Managing a Personal Medical Services contractors’ right to a General Medical Services contract
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Standard operating policies and procedures for primary care

Issue Date: June 2013

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Prepared by: Primary Care Commissioning
NHS England
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Document Status

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Purpose of 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 care1, 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.

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1 Securing excellence in commissioning primary care http://bit.ly/MJwrfA
Policy aims and objectives

This policy outlines the approach to be taken by NHS England when a Personal Medical Services (PMS) agreement holder (the contractor) exercises their right to a General Medical Services (GMS) contract.

Background

Following the introduction of the 1997 Primary Care Act, the NHS introduced Personal Medical Services pilots over a four year period to test different ideas for delivering existing GMS, focusing on local service problems and improvements. In 2004 PMS moved from pilot status to a more permanent arrangement and approximately 44 percent of previous GMS contractors took up the opportunity to provide services under a local PMS agreement.

As PMS was a voluntary arrangement, agreement holders were given the option to revert back to GMS contracts, having given the appropriate notice to terminate their PMS agreement (right to return), and that right still exists in current PMS regulations.

Types of contract

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:

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

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.

General Medical Services (GMS) 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 set out in the Statement of Financial Entitlements (SFE).
Personal Medical Services (PMS) arrangements are an alternative to GMS, in which the contract (the PMS agreement) is agreed locally between the 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 contracts must be managed.

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. QOF, but this also needs to be taken into consideration when processing an application from a PMS agreement holder to exercise its rights to a GMS contract.

It is important to note that this right is conferred under the regulations to PMS agreement holders only. While the PMS regulations are also the main basis for the development of APMS and SPMS agreements, neither of these forms of agreement shall include any such right to a GMS contract.

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.

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

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
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agreed contracts.

Scope of the policy

22 This policy outlines the approach to be taken by NHS England when a PMS agreement holder exercises their right to a GMS contract in accordance with the PMS Regulations 2004.

23 While it is entirely possible for a primary medical services contractor to hold more than one form of contract, this policy details the arrangements for implementing a ‘right to return’ to GMS, resulting in the termination of the PMS agreement.

24 It is essential that NHS England and area teams (ATs) maintain thorough and accurate records of all communications and discussions regarding all actions taken under this policy.

25 ATs should refer to relevant published guidance and should take appropriate advice at an early stage when following the actions under this policy.

PMS contractor exercising its right to a GMS contract

26 A PMS contractor providing essential services that wishes a General Medical Services contract to be entered into shall notify NHS England AT in writing at least three months before the date on which it wishes the contract to be entered into.

27 While it is not a requirement of the regulations, when the AT receives such a notice it is recommended it discusses the full implications of this action with the contractor to ensure it has fully understood the necessary changes to the contractual income streams (see paragraph 8) and may advise him/her to seek their own independent, financial and legal advice.

28 1. A notice under this section shall:

   a) state that the contractor wishes to terminate the PMS agreement on a specific date which must be at least three months after the date of service of the notice;
   b) subject to paragraph (3), give the name or names of the person or persons whom the contractor wishes NHS England to enter into a General Medical Services contract with and whether they are to be an unlimited or limited partner; and
   c) confirm that the person or persons so named meet the conditions set out in section 28S of the Act (persons eligible to
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enter into GMS contracts)(annex 2) and regulations 4 and 5 of the General Medical Services Regulations or, why the contractor is unable to confirm and confirmation that the person or persons immediately before entering into the GMS contract will meet those conditions.

2. A person's name may only be given in a notice referred to above if that person is a party to the PMS agreement and each signatory to the PMS agreement must sign the notice to accept this proposal.

3. The AT must then acknowledge receipt of that notice in writing within seven days.

4. Once the AT is satisfied the information provided is accurate and the named persons are eligible to hold a GMS contract, NHS England shall enter into a GMS contract with the person or persons named in the notice (see annex 2).

5. As well as the terms required by the Act and the GMS Regulations, a GMS contract entered into regarding this section shall provide for:

   a. the GMS contract to start immediately after the termination of the PMS agreement;
   b. the names of the patients included in the contractor's list of patients immediately before the termination of the agreement to be included in the first list of patients to be prepared and maintained by NHS England;
   c. the same services to be provided under the GMS contract as were provided under the agreement immediately before it was terminated unless the parties otherwise agree; and
   d. the opt out of out-of-hours services referred to in paragraph 7 in accordance with the terms specified in schedule 3 to the GMS contracts regulations.

6. In regard to 5c above, ATs should be mindful that some specifically commissioned PMS services may not be suitable or appropriate for delivery under a GMS contract. In these circumstances it would be for the parties to agree which of the services provided under the agreement immediately before it was terminated will continue to be provided under the GMS contract.

7. The out-of-hours services are those that the contractor was providing under the agreement and regulation 20 immediately

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3 GMS contracts regulations 2004, schedule 6, para 14
8. Note: Neither the PMS nor GMS regulations are specific about this, but it is essential that NHS England knows the instructions under the SFE on first setting up a GMS contract and calculating the global sum monthly payment (GSMP). While the PMS contractor has the right to a GMS contract, there is no such entitlement for the contractor to carry the same funding arrangements it had under the PMS agreement into that GMS contract. GMS contracts are funded according to terms set out in the SFE. PMS is funded through local agreement, which often attracts additional payments, such as PMS growth, which is not payable under GMS. It is essential that NHS England has carefully ascertained the financial impact of this section and considered the direction under the SFE part 1(3), which states that any new GMS contracts after 1 April 2004 would not attract an MPIG, as this was a one-off calculation.

9. An agreement shall terminate on the date stated in the notice given by the contractor under this section unless a different date is agreed by the contractor and NHS England or no GMS contract is entered into by NHS England.

10. Where there is a dispute over whether or not a person satisfies the conditions in section 28S of the act or regulations 4 and 5 of the GMS Regulations, the contractor may appeal to the first tier tribunal and NHS England shall be the respondent. Please see the Policy for managing disputes for primary medical services.

Preparing and issuing a GMS contract

29 The AT should use the most current standard General Medical Services contract available on the Department of Health website for these purposes, ensuring that any subsequent variations are also included in the main document.

30 In processing the new contract NHS England must follow the instructions in the footnotes to that standard contract to ensure the document is fit for purpose. Please see http://tinyurl.com/b5ybpyt.

31 The AT must ensure that where there are options provided within the standard GMS contract, for example notice periods, only one of those options should be left in the final document and footnotes should be removed when they are for instruction purposes only.

32 Where it is necessary to remove the content of a specific clause, i.e. those
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terms do not apply to this contractual arrangement such as specific additional services, the AT must ensure the clause number remains within the body of the document to maintain accurate referencing throughout. This may be achieved by replacing the text of a clause with the word ‘reserved’ or ‘omitted’. ATs should endeavour to ensure this is consistent, where possible, with other GMS contracts.

33 A new GMS contract being issued to a contractor should be duplicated so NHS England and the contractor retain a signed copy for their files. This is best managed by agreeing a signature date and venue, when both relevant parties can be present and both retain one copy at that time. If this is not possible, the contract should be manually transferred between the AT and the contractor or as a last resort by Royal Mail recorded or special delivery, with all tracking information kept on file for completeness.

34 Once a GMS contract is agreed and entered into and the PMS agreement has been terminated accordingly, the AT must ensure all nationally held records of the contractor’s status are adjusted appropriately. This must include, but not be limited to, changing the contractor’s status on QMAS/CQRS, from PMS to GMS, to ensure that the correct quality and outcomes framework (QOF) calculations are completed at year end and any contractual payment systems used, i.e. Exeter.

Calculating a first initial global sum monthly payment

35 Global sum payments are a contribution towards the contractor’s costs in delivering essential and additional services, including its staff costs. Although the payment is notionally an annual amount, it is to be revised quarterly and a proportion paid monthly.

36 ATs must ensure they work closely with their finance colleagues to calculate the appropriate financial arrangements for a new GMS contract under this policy.

37 Finance colleagues will need to refer to the current SFE to apply the correct calculations based on the information the AT will provide regarding the services to be delivered under the contract.

38 Some key pieces of information the finance team will need to calculate the first GSMP for the new GMS contract include:

• proposed start date of the new GMS contract;

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4 Statement of financial entitlements, part 1, para 2.1
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- contractor’s registered population;
- additional services to be provided under the contract; and
- out of hours services to be provided under the contract.

Conditions attached to payable global sum monthly payments

39 Payable GSMPs, or any part thereof, are only payable if the contractor satisfies the following conditions:

- the contractor must make available to the AT any information the AT does not have but needs, and the contractor either has or could reasonably be expected to obtain, to calculate the contractor's payable GSMP;
- the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter registration system promptly and fully;
- the contractor must immediately notify the AT if it is not providing (albeit temporarily) any of the services it has to under its GMS contract; and
- all information supplied to the AT pursuant to or in accordance with this paragraph must be accurate.

40 If the contractor breaches any of these conditions, the AT may, in appropriate circumstances, withhold payment of any or any part of a payable GSMP that is otherwise payable.

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5 Statement of financial entitlements, part 1, para. 2.14
Annex 1: abbreviations and acronyms

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<th>Description</th>
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<tr>
<td>A&amp;E</td>
<td>accident and emergency</td>
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<td>APHO</td>
<td>Association of Public Health Observatories (now known as the Network of Public Health Observatories)</td>
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<td>APMS</td>
<td>Alternative Provider Medical Services</td>
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<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>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>CCG</td>
<td>clinical commissioning group</td>
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<td>CD</td>
<td>controlled drug</td>
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<td>CGST</td>
<td>NHS Clinical Governance Support Team</td>
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<td>community interest company</td>
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<td>CMO</td>
<td>chief medical officer</td>
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<td>COT</td>
<td>course of treatment</td>
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<td>CPAF</td>
<td>community pharmacy assurance framework</td>
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<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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<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>
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<td>DES</td>
<td>directed enhanced service</td>
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<td>European Economic Area</td>
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<td>ePACT</td>
<td>electronic prescribing analysis and costs</td>
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<td>essential small pharmacy local pharmaceutical services</td>
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<td>European Union</td>
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<td>family health services appeals unit</td>
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<td>first-tier tribunal</td>
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<td>general dental practitioner</td>
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<td>GDS</td>
<td>General Dental Services</td>
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<td>GMC</td>
<td>General Medical Council</td>
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GMS General Medical Services
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
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OJEU Official Journal of the European Union
OMP ophthalmic medical practitioner
ONS Office of National Statistics
OOH out of hours
PAF postcode address file
PALS patient advice and liaison service
PAM professions allied to medicine
PCC Primary Care Commissioning
PCT primary care trust
PDS personal dental services
PDS NBO Personal Demographic Service National Back Office
PGD patient group direction
PHE Public Health England
PLDP performers’ list decision panel
PMC primary medical contract
PMS Personal Medical Services
PNA pharmaceutical needs assessment
POL payments online
PPD prescription pricing division (part of NHS BSA)
PSG performance screening group
PSNC Pharmaceutical Services Negotiating Committee
QOF quality and outcomes framework
RCGP Royal College of General Practitioners
RO responsible officer
SEO social enterprise organisation
SFE statement of financial entitlements
SI statutory instrument
SMART specific, measurable, achievable, realistic, timely
SOA super output area
SOP standard operating procedure
SPMS Specialist Personal Medical Services
SUI serious untoward incident
UDA unit of dental activity
UOA unit of orthodontic activity
Annex 2: Person eligible to enter into a GMS contract

The following section summarises the legal requirements surrounding eligibility for primary medical services contracts and full details of regulation 4 and 5 of the GMS Contract Regulations 2004, but does not replicate the full legal text. This guide can only offer a broad introduction. Anyone entering into, or seeking, a primary medical services contract should refer directly to the relevant legislation, or seek independent legal advice.

Potential contractors should also be aware that, as well as the requirements on eligibility, there are further requirements across all contracting routes to ensure the persons entering into the contract with NHS England are fit and proper e.g. they have not been adjudged bankrupt or have certain types of criminal record.

GMS contractors

GMS contracts can be made with:

- a general medical practitioner;
- two or more individuals practising in partnership with at least one partner (who must not be a limited partner) being a general medical practitioner and other partners coming from within the NHS family;
- Company limited by shares with at least one share legally and beneficially owned by a general medical practitioner and all other shares legally and beneficially owned by a general medical practitioner or a person who could enter into a GMS contract as part of a partnership.

NHS family means:

- medical practitioners;
- healthcare professionals;
- GMS providers or their employees;
- PMS providers or their employees; or
- employees of PCTs, NHS trusts or foundation trusts.

Note: Healthcare professionals are not restricted to employees of the NHS. It is a broad definition that includes persons registered with the professional bodies set out in legislation (provided that such professionals are engaged in providing services under the NHS Act). It can include doctors, nurses, professions allied to medicine (PAMs), pharmacists, dentists, osteopaths, chiropractors and others.
Annex 3: Regulations 4 and 5

The information provided in this annex is a summary of the regulatory provisions and ATs should ensure that they refer to the full detail of the regulations or directions when considering suitability or eligibility.

Regulations 4 & 5

4. Conditions relating solely to medical practitioners

1. When entering into a contract with a medical practitioner, they must be a general medical practitioner.

2. When entering into a contract with two or more individuals practising in partnership:
   a) at least one partner (who must not be a limited partner) must be a general medical practitioner; and
   b) any other partner who is a medical practitioner must be a general medical practitioner, or be employed by a primary care trust, local health board, (in England and Wales and Scotland) NHS trust, an NHS foundation trust, (in Scotland) a health board or (in Northern Ireland) a health and social services trust.

3. When entering into a contract with a company limited by shares:
   a) at least one share in the company must be legally and beneficially owned by a general medical practitioner; and
   b) any other share or shares in the company that are legally and beneficially owned by a medical practitioner must be owned by a general medical practitioner, or a medical practitioner employed by a primary care trust, local health board, NHS trust, (in England and Wales and Scotland) an NHS foundation trust, (in Scotland) a health board or (in Northern Ireland) a health and social services trust.

4. In paragraphs (1), (2)(a) and (3)(a), general medical practitioner does not include a medical practitioner whose name is included in the general practitioner register by virtue of:
   a) article 4(3) of the 2010 order (general practitioners eligible for entry in the general practitioner register) because of an exemption under regulation 5(1)(d) of one or more of the sets of regulations specified in paragraph (5);
b) article 6(2) of the 2010 order (persons with acquired rights) by virtue of being a restricted services principal (within the meaning of one or more of the sets of Regulations specified in paragraph (6)) included in a list specified in that article; or
c) article 6(6) of the 2010 order.

5. The regulations referred to in paragraph (4)(a) are the National Health Service (Vocational Training for General Medical Practice) Regulations 1997, the National Health Service (Vocational Training for General Medical Practice) (Scotland) Regulations 1998 and the Medical Practitioners (Vocational Training) Regulations (Northern Ireland) 1998.

6. The regulations referred to in paragraph (4)(b) are the National Health Service (General Medical Services) Regulations 1992, the National Health Service (General Medical Services) (Scotland) Regulations 1995 and the General Medical Services Regulations (Northern Ireland) 1997.

5. General condition relating to all contracts

1. Where a contract is to be entered into with a medical practitioner, it is a condition that the medical practitioner must not fall within paragraph (2). This includes those with two or more individuals practising in partnership and any individual or the partnership itself

2. Where a contract is to be entered into with a company limited by shares, they also must not fall within paragraph (2). This includes:
   i. the company;
   ii. any person legally and beneficially owning a share in the company; and
   iii. any director or secretary of the company.

3. A person falls within this paragraph if -
   a) he or it is the subject of a national disqualification;
   b) subject to paragraph (3), he or it is disqualified or suspended (other than by an interim suspension order or direction pending an investigation) from practising by any licensing body anywhere in the world;
   c) within the period of five years before the signing of the contract or start of the contract, whichever is the earlier, he or she has been dismissed (otherwise than by reason of redundancy) from any employment by a health service body, unless he or she has subsequently been employed by that health service body or another health service body
and paragraph (4) applies to him/her or that dismissal was the subject of a finding of unfair dismissal by any competent tribunal or court;

d) within the five years before signing the contract or start of the contract, whichever is the earlier, he, she or it has been removed from, or refused admission to, a primary care list by reason of inefficiency, fraud or unsuitability (within the meaning of section 49F(2), (3) and (4) of the act respectively unless their name has subsequently been included in such a list;

e) he or she has been convicted in the United Kingdom of murder;

f) he or she has been convicted in the UK of a criminal offence other than murder, committed on or after 14 December 2001, and has been sentenced to a term of imprisonment of over six months;

g) subject to paragraph (5) he or she has been convicted elsewhere of an offence:

   i. which would, if committed in England and Wales, constitute murder; or

   ii. committed on or after 14 December 2001, which would if committed in England and Wales, constitute a criminal offence other than murder, and been sentenced to a term of imprisonment of over six months;

h) he has been convicted of an offence referred to in schedule 1 to the Children and Young Persons Act 1933 (offences against children and young persons with respect to which special provisions of this act apply) or schedule 1 to the Criminal Procedure (Scotland) Act 1995 (offences against children under the age of 17 years to which special provisions apply) committed on or after 1 March 2004;

i) he, she or it has:

   i. been adjudged bankrupt or had sequestration of their estate awarded unless (in either case) they have been discharged or the bankruptcy order has been annulled;

   ii. been made the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order under schedule 4A to the Insolvency Act 1986 or schedule 2A to the Insolvency (Northern Ireland) Order 1989 unless that order has ceased to have effect or has been annulled, or

   iii. made a composition or arrangement with, or granted a trust deed for, his, her or its creditors unless he, she or it has been discharged in respect of it;
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j) an administrator, administrative receiver or receiver is appointed in respect of it;

k) within the period of five years before signing the contract or its start, whichever is the earlier, he or she has been:
   i. removed from the office of charity trustee or trustee for a charity by an order made by the charity commissioners or the high court on the grounds of any misconduct or mismanagement in the administration of the charity for which he or she was responsible or to which he or she was privy, or which he or she by their conduct contributed to or facilitated; or
   ii. removed under section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990 (powers of the Court of Session to deal with management of charities) or under section 34 of the Charities and Trustee Investment (Scotland) Act 2005 (powers of Court of Session), from being concerned in the management or control of any body; or

l) he or she is subject to a disqualification order under the Company Directors Disqualification Act 1986, the Companies (Northern Ireland) Order 1986 or to an order made under section 429(2)(b) of the Insolvency Act 1986 (failure to pay under county court administration order).

4. A person shall not fall within paragraph (2)(b) where the primary care trust is satisfied that the disqualification or suspension from practising is imposed by a licensing body outside the UK and it does not make the person unsuitable to be:
   a) a contractor;
   b) a partner, in the case of a contract with two or more individuals practising in partnership;
   c) in the case of a contract with a company limited by shares:
      i. a person legally and beneficially holding a share in the company; or
      ii. a director or secretary of the company.

5. Where a person has been employed as a member of a healthcare profession any subsequent employment must also be as a member of that profession.

6. A person shall not fall within paragraph (2)(g) where the primary care trust is satisfied that the conviction does not make the person unsuitable to be:
   a) a contractor;
   b) a partner, in the case of a contract with two or more individuals practising in partnership;
c) in the case of a contract with a company limited by shares:
   i. a person legally and beneficially holding a share in the company, or
   ii. a director or secretary of the company.
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