Branch closure for primary medical services
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Standard operating policies and procedures for primary care

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Prepared by: Primary Care Commissioning (PCC)
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**Purpose of the policy**

1 NHS England is responsible for direct commissioning of services beyond the remit of clinical commissioning groups, namely primary care, offender health, military health and specialised services.

2 This document forms part of a suite of policies and procedures to support commissioning of primary care. They have been produced by Primary Care Commissioning (PCC) for use by NHS England’s area teams (ATs).

3 The policies and procedures underpin NHS England’s commitment to a single operating model for primary care – a “do once” approach intended to ensure consistency and eliminate duplication of effort in the management of the four primary care contractor groups from 1 April 2013.

4 All policies and procedures have been designed to support the principle of proportionality. By applying these policies and procedures, area teams are responding to local issues within a national framework, and our way of working across NHS England is to be proportionate in our actions.

5 The development process for the document reflects the principles set out in *Securing excellence in commissioning primary care*¹, including the intention to build on the established good practice of predecessor organisations.

6 Primary care professional bodies, representatives of patients and the public and other stakeholders were involved in the production of these documents. NHS England is grateful to all those who gave up their time to read and comment on the drafts.

7 The authors and reviewers of these documents were asked to keep the following principles in mind:

- Wherever possible to enable improvement of primary care
- To balance consistency and local flexibility
- Alignment with policy and compliance with legislation
- Compliance with the Equality Act 2010
- A realistic balance between attention to detail and practical application
- A reasonable, proportionate and consistent approach across the four primary care contractor groups.

8 This suite of documents will be refined in light of feedback from users.

9 This document should be read together with:

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Policy aims and objectives

10 This document describes the process to determine the steps required to undertake a branch closure and the associated contract variation, whether by mutual agreement or under order, to ensure that any changes reflect and comply with national regulations. The aim is to maintain robust contracts.

11 The document focuses on primary medical care contracts in their various forms and has been developed in line with national legislation and regulations.

Background

12 This guidance outlines the principles and provides detail of the steps required to process a branch closure across all primary medical care contracting routes.

Primary medical services contracting routes

13 Where a primary medical services contractor holds a registered list of patients, and provides the full range of essential services, there are three possible contracting routes. These are:

- A General Medical Services (GMS) contract;
- A Personal Medical Services (PMS) agreement; or
- An Alternative Provider Medical Services (APMS) contract.

14 A single contractor may hold a variety of contract types with various commissioners. For example, an existing GMS contractor might also hold an APMS contract with the same or another commissioner.

15 General Medical Services arrangements are governed by the GMS regulations (SI No 2004/291, as amended from time to time). These are based on national agreement between the Department of Health (or bodies acting on its behalf) and the British Medical Association and are underpinned by nationally agreed payment arrangements as set out in the Statement of Financial Entitlements (SFE).

16 Personal medical services arrangements are an alternative to GMS, in which the contract (the PMS agreement) is agreed locally between the commissioner and the contractor. This model has been developed to provide the flexibility needed to meet local needs while maintaining the key principles of a contract that is robust and fair to all parties.
contractor and the commissioning organisation. The mandatory contract terms are set out in the PMS regulations (SI No 2004/627 as amended from time to time) but still allow local flexibility for negotiation and there are some distinct differences in the way in which GMS and PMS contract variations must be managed.

17 Importantly there is no requirement to follow the nationally agreed pay structure for GMS, i.e. the statement of financial entitlements does not apply to PMS agreements. Commissioners and PMS contractors are therefore free to negotiate entirely separate payment arrangements, although common elements are often found in both contract types e.g. quality and outcome framework (QOF), but this also needs to be taken into consideration for the purposes of variations across the differing routes.

18 The mandatory requirements that apply to Alternative Provider Medical Services (APMS) contracts are set out in the Alternative Provider Medical Services Directions 2010 (as amended). These Directions place minimum requirements on APMS contractors which broadly reflect those for PMS contractors but otherwise enable the remainder of the contract to be negotiated between the commissioner and the contractor or, more commonly, stipulated by the commissioner during the course of a tender process.

19 Unlike GMS and PMS arrangements, which place significant restrictions on the organisational structure of the contractor, there are fewer such restrictions for APMS contractors.

20 All contractors who have a list of registered patients must provide essential services. However, unlike GMS regulations, PMS regulations do not require provision of essential services and therefore a list of registered patients is not required. Those PMS agreements that take advantage of this flexibility and do not include the full range of essential services are known as Specialist PMS (SPMS) arrangements and are again locally agreed contracts.

21 A branch closure variation to contract falls into the following category: changes to the detail of the contracting parties/organisational structure, alterations in the service provision covered and/or changes to the payment mechanisms.

22 In determining all variations the following guidance, legislation and regulations are considered:

- GMS Regulations
- PMS Regulations and guidance
Scope of the policy

23 The scope of this policy is to outline the principles and steps required to process an application for a branch closure variation.

24 The different mechanisms for contract variations are located within the primary regulations or directions for each contracting route:

GMS contract regulations – schedule 6, part 8
PMS agreement regulations – schedule 5, part 8
APMS directions – schedule 5 – part 8 of the PMS agreement regulations but with the amendments cited at part 3.6(s) of the APMS directions.

25 This guide outlines the approach to be taken by NHS England when there is a need for a contract/agreement to be varied where a branch closure is requested and then acted upon.

Changes to services – branch closure

26 The closure of a branch surgery may be as a result of an application made by the contractor to the AT or due to the AT instigating the closure following full consideration of the impact such a closure would have.

27 In the circumstances that the AT is instigating a branch closure, the AT must be able to clearly demonstrate the grounds for such a closure and have fully considered any impact on the contractors registered population and any financial impact on the actual contractor. ATs will also be expected to demonstrate that they have considered any other options available prior to instigating a branch closure and entering into a dialogue with the contractor as to how the closure is to be managed.

28 Where a contractor wishes to close a branch surgery, the contractor should have preliminary discussions with the AT to determine appropriate and proportionate consultation requirements prior to the consideration of such a service provision change.
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29 The closure of a branch surgery would be a significant change to services for the registered population and as such the AT and the contractor should engage in open dialogue in the first instance to consider the consequences and implications of the proposed change and discuss any possible alternatives that may be agreed between them.

30 Contractor and AT discussions resulting ultimately in a decision about a branch closure will often include consideration of (but not be limited to):

- financial viability;
- registered list size and patient demographics;
- condition, accessibility and compliance to required standards of the premises;
- accessibility of the main surgery premises;
- NHS England’s strategic plans for the area; and
- other primary health care provision within the locality (including other providers and their current list provision, accessibility, dispensaries and rural issues)
- dispensing implications (if a dispensing practice);
- Possible co-location of services;
- Rurality issues; and
- Patient feedback.

31 The AT and contractor, through their dialogue, may establish that there is a need to retain medical service provision in the locality and must find a solution, which could include tendering for a new provider within that locality though not necessarily within the same premises.

32 The AT may wish to consider providing additional support to the contractor in the short term so they might maintain the branch surgery premises, particularly when there is a need to follow a tender process.

33 If support is mutually acceptable the branch surgery should remain open for a specific period to allow matters to be resolved satisfactorily.

34 The AT should confirm any such arrangements and agreements in writing to the contractor as soon as is practicably possible after the agreement is reached.

35 If the AT and the contractor are unable to reach an agreement to keep the branch surgery open, then the contractor, based upon their previous discussions with the AT regarding appropriate and proportionate consultation, will begin the consultation process. The contractor is
required to follow the PPI consultation process\(^2\) as appropriate to the level of consultation agreed with the AT. Adherence to the PPI consultation process will ensure that all standards and legislation are upheld with regard to an appropriate level of consultation. Once this consultation has been undertaken, the contractor would then submit a formal application to close the branch surgery to the AT for consideration (Annex 2).

The AT will then assess the application regarding the closure with a view to either accepting or declining the proposal. These assessments will need to include (but are not limited to) access to other primary care in the locality, patient demographics and distribution and patient engagement.

Either the contractor or the AT may invite the local medical committee to be party to these discussions at any time.

Where the AT declines the branch closure (Annex 3) through its internal assessment procedure the contractor shall be notified in writing within 28 days following the internal assessment and the contractor may then follow the relevant NHS dispute resolution process where they disagree with the decision that has been made. Reference should be made to the *Dispute resolution for primary medical services policy*.

Where the AT approves the branch closure (Annex 4) the AT will need to ensure that it retrieves all NHS owned assets from the premises.

However the contractor remains responsible for ensuring the transfer of patient records (electronic and paper Lloyd George notes\(^3\)) and confidential information to the main surgery, having full regard to Caldicott guidance\(^4\), **[Records Management: NHS Code of Practice guidance](https://www.gov.uk/government/publications/records-management-nhs-code-of-practice)** (Annex 5) and information governance principles. The contractor remains responsible for consulting and informing the registered patients of the proposed changes, throughout the process and the AT should be assured this requirement is being met satisfactorily.

Once the final date for closure is confirmed the AT will issue a standard variation notice to remove the registered address of the branch surgery from the contract, and as in other variations under the policy for *Managing contract variations for primary medical care services contracts*, include the amended sections for completeness.

Where the contractor has previously been granted with premises consent to dispense, and these rights are only associated to the closing premises

\(^2\) **NHS Act 2006 Part 12**
\(^3\) **Records Management: NHS Code of Practice 2006 Part 1**
\(^4\) **The Caldicott Guardian Manual 2010**
in question (that is also listed on NHS England dispensing contractor list), the contractor’s consent to dispense will cease\(^5\).

Also, the AT shall update its records and dispensing contractor list appropriately to reflect the removal of the premises.

While it is entirely likely that a PMS agreement would reflect the terms as laid out in the GMS example above, it is essential that the AT reviews the individual agreement for these, and any other relevant amendments that may be necessary, to effectively remove the closing premises and any rights associated with that premises alone, from the PMS agreement.

**Consultation**

As outlined in Section 1, the contractor in agreement with the AT must ensure the consultation process is appropriate and proportionate to the individual circumstances of the branch closure.

Where it is deemed appropriate for a full consultation process to be followed, the contractor must consult all key stakeholders.

Those stakeholders should include:

- local residents;
- registered patients;
- local community groups;
- other local GP practices;
- patient representative groups; and
- other local allied health care professional organisations.

The contractor should ensure they have provided various routes through which stakeholders can respond to the consultation, such as the practice web site, posters, direct mail and surgery questionnaires.

The AT and the contractor must ensure they consult with the LMC and the Overview and Scrutiny Committee and discuss the feedback and that this could form part of the formal application.

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\(^5\) *Standard GMS Contract, Part 13, Section 321BB, 321BB.1*
Annex 1: abbreviations and acronyms

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>A&amp;E</td>
<td>accident and emergency</td>
</tr>
<tr>
<td>APHO</td>
<td>Association of Public Health Observatories (now known as the Network of Public Health Observatories)</td>
</tr>
<tr>
<td>APMS</td>
<td>Alternative Provider Medical Services</td>
</tr>
<tr>
<td>AT</td>
<td>area team (of NHS England)</td>
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<td>AUR</td>
<td>appliance use reviews</td>
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<td>BDA</td>
<td>British Dental Association</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>CCG</td>
<td>clinical commissioning group</td>
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<tr>
<td>CD</td>
<td>controlled drug</td>
</tr>
<tr>
<td>CDAO</td>
<td>controlled drug accountable officer</td>
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<tr>
<td>CGST</td>
<td>NHS Clinical Governance Support Team</td>
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<tr>
<td>CIC</td>
<td>community interest company</td>
</tr>
<tr>
<td>CMO</td>
<td>chief medical officer</td>
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<tr>
<td>COT</td>
<td>course of treatment</td>
</tr>
<tr>
<td>CPAF</td>
<td>community pharmacy assurance framework</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<td>CQRS</td>
<td>Calculating Quality Reporting Service (replacement for QMAS)</td>
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<tr>
<td>DAC</td>
<td>dispensing appliance contractor</td>
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<td>Days</td>
<td>calendar days unless working days is specifically stated</td>
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<td>DBS</td>
<td>Disclosure and Barring Service</td>
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<td>DDA</td>
<td>Disability Discrimination Act</td>
</tr>
<tr>
<td>DES</td>
<td>directed enhanced service</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>EEA</td>
<td>European Economic Area</td>
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<td>ePACT</td>
<td>electronic prescribing analysis and costs</td>
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<td>ESPLPS</td>
<td>essential small pharmacy local pharmaceutical services</td>
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<td>family health shared services</td>
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<td>family practitioner committee</td>
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<td>FTA</td>
<td>failed to attend</td>
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<td>first-tier tribunal</td>
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<td>GDP</td>
<td>general dental practitioner</td>
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<td>General Dental Services</td>
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<td>General Medical Council</td>
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<td>GMS</td>
<td>General Medical Services</td>
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GP
general practitioner

GPES
GP Extraction Service

GPhC
General Pharmaceutical Council

GSMP
global sum monthly payment

HR
human resources

HSE
Health and Safety Executive

HWB
health and wellbeing board

IC
NHS Information Centre

IELTS
International English Language Testing System

KPIs
key performance indicators

LA
local authority

LDC
local dental committee

LETB
local education and training board

LIN
local intelligence network

LLP
limited liability partnership

LMC
local medical committee

LOC
local optical committee

LPC
local pharmaceutical committee

LPN
local professional network

LPS
local pharmaceutical services

LRC
local representative committee

MDO
medical defence organisation

MHRA
Medicines and Healthcare Products Regulatory Agency

MIS
management information system

MPIG
minimum practice income guarantee

MUR
medicines use review and prescription intervention services

NACV
negotiated annual contract value

NCAS
National Clinical Assessment Service

NDRI
National Duplicate Registration Initiative

NHAIS
National Health Authority Information System (also known as Exeter)

NHS Act
National Health Service Act 2006

NHS BSA
NHS Business Services Authority

NHS CB
NHS Commissioning Board (NHS England)

NHS CfH
NHS Connecting for Health

NHS DS
NHS Dental Services

NHS LA
NHS Litigation Authority

NMS
new medicine service

NPE
net pensionable earnings

NPSA
National Patient Safety Agency

OJEU
Official Journal of the European Union
NHS England
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Annex 2: Example application form for branch closure

Please complete the following:

1) Details of branch proposed for closure:
   …………………………………………………………………………………
   …………………………………………………………………………………
   …………………………………………………………………………………

2) Do you have premises approval to dispense from the branch surgery?
   Yes/No
   a. If yes, how many patients do you currently dispense to?
      …………………………………………………………………………………

3) Do you have premises approval to dispense from any other premises?
   Yes/No
   a. If no, do you intend to give three months’ notice of ceasing to dispense as required by NHS Pharmaceutical Services Regulations 2012 schedule 6 para 10 as amended? Yes/No
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Application for branch closure (cont’d)

4) How have you consulted with your patients regarding this proposal and how will you be communicating the actual change to patients, ensuring that patient choice is provided throughout, should NHS England approve this variation? Also, please provide a summary of the consultation feedback and confirm that you will supply evidence of this consultation should it be requested.

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5) Please provide as much detail as possible about how this proposed closure will impact on your current registered patients, including:

- access to the main surgery site i.e. public transport, ease of access;
- capacity at main surgery site;
- booking appointments;
- additional and enhanced services;
- opening hours;
- extended hours; and
- dispensing services (if applicable).

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                                    …………………………………………………………………………………
6) From which date do you wish the branch closure to take effect?

Note: Where an application to close premises is granted by NHS England, the contractor shall remain fully responsible for cessation or assignment of the lease for any rented premises and any disposal of owner-occupied premises. In both cases, payments under the premises directions will cease from the day of closure.

Please note that this application does not concert any obligation on NHS England to agree to this request.

To be signed by all parties to the contract

Signed:

Print:

Date:

Signed:

Print:

Date:
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Signed:

Print:

Date:

Signed:

Print:

Date:

Please continue on a separate sheet if necessary
Annex 3: Example letter to decline a branch closure

[date]

Dear [contractor name]

Ref: [contract details]

Further to your request to close your branch surgery dated [notification date], I can confirm after consultation held on [date] that the request has been declined for the following reason(s):

[details].

If you would like to appeal against the decision made, you can do so under the dispute resolution policy and guidelines. If this is a route you wish to pursue you are required to enter a written request for dispute resolution, detailing:

- the names and addresses of the parties to the dispute;
- a copy of the contract; and
- a brief statement describing the nature and circumstances of the dispute.

[where and to whom the appeal should be addressed]

Yours sincerely,

[name]

[title]
Annex 4: Example letter to accept a branch closure

[date]

Dear [name]

Ref: [contract details]

Further to your request to close your branch surgery dated [notification date], I can confirm your request has been accepted. Therefore please find enclosed the [insert relevant sections of the contract/agreement], which lists the premises to be used by you for the provision of services under your contract.

Also attached is a revised schedule [insert relevant section of the contract/agreement] where your branch surgery has now been removed. Please complete and sign both copies and return them to the above address. Both copies will then be countersigned and one copy will be returned to you for your records.

At this point you can update all websites, literature, practice leaflets and make all patients aware of the branch closure, the date that services will cease at the branch location and provide reassurance in respect of their continued care from your main surgery.

Yours sincerely,

[name]

[title]
Overview

The two-part NHS code of practice is a guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in England. It is based on current legal requirements and professional best practice.

For historic purposes, the code of practice also replaces the following guidance:

- HSC 1999/053 – For the record
- HSC 1998/217 – Preservation, retention and destruction of GP General Medical Services records relating to patients (replacement for FHSL (94)(30))

The code provides a key component of information governance arrangements for the NHS. This is an evolving document because standards and practice covered by the code will change over time and will be subject to regular review and updated as necessary. As a result of a review, part 2 only of the code relating to the retention schedules has been updated in light of guidance and advice given from the NHS and professional best practice. The updated part 2 was published on 8 January 2009.

The guidelines contained in this code of practice apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held.
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<td>June 2013</td>
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