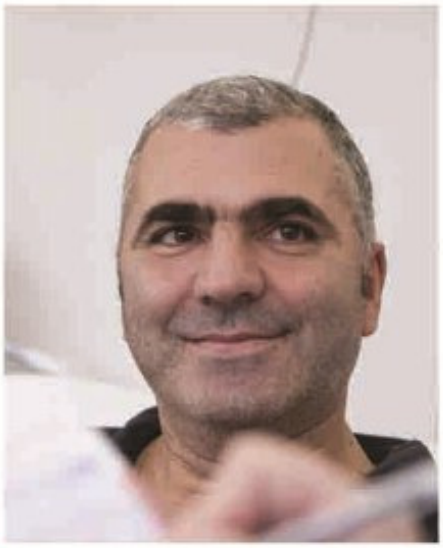
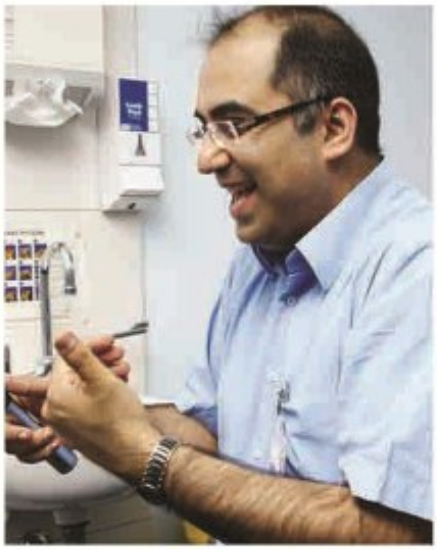
NHS England

Managing disputes for primary medical services





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Managing disputes for primary medical services

Standard operating policies and procedures for primary care

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Information Reader Box

Directorate	Purpose
Medical	Tools
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Finance	Consultations
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Contents

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 care*[1], including the intention to build on the established good practice of predecessor organisations.

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

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

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

[1] *Securing excellence in commissioning primary care http://bit.ly/MJwrfA*

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

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. managing contract variations for primary medical services contracts;
d. tackling list inflation for primary medical services;
e. dispute resolution for primary medical services;
f. managing the death of a contractor in primary medical services;
g. managing closed lists for primary medical services;
h. managing a Personal Medical Services (PMS) contractor's right to a General Medical Services (GMS) contract;
i. managing the end of time limited contracts for primary medical services;
j. primary medical services assurance framework;
k. Guidance to support delivery of assurance management in primary medical services.

Policy aims and objectives

10 This document describes the process to determine the action required when a contractor has requested to follow the dispute resolution process in relation to a decision that has been made or effected against their contract to deliver primary medical service. The process is present to comply with national regulations so as to maintain robust contracts with a structured dispute process.

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

Background

12 This guidance outlines the principles and provides detail as to the action required when a contractor raises a dispute over one or more decisions that NHS England has made in relation to their contract.

13 There are two main types of dispute that can arise from GMS/PMS contracts:

- NHS body.
- Non-NHS body.

14 **An NHS body** is where the contract is an NHS contract and held by a person (or persons) with NHS body status or regarded as such for the purpose of the contract or agreement (NHS Act S90(3)).

15 **A non-NHS body** is where the contract is legal rather than NHS (normally due to the contractor not holding, or electing to be regarded as holding, NHS body status). Contractors who normally hold this status are likely to be holders of Alternative Provider Medical Services (APMS) or Specialist Personal Medical Services (SPMS) contracts and those which have not elected to be regarded as NHS Bodies for the purpose of their GMS or PMS contract/agreement.

16 GMS and PMS contractors have the right to be regarded as an NHS body under regulation 10 (part 4, page 17) of the NHS (General Medical Services Contracts) Regulations 2004 as amended or regulation 9 (part 4, page 16) of the NHS (Personal Medical Services Agreements) Regulations 2004 as amended.

17 APMS contracts can only be NHS contracts if the legal entity holding the contract already holds an NHS contract for other purposes, or if it is one of those bodies detailed in section 9(4) of the National Health Service Act 2006.

18 Whenever the contractor is regarded as being an NHS body, its GMS contract/PMS agreement will be an NHS contract. Whenever the contractor is not regarded as a Health Service Body, its GMS contract/PMS agreement will not be an NHS contract. Whilst disputes involving non NHS contracts would ordinarily follow the legal path (court proceedings) contractors may elect to use the NHS dispute process at any time during the proceedings.

19 In determining the managing disputes process the following guidance, legislation and regulations are considered:

- GMS contract regulations.
- PMS agreement regulations and guidance.
- APMS directions.
- Statement of financial entitlements.
- Primary Legislation including the NHS Act 2006 as amended.
- EU procurement legislation.
- The public contracts regulations.
- Department of Health procurement guide.
- Principle rules of co-operation and competition panel.
- Family Health Service Appeals Unit.
- National Health Service Act.
- Health and Social Care (Community Health and Standards) Act.

Scope of the policy

20 For all matters of dispute:

"…any dispute arising out of or in connection with the Contract, the Contractor and NHS England must make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute, before referring the dispute for determination in accordance with the NHS dispute resolution procedure (or, where applicable, before commencing court proceedings)." [2]

21 There are two different routes that can be taken for resolving contractual disputes, depending on the contract holder's NHS body status:

- With an NHS body, the steps laid out in this policy will be used to resolve all matters of dispute (where the contract is an NHS contract and held by person(s) that have NHS body status).

- With a non-NHS body, where a contract holder is deemed to be a non-NHS body, the dispute can either be heard using the process described within this policy, or using the judicial court system (where the contract is legal rather than NHS (normally due to the contractor not holding, or electing to be regarded as not holding, NHS body status).

22 However, the use of the judicial court system can be an expensive and public route. In normal circumstances and across most cases, non-NHS bodies will elect to follow the route laid out below.

23 Where a contractor and NHS England have followed this policy route to the end determination, it should be noted that the resulting outcome is binding and final and cannot then be referred to the court system for a further ruling other than to enforce the decision as having the status of a County Court Judgement or to seek Judicial Review of the process.

24 There is a preference for NHS England to always follow the NHS body route using this policy as guidance, rather than the judicial route due to the expense involved and the timescales that are prevalent with a non-NHS body hearing.

25 Where this procedure is unsuccessful in reaching a resolution the contractor is able under the regulations[3] to refer a dispute to the secretary of state for determination within three years of the date on which the dispute arose.

[2] *Standard GMS model contract, Part 24, paragraph 518*
[3] *GMS regulations, schedule 6, paragraph 101*

However, it should be noted that this is a final resort and all parties should endeavour to resolve any dispute within the three-year period to allow sufficient time to refer the matter to the secretary of state if necessary.

Managing disputes – informal process

26 NHS England and the contractor should make every reasonable effort to communicate their issues in relation to decision-making and rationale and, furthermore, should co-operate with each other to resolve any disputes that emerge informally before considering referring the matter for determination through formal dispute resolution procedures.

27 The formal process cannot be initiated until the informal process has been exhausted and it should be noted that both parties may wish to involve the relevant professional representative (local medical committee) or suitably qualified and experienced mediator/conciliator committee at this stage in an advisory or mediation role.

28 The use of an informal resolution process helps develop and sustain a partnership approach between contractors and NHS England.

29 The informal process may include (but not be limited to):

- Regular telephone communications;
- Face-to-face meetings at a mutually convenient location;
- Written communications.

30 It is essential that the AT maintains accurate and complete written records of all discussions and correspondence on the contract file in this respect. The AT should ensure that it responds to contractor concerns and communications in a timely and reasonable manner.

Managing disputes – stage 1 (local dispute resolution[4])

31 Every reasonable effort to communicate and cooperate with each other should be made prior to invoking the first stage of the formal local dispute resolution process.

32 The contractor is required to notify NHS England of its intention to dispute one or more decisions made against its contract or agreement. This notification should usually be received no later than 28 days after the NHS England advises the contractor of their decision.

[4] *GMS regulations, schedule 6, Part 7, paragraph 99*

33 1. NHS England will immediately cease all action in relation to the disputed notice or decision, until:

1.1. there has been a determination of the dispute and that determination permits NHS England to impose the contract sanction; or

1.2. the contractor ceases to pursue the NHS dispute resolution procedure or court proceedings;

whichever is the sooner.

2. Where NHS England is satisfied that it is necessary to impose the contract sanction before the NHS dispute resolution procedure is concluded in order to:

2.1. protect the safety of the contractor's patients; or

2.2. protect itself from material financial loss;

then NHS England shall be entitled to impose the contract sanction forthwith, pending the outcome of that procedure.

3. NHS England will acknowledge the notification of dispute within seven days of receipt (posted by recorded delivery) and request the submission of supporting evidence from the contractor within a further 28 days from the date they receive the letter. (Annex 2)

4. Upon receipt of the evidence the AT will have 28 days to review the evidence and invite the contractor to attend a meeting, which should be as soon as possible, but at the very latest within a further 28 days. The contractor(s) has the opportunity to invite representative bodies to support it at the meeting, for example, the local medical committee (LMC). A sample invite letter is set out in annex 3.

5. Once the meeting has been held, the AT will notify the contractor in writing the outcome of the meeting, whether this be that the dispute will now need to be moved to stage 2 of the NHS dispute resolution procedure (annex 4), or that the dispute has been successfully resolved (annex 5).

34 Where the matter is resolved the issue can now be deemed as closed and the AT shall document the outcome accordingly on the contract file.

35 Where the matter remains unresolved, the process may then be escalated to the stage 2 NHS dispute resolution procedure.

36 At this point the AT should commence preparation of the contract file to ensure that if and when the Family Health Services Appeal Unit (FHSAU) or court requests submission of evidence in respect of the dispute the documentation is in order. (See section 3 of this policy).

Managing disputes – stage 2 (NHS dispute resolution procedure[5])

37 The informal process of resolution and stage 1 should be exhausted before proceeding to this stage of the process. The AT or a contractor wishing to follow this route must submit a written request for dispute resolution to the secretary of state (FHSAU process), which should include:

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

38 The written request for dispute resolution must be sent within a period of three years from the date on which the matter gives rise to the dispute occurred, or should have reasonably come to the attention of the party wishing to refer the dispute.

39 The AT will be required to prepare documentation, evidence and potentially an oral presentation in response to evidence presented in support of the dispute.

40 The AT should not underestimate the preparation that will be required in the event that evidence is required by the FHSAU, as all records pertaining to the contractor in question may be required, including (but not limited to) all contract documentation and contract variations, all written correspondence (both to and from NHS England and the contractor) and any electronic correspondence that may have passed between the parties.

41 The AT must ensure that records of communications and contract files are maintained to a high standard and all documentary evidence is collated correctly prior to submission to the FHSAU.

42 Once the FHSAU has reached a conclusion the AT will receive notification of the determination and will be required to act upon it accordingly[6].

[5] *GMS regulations, schedule 6, Part 7, paragraph 101*
[6] *GMS regulations, schedule 6, Part 7, paragraph 102*

Appealing a notice – first-tier tribunal

42 Where the AT is of the view that the conditions in the GMS regulations 4 and/or 5 (annex 6) are not being met, it shall notify in writing the proposed or existing contractor of its view and the reasons for that view. This notice should include guidance on the proposed/existing contractor's right of appeal under regulation.[7]

44 This right exists in both GMS contracts and PMS agreements.

45 The AT shall also notify in writing of its view and the reasons for that view any person legally and beneficially owning a share in, or a director or secretary of, a qualifying body where its reason for the decision relates to that person or those persons.

46 Where the AT has issued a notice in accordance with perceived non-compliance with the regulations 4 and/or 5 and the contractor is in dispute with that decision, the contractor has the right of appeal to the first-tier tribunal.[8]

Assignment of patients to lists: procedure relating to determinations of the assessment panel

47 Where an assessment panel makes a determination that the AT may assign new patients to contractors which have closed their lists of patients, any contractor specified in that determination may refer the matter to the secretary of state to review the determination of the assessment panel.

48 If a referral is made to the secretary of state, it shall be reviewed in accordance with the following procedure:

a. Where more than one contractor specified in the determination of the assessment panel wishes to refer the matter for dispute resolution, those contractors may, if they all agree, refer the matter jointly, and in that case the secretary of state shall review the matter in relation to those contractors together

b. Within the period of seven days beginning with the date of the determination by the assessment panel, the contractor(s) shall send to the secretary of state a written request for dispute resolution which shall include or be accompanied by:

[7] *GMS and PMS regulations, Part 2, paragraph 7*
[8] *GMS regulations, Part 2, paragraph 7*

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

c. Within the period of seven days, beginning with the date on which the matter was referred to him, the secretary of state shall:

- give to the parties notice in writing that he is dealing with the matter; and
- include with the notice a written request to the parties to make in writing within a specified period any representations which they may wish to make about the dispute;
- include a copy of any document by which the dispute was referred to dispute resolution, to the other party.

d. The secretary of state shall, upon receiving any representations from a party, give a copy of them to the other party, and shall in each case request (in writing) a party to which a copy of the representations is given to make within a specified period any written observations which it wishes to make on those representations.

e. For the purpose of assisting in consideration of the matter, the secretary of state may:

- invite representatives of the parties to appear before him to make oral representations either together or, with the agreement of the parties, separately, and may in advance provide the parties with a list of matters or questions to which he wishes them to give special consideration; or

- consult other persons whose expertise he considers will assist him in his consideration of the dispute.

f. Where the secretary of state consults another person, he shall notify the parties accordingly in writing and, where he considers that the interests of any party might be substantially affected by the result of the consultation, he shall give to the parties such opportunity as he considers reasonable in the circumstances to make observations on those results.

g. In considering the dispute, the secretary of state shall consider:

- any written representations made in response to his requests, but only if they are made within the specified period;

- any written observations made in response to his requests, but only if they are made within the specified period;
- any oral representations made in response to his invitation;
- the results of any consultation undertaken;
- any observations made in relation to the consultation undertaken.
- Specified period means such period as the secretary of state shall specify in the request, being not less than one, nor more than two weeks beginning with the date on which the notice referred to is given.

h. Within the period of 21 days beginning with the date on which the matter was referred to him, the secretary of state shall determine whether the AT may assign patients to contractors which have closed their lists of patients. If he determines that the AT may make such assignments, he shall also determine those contractors to which patients may be assigned.

i. The secretary of state may not determine that patients may be assigned to a contractor which was not specified in the determination of the assessment panel.

j. In the case of a matter referred jointly by contractors, the secretary of state may determine that patients may be assigned to one, some or all of the contractors that referred the matter.]

k. The period of 21 days for determination may be extended (even after it has expired) by a further specified number of days if an agreement to that effect is reached by:

- the secretary of state;
- the primary care trust;
- the contractor(s) that referred the matter to dispute resolution.

l. The secretary of state shall record his determination and the reasons for it in writing and shall give notice of the determination (including the record of the reasons) to the parties.

Annex 1: abbreviations and acronyms

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

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 CfH	NHS Connecting for Health
NHS DS	NHS Dental Services
NHS LA	NHS Litigation Authority
NMS	new medicine service
NPE	net pensionable earnings
NPSA	National Patient Safety Agency

OJEU	Official Journal of the European Union
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: Example acknowledgement letter

[*date*]

Dear [*contractor name*]

Ref: [*contract details*]

Further to your recent notification, dated [*notification date*], I can confirm we have received your intention to dispute NHS England decision in relation to:

[*matter 1 details*]

[*matter 2 details*]

[*matter 3 details*]

To proceed with the dispute resolution process, please submit to the above address your supporting evidence in relation to the matters under dispute within 28 days from receipt of this letter.

Yours sincerely,

[*name*]

[*title*]

Annex 3: Example invite letter

[*date*]

Dear [*contractor name*]

Ref: [*contract details*]

Following the receipt of evidence regarding your dispute relating to:

[*matter 1 details*]

[*matter 2 details*]

[*matter 3 details*]

NHS England would like to invite you to discuss the matter at a meeting on:

[*proposed date*],

[*proposed time*],

[*insert proposed location*]

With the appropriate NHS England representatives [*insert names of NHS England representatives*].

It is within your rights to attend with a representative from your local medical committee or a friend (or other appropriate professional body colleague). Please be aware that any representative/s present as a supportive colleague(s) will not normally be permitted to speak at the meeting. Where a solicitor accompanies you, the Chair of the meeting will make it clear that the meeting does not have statutory status. Professional advisors, such as solicitors or accountants, will not normally be in attendance in a representative role unless especially requested in advance of the meeting.

I would be grateful if you would confirm in writing your acceptance to attend this meeting and provide details of any representatives you may wish to accompany you.

Yours sincerely,

[*name*]

[*title*]

Annex 4: Example stage 1 outcome letter (1 – FHSAU referral)

[*date*]

Dear [*contractor name*]

Ref: [*contract details*]

Further to our recent meeting on [*date/time/location of meeting*] to discuss your dispute, I am writing to confirm the following outcome(s):

[*outcome 1 details*]

[*outcome 2 details*]

[*outcome 3 details*]

As this matter was unable to be resolved via local dispute resolution with NHS England, you may now wish to refer this/ese matter(s) to the secretary of state for dispute resolution in accordance with GMS Contract Regulations 2004 Section 101(3). If you do wish to refer this/ese matter(s) to the secretary of state, then please send all supporting documentation to …..

Yours sincerely,

[*name*]

[*title*]

Annex 5: Example stage 1 outcome letter (2 – Matter(s) resolved)

[*date*]

Dear [*contractor name*]

Ref: [*contract details*]

Further to our recent meeting on [*date/time/location of meeting*] to discuss your dispute, I am writing to confirm the following outcome(s):

[*outcome 1 details*]

[*outcome 2 details*]

[*outcome 3 details*]

NHS England is pleased to confirm the outstanding matters are now resolved and your contract file has been updated to reflect this mutual resolution.

Yours sincerely,

[*name*]

[*title*]

Annex 6: Regulations 4 and 5 (conditions relating solely to medical practitioners and general conditions relating to contracts)

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 eligibility and suitability.

4. Conditions relating solely to medical practitioners

1. In the case of a contract to be entered into with a medical practitioner, that practitioner must be a general medical practitioner.
2. In the case of a contract to be entered into 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 -

   i. be a general medical practitioner, or
   ii. be employed by a local health board, (in England and Wales and Scotland) an NHS trust or an NHS foundation trust, (in Scotland) a health board or (in Northern Ireland) a health and social services trust.

3. In the case of a contract to be entered into 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 so owned by -

   i. a general medical practitioner; or
   ii. a medical practitioner who is employed by a local health hoard, 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) (Northern Ireland) regulations 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. It is a condition in the case of a contract to be entered into -

a. with a medical practitioner, that the medical practitioner;
b. with two or more individuals practising in partnership, that any individual or the partnership; and
c. with a company limited by shares, that -

i. the company,
ii. any person legally and beneficially owning a share in the company, and
iii. any director or secretary of the company,

must not fall within paragraph (2).

2. 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 prior to the signing of the contract or commencement of the contract, whichever is the earlier, he has been dismissed (otherwise than by reason of redundancy) from any employment by a health service body, unless he has subsequently been employed by that health service body or another health service body and paragraph (4) applies to him or that dismissal was the subject of a finding of unfair dismissal by any competent tribunal or court;
d. within the period of five years prior to signing the contract or commencement of the contract, whichever is the earlier, he 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 his name has subsequently been included in such a list;
e. he has been convicted in the United Kingdom of murder;
f. he has been convicted in the United Kingdom of a criminal offence other than murder, committed on or after 14th December 2001, and has been sentenced to a term of imprisonment of over six months;
g. subject to paragraph (5) he has been convicted elsewhere of an offence -

    i. which would, if committed in England and Wales, constitute murder, or
    ii. committed on or after 14th 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 1st March 2004;

i. he or it has -

    i. been adjudged bankrupt or had sequestration of his estate awarded unless (in either case) he has 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 or its creditors unless he or it has been discharged in respect of it;

j. an administrator, administrative receiver or receiver is appointed in respect of it;
k. within the period of five years prior to signing the contract or commencement of the contract, whichever is the earlier, he 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 was responsible or to which he was privy, or which he by his 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 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).

3. 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 United Kingdom 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,

as the case may be.

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

as the case may be.

Version control tracker

Version Number	Date	Author Title	Status	Comment/Reason for Issue/Approving Body
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