisis period: keep your personal tax affairs in order! HMRC has highlighted that these returning workers have been targeted by unscrupulous promoters of tax avoidance schemes and it will be challenging any such schemes and seeking to collect underpaid tax.

With a lessening of the strict social distancing measures now it means starting to look ahead and plan for whatever the next 'new normal' becomes. James Gransby, our new vice chairman, has provided an excellent article in this edition to assist with this planning process.

For practices and GPs this will mean taking the opportunity for a mid-year review of finances, assessing what patients are going to need over the next few months and establishing staff capacity to safely deliver the priorities within the current year's contract and the NHS Long Term Plan.

There may be a resumption of more face-to-face consultations and the opportunity for practices to consider the impact for equitable healthcare systems on their more vulnerable patients who have been unable to adapt so easily to the economic and social requirements they have been placed under.

Collaboration across the PCN footprint and wider federations has continued at pace and has no doubt assisted the 'hot hub' Covid-19 patient experiences in recent months.

This is ramping up again with more additional roles funded and demand, particularly around the care home sector and requests to do work usually carried out in secondary care, increasing. The BMA has identified a significant backlog of care needs which will soon need to be addressed.

As is usual at this time of year, AISMA accountants will now be helping practices check they have received the income streams they are entitled to and know their correct tax and superannuation position arising, in particular from any surplus funds held in PCN bank accounts, as they prepare the annual financial information for 2019-20 and consider the impact of likely changes during 2020-21 on tax and superannuation payments on account.

One tip is to plan now to purchase additional supplies of PPE prior to 31 July 2020 while the rate of VAT is temporarily reduced to 0%.

Part of our client work will involve consideration of the annual allowance tax charges applicable and the need to consider scheme pays elections by the relevant due dates (31 July 2020 for the 2018-19 charges). GPs who think this affects them need to seek specialist independent financial advice.

AISMA continues to work with many organisations such as PCSE, NHS Pensions, NHSE/I, the BMA and HMRC to try to ensure GPs and practices are receiving relevant and up-to-date information to assist them to manage their affairs on a timely and efficient basis.

There are still backlogs of unprocessed pension certificates, missing service records, uncollected contributions, and unreconciled seniority payments. Expected improvements to systems should eventually start to make an impact.

Finally I hope that all our readers are able to find some time to take a break, have a change of scene and recharge their batteries over the summer ready for the coming months, hopefully without a second spike.

10 steps to help you cope with Covid-19 changes

Massive changes experienced during the pandemic require some crucial management input for the path ahead. Fiona Dalziel sets out her way forward

A little ironically, my last article in the Spring issue of AISMA Doctor Newsline was entitled 'Ten tips for keeping your distance'. Now, the world has changed and we are all keeping our distance - in a different way - as if our lives depended on it.

Although general practice has experienced much change and, indeed, some people would say that it has been almost constant for about 30 years, the changes forced through in reaction to the pandemic have been massive.

Practice teams have coped magnificently with enormous changes in service delivery that would normally take months to plan and implement. Staff have stepped out of their comfort zones and taken on new roles and different ways of working with commitment and good will.

This is what usually happens in an emergency and thank goodness for people stepping up to cope with a challenge and support each other. GP practices are good at both handling emergency situations and coping with change. However, now that we are starting to emerge blinking into the daylight of the 'new normal' what next for practices?

What do we want our 'new normal' to be and how do we work this all out? How you handle these changes is crucial and sets the tone for the future.

Be prepared for significant shifts. Two GPs

I have spoken to recently now have opposing viewpoints. One was horrified at not having touched a patient for a whole week and the other was really loving the video consultation model.

Step 1 - Gather some data

Of necessity, decisions were taken fast, but they may have had unintended consequences.

The data you gather will need to be both quantitative and qualitative and gathering it should be a shared activity, indicating to staff and patients that you are actively listening.

As well as data such as consultation rates, referrals, and other workload data, talk to people and see how they are feeling. Find out what the important questions are now and ask these questions of both staff and patients. Be prepared for people having a lot to say.

Step 2 - Ask these questions about experiences

What has been the impact on interacting with patients (clinical team's points of view and patients' points of view)?

What has been the impact on quality of care/ continuity?

What has been the impact on how the team functions?

What has been the impact on your work content?

What has been the impact on you as an individual?

Clearly, this is not an exhaustive list.

Step 3 - Share the data

Sometimes, this stage is forgotten. You may feel that this is important enough to be done in writing followed up with a whole team meeting to discuss (see items below).

Step 4 - Get together again as a team

After weeks of home-working, working in separated teams and wearing hot PPE (and within current distancing guidance), simply meeting as a team is vital.

Make it a big 'thank you' and as much of a celebration as you can, bearing in mind the extent to which your team members have been personally impacted by the pandemic. This may need to wait until lockdown rules allow larger gatherings.

Step 5 - Have a whole team significant event meeting

Someone with experience should chair this and stick as much as possible to well-tried significant events analysis structure so that positives do not get lost. This may feel emotional for some – think about how best to approach this sensitively. Focus on the learning and how you will take it forward.

Step 6 - Meet to plan

Another get-together, again once rules allow, but this time to work out how the practice will move forward.

By this stage, you should have accumulated and shared your data and, hopefully, had both a thank you/celebration and possibly a significant event meeting – you will have already learned a lot.

Step 7 - Check out values first

This is an opportunity to get back to basics. Consider questions such as:

What does it mean to work in this practice?

What are the important values to which we all subscribe?

What kind of behaviours fit with this value set?

Step 8 - Review the current position

Use a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis to explore the following:

Where do we stand on such important issues as standards of care, access, continuity of care, workforce, safe systems/risk management, premises? As these are mainly internal, these will

"This is an opportunity to harness the commitment everyone had during lockdown, give everyone back a sense of control and make changes for the future which involve the whole team "

be strengths or weaknesses.

What is on the horizon for us? This will mainly concentrate on external influences, so these are opportunities and threats.

Step 9 - What are our options for the future?

What are the important things in the practice now?

Looking back at the agreed values, what do we need to prioritise?

What do we value that is now lost or threatened?

Looking back at the agreed values, what do we need to do less of?

What is better now, that we want to keep or develop?

What do we need to investigate further?

Step 10 - What needs to happen next?

Having spent time looking in depth at the complex issues above, this should be a relatively simple process.

What action areas do we have now?

What is going to be the best sequence in which to tackle these? This may involve identifying an interim position as pandemic guidance changes.

Within which timescales do things need to happen?

Who will lead on each action area?

How will progress and problems be reported back and to whom?

Make sure this is all written down and distributed quickly after the event.

And another thing...

People are the practice's most precious resource, as you know.

Now is the moment to take the time to show them how they are valued and thank them. It is equally important that you now take the opportunity to give everyone a part to play in shaping the future.

Think about how this can be more than just coming to a meeting. It may be that you ask them to take part in a working group, research something or take forward introducing a change in the practice.

This is an opportunity to harness the commitment everyone had during lockdown, give everyone back a sense of control and make changes for the future which involve the whole team.

Reference material

Guidance on Significant Event Analysis for the team can be found at

https://www.nes.scot.nhs.uk/media/346578/sea_-_full_guide_-_2011.pdf

Fiona Dalziel runs DL Practice Management Consultancy

AISMA Doctor Newsline is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK.
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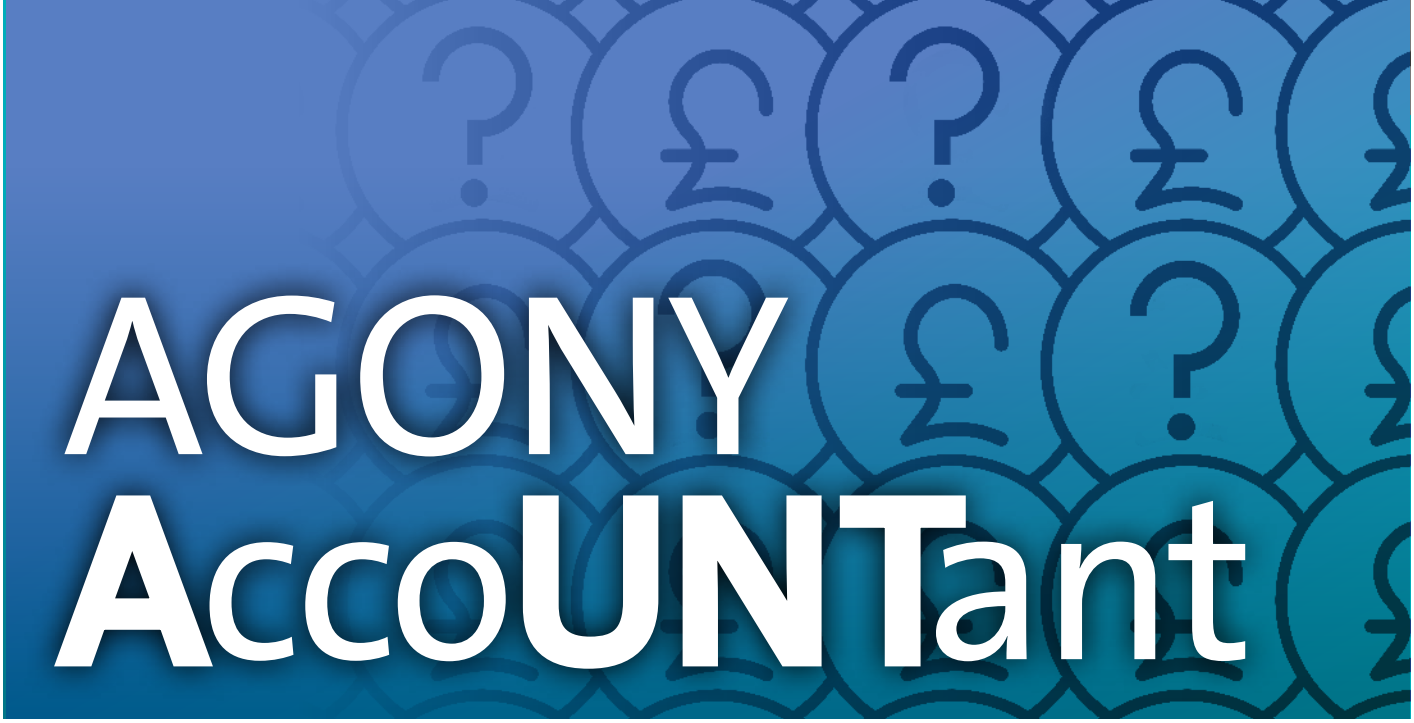


AGONY AccoUNTant

Our Agony Accountant Abi Newbury** answers more of your questions about general practice financial issues

You can ask a question by contacting your local AISMA accountant or messaging us through Twitter @AISMANewsline

In this issue she tackles a query about superannuation in the accounts

OUR NEW ACCOUNTS FORMAT WON'T HIT YOU IN THE POCKET

Q **My accountant has changed how they show superannuation in the accounts and it's made the profit bigger – won't that mean I pay more tax?**

A Short answer = no! But let's travel back through history to explain what has happened over the years and why the treatment is changing.

Before the 'new' contract in 2004, income was paid to practices net of the employer superannuation and it was effectively ignored.

When the 2004 contract came in, the new funding included an element intended to cover the employer's superannuation, so gross funding increased. The 'employer' so far as the practice is concerned, is broadly the NHS (the names have changed over the years), so it was correct to show superannuation paid as a cost to the practice, rather than a cost to the individuals.

Charged to the profit and loss account

The accounts treatment at the time, therefore, was to show the increased gross income, but with a deduction for the employer element of the partners' superannuation, so that there was no net effect on income declared.

To ensure the right partners bore the correct superannuation, the charge for the employers' superannuation was shown as a 'prior charge' to each partner, along with any other income or expense pre-shares before the balance of profits were shared out.

Then for tax purposes employer superannuation paid by each partner was 'added back' to give a higher taxable profit – enabling the amount paid to be claimed on the tax return in line with HMRC requirements – to end up with the same net effect.

Why the change in treatment?

Over the years, the gap between funding received for superannuation and what was actually paid widened and blurred, and now the employer contribution has increased by an additional 6% – but the increase is met outside practice funding – that does not show up in the accounts at all.

With more people opting out of the pension scheme this has been distorting base line profit levels on the face of the accounts. And that in turn makes comparison between years difficult, as well as comparison with the other partners' profit levels, other practices and indeed across the country in AISMA's annual GP survey.

Charged to drawings

So while accountants still believe that the employer element is technically a correct charge in the profit and loss account, AISMA has decided that the time has come to simplify it and charge the employer element of superannuation directly to drawings, just like the employee element.

This does mean that the individual profit shares in the accounts will increase but it will not give any extra to take out because the employer contribution is shown in drawings, leaving the net effect (year-end current account balance) exactly the same as before.

For tax purposes, the superannuation has always been 'added back' – so the tax return figures will not change, and the claim on the tax return for superannuation will be the same as before. So, there is no change to the taxable income at all.

In future this should bring clarity, and for those that have been on the historical basis up to now, rest assured that there is:

- No effect on tax and
- No effect on your current account or what you can draw from the practice.

But it might make it easier for you to understand the accounts!

WHY WE STILL NEED YOUR TOTAL REWARD STATEMENT

Q **I thought I didn't need to worry about Annual Allowance charges since the limits went up in the Budget so why does my accountant keep telling me to get a copy of my total reward statement?**

A The 2020 Budget increased the levels at which the pension allowance started to reduce, with the new limits as follows (see table below):

These increases mean that most doctors who have previously been caught by Annual Allowance tax charges will no longer suffer from a tapered annual allowance, and therefore may well escape ongoing charges.

	2019-20	2020-21
Earnings limit for full £40k pension allowance	**£110,000**	**£200,000**
Limit including pension input	**£150,000**	**£240,000**
Limit at which allowance reduced to minimum	**£210,000**	**£312,000**
Minimum allowance	**£10,000**	**£4,000**

"It is good practice for every doctor in the NHS Pension Scheme to keep an eye on their pension record each year"

But high earners may still be caught - and the very highest earners are actually worse off.

Note that the maximum pension allowance itself did not change and there will still be occasions where the pension input exceeds £40,000.

Anticipating the position in advance is not necessarily possible. For a GP partner it might be that profits are particularly high for a year, and not always deliberately.

For example, we have seen huge one-off hikes in pensionable profit in a year where a mixture of retiring partners, resilience funding and inability to get locums has coincided. CCG appointments can produce unexpected results, and for hospital consultants, promotion will give rise to a one-off increase which can be huge.

So, the accountant will want to keep an eye on unused relief each year. If there is a high year they will then be able to work out if a tax charge might arise with sufficient warning for the scheme member to decide whether to use the scheme pays mechanism or fund the tax themselves.

It is good practice for every doctor in the NHS Pension Scheme to keep an eye on their pension record each year so that they can follow up on any errors or omissions.

There are too many cases of primary care support services not acting on pension certificates and pension records not being updated, or CCGs being unsure if a post is practitioner or officer which can make material differences and need to be followed up sooner rather than later.

It would not be easy to track down pension input errors if you do not discover them until retirement.

So, while the rule changes will certainly take many more doctors out of this tax charge it will not be 100% of them and keeping an eye on your pension record continues to remain vital.

Covid-19 brings legal issues for GP practices to consider

General practice has faced its own unique challenges during the pandemic. Alison Oliver examines legal issues arising during Covid-19 and highlights points for practices to be aware of

NHS contract amendments

Early on during the Covid-19 pandemic, regulations were passed to amend the GMS and PMS regulations and APMS directions aiming to free up capacity in general practice.

These changes enable NHS England to temporarily suspend certain specific terms of GP contracts, temporarily amend the definition of 'core hours' to include Good Friday, Easter Monday and bank holidays and increase the minimum number of appointments made available for 111 direct booking.

Suspended services included new patient reviews, over-75 health checks and certain other routine patient reviews that cannot be viably conducted remotely.

The amendments to the GP contract regulations remain in place and these measures remain available to NHS England where a disease is or is anticipated as being pandemic or a serious or potentially serious risk to human health.

Patient services

Recent surveys by the BMA and Medical Protection Society have identified the medical profession is concerned that prioritising treatment of Covid-19 has had an impact on care for non-Covid-19 patients and that this could lead to an increase in claims against practitioners and providers.

It is important for practices to make information available to all their patients about how they can access care if they need it and that they continue to provide care to their patients on the basis of what they decide is clinically appropriate.

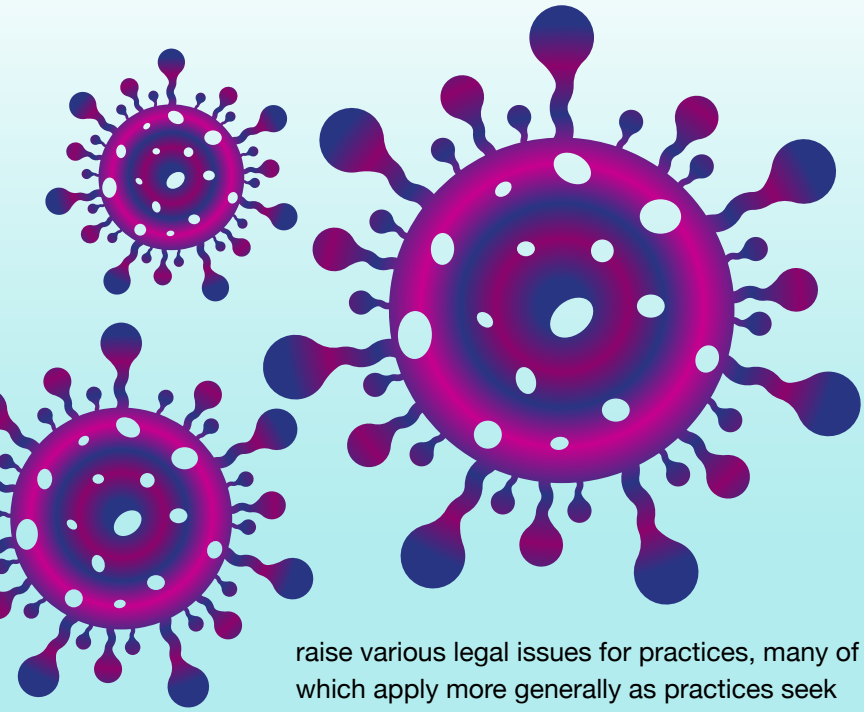
NHS England's letter to practices on 4 June 2020 reiterated that patients identified as clinically extremely vulnerable (shielding patients)

"Confidentiality is obviously paramount. The practitioner conducting the consultation must ensure no one can view or overhear the call without the patient's consent. The security of the platform used for the consultation must also be considered"

may be less likely to seek and access NHS care, and outlined guidance on meeting their needs.

This includes identifying a named care coordinator or point of contact, providing care at home, virtually or online where necessary, providing safe infection-controlled clinical settings where patients do need to attend in person and coordinating across primary, community, mental health and hospital care to make every contact count.

GP practices obviously have a key role to play in identifying and supporting shielding patients and the measures proposed in the guidance



raise various legal issues for practices, many of which apply more generally as practices seek to find new ways of delivering care safely for patients and their staff. Some of these issues, such as remote consulting and premises considerations, are explored further below.

Remote consultations

The Covid-19 crisis has accelerated interest in the use of technology to facilitate non face-to-face consultations with patients. As well as protecting patients, remote consultations have also enabled practice medical staff to provide patient consultations from home where they are unable to attend the surgery. But there are many potential pitfalls and risks associated with remote consultations.

Clearly it is essential that whatever platform is used it enables the practitioner to confirm the person they are speaking to is in fact the patient and then to interact with them appropriately to assess their condition and their needs.

They also need to obtain the client's consent to consulting in this way – while this is implied by them accepting the appointment, it is good practice to expressly confirm and record this consent and confirm if the consultation is being recorded. The practitioner should consider whether there are any safeguarding issues and whether these can be explored fully via a remote consultation.

Confidentiality is obviously paramount. The practitioner conducting the consultation must ensure no one can view or overhear the call without the patient's consent. The security of the platform used for the consultation must also be considered.

Most readers will have seen news of the software error that resulted in a Babylon Health patient being able to view recordings of several other patients' video consultation (see, for example, the *GPonline* article on 12 June 2020). While all possible measures should be taken to avoid data breaches, if they do occur, practices will need to report them to the Information Commissioner and inform any patients whose data has been affected.

Network Contract DES

Although not directly related to Covid-19, the 2020-21 Network Contract DES Specification was published at the end of March and has been an additional matter for practices to consider.

The deadline for practices to sign up was 31 May, despite calls for this to be delayed. The new specification introduces the early cancer diagnosis, structured medication review and medicines optimisation and enhanced health in care home services alongside the existing extended hours access and social prescribing services.

"It is important when asking staff to do different tasks and in different ways to consider whether what you are asking them to do is permitted under their employment contract"

Although certain obligations do not start until later in the year, there is still much for practices to do to ensure they comply with the Network Contract DES requirements if they have signed up, including:

- submitting a workforce plan to their commissioner setting out their plans for employing additional roles under the Network DES reimbursement scheme
- considering how they will work with other providers and forming multidisciplinary teams to deliver the enhanced health in care home service
- delivering their existing extended hours access and social prescribing obligations – these have not been suspended under the GP contract pandemic measures.

There is an express obligation on Primary Care Networks (PCNs) to update their network agreements to reflect updated DES requirements and practices need to be addressing these matters alongside dealing with their core work and Covid-19 response.

Employment

There have been many employment issues for practices to consider arising from the Covid-19 response, including:

- Ensuring staff are, as far as possible, protected from exposure to the virus
- Making arrangements for staff who are shielding or in quarantine to work from home
- Redeploying staff into different roles either within the practice or in other parts of the NHS
- Working with retired staff who have come back to work to assist with the Covid-19 response
- Helping staff to work in different ways, such as providing remote consultations.

As an employer, you are responsible for an employee's safety at work and for ensuring they do their work safely. It is important that practices carry out risk assessments regularly and make reasonable efforts to respond to identified risks.

Where appropriate, those assessments should take account of the personal circumstances and vulnerabilities of individual staff members. Practices also need to ensure they have adequate insurance in case things go wrong – they should check that insurance cover is sufficient if asking staff to work in different locations or in different roles.

If staff are working in other organisations, practices should agree with those other organisations how risks and liabilities for those staff will be shared. The same applies if practices are utilising staff from other organisations.

It is important when asking staff to do different tasks and in different ways to consider whether what you are asking them to do is permitted under their employment contract: if not, you should if possible seek their agreement to such changes.

While you can issue a 'reasonable management instruction' to enforce changes in working arrangements, this must be reasonable and have regard to the qualifications, skills and competencies of the staff members concerned.

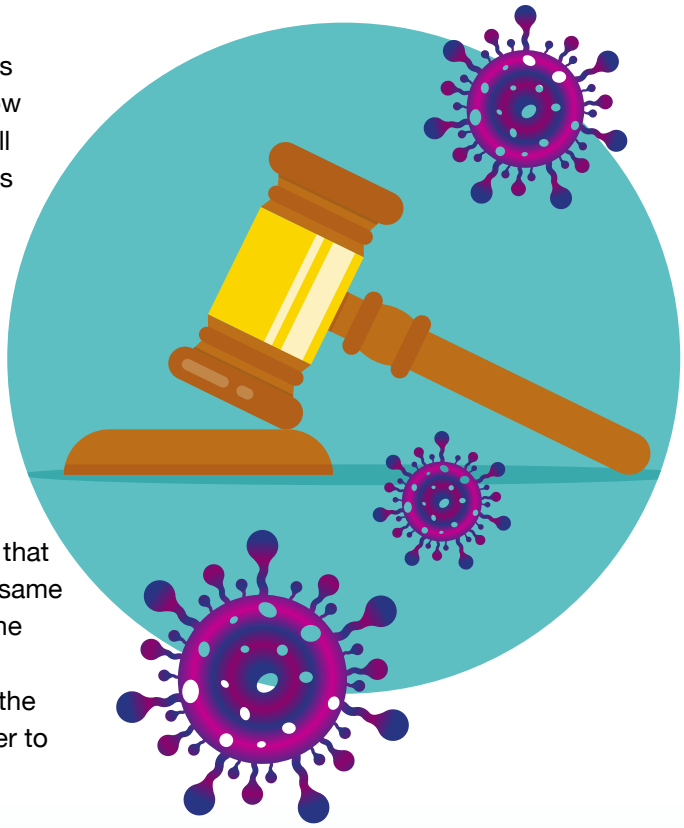
Practices should also provide training and support to help employees who are having to work in different ways or do different jobs from those that they are used to.

Premises

Practices have had to work particularly hard to adapt how their premises are used to minimise the risk of infection for patients and staff.

Practices have also been working collaboratively so that different types of service can be provided from different sites, for example, with some premises being used as 'hot' sites and others as 'cold' and even 'super-green' sites. There are various important considerations to bear in mind in relation to these matters:

- If making physical adaptations to premises, is this permitted under the practice's lease (if applicable) and is it likely to change the assessment of rent reimbursement under the NHS premises costs directions (for example if the amount of space allocated to NHS clinical services changes)?



- If sharing premises with other providers, is there a clear basis for this? For example, how long will the arrangement go on and how will costs be shared? Ideally these arrangements should be properly documented.

If practices are making premises available to others, is this permitted under the lease (if applicable)? If practices are providing services from different premises, is this permitted under their GP contract (which defines the premises from which services are provided)?

- Have the insurers of the premises been made aware of the changes? It is important that they are to avoid invalidating cover. For the same reason any consequential requirements of the insurers should be satisfied.
- Likewise, if the premises are mortgaged, the changes should be discussed with the lender to avoid breaching the terms of the mortgage.

Management and administrative issues

Management and decision making are more challenging in times of crisis. If practices have partners who are absent because they are self-isolating or ill, there is no reason why a meeting cannot take place with partners in different locations, but practices should check that their partnership agreement permits this.

This might be a good time to review partnership decision-making to ensure that there is the flexibility to make decisions quickly in an emergency.

It is possible that practices will need official documents signed while partners are absent from the practice in isolation. If a partner is in isolation, electronic signature platforms may be an effective and efficient way to get documents signed where a witness is not needed. Alternatively, the documents could be printed, signed and returned perhaps as a scanned copy by email.

However, if a witness is required (such as a partnership deed, declaration of trust, lease or Land Registry transfer deed), the witness must be physically present when the deed is signed.

At the time of writing, it is not possible under the law of England and Wales (where Hempsons operates) for deeds to be witnessed via video link or other remote means. There might be different rules in Scotland and Northern Ireland which a local solicitor would be able to verify. Some creative solutions we have heard include having the signature witnessed through a closed window with the document then posted back and forth through a letterbox to enable the witness to sign also (perhaps using disposable gloves to be on the safe side).

Collaborative working

The Covid-19 crisis has led many practices to work much more closely. PCNs have often been a vehicle for this cooperation. There is an expectation that practices will work with non-GP providers, for example to deliver enhanced health in care homes and care for vulnerable patients.

When working with others in this way, it is important for practices to agree with other organisations what their respective roles and obligations will be, how liabilities and risks will be shared and how joint decisions will be taken. They also need to have appropriate data sharing and processing arrangements.

Alison Oliver is a partner in the primary care team at health and social care law firm Hempsons. She advises GP practices, provider companies and primary care networks on partnership and company law issues, NHS contracting, collaboration and governance arrangements.