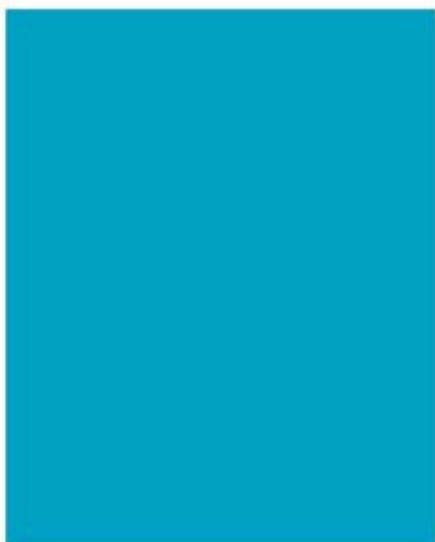


Managing regulatory and contract variations



# Managing regulatory and contract variations

## *Standard operating policies and procedures for primary care*

Issue Date: June 2013

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Prepared by: Primary Care Commissioning (PCC)

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NHS England  
 Managing regulatory and contract variations

**Information Reader Box**

| Directorate               | Purpose       |
|---------------------------|---------------|
| Medical                   | Tools         |
| Nursing                   | Guidance      |
| Patients & Information    | Resources     |
| Finance                   | Consultations |
| Operations                |               |
| Commissioning Development |               |
| Policy                    |               |
| Human Resources           |               |

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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*<sup>1</sup>, 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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<sup>1</sup> Securing excellence in commissioning primary care <http://bit.ly/MJwrfA>

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- 9 This document should be read in conjunction with:
- a. Identification management and support of independent contractors whose performance gives cause for concern
  - b. Managing contract breaches, sanctions and termination for primary medical services contracts
  - c. Tackling list inflation for primary medical services
  - d. Dispute resolution for primary medical services
  - e. Managing the death of a contractor in primary medical services
  - f. Managing closed lists for primary medical services
  - g. Managing a Personal Medical Services contractors' right to a General Medical Services contract.
  - h. Managing the end of time limited contracts for primary medical services
  - i. Primary Medical Services Assurance Framework
  - j. Guidance to support delivery of assurance management in primary medical services.

### **Policy aims and objectives**

- 10 This document describes the process to determine any contract variation, whether by mutual agreement or required by regulatory amendments, to ensure that any changes reflect and comply with national regulations so as 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 The requests to vary and need for legislative changes to be included in primary medical care contracts are numerous and cover a number of different areas. This guidance outlines the principles and provides detail as to the steps required to process some of the most commonly occurring changes 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

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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 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.
- 16 General Medical Services (GMS) arrangements are governed by the GMS Contract 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.
- 17 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 Agreement 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.
- 18 There is no requirement to follow the nationally agreed pay structure for GMS, ie 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 eg QOF, but this also needs to be taken into consideration for the purposes of variations across the differing routes.
- 19 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 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

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process. Please see annex 2 for further information.

- 20 Unlike GMS and PMS arrangements, which place significant restrictions on the organisational structure of the contractor, there are fewer such restrictions for APMS contractors.
- 21 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.
- 22 Variations to contracts fall broadly within three categories: changes to the detail of the contracting parties/organisational structure, alterations in the service provision covered and/or changes to the payment mechanisms.
- 23 These include but are not limited to:
- a) contracting party changes:
    - partnership changes;
    - mergers and splits; and
    - 24-hour retirement.
  - b) Changes to services e.g.:
    - premises (e.g. branch closures);
    - boundary alterations;
    - opt outs from service provision; and
    - regulatory changes affecting the terms of the contract.
  - c) Changes to the payment arrangements:
    - in accordance with amendments to the Statement of Financial Entitlements for GMS; and/or
    - locally negotiated payment arrangements for PMS/APMS/SPMS.
- 24 In determining all variations the following guidance, legislation and regulations are considered:
- GMS regulations.
  - PMS regulations and guidance.
  - APMS directions.
  - Statement of Financial Entitlements.
  - NHS Act(s).

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- EU procurement legislation.
- The public contracts regulations.
- Department of Health procurement guide.
- Principle and rules of co-operation and competition (issued by the Department of Health).

### **Payment systems for contractors**

- 25 Regardless of the contract type, most payments to medical contractors are made through the central registration and payment system known as the Exeter system.
- 26 The current system of payment to GPs and practices via GMS is complex. In 2004 a new practice-based contract replaced the previous GMS, replacing the Red Book items of service payment. The GMS quarterly payments system maintains administrative information on practices and individual GPs, registrars, assistants and retainees, including a list of patients registered with each GP.
- 27 The Exeter system stores the banking details of each practice and is able to calculate the monthly global sum payment for each contractor in accordance with the terms within the SFE.
- 28 Payments for each contractor are generated by the Exeter system based on a range of data gathered from a number of sources and by regular adjustments made by ATs. It is therefore essential that AT primary care teams work closely with their finance colleagues, who manage the Exeter system, to ensure that payments made are accurate.

### **Scope of the policy**

- 29 The different mechanisms for contract variations are located within the applicable regulations or directions for each contracting route:
- 30 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 and direction 15 of the APMS Directions.
- 31 This guide outlines the approach to be taken by NHS England when there is a need for a contract/agreement to be varied.
- 32 Where possible the guide will look to describe possible scenarios and situations where variations will be required.

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## Types of contract variation

### A. Variation to a contract: Changes to legislation

- 33 As well as specific provisions NHS England may vary the contract without the contractor's consent where it is reasonably satisfied that it is necessary to do so to comply with the NHS Act, any regulatory changes pursuant to the Act or any direction given by the Secretary of State pursuant to the Act.
- 34 NHS England must notify the contractor in writing of the wording of the variation and the date of effect, which shall not be less than 14 days after the notice is served.
- 35 The changes then automatically come into effect on the immediate expiry of the notice. There is no need for the area team (AT) to seek agreement or require a signature of acceptance for a statutory variation notice, as there is no right of refusal or points for negotiation of the terms.

### Process for issuing a variation notice due to changes to legislation

- 36
- The Department of Health (DH) issues a regulatory amendment under statutory instrument (SI) to the GMS/PMS regulations. It is essential that ATs maintain a good overview of the DH site to ensure they take the appropriate action as quickly as possible after the issue of an amendment.
  - Where the GMS regulations are amended, the DH also issues a GMS variation to the standard contract template and a supporting notice both of which should be used to inform the contractors of the change. However, this is not possible for PMS/APMS or SPMS agreements as these are locally defined contracts, which vary significantly across the country.
  - ATs shall notify GMS contractors, using the standard variation notice of the variation and its effective date, including the relevant pages of the amended contract document for completeness.
  - ATs should notify PMS contractors of any statutory amendments to the regulations. ATs will be required to translate the regulatory amendments into a contractual amendment, citing the correct clause numbers affected within their individually held PMS agreements and including the relevant pages of the document for completeness. It is likely that ATs will be managing a number of different PMS agreements so must ensure that each SI is accurately applied to each form of agreement (annex 3).
  - Regarding APMS agreements, where the contract contains a provision giving the commissioner the right to issue a unilateral variation, then the AT should proceed on that basis. Where no such right exists, NHS

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England should enter into negotiations with the contractor in order to agree the terms of a variation. As APMS agreements can take a variety of different forms each agreement will have to be considered on an individual basis.

- All electronically held contracts should be updated with the variations at this stage to ensure that the centrally held documents remain up to date with current legislation.
- ATs should retain a copy of the notice on file for completeness.
- Each contract file should contain a variation log and ATs should ensure that this is updated accordingly.

## **B. Changes to the contract (other than legislative changes)**

37 There are three main types of changes, which require a (individual) variation agreement:

- 1) changes to the contracting parties;
- 2) changes to the individually contracted services; and
- 3) changes to the financial arrangements.

38 Where there is a local variation needed (a change that affects all contracts within a specific region) a local variation agreement notice should be issued. These changes are rare and will be only as a result of a locally negotiated position regarding a specific commissioning or locality issue following due consultation processes and agreement from all parties.

## **Changes to the contracting party**

39 Changes to the composition of a partnership may require a variation to the standard registration conditions with the Care Quality Commission (CQC).

40 Also note that procurement law may be relevant as, in some circumstances, the admittance of a new contracting party may give rise to procurement obligations. ATs should refer to relevant published guidance and should take appropriate advice at an early stage.

41 It is equally important to note that the regulations surrounding primary medical services contracts place restrictions on the organisational structures that are acceptable for some contracting routes, namely GMS and PMS. These eligibility criteria are detailed in annex 4.

## **A. Variation provisions specific to a contract with an individual medical practitioner (single handed into partnership) (GMS)**

42 If the contractor is currently an individual medical practitioner, with a GMS

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contract, and they wish to enter into partnership with one or more individuals under that contract, then they shall notify NHS England in writing<sup>2</sup> and provide the following:

- 1) Contractor must provide a written notice to NHS England of their intention to change the status of their contract from that of a single handed to a partnership, such notice to include the date on which the contractor wishes to change its status, which shall not be less than 28 days from the proposed date of the change of status (annex 6, 1).
- 2) The contractor must state:
  - a. whether or not it is to be a limited partnership and if so, who is a limited and who is a general partner;
  - b. confirm that the proposed partner is either a medical practitioner, or a person who satisfies the conditions specified in the NHS Act;
  - c. confirm that he is a person who satisfies the conditions imposed by regulations 4 and 5 of the regulations;

and the notice must be signed by the individual contractor and by the person or each of the persons (as the case may be), with whom he is proposing to practise in partnership.

- 3) ATs must ensure the accuracy of the information provided in the notice. This may be achieved, for example, by checking the registration status of the proposed partner(s) and that the proposed partner(s) meet the eligibility criteria for holding a GMS contract (annex 4).
- 4) ATs shall confirm in writing that the new partner(s) is an eligible person to be a partner on the contract (see annex 5) and issue a variation agreement notice accordingly to amend the relevant sections of the contract.
- 5) If the new partner is not accepted as eligible the AT must advise the contractor in writing of the reasons they believe the proposed partner(s) to be ineligible and confirm that the contract status will remain single handed until the matter can be resolved or a further

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<sup>2</sup> GMS Regs, Sch. 6, para. 105

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notice is provided by the contractor proposing an alternative eligible partner.

- 6) A variation notice issued under 4 should include the appropriate amendments to the following GMS contracted terms, however, ATs should always ensure that all relevant clauses are amended as this list is not exhaustive and may be subject to later amendments:
- a. Paragraph 12.
  - b. Paragraphs 460 and 461.
  - c. Paragraphs 532 to 537.
  - d. Paragraphs 538 to 542A.
  - e. Paragraphs 543A to 543C.
  - f. Paragraph 545.
  - g. Paragraph 546.
  - h. Paragraph 574 (unless partnership limited by shares).
  - i. Paragraphs 575 to 576.
  - j. Schedule 1 (partnership) to replace (individual).
  - k. Schedule 2 to include additional partner(s) signature(s).

And the electronically held contract document amended accordingly.

- 7) ATs must refer to the footnotes in the most current standard General Medical Services contract for the appropriate action to take regarding the amended terms identified in 5 (a) to (k) above.
- 8) ATs may choose to manage this process by sending two copies of the contract variation agreement form and amended pages of the contract to be signed by all parties to the contract.
- 9) The contractor would then be required to return both signed copies of the contract variation agreement form for counter-signature and one completed form and attachments should be returned to the contractor with the remainder retained by the AT for the contract file.
- 10) ATs should then update their contract variation log accordingly.

43 The ATs must specify in the notice the date on which the contract will continue as a partnership. Where reasonably practicable this should be the date requested by the contract holder in their initial notice, or the nearest

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date to it.

**B. Variation of a sole practitioner agreement (PMS/APMS)**

- 44 If the contractor is currently an individual medical practitioner, with a PMS/APMS agreement, and they wish to have one or more individuals join them under that agreement, then they must seek NHS England consent in writing for any such variation to the contract. NHS England must have consideration of any procurement implications, along with other influencing factors, when considering such an application.
- 45 The PMS agreement is made with individuals, or a qualifying body. In the case of individuals they may then choose to deliver their contractual obligations by means of a partnership.
- 46 Subject to specific regulatory provisions, no amendment or variation shall have effect, under PMS, unless it is agreed in writing and signed by or on behalf of NHS England and the contractor(s).
- 47
- 1) The contractor must provide a written application to NHS England for consideration of their intentions to have one or more individuals joining them under their PMS agreement (annex 6, 2). The regulations are silent in respect of the timings for this notice; therefore, ATs should refer to the individual agreement for the local arrangements, however, if the individual agreements are also silent, it would be advisable for ATs to demonstrate equity and to reflect the GMS timescales in this process.
  - 2) The detail of any such notice will also be defined differently in the local PMS agreements, though they are most likely to reflect those in GMS, so it is essential that ATs refer to the individual agreement.
  - 3) ATs must review and ensure the accuracy of the information provided in the notice by checking the registration status of the proposed individual(s) and that the proposed individual(s) meet the eligibility criteria for holding a PMS/APMS agreement (annex 4).
  - 4) Once the ATs have reached their decision regarding the application, they shall confirm this in writing to the contractor detailing the reasons for the decision and details of any information that they have relied upon in the process.
  - 5) If the decision is to consent to the variation then the AT shall issue a variation agreement form accordingly to amend the relevant sections of the contract.

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- 6) A variation agreement form should include the appropriate amendments to the individual agreement terms, in particular the schedule of signatories to the contract.
- 7) ATs must send two copies of the variation agreement form (annex 3) and amended pages of the agreement to be signed by all parties.
- 8) NHS England must specify in the form the date on which the agreement will continue with the new individuals included. (Where reasonably practicable this should be the date requested by the contract holder in their initial notice, or the nearest date to it.)
- 9) The contractor should return both signed copies for counter-signature and one completed form and attachments must be returned to the contractor with the remainder retained by the AT for the contract file.
- 10) The PMS/APMS agreement (whether stored electronically or as a hard copy, or both) should not be formally amended until such time as the completed variation agreement form is received together with confirmation in writing that all parties agree to the variation.
- 11) If the contractor does not return the variation agreement documentation, then no amendment to the agreement can take place and the individual contract holder will continue to practise as a sole practitioner and it is important that the contractor be made aware of this within the form.
- 12) ATs should then update their contract variation log accordingly.

**C. Variation provisions specific to a contract with two or more individuals practising in partnership (GMS)**

- 48 Where a GMS contractor consists of two or more individuals practising in partnership, in the event that the partnership is terminated or dissolved, the contract shall only continue with one of the former partners if the name of that partner is specified in accordance with paragraph two below and is a medical practitioner who is a general (not limited) partner<sup>3</sup>.
- 49 1. Contractor writes to the NHS CB, not less than 28 days before the proposed date of the change taking effect, to advise them that the partnership is to be dissolved or terminated (annex 6, 3).

<sup>3</sup> GMS Regs, Sched 6 - Part 8, Para 106.1

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2. The notice must:
  - 2.1. specify the date on which the contractor proposes to change its status from that of a partnership to that of an individual medical practitioner;
  - 2.2. specify the name of the medical practitioner with whom the contract will continue, which must be one of the partners; (ownership or access to premises is often the deciding factor here); and
  - 2.3. be signed by all of the persons who are practising in partnership.
  
3. ATs must acknowledge, in writing, receipt of this notice as soon as possible and before the date notified in 2.1 above.
  
4. ATs should consider this notice carefully having full regard of the implications of such a change and may seek further clarification from the remaining partner(s) as to the proposed arrangements for continuity of the full range of services to the contract's registered population.
  
5. ATs should ensure that the remaining partner is eligible to hold the contract (annex 4 and 5) and may vary the contract only to the extent that is necessary to reflect the change in status of the contractor from a partnership to an individual medical practitioner.
  
6. ATs should send two copies of the contract variation agreement form and amended pages of the contract to be signed by the remaining partner. (See section 2, A.5 (a to k) of this document)
  
7. Contractor returns both signed copies of contract variation agreement form for counter-signature and one completed form and attachments must be returned to the contractor with the remainder retained by the AT for the contract file.
  
8. ATs to update their contract variation log accordingly.
  
- 50 The AT would wish to be satisfied that the arrangements in place for continuity of service provision to the contracts registered population are robust. However, any concerns raised in this respect should be managed under the policy for the Identification management and support of independent contractors whose performance gives cause for concern after the variation has taken effect.

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- 51 In circumstances where the AT is not satisfied that the nominated partner is eligible to hold the contract as an individual they should enter into dialogue with all of the partners, before the variation taking effect, to explore potential solutions.
- 52 These might include the partners nominating an alternative partner to continue with the contract, in which circumstances a new notice should be issued to NHS England to include these details and propose a new date on which the changes will occur.
- 53 If no satisfactory solution can be found, both parties may agree in writing to terminate the contract, and if so, they shall agree the date upon which that termination should take effect and any further terms upon which the contract should be terminated<sup>4</sup>.

**D. Variation provisions specific to a contract with two or more individuals practising jointly under a PMS agreement**

- 54 Similarly to the provision under section 2 B of this document, the PMS regulations do not define a process for consideration of any variation to the individual parties, though individual PMS agreements may have such provisions.
- 55 It is essential that the ATs review the individual agreement of the contractor seeking authorisation for such a change before following any process for varying their agreement.
- 56 If the contractor includes two or more individual medical practitioners, with a PMS agreement, and one or more of those individuals wish to resign from that agreement, then they must seek NHS England agreement in writing for any such variation to take effect.
- 57 Subject to specific regulatory provisions, no amendment or variation shall have effect, under PMS, unless it is agreed in writing and signed by, or on behalf of, the NHS CB and the contractor(s).
- 58 A PMS provider may be made up of one or more individuals practising together.
- 59 A change in the individual members may require a variation of the PMS agreement, but this is subject to NHS England agreement and continued compliance with the provider conditions, so would not ordinarily result in

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<sup>4</sup> *GMS Regs Sched 6 – Part 8, para 107*

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the termination of the contract.

- 60 However, if in the reasonable opinion of NHS England, the change in membership of the agreement is likely to have a serious adverse impact on the ability of the contractor or NHS England to perform its obligations, NHS England may serve notice terminating the contract.
- 61 ATs must be satisfied that the arrangements for continuity of service provision to the registered population covered within the contract are robust and may wish to seek written assurances of the remaining member(s) ability and capacity to fulfill the obligations of the contract and their proposals for the future of the service (annex 6, 4)
- 62 If the AT is satisfied with the proposals and that all remaining member(s) of the agreement continue to meet the criteria for holding a contract, then they will issue the appropriate variation agreement form and include the appropriate amended pages.
- 63 The process for issuing any such variation is the same as in section 2 B of this document.
- 64 Any application for variation to a PMS agreement is an opportunity for NHS England ATs to review the existing terms and seek to negotiate alternative local terms where appropriate.
- 65 In these negotiations it is essential that none of the mandatory requirements of the regulations are varied and again any such variation can only take place if agreed in writing by both parties.

### **Death of a contractor**

- 66 More comprehensive details of the processes regarding dealing with the death of a contractor and supporting templates are provided separately in the Policy for managing the death of a contractor for primary medical services. This section sets out the contractual arrangements only and should be read with that policy.
- 67 1. Where the GMS contract is with an individual medical practitioner and that practitioner dies, the contract shall terminate at the end of the period of seven days after the date of his death unless, before the end of that period:

1.1 the AT has agreed in writing with the contractor's personal representatives that the contract should continue for a further

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period, not exceeding 28 days after the end of the period of seven days; and

1.2 only in the case of GMS, the contractor's personal representatives have employed or engaged one or more general medical practitioners to assist in providing clinical services under the contract throughout the period for which it continues.

2. If a GMS partnership is terminated or dissolved because, in a partnership consisting of two individuals practising in partnership, one of the partners has died, the remaining individual must notify the NHS CB in writing as soon as is reasonably practicable of the death of his partner. The contract shall continue with the remaining individual, only if that person is a medical practitioner who is not a limited partner and who meets the criteria for holding a GMS contract.

2.1 The AT shall issue a variation agreement notice in accordance with the process outlined in section 2 C of this document.

3. If the remaining partner does not meet these requirements then, the AT shall serve notice in writing on the remaining individual confirming that NHS England will allow the contract to continue with that individual, for a period specified by the AT, not exceeding six months (the interim period) provided that he employs or engages a general medical practitioner for the interim period for the provision of clinical services under the contract.

4. If, during the interim period, the contractor withdraws from the agreement to employ or engage a general medical practitioner, the AT shall serve notice in writing on the contractor terminating the contract forthwith.

5. If, at the end of the interim period, the contractor has not entered into partnership with a general medical practitioner who is not a limited partner, the AT shall serve notice on the contractor terminating the contract forthwith.

68 The PMS regulations are silent about the death of an individual working with another or other members under the agreement. However, in cases where these terms are not defined clearly in the individual PMS/APMS agreements, it would be a practical solution to mirror the arrangements set

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out in GMS, for these purposes, and removing any reference to partnership.

- 69 Please refer to the Policy for managing the death of a contractor for primary medical services for some of the key actions to be addressed when managing the death of a contractor that may result in the termination of the contract.

### **Retirement of a contractor – single handed**

- 70 If an individual (single-handed) contractor wishes to retire, the GMS/PMS/APMS contract will automatically terminate on the retirement date.
- 71
1. The contractor shall provide NHS England with a written notification of their intended retirement and therefore termination date of the contract. This notice should be of not less than three months under GMS and is likely to be of six months under PMS/APMS. (Though some individual agreements may have alternative notice periods these should not be for less than six months).
  2. For GMS contracts, if the termination date is not the last calendar day of a month, the contract shall instead terminate on the last calendar day of the month in which the termination date falls.
  3. For PMS, there is no such requirement; instead the AT must calculate the date of termination, based on the terms in the individual PMS agreement (which must be not less than six months) and from the date of the notice.
  4. In exceptional circumstances, such as ill health, NHS England may wish to waive its right to the full notice period but it remains its right alone to do so. Consideration should be given, amongst other matters, to the effect that holding a contractor who's unwell to the full notice term may have on the practitioner concerned and the practice patients and colleagues.
  5. In either case the AT must confirm receipt and acceptance of the retirement/termination notice in writing, the date on which the contract will terminate and any consequences and actions that the contractor must take as a result of the notice.
  6. The GMS contract (clauses 594 to 600 – consequences of termination) clearly set out the arrangements that must be made on termination of a contract, which include (but are not limited to) the

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contractor having to:

- 6.1. cease performing any work or carrying out any obligations under the contract;
  - 6.2. co-operate with NHS England AT to enable any outstanding matters under the contract to be dealt with or concluded satisfactorily;
  - 6.3. co-operate with NHS England AT to enable the contractor's patients to be transferred to one or more other contractors or providers of essential services (or their equivalent); and
  - 6.4. deliver up to the NHS England AT all property belonging to NHS including all documents, forms, computer hardware and software, drugs, appliances or medical equipment which may be in the contractor's possession or control.
7. The AT shall have in place arrangements for collecting any property owned by the NHS on or immediately after the termination date, which should be included on a log of collection, and against any NHS England held asset list, and where possible the contractor should be asked to sign to confirm the property that has been removed, accepting that it is owned by the NHS.
  8. On termination of the contract, the AT shall perform a reconciliation of the payments made by NHS England to the contractor and the value of the work undertaken by the contractor under the contract. The AT must then serve the contractor with written details of the reconciliation as soon as reasonably practicable, and in any event no later than 28 days after the termination of the contract.
  9. Each party shall pay the other any monies due within three months of the date on which the AT served the contractor with written details of the reconciliation, or the conclusion of any NHS dispute resolution procedure, or court action as appropriate as the case may be.
  10. The PMS regulations require that each PMS/APMS agreement make suitable provision for arrangements on termination of an agreement, including the consequences (whether financial or otherwise) of the agreement ending, subject to any specific requirements in the regulations. While these terms are likely to mirror those set out in GMS for most PMS agreements, the individual agreements must be checked by the AT to ensure that no additional or alternative terms were included. This is especially important when considering termination of an APMS agreement, which often included very specific additional terms in this respect.

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11. However, the key elements for consideration leading up to a termination remain the same in respect of patients, property and transfer of records and confidential information and so on, and an obligation on the contractor to co-operate with NHS England in managing each of these.

72 These should include, but not be limited to:

- A Premises: Are they still required post retirement? Who owns them and what arrangements might NHS England need to enter into to secure them for the interim period of consultation, patient list dispersal or procurement. Premises reimbursements under the Premises Directions can only be made to primary medical care contractors.
- B Patient rights of choice: NHS England must not simply transfer all of the registered patients to an alternative provider as they should be provided with a detailed list of other local practices that are currently accepting new patients and asked to register with one of them.
- C What steps will be taken regarding patients who have not registered elsewhere at the end of the interim period or the 28-day period in respect of a sole/single handed practitioners death. It is often the case that the majority will voluntarily seek alternative registration; however, there is usually a number of patients who do not, some of whom may no longer be resident in the UK, some who have died themselves or simply moved within the UK and not changed their address details at the practice and others who have not yet chosen an alternative provider. In these circumstances NHS England must be clear on the process of dispersal or allocation that they will follow to avoid the risk of challenge from other local providers.
- D IT and other NHS owned equipment: NHS England will need to make arrangements to retrieve this after services cease.
- E Management of patient paper records (Lloyd George notes) and any subsequent clinical mail: it is possible that the provider has retained a significant number of patient paper records both in the reception area and often stored elsewhere in the practice premises, including loft spaces and store cupboards. NHS England must be able to securely retrieve these records and communications, having full regard of data protection and confidentiality so these can be distributed accordingly to any new providers or returned to central storage. The contractor (or their representative) is responsible for any non-NHS patient or client record, though agreement may be reached with the AT to manage (dispose of) any confidential information on their behalf.
- F Prescriptions pads, electronic prescriptions and any uncollected completed prescriptions: these will also need to be retrieved and dealt with accordingly. NHS England may wish to decide on a specified age of a current prescription (such as one month) and make appropriate

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arrangements for the handling of these and disposal of any that are older.

- G Practice held drugs: these will need to be disposed of but some (eg not centrally provided vaccines) will be the property of the contractor, or, in the case of a single-handed contractor death, their representative.
- 73 This list is not exhaustive and there are likely to be other issues that need due consideration under these provisions.

### **Retirement of a contractor –two or more partners/individuals**

- 74 Where a partner wishes to retire from a GMS partnership, as constituted from time to time, they should write, providing at least 28 days' notice in advance. ATs should then follow the process in section 2C of this policy in line with the regulations.
- 75 Where an individual wishes to retire from a PMS contract, where that contract is also held by one of more other individuals, ATs should then follow the process in section 2D of this policy in line with the regulations.
- 76 Where a partner of a partnership holding an APMS contract wishes to retire, ATs should follow any process defined within the contract, or in the absence of any defined process the consent of the AT must be sought through a contract variation.
- 77 ATs should always keep in mind the possible implications on procurement and competition when applying the guidance in this policy.
- 78 Any changes to the partners within a contract will require a new registration with CQC.

### **Twenty-four hour retirement**

- 79 24-hour retirement is a process by which members of the NHS pension scheme seek to qualify for their retirement benefits whilst continuing to work (albeit with a break).
- 80 The NHS Pensions Agency advises<sup>5</sup> that members must:
- 6.1 resign from all involvement in an NHS contract and cannot return to the NHS in any capacity for at least 24 hours; and

<sup>5</sup> *NHS Pensions Newsletter – NHS Pension Benefits & Retirement 15 August 2006*

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6.2 must not work for more than 16 hours a week in the first month of retirement.

- 81 When NHS England is approached by a pension scheme member wishing to take 24-hour retirement (annex 6, 5) it will not offer advice relating to a pension scheme member's pension arrangements and will advise him/her to seek their own independent financial and legal advice and advice from the NHS Pensions Agency.
- 82 Different rules may apply depending on which NHS pension scheme is applicable. It is therefore not the case that all pension scheme members will need necessarily to take 24-hour retirement to qualify for their entitlements.
- 81 Where a pension scheme member confirms that 24-hour retirement requires him/her to resign from the NHS contract and the pension scheme member is part of a contracting unit, whether that is as a partner in a contracting partnership (for example under a GMS contract), as a co-contractor (for example under a PMS contract) or as a director or officer of a corporate contractor steps will need to be taken to ensure that (i) the pension scheme member is removed from the contracting unit and (ii) if appropriate, they are restored to the contracting unit more than 24 hours later. Any such changes will need to be consistent with the regulatory frameworks governing GP contracts<sup>6</sup> and the specific terms of the relevant contract<sup>7</sup>.
- 82 In certain circumstances, NHS England will have discretion as to whether or not to agree a change required as part of 24-hour retirement. For the avoidance of doubt, NHS England reserves its right to exercise its discretion as it deems fit in all the circumstances.
- 83 Single-handed practitioners in particular should take advice, as 24-hour retirement using the method described above would necessitate the termination of the contract (see section 5 of this policy). In those circumstances, there is no guarantee that NHS England would commission services from that individual following termination.

### **Variation provisions specific to a contract with a company limited by shares (GMS) or a qualifying body (PMS)**

<sup>6</sup> *NHS (General Medical Services Contracts) Regulations 2004; NHS (Personal Medical Services Agreements) Regulations 2004; Alternative Provider Medical Services Directions 2010 (as amended)*

<sup>7</sup> *For example, contracts may contain notification requirements in relation to changes of control of corporate entities.*

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- 84 GMS may be held by a company limited by shares (subject to certain conditions). PMS and SPMS may be held by a qualifying body (a company limited by shares, all of which are legally and beneficially owned by persons who may enter a PMS agreement).
- 85 APMS, in principle, has fewer restrictions on the types of organisations that may hold contracts under APMS arrangements and therefore NHS England can enter APMS contracts with any individual or organisation that meets the provider conditions detailed in Directions.
- 86 It should be noted that a change from a single-handed or partnership contract to a limited company is a significant change and would, therefore, require the issue of a new contract or a novation or contract variation. Procurement law is likely to be relevant here and ATs should give due consideration to its requirements.
- 87 This section of the policy highlights some of the most common organisational structures that NHS England's ATs may encounter in primary medical care contracting and offers some guidance as to their eligibility for the contracting routes.

### **A. Limited company**

- 88 One of the issues associated with trading as an individual (a sole trader), or a partnership, is the disadvantage to the owner(s) that they remain personally liable for all debts should the business fail. To limit this liability, some form of incorporation (e.g. the creation of a company) is required.
- 89 A company is a separate legal entity and is recognised by the courts as being able to take, or respond to, legal action in its own right, separate from either the owners of the company (shareholders) or the people running the company (the directors). It is the company that enters into contracts, employs staff, owns assets and is liable for all debts.
- 90 Shareholders own the company if it is limited by shares or its members if it is limited by guarantee. In the former, the liability of the shareholders is limited to the nominal value of the share, and in the latter, it is limited to the value of the guarantee, which is usually £1.
- 91 Although they are a common form for delivery of out-of-hours primary care services (where the contract is likely to be in the form of an APMS contract), NHS England should note that companies limited by guarantee are not an acceptable form for either GMS or PMS arrangements. The only allowable corporate vehicle for GMS and PMS arrangements is a company

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limited by shares, and even then there are restrictions on share ownership.

- 92 Any change to shareholder composition should be notified in writing to NHS England.

**B. Companies limited by shares (qualifying body)**

- 93 A qualifying body for the purposes of contracting for PMS or SPMS, is a company limited by shares, all of which are legally and beneficially owned by persons who may enter a GMS or PMS agreement.

- 94 The ownership of shares confers certain rights and responsibilities in relation to the company and shares can have a monetary value. These rights and responsibilities include:

1. a return from the company's profits (which can be by way of dividend);
2. a right (often subject to conditions) to transfer their interests to another person (sell shares); and
3. a vote at general meetings where numerous issues including the terms of the constitution and the appointment and resignation of directors may be discussed.

- 95 NHS England should note that the ability of shareholders to sell their shares in a company holding a GMS/PMS contract is restricted by regulations and that, in all cases, changes in ownership have to be reported to NHS England.<sup>8</sup>

**C. Limited liability partnerships (LLPs)**

- 96 Recent developments in the NHS have led to the exploration of organisational structures that allow practices to work together. One such structure is that of the limited liability partnership.

- 97 A limited liability partnership (LLP) is an alternative corporate business vehicle that gives the benefits of limited liability but allows its members the flexibility of organising their internal structure as a traditional partnership. The LLP is a separate legal entity and, while the LLP itself will be liable for the full extent of its assets, the liability of the members will be limited.

- 98 However, NHS England should be aware that, currently, legal restrictions do not allow them to enter into either GMS or PMS arrangements with limited liability partnerships.

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<sup>8</sup> *PMS Regulations, Schedule 5, Part 5, para 80 (1a)*

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### Summary

- 99 This is by no means an exhaustive list of the forms of company that might present to NHS England to either take on or be varied to become a holder of an NHS contract, however, these are the most common.
- 100 There are other forms such as Industrial and Provident Societies (IPS); social enterprises (including community interest companies (CICs)), which are becoming more frequent organisational structures. NHS England should seek advice about its appropriateness to hold an NHS contract at the appropriate time.

### Variations to PMS agreements

- 101 Under PMS NHS England still cannot contract with a partnership because a partnership is not a distinct legal entity capable of entering into a legally binding agreement. A PMS agreement with more than one member is therefore entered into with each of the individual signatories to that PMS agreement. All signatories (members) are jointly and severally liable under the terms of the agreement and must all individually meet the criteria for eligibility to hold a PMS agreement.
- 102 Furthermore, unlike GMS arrangements, PMS regulations do not provide a right for new parties to join PMS agreements nor to vary the shareholders of a qualifying body.
- 103 Though many individual PMS agreements may include terms that mirror the arrangements under the GMS regulations, others will not. Any agreed variation to the parties to the agreement should be treated as a variation and therefore managed under the processes identified within this policy.
- 104 ATs may, however, come across changes to PMS agreements that have been managed by instruments bearing the title of novation where in fact such an instrument does not amount to a true novation. For the purposes of clarity novation can be defined as a complete change in the identity of the contracting party or parties on one side of the contract (such that a contract between A and B is replaced by contract between A and C, where C has stepped into the shoes of B).
- 105 For these purposes it is very important to note that novation is only appropriate when the contract is transferring from one party to an entirely different party. This results in a brand new contract and as such is subject to the rules of procurement and competition.
- 106 As there is no right of transfer for PMS, novation would only ever apply if

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NHS England were to agree and, given procurement regulations, it would normally be irregular to use novation instead of following a formal tender process.

- 107 In any event, it is recommended that ATs seek further legal advice before entering into a novation to ensure they are not in breach of procurement or other applicable laws.

### **Partnership splits/members dispute – GMS and PMS**

- 108 Dissolving a partnership in GMS usually results in a contract termination unless all parties can agree for the contract to continue with one partner (section 2C of this policy).
- 109 Depending on the terms of the individual PMS agreements, it is likely that similar arrangements are in place there too (section 2D). However, the terms of any agreements should always be checked before any steps are taken.
- 110 NHS England expects that the statutory six months<sup>9</sup> notice be given by the contractor to terminate a GMS contract that is held by a partnership. Failure to give six months' notice of termination is a breach of contract and the appropriate action will be taken in line with the policy on *Contract breaches, sanctions and termination*.
- 111 It is, therefore, desirable that the partners of a GMS contract or members under a PMS agreement are able to resolve disputes internally, where possible, with the support of the Local Medical Committee and/or mediation services.
- 112 Where partnerships or membership are formalised through a partnership deed, it is very helpful if the parties are able to rely on the detail of these agreements to support the early resolution of internal disputes and to ensure that such agreements are reviewed and maintained to be current with associated legislation.
- 113 Unfortunately, many partnership or member organisations do not have deeds in place, or have insufficient or outdated documents, and this can often lead to very protracted and acrimonious disputes between the parties in general practice.
- 114 NHS England should not get involved in endeavouring to resolve the dispute between the partners, instead insisting that the parties notify NHS

<sup>9</sup> *GMS regulations Schedule 6 part 8 (108)*

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England of their final decision when it is reached. NHS England must notify the partnership or members that they will seek to terminate the contract or agreement if the matter cannot be resolved and services or patient safety may consequently be at risk.

- 115 It is likely that in such cases NHS England will have numerous contacts from different partners/members and their staff about the dispute but NHS England should try to maintain a detached position in this respect. Of course, any accusations of inappropriate behavior or concerns should be considered under the terms of the policy for the *Identification management and support of independent contractors whose performance gives cause for concern*. However, this should not be used as a means to endeavour to resolve the dispute.
- 116 ATs should advise the contractors to seek their own legal and financial advice and support.
- 117 All contacts between the parties and the NHS England ATs must be carefully noted and other NHS departments who might also be contacted should be requested to provide written details of communications for the main contract file. This is likely to include finance and human resources colleagues as a minimum.
- 118 In the case of partnership/member disputes the AT should issue the contractor with a letter advising them of the NHS England position in this matter, the advice to seek their own mediation or support services and the consequences of the dispute not being resolved satisfactorily. The letter should also detail the names of the provider parties with whom NHS England is contracting and will continue to contract with until such time as the AT has received a single notice, signed by all parties, proposing an amendment or termination.
- 119 Once the parties have reached a decision on how to progress, NHS England should require them to provide written notification of that decision and any notice or request for variation. Depending on the detail of that notice, the AT should consider following the policy details defined in section 2 of this document.
- 120 Throughout the dispute the ATs should maintain open dialogue with the Local Medical Committee and implement contract performance management protocols, if and when necessary.

### **Practice mergers and/or contractual mergers**

- 121 A GP or partnership may hold more than one form of primary care contract

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with NHS England and can also be a party to more than one contract. For example a GMS contractor can also be a party under a PMS agreement and vice versa and either can also hold or be a party to an APMS agreement.

- 122 This flexibility has enabled GP practices to come together in varying ways to provide support for each other, expand on the services available and/or resolve premises issues and achieve economies of scale, though each will have their own reasons for considering such a union.
- 123 The underlying principle for NHS England to consider when any such proposal is made to them is what the benefit is for the patients and what the financial implications for NHS England are.
- 124 There are three ways in which practices will propose to merge:
1. As becoming a party to each other's contracts, while still retaining two separate NHS contracts and registered lists with NHS England (Variations – section 2 of this policy); or
  2. Formally as a merger of the two contracts creating a single organisation or partnership operating under one single contract and maintaining a single registered list of patients.
  3. Informal arrangements such as sharing staff requires no input from NHS England as this is a private arrangement between the parties.

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**Annex xx**

*Add any annexes to support policy such as definitions specific to the policy document, flow charts etc.*

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