



Primary Medical Care Policy and Guidance Manual (PGM) (v3)

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Description This policy book provides commissioners of primary care services the context, information and tools to safely commission and contract manage primary medical care contracts.

Cross Reference This replaces individual policies that have been available on the NHS England website

Superseded Docs
(if applicable) Policy Book for Primary Medical Services

Action Required To be adhered to by all Commissioners of Primary Medical Care

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Primary Medical Care Policy and Guidance Manual (PGM)

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact the Primary Care Commissioning Team on england.primarycareops@nhs.net

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Executive summary

This policy and guidance manual has been updated to reflect ongoing development and changes in the commissioning and contractual management landscape. This suite of policies should be followed by all commissioners of NHS Primary Medical Care. This approach ensures that all commissioners, providers and most importantly patients are treated equitably and that NHS England and CCGs meet their statutory duties.

Provisions during the Covid pandemic

This update is being made in a pandemic and it is recognised that the challenges this presents may require flexibility in how commissioners exercise their commissioning and contractual management responsibilities.

Statutory duties remain and commissioners have a critical role to play in supporting both the recovery and maintenance of general practice services and may also be faced with further outbreaks. Commissioners' responsibilities for quality and safety also remain.

In this context commissioners should ensure that their contractual management responsibilities are aligned with the following principles:

- Recovery progress in response to the resumption of contractual responsibilities will be clinically led. Commissioners will support through a range of local mechanisms, including partnership working with Local Medical Committees and Primary Care Network Leaders.
- The scope and/or pace of recovery will not be uniform across GP practices. Commissioners will recognise the context in each practice will be different including the starting point prior to the pandemic, the impact of how the pandemic presented; and, practice decisions on workload prioritisation in response.
- There is no single test or set of rules that can be applied in coming a judgement about whether a practices' capacity to address contractual actions identified before the pandemic and/or its recovery progress will or have resulted in contractual compliance. Again, commissioners will need to take into account the individual practice context and will recognise getting the best from relationships is achieved through a focus on problem solving.
- Support for GP practices should always come before the use of contractual sanctions, unless there are serious breaches or safety concerns, including pre Covid action plans
- Commissioners will continue to work collaboratively with CQC as required concerning any services identified as high risk (see Part A, Chapter 5 (Working Together – Commissioning and Regulating
- Local systems for identifying variation in quality and safety will be maintained/in place and will continue to be guided by Assurance Framework Contract Review (see Part B, Chapter 2).

As part of the co-commissioning strategy, as of 1 April 2020, 98% of Clinical Commissioning Groups (CCGs) have responsibility for commissioning and contract monitoring GP services in their locality, with NHS England maintaining overall accountability. Local Offices of NHS England retain responsibility for commissioning and monitoring the performance of GP services for the remaining CCGs.

In 2016, the first 'Policy Book' for Primary Medical Services was published (Gateway Ref 04171), which provided commissioners of GP services with the context, information and tools to commission and manage GP contracts. The 'policy book' was superseded in November 2017 by the Primary Medical Care Policy and Guidance Manual (PGM) which was last refreshed in April 2019.

NHS England is committed to reviewing the PGM, its use and application and the feedback received each year. The amendments and additions of this refresh are summarised below.

Due to the Covid-19 pandemic, there is a pause on Primary Care Activity Report (PCAR) data collection for 2019/20.

The PGM is divided into 4 parts (A-D). Templates have been embedded as extractable documents for easier onward use.

Part A – Excellent Commissioning and Partnership Working

- 1 Introduction – **Added Links to suite of Health Education England e-learning modules to support commissioners**
- 2 Abbreviations and Acronyms – **No Change**
- 3 Commissioning Described – **Minor amendments reflecting the outcome of CCGs merger programme**
- 4 General Duties of NHS England (including addressing health inequalities – **No Change**
- 5 Working Together – Commissioning and Regulating – **Minor factual accuracy amendments**

Part B – General Contract Management

- 1 Contracts Described – **Minor amendments**
- 2 Assurance Framework Contract Review – **Minor amendments to reflect PCN membership and PCN workforce and estate guidance**
- 3 Managing Patient Lists – **Minor amendment relating to safeguarding**
- 4 GP Patient Registration Standard Operating Principles for Primary Medical Care – **No change**
- 5 Temporary Suspension to Patient Registration – **Minor amendments to strengthen list closure**
- 6 Special Allocation Scheme (SAS) – **Minor Amendments**
- 7 Contract Variations (templates available) – **Additions to strengthen Incorporation and Disincorporation and practice mergers**
- 8 Managing a PMS Contractor's Right to a GMS Contract – **No change**
- 9 Practice Closedown (Planned / Scheduled) – **Minor Amendments**
- 10 Discretionary Payments (made under Section 96) – **No change**
- 11 National Procurement Support Contract – **Minor amendment to strengthen procurement of APMS and Caretaker GP services**

- 12 Premises Running Costs and Service Charges – **Minor amendments to strengthen eligibility criteria. Additions on PCN workforce and estates.**
- 13 Sub-contracting of Clinical Services – **Minor amendments**

Part C – When things go wrong

- 1 Contract Breaches, Sanctions and Terminations – **No change**
- 2 Unplanned / Unscheduled and Unavoidable Practice Closedown – **Minor amendment – links to PCSS information**
- 3 Death of a Contractor – **Minor Amendment**
- 4 Managing Disputes – **No amendment**
- 5 Adverse Events (e.g. flood fire) – **Separated from chapter 3 to form a new chapter**

Part D – General

- 1 GP IT Operating Model: Data and Cyber Security Arrangements – **Minor amendments**
- 2 Protocol in respect of locum cover or GP performer payments for parental and sickness leave – **No amendment**
- 3 Guidance Note: GP Practices serving Atypical Populations – **No Amendment**

NHS England recognises the scale and pace of change in Primary Medical Care commissioning, service delivery and redesign. As such it is committed to reviewing this policy and guidance regularly, to ensure it supports the commitments set out in the General Practice Forward View, Next steps on the Five Year Forward View and with changes in legislation and regulation.

Part A – Excellent Commissioning and Partnership Working

1 Introduction

1.1 Introduction

1.1.1 NHS England became responsible for direct commissioning of primary care services on 1 April 2013 and since then, the emergence of co-commissioning has seen upwards of 95% of CCGs taking on delegated authority. This revised policy book will refer to 'The Commissioner' which includes those local teams within in NHS England that still commission Primary Medical Care and CCGs with delegated authority.

This policy has been reviewed and refined in light of:

- Increased CCG delegation;
- feedback from users;
- engagement with stakeholders;
- the introduction of Primary Care Networks and
- contractual and regulatory changes.

1.1.2 This policy and guidance manual provides new and revised policies to support a consistent and compliant approach to primary care commissioning across England.

1.1.3 The manual will aim to identify sections which describe mandatory functions (i.e. those absolutely defined in legislation and law) versus those which are provided as guidance or best practice.

1.1.4 This manual is supported by a suite of e-learning modules to provide commissioners a deeper appreciation of some of the more complicated commissioning or contract management scenarios they may face and complement the content within the manual. A link to each can be found in the following sections and you will need to create a user account with Health Education England's e-Learning for Healthcare to access them;

- *Part B – Chapter 7 Contract Variation (7.14): Approving GP Practice Boundary Changes* <https://portal.e-lfh.org.uk/Component/Details/646429>
- *Part B – Chapter 6: Special Allocation Schemes (SAS)* <https://portal.e-lfh.org.uk/Component/Details/647035>
- *Part B – Chapter 7 Contract Variation (7.10): GP Contractor Changes: Incorporation And Novation*

- <https://portal.e-lfh.org.uk/Component/Details/647038>
- *Part C – Chapter 2 Unplanned / Unscheduled and Unavoidable Practice Closedown: Handling threats to the continuity of GP services*
<https://portal.e-lfh.org.uk/Component/Details/647041>
- *Part B – Chapter 11 NHS England Procurement Support Contract and National Procurement Tool: Developing a Primary Medical Care Service Procurement Strategy*
- <https://portal.e-lfh.org.uk/Component/Details/647056>

Each module should take between 30-40 minutes to complete and there is a short self-assessment at the end of each module with results provided immediately.

1.2 Structure

- 1.2.1 A number of new policies have emerged since the policy book was first published and these have been incorporated in to this manual. The PGM is structured into four main sections for ease of navigation. These are:
- **Part A – Excellent Commissioning and Partnership Working**
 - **Part B – General Contract Management**
 - **Part C – When things go wrong**
 - **Part D – General**
- 1.2.2 NHS England will update and refine policies periodically and following changes in legislation, contracts or central policy and guidance. Users of this manual are advised this is a controlled document and the most up to date version should always be used. That is, the version which is published on NHS England's website www.england.nhs.uk

1.3 Transitional arrangements

- 1.3.1 This Policy and Guidance Manual (PGM) replaces all previous versions. In addition, we have embedded as chapters some other related policy / guidance that have been published by NHS England as standalone documents since the original 'Policy Book' was published in July 2016. The processes and procedures set out in this PGM must be followed where a matter arises after the date of publication of this PGM.

- 1.3.2 Where a matter arose prior to the publication of this policy book (and the parties are therefore following a previous policy) the parties should continue to follow that previous policy as this would have been the expectation of the parties.
- 1.3.3 Parties following a previous policy should consider switching to the relevant policy set out in this policy book if there is a natural transitional point in the matter and provided all parties agree.

2 Abbreviations and Acronyms

2.1 Abbreviations and Acronyms

2.1.1 The following abbreviations and acronyms are used in the medical policies:

5YFV	5 Year Forward View
ACO	Accountable Care Organisation
APMS	Alternative Provider Medical Services
APMS Directions	Alternative Provider Medical Services Directions
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
FHSAU	Family Health Services Appeal Unit
GMS	General Medical Services
GMS Regulations	The National Health Service (General Medical Services Contracts) Regulations 2015
GMS SFE	General Medical Services Statement of Financial Entitlements Directions 2013
GP	General Practitioner
GPVF	General Practice Forward View
HWB	Health and Wellbeing Board
LMC	Local Medical Committee
MCP	Multispecialty Community Provider
NBM	New Business Models
NCM	New Care Models
NHS Act	National Health Service Act 2006
NHS BSA	NHS Business Services Authority
NHSR	NHS Resolution
PACS	Primary and Acute Care Systems

PCA	Primary Care Appeals (Part of NHSR)
PCSE	Primary Care Support England (delivered by Capita on behalf of NHS England)
PCN	Primary Care Network
PHSO	Parliamentary and Health Service Ombudsman
PMS	Personal Medical Services
PMS Regulations	The National Health Service (Personal Medical Services Agreements) Regulations 2015
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006

Staff working with the NHS may also find this [acronym buster](#) helpful (which provides a broader list of NHS acronyms in use beyond this document), alongside our [understanding the NHS](#) section.

3 Commissioning Described

3.1 Commissioning Arrangements

3.2 Introduction

- 3.2.1 Since 1 April 2020, as a result of the CCG mergers programme, the number of CCGs has reduced to 135 with 98% of those with delegated authority. This chapter provides an overview of the models of co-commissioning and how the policies reflect the involvement of CCGs under different co-commissioning models. This will become less relevant as the remaining CCGs take on delegation.

3.3 Background

- 3.3.1 In May 2014, NHS England invited CCGs to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities.
- 3.3.2 The scope of primary care co-commissioning for 2015/16 was primary medical services only.
- 3.3.3 CCGs could choose which form of co-commissioning they would like to adopt:
- greater involvement in primary care decision-making;
 - joint commissioning arrangements; or
 - delegated commissioning arrangements.
- 3.3.4 In 2020/21 132 CCGs (out of 135) had delegated arrangements, 2 CCGs had joint commissioning arrangements and 1 CCG had 'greater involvement'..

3.4 Co-commissioning Models:

3.5 Greater involvement in primary care co-commissioning:

Greater involvement in primary care co-commissioning is an invitation to CCGs to collaborate more closely with NHS England to ensure that decisions taken about healthcare services are strategically aligned across the local health economy.3.5.2 CCGs who wish to have greater involvement in primary care decision making could participate in discussions about all areas of primary care including primary medical care, eye health, dental and community pharmacy services, provided that NHS England retains its statutory decision-making responsibilities and there is appropriate involvement of local professional networks.

3.6 Joint commissioning arrangements:

3.6.1 A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with NHS England, either through a joint committee or “committees in common”. Joint commissioning arrangements allow CCGs and NHS England to more effectively plan and improve the provision of out of hospital services for the benefit of patients and local populations.

3.6.2 The functions that joint committees cover include:

- GMS, PMS, APMS contracts, (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing breach/remedial notices, and terminating a contract;
- newly designed enhanced services (“Local Enhanced Services (LES)” and “Directed Enhanced Services (DES)”);
- design of local incentive schemes;
- the ability to establish new GP practices in an area;
- approving practice mergers; and
- making decisions on ‘discretionary’ payments (e.g., returner/retainer schemes); and

- where appropriate considerations in relation to primary care and the development of MCP/PACS arrangements.

3.6.3 Joint commissioning arrangements exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England is also responsible for the administration of payments and list management.

3.6.4 CCGs have the opportunity to discuss dental, community optometry and community pharmacy commissioning with NHS England and local professional networks but have no decision making powers over general optometry or community pharmacy services commissioned under the regulations. However, CCGs do have the opportunity to commission local enhanced services from community pharmacy and optometry providers.

3.7 Delegated commissioning arrangements:

3.7.1 Delegated commissioning is an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively. CCGs continue to remain responsible for discharging their statutory duties, for instance, in relation to the quality, financial resources and public participation.

3.7.2 The following primary care functions are included in delegated arrangements:

- GMS, PMS, APMS (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing breach/remedial notices, and removing a contract);
- newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- the ability to establish new GP practices in an area;
- approving practice mergers; and

- making decisions on 'discretionary' payments (e.g., returner/retainer schemes).
- 3.7.3 Where a CCG is considering developing an MCP / PACS arrangement, it should discuss this with NHS England to consider the implications in relation to delegated co-commissioning and the involvement of NHS England.
- 3.7.4 Delegated commissioning arrangements exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England is also responsible for the administration of payments and list management.
- 3.7.5 Paragraph 3.6.4 also applies to delegated commissioning arrangements

3.8 Co-Commissioning and Primary Care Policies:

- 3.8.1 For the purposes of the primary care policies, the Commissioner of the primary care service is not referred to by name but simply as the "Commissioner". This is to reflect the fact that for primary medical services, the identity of the Commissioner in an area will depend on the model of co-commissioning that the CCG has adopted:
- 3.8.2 Where a CCG has adopted greater involvement in primary care co-commissioning, the Commissioner will usually be NHS England;
- 3.8.3 Where a CCG has adopted joint commissioning arrangements, the Commissioner will usually be NHS England and the CCG acting under the governance of the joint committee; and
- 3.8.4 Where a CCG has adopted delegated commissioning arrangements, the Commissioner will usually be the CCG.
- 3.8.5 Although CCGs may assume the role of the Commissioner for the purposes of the policies, legally NHS England retains the residual liability for the performance of primary medical care commissioning. There will be matters which have not been delegated to CCGs or are not able to be carried out by a CCG in which case the Commissioner will be NHS England.
- 3.8.6 The primary care policies that cover dental, community eye health and pharmacy services retain the reference to Commissioner but for 2015/16 this is NHS England.

- 3.8.7 Where a CCG is operating under the joint commissioning arrangements, the CCG and NHS England should review the governance arrangements to ensure each is aware of its responsibilities as Commissioner.
- 3.8.8 Under delegated commissioning arrangements, a CCG will have agreed on a delegation agreement with NHS England. This document will set out for what matters the CCG has decision-making responsibilities. Where the delegation agreement sets out obligations on the CCG, e.g. liaising with NHS England in relation to managing disputes, the relevant primary medical policy refers to the delegation agreement and highlights relevant points.
- 3.8.9 Equality and Health Inequalities:
- 3.8.10 CCGs and NHS England have legal duties in respect of equality and health inequalities. Supporting guidance has been issued within the [2020-2021 Planning and Contracting Guidance](#). [Guidance for NHS Commissioners on equality and health inequalities legal duties](#). A number of data and analysis tools are published by [Public Health England](#) (e.g. the Inequalities Calculation Tool). In the commissioning and operational implementation of primary medical services due regard should be given to these duties. Further detail is also provided in the next section.

3.9 Primary Care Networks

- 3.9.1 Since the NHS was created in 1948, the population has grown and people are living longer. Many people are living with long term conditions such as diabetes and heart disease, or suffer with mental health issues and may need to access their local health services more often.
- 3.9.2 To meet these needs, practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in primary care networks (PCNs).
- 3.9.3 PCNs build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. Clinicians describe this as a change from reactively providing appointments to proactively caring for the people and communities they serve. Where emerging primary care networks are in place in parts of the country, there are clear benefits for patients and clinicians.

- 3.9.4 [Refreshing NHS Plans for 2018-19](#) set out the ambition for CCGs to actively encourage every practice to be part of a local PCN so that these cover the whole country as far as possible by the end of 2018/19. Primary care networks will be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000. They should be small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system.
- 3.9.5 As part of the GP contract five-year framework announced in January 2019, A PCN contract was introduced from 1 July 2019 as a Directed Enhanced Service (DES). Its goal is to ensure general practice plays a leading role in every PCN and means much closer working between networks and their Integrated Care System. This is supported by a PCN Development Programme which is being centrally funded and locally delivered.
- 3.9.6 By 2023/24, the PCN contract is expected to invest £2.376 billion, or £1.90 million per typical network covering 50,000 people. This will include funding for around 26,000 more health professionals including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers. Bigger teams of health professionals will work across PCNs, as part of community teams, providing tailored care for patients and will allow GPs to focus more on patients with complex needs.
- 3.9.7 Find out more through [case studies](#) from across the country where primary care networks are already making a difference to staff and patients.
- 3.9.8 In March 2020 , NHS England published [Network Contract Directed Enhanced Services – Contract specification 20/21 PCN Requirements and entitlements](#) , additional information to assist commissioners and providers in further developing PCNs.

4 General Duties of NHS England (including addressing health inequalities)

4.1 Introduction

- 4.1.1 This chapter outlines the general duties that NHS England must comply with that are likely to affect the decisions it takes regarding the provision of primary care.
- 4.1.2 CCGs carrying out co-commissioning under delegated authority do so on behalf of NHS England. Such CCGs need to comply with NHS England's legal duties when doing this – this is set out in the co-commissioning Delegation Agreement. Therefore, this chapter is also relevant to co-commissioning CCGs.
- 4.1.3 In many instances the duties placed on NHS England are mirrored by similar duties placed on CCGs. Where this is the case we have highlighted the equivalent CCG duty. However, this note does not cover any further CCG duties that apply only to CCGs and not to NHS England. In this chapter "commissioners" refers to NHS England and any CCGs carrying out co-commissioning.
- 4.1.4 There are many general duties on commissioners. It is important that decision-makers are familiar with all these duties because if a duty has not been complied with when a decision is taken, that decision can be challenged in the courts on the grounds that it is unlawful.
- 4.1.5 This guidance looks at the general duties that commissioners are required to comply with that are most applicable to primary care, providing examples to illustrate how they might affect decision making.
- 4.1.6 Reference should be made to the previous chapter on delegated commissioning arrangements for primary care. As has been noted, under such arrangements NHS England retains the legal responsibility for compliance with the duties in respect of primary medical care commissioning. Accordingly, NHS England will require assurance that its statutory functions are being discharged effectively by a CCG. This underlines the importance of compliance with the duties outlined in this chapter.
- 4.1.7 In the text box below is a summary of the duties that are covered by this chapter. The chapter (from 2 onwards) goes on to look at each of the duties in more detail. A table of contents is also provided for clarity.

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Page [26] – [29]	Summary of duties covered by this chapter
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Page [39] – [57]	Other non-equality and health inequalities related duties The "Regard Duties" The "View To Duties" The "Promote Duties" The "Involvement Duty" Duty to act fairly & reasonably Duty to "obtain appropriate advice" Duty to exercise functions effectively Duty not to prefer one type of provider

Summary of duties covered by this chapter:

Equality and Health Inequalities duties

a) Equality Act 2010

4.1.8 The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. These are the "protected characteristics".

4.1.9 As well as these prohibitions against unlawful discrimination, the Equality Act 2010 requires commissioners to have "due regard" to the need to:

4.1.9.1 eliminate discrimination that is unlawful under the Equality Act;

4.1.9.2 advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it; and

4.1.9.3 foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

This can require NHS England to take positive steps to reduce inequalities

4.1.10 The duty is known as the public sector equality duty or PSED (see section 149 of the Equality Act 2010). The Equality Act 2010 also imposes (through Regulations made under the Act) particular inequality related duties on commissioners. Failure to comply with these specific duties will be unlawful.

b) NHS Act 2006 (as amended by the Health and Social Care Act 2012)

4.1.11 Under the NHS Act 2006 (as amended by the Health and Social Care Act 2012) commissioners also have a duty to have regard to the need to:-

4.1.11.1 reduce inequalities between patients with respect to their ability to access health services; and

4.1.11.2 reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services

4.1.11.3 (in respect of NHS England, see section 13G of the NHS Act 2006; and, in respect of CCGs, see section 14T of the NHS Act 2006)

Other non-equality and health inequalities related duties

The "Regard Duties"

4.1.12 In addition to the above, there are other obligations on commissioners to "have regard" to particular factors. These are set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The other "Regard Duties" are:

4.1.12.1 the duty to have regard to the desirability of allowing others in the healthcare system to act with autonomy and avoid imposing unnecessary burdens upon them, so far as this is consistent with the interests of the health service (in respect of NHS England, see section 13F of the NHS Act 2006)

4.1.12.2 the duty to have regard to the need to promote education and training of those working within (or intending to work within) the health service (in respect of NHS England, see section 13M of the NHS Act 2006; and, in respect of CCGs, see section 14Z of the NHS Act 2006)

4.1.12.3 the duty to have regard to the likely impact of commissioning decisions on healthcare delivered in areas of Wales or Scotland close to the border with England (in respect of NHS England, see section 13O of the NHS Act 2006)

The "View To Duties"

4.1.13 The "View To Duties" are:

4.1.13.1 the duty to act with a view to delivering services in a way that promotes the NHS constitution (in respect of NHS England, see section 13C(1)(a) of the NHS Act 2006; and, in respect of CCGs, see section 14P of the NHS Act 2006)

4.1.13.2 the duty to act with a view to securing continuous improvement in the quality of services in health and public health services (in respect of NHS England, see section 13E of the NHS Act 2006; and, in respect of CCGs, see section 14R of the NHS Act 2006)

4.1.13.3 the duty to act with a view to enabling patients to make choices about their care (in respect of NHS England, see section 13I of the NHS Act 2006; and, in respect of CCGs, see section 14R of the NHS Act 2006)

4.1.13.4 the duty to act with a view to securing integration, including between health and other public services that impact on health, where this would improve health services (in respect of NHS England, see section 13N of the NHS Act 2006; and, in respect of CCGs, see section 14Z1 of the NHS Act 2006)

The "Promote Duties"

4.1.14 The "Promote Duties" are:

- 4.1.14.1 the duty to promote awareness of the NHS Constitution among patients, staff and members of the public (in respect of NHS England, see section 13C(1)(b) of the NHS Act 2006; and, in respect of CCGs, see section 14P(1)(b) of the NHS Act 2006)
- 4.1.14.2 the duty to promote the involvement of patients and carers in decisions about their own care (in respect of NHS England, see section 13H of the NHS Act 2006; and, in respect of CCGs, see section 14U of the NHS Act 2006)
- 4.1.14.3 the duty to promote innovation in the health service (in respect of NHS England, see section 13K of the NHS Act 2006; and, in respect of CCGs, see section 14X of the NHS Act 2006)
- 4.1.14.4 the duty to promote research and the use of research on matters relevant to the health service (in respect of NHS England, see section 13L of the NHS Act 2006; and, in respect of CCGs, see section 14Y of the NHS Act 2006)

The "Involvement Duty"

4.1.15 Commissioners have a duty to make arrangements to secure that service users and potential service users are involved in:

- 4.1.15.1 the planning of commissioning arrangements by commissioners;
- 4.1.15.2 the commissioners' development and consideration of proposals for changes to commissioning arrangements, if the implementation of the proposals would impact on the range of health services available to service users or the manner in which they are delivered; and
- 4.1.15.3 the commissioners' decisions affecting the operation of commissioning arrangements, if those decisions would have such an impact.

(in respect of NHS England, see section 13Q of the NHS Act 2006; in respect of CCGs, see section 14Z2 of the NHS Act 2006)

Duty to act fairly & reasonably

4.1.16 Commissioners have a duty to act fairly and reasonably when making its decisions. These duties come from case law that applies to all public bodies.

Duty to obtain advice

4.1.17 Commissioners have a duty to "obtain appropriate advice" from persons with a broad range of professional expertise (in respect of NHS England, see section 13J of the NHS Act 2006; and, in respect of CCGs, see section 14W of the NHS Act 2006)

Duty to exercise functions effectively

4.1.18 Commissioners have a duty to exercise their functions effectively, efficiently and economically (in respect of NHS England, see section 13D of the NHS Act 2006; and, in respect of CCGs, see section 14Q of the NHS Act 2006)

Duty not to prefer one type of provider

4.1.19 Commissioners must not try to vary the proportion of services delivered by providers according to whether the provider is in the public or private sector, or some other aspect of their status.

4.2 Equality and Health Inequalities Duties

4.2.1 This section considers equality and health inequality duties. First, the duties under the Equality Act 2010 are considered followed by the other health inequality-related duties.

a) EQUALITY ACT 2010

4.2.2 Commissioners have both general and specific equality related duties under the Equality Act 2010. The general duty can be found in section 149 of the Equality Act. It is known as the public sector equality duty or the PSED. The specific duties are imposed on commissioners by secondary legislation, namely the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. Further details on both the PSED and the 2017 Regulations are provided in the sections below.

4.2.3 The duty to have regard to the PSED will arise when commissioners are exercising their functions. A commissioner will be open to legal challenge if they are unable to demonstrate their regard to the PSED when publishing guidance or policies, or making decisions. A failure to comply with the prescribed duties outlined in the 2017 Regulations will also be unlawful.

The protected characteristics

4.2.4 The Equality Act 2010 prohibits unlawful discrimination in the provision of services (including healthcare services) on the basis of "protected characteristics". The protected characteristics are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief (which can include an absence of belief)
- sex
- sexual orientation

4.2.5 Unlawful discrimination can also occur if a person is at a disadvantage because of a combination of these factors.

Unlawful discrimination

4.2.6 There are broadly four types of discrimination in the provision of services that are unlawful under the Equality Act 2010:

- Direct discrimination services are not available to someone because they are e.g. not married, over 35, a woman. Apart from a few limited exceptions, direct discrimination will always be unlawful, unless it is on the grounds of age and the discrimination is a proportionate means of achieving a legitimate aim.
- Indirect discrimination occurs when commissioners apply a policy, criterion or practice equally to everybody but which has a disproportionate negative impact on one of the groups of people sharing a protected characteristic, and where the complainant cannot themselves comply. The classic example is a height requirement, which is likely to exclude a much greater proportion of women than men because women are on average significantly shorter. Requirements that require people to behave in a certain way will amount to indirect discrimination if compliance is not consistent with reasonable expectations of behaviour. For example, a requirement not to wear a head covering would be indirectly discriminatory on the grounds of religion, even though followers of religions which require a head covering are physically able to remove it. Indirect discrimination is not unlawful if it is a proportionate means of achieving a legitimate aim.
- Disability discrimination occurs if a person is treated unfavourably because of something "arising in consequence of their disability". This captures discrimination that occurs not because of a person's disability per se (e.g. a person has multiple sclerosis) but because of the behaviour caused by the disability (e.g. use of a wheelchair). So an inability of someone with multiple sclerosis to access services when using their wheelchair could be an instance of disability discrimination.
- Disability discrimination is not unlawful if it is a proportionate means of achieving a legitimate aim.

- A failure to make "reasonable adjustments" for people with disabilities who are put at a substantial disadvantage by a practice or physical feature. The duty also requires bodies to put an "auxiliary aid" in place where this would remove a substantial disadvantage e.g. a hearing aid induction loop. The duty to make reasonable adjustments might e.g. require NHS England or a CCG to make consultation materials available in braille. However, some care is needed here. People with disabilities have a right to access services in broadly the same way as people without disabilities, so far as is reasonable. Offering a telephone consultation to a wheelchair using patient who is prevented from accessing a clinic by steps may in fact be unlawful discrimination rather than a reasonable adjustment. The wheelchair user should be able to access services in broadly the same way as others i.e. by attending practice premises for a consultation.

(Unlawful discrimination is also prohibited in the field of employment and other areas but these are not covered in this guidance.)

Public sector equality duty

4.2.7 The Equality Act 2010 requires commissioners to have "due regard" to the need to:

- eliminate discrimination that is unlawful under the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and

foster good relations between persons who share a protected characteristic and persons who do not share it.

4.2.8 These objectives are often referred to as the "three aims" of the PSED. The aims are amended for the protected characteristic of marriage and civil partnership. Commissioners do have to have due regard to eliminate unlawful discrimination based on marriage and civil partnership (the first aim). However, they are not required to have due regard to the need to advance equality of opportunity or foster good relations in relation to marriage and civil partnership (the second and third aims).

4.2.9 Compliance with the three aims of the PSED can require a commissioner to take positive steps to reduce inequalities. In this regard the Act permits treating some

people more favourably than others but not if this amounts to unlawful discrimination (what is meant by unlawful discrimination is considered below). The PSED has been used successfully on many occasions to challenge changes to services.

- 4.2.10 This means that a commissioner has a duty to help eliminate any unlawful discrimination practised by the providers of primary care e.g. through requiring premises to be accessible. Failing to use its negotiating power to secure such changes could be seen as a breach by a commissioner of the PSED, as well as a breach of the non-discrimination rules by the service provider.

Example:

After a site visit the commissioner becomes aware that consulting rooms in a GP surgery are no longer accessible to those with limited mobility as they have been moved upstairs. The commissioner decides that as there are no downstairs consulting rooms and there is no lift or stair lift, this is a breach of the practice's duty to make reasonable adjustments under the Equality Act. This in turn is a breach of the practice's duty under its contract with the commissioner to comply with legislation. In order to comply with the PSED the commissioner takes steps to ensure that the practice complies with its Equality Act duties by raising the issue informally and issuing a breach notice if the problem is not remedied

Example:

A hearing impaired patient complains to the commissioner about their experience with a local (NHS commissioned) provider. The patient was unable to communicate effectively with the provider because of their hearing impairment. When the patient suggested that the provider obtain a sign language interpreter to translate for them this was refused.

It is likely that the provider will be in breach of their obligations under the Equality Act 2010 to make reasonable adjustments. In order to comply with the PSED NHS England takes steps to investigate and enforcement action if needed.

- 4.2.11 Carrying out appropriate equality and health inequalities impact assessments (EHIAs) is usually critical to proving discharge of the PSED, although they are not as such a legal requirement. This is because if there is no assessment of the impact of a possible change on groups with protected characteristics, it is very difficult to argue that the commissioner had the impact properly in mind when it made its decision. This is the case even if the impact on protected groups is minimal.
- 4.2.12 It is not always easy to assess the equality impact. A robust service user involvement exercise will help the commissioner to identify any issues. It is

advisable to ask question(s) directly aimed at equalities issues. In many cases, it is advisable to take special steps to reach seldom heard groups affected by the decisions (e.g. by working with local voluntary, community and faith sector groups and holding meetings in community venues). The more likely a decision is to disproportionately affect a protected group, the more important it is to get feedback from that group about the decision. Undertaking a literature search can also be helpful to see what evidence is available. NHS England's Equality and Health Inequalities Unit has a Resource Hub with information which can be found here: <https://www.england.nhs.uk/about/equality/equality-hub/>

- 4.2.13 The PSED means that the commissioner must consider equalities issues when making decisions. In some cases, there may be a solution that causes less disadvantage to a protected group but for other reasons is undesirable. In these situations, it is important to acknowledge the disadvantage, work towards reducing the negative impact caused and be clear about why the decision was taken. This may include outlining costs concerns. It also makes sense to monitor the situation e.g. does the demographic of service users change as a result of the decision and timetable a formal review in e.g. a year's time.
- 4.2.14 There are a few themes arising from the cases we have seen on the application of the PSED (and similar duties in previous legislation).

- 4.2.14.1 A need to explicitly recognise that the PSED applies and equalities issues need to be considered.
- 4.2.14.2 The duty is an ongoing one – to be considered at all stages of decision-making not just at the end.
- 4.2.14.3 A need to be clear about the factors driving a decision, even if these are unpalatable e.g. budgetary pressures.
- 4.2.14.4 A need to analyse in some detail the impact of a proposed policy or decision so that the public authority has a clear idea of who is affected and how. Statements of impact need to be supported by evidence where possible.
- 4.2.14.5 If a decision is made that will impact negatively on a protected group, that should be acknowledged and the rationale explained.
- 4.2.14.6 There should be a detailed consideration as to how any negative impact of the decision could be mitigated. If the steps identified are not practicable, this should be explained.
- 4.2.14.7 The duty must be complied with at the time of the decision. After the event reasoning is rarely allowed so a record should be made at the time about how equalities issues were considered.
- 4.2.15 Further guidance on the PSED can be found on NHS England's Equality and Health Inequalities Unit has a Resource Hub with information which can be found here: <https://www.england.nhs.uk/about/equality/equality-hub/>. Additionally, the Equality and Human Rights Commission publish a wealth of information here: <https://www.equalityhumanrights.com/en>
- 4.2.15.1 Guidance on the PSED can also be found on the EHRC's website: <https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty>.

THE EQUALITY ACT 2010 SPECIFIC DUTIES

- 4.2.16 In addition to the PSED NHS England and CCGs are also required to comply with the specific duties contained in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.
- 4.2.17 The 2017 Regulations came into force on 31 March 2017. The 2017 Regulations replace the first set of specific duty regulations made in 2011.
- 4.2.18 The 2017 Regulations among other things require commissioners to publish:

equality objectives that should be achieved to comply with the PSED (Regulation 5). This has to be done by 30 March 2018 and the objectives need to be updated once every four years. Details of NHS England's equality objectives have been published on the Resource Hub:

<https://www.england.nhs.uk/about/equality/equality-hub/>. Co-commissioners should ensure that they are familiar with NHS England's equality objectives.

4.2.19 The Equality and Human Rights Commission can, under sections 31 and 32 of the Equality Act 2006, investigate and enforce a failure to comply with the PSED or the specific duties. Alternatively, a failure to comply with the general and specific duties could be challenged by way of judicial review. Such a claim could be brought by a person or group directly affected by a failure to comply with these duties.

b) Health Inequalities duties and the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

4.2.20 Under the Health and Social Care Act 2012, commissioners are required to have regard to the need to:

- reduce inequalities between patients with respect to their ability to access health services, and
- reduce health inequalities between patients with respect to the outcomes achieved for them by the provision of health service

4.2.21 When making decisions about primary care – particularly about service changes – decision-makers will need to bear in mind the impact on health inequalities. To do this the commissioner will need some data on existing health inequalities, and to consider whether its decision can be used to diminish these. A vast amount of data is available e.g. JNSA's; Right Care packs to help commissioners identify health inequalities in their area.

4.2.22 The key point is that the commissioner can show (through documentation, principally an EHIA) that the impact a decision will have on health inequalities has been taken into account, and that its decision is based on some relevant data and evidence.

4.2.23 NHS England and Public Health England have made available several resources to assist organisations to find out about information, resources and action being taken to reduce health inequalities in England. See here: <https://www.england.nhs.uk/about/equality/equality-hub/resources/>. Local Joint

Strategic Needs Assessments (JSNA) prepared by local Health and Wellbeing Boards, CCG Improvement & Assessment Framework indicators and NHS RightCare can be valuable sources of information about local health inequalities.

THE OTHER NON-EQUALITY AND HEALTH INEQUALITIES RELATED DUTIES

4.3 The Regard Duties

Introduction

4.3.1 The "Have regard", "act with a view to" or "promote" duties under the NHS Act 2006 form a loose hierarchy of legal duties:

- The duty to have regard means that when taking actions, a certain thing must be considered
- The duty to promote means action must be taken that actually achieves an outcome. Additionally, it is possible to promote something by encouraging others to do it.
- The duty to act with a view to means that action must be taken with a purpose in mind.

4.3.2 In contrast to the Promotion Duties and the View To Duties, the Regard Duties apply to every action of a commissioner where it is carrying out its primary care functions. (Pausing there, the duty will not normally apply to "private law" decisions that would be taken by any private sector organisation – leasing estate etc.)

4.3.3 The PSED cases are the best guide that we have to how a court would interpret a commissioner's Regard Duties under the NHS Act 2006. We can learn from these that:

- Commissioners who have to take decisions must be made aware of their duty to have regard to the various issues outlined in the duties. Failure to do so will render the decision unlawful.
- The Regard Duties must be fulfilled before and at the time that a particular decision is being considered. If they are not, any attempts to retrospectively justify a decision as consistent with the Regard Duties will not be enough to discharge them.
- Commissioners need to engage with the Regard Duties with rigour and with an open mind.
- It is good practice for the decision-maker to make reference to the Regard Duties.
- It is not possible for the commissioner to delegate the duties down to another organisation to comply with. This applies in respect of NHS England delegated co-commissioning arrangements for primary care services (see above). NHS

England will always have to comply with its duties under the NHS Act 2006, even if a CCG is carrying out commissioning on its behalf. However, it is a requirement of the delegation agreement that CCGs act in such a way that enables NHS England to comply with its duties. If a commissioner acts through contractors it must ensure as necessary that they act consistently with the duties.

- The Regard Duties are continuing ones that apply throughout decision-making. It is not enough to only "rubber stamp" a decision by reference to the Regard Duties at the end of a decision-making process. The Regard Duties need to be borne in mind throughout.
- It is crucial to keep an adequate record of how the Regard Duties are considered. If records are not kept it will make it more difficult, evidentially, for the commissioner to persuade a court that the duties imposed have been fulfilled.

4.3.4 One key point to understand is that there is no obligation to achieve the object of the Regard Duties e.g. it is not unlawful not to eliminate health inequalities (although equally, if health inequalities persist and widen, that fact would need to inform consideration of the regard duty). Nor does the commissioner have the luxury of "pausing" the health service while it investigates health inequality or any other matter. The duties are to have regard, not to achieve perfection, and this is a practical rather than an academic exercise.

REDUCE HEALTH INEQUALITIES

4.3.5 This duty has been discussed above. It is listed here for completeness, as it is one of the Regard Duties under the NHS Act 2006.

ACT WITH AUTONOMY

4.3.6 NHS England has a statutory duty to have regard to the desirability of allowing others in the healthcare system to act with autonomy and avoid imposing unnecessary burdens upon them, so far as this is consistent with the interests of the health service.

Example:

NHS England is considering commissioning new primary care services in a particular area. When deciding what type of contract it wants to award (GMS, PMS or APMS) it should weigh in the balance the desirability of the extra autonomy a PMS or APMS contract offers.

PROMOTE EDUCATION AND TRAINING

4.3.7 Commissioners have a duty to have regard to the need to promote education and training of those working within (or intending to work within) the health service.

IMPACT IN AREAS OF WALES OR SCOTLAND

4.3.8 NHS England has a duty to have regard to the likely impact of commissioning decisions on healthcare delivered in areas of Wales or Scotland close to the border with England. This will clearly be relevant for those working in NHS England regional teams that border Wales or Scotland. NHS England will also need to comply with the duty when making national strategic decisions about the delivery of primary care – that affect bordering areas as well as others.

Example:

The Commissioner is considering commissioning new primary care services for a town in England close to the border with Scotland. It is concerned that many of the local residents have difficulty in accessing local primary care services, the nearest practice being based over the border in Scotland. That provider is difficult to access by public transport and in the winter the short route is often impassable. To comply with its duty to have regard to the likely impact of commissioning decisions on healthcare delivered in areas Scotland close to the border with England, the regional team or CCG discusses the impact that commissioning services on the English side of the border would have on the Scottish provider. It takes this impact into account when it makes its decision about the commissioning of services.

4.4 The Promote Duties

4.4.1 It is helpful to look next at the Promote Duties. These are:

- the duty to promote awareness of the NHS Constitution among patients, staff and members of the public (in respect of NHS England, see section 13C(1)(b) of the NHS Act 2006; and, in respect of CCGs, see section 14P(1)(b) of the NHS Act 2006)
- the duty to promote the involvement of patients and carers in decisions about their own care (in respect of NHS England, see section 13H of the NHS Act 2006; and, in respect of CCGs, see section 14U of the NHS Act 2006)
- the duty to promote innovation in the health service (in respect of NHS England, see section 13K of the NHS Act 2006; and, in respect of CCGs, see section 14X of the NHS Act 2006)
- the duty to promote research and the use of research on matters relevant to the

health service (in respect of NHS England, see section 13L of the NHS Act 2006; and, in respect of CCGs, see section 14Y of the NHS Act 2006)

- A decision which is positively contrary to achieving the relevant outcome might breach a promote duty unless there was some compelling reason to adopt it. In this situation, if the decision is being made by NHS England or by a CCG on NHS England's behalf as part of co-commissioning, the NHS England legal team should be contacted for further guidance.
- Additionally, some decisions will be obvious opportunities where e.g. patient involvement could easily be promoted. In such cases the safest course of action is to ensure that this is done.

4.4.2 To meet the duty a commissioner does not have to do everything itself – be more innovative, improve its use of research data etc. It can meet the duty by encouraging other people to do things.

Example:

A commissioner decides to run a competition to reward GP practices that are innovative in their use of telehealth devices – smart medical devices that transmit data from a patient to their treating clinician, without the need for the patient to attend surgery. The winners will be showcased so that other practices can follow their lead. This helps to meet the duty to promote innovation in the health service. If a request was received by a commissioner for e.g. extra funding to support the implementation of a local telehealth initiative they would not be obliged to support it because of the duty to promote innovation. That duty has already been met by the commissioner in a different way.

4.5 The View to Duties

4.5.1 The "View To Duties" are:

- the duty to act with a view to delivering services in a way that promotes the NHS constitution (in respect of NHS England, see section 13C(1)(a) of the NHS Act 2006; and, in respect of CCGs, see section 14P of the NHS Act 2006)
- the duty to act with a view to securing continuous improvement in the quality of services in health and public health services (in respect of NHS England, see section 13E of the NHS Act 2006; and, in respect of CCGs, see section 14R of the NHS Act 2006)
- the duty to act with a view to enabling patients to make choices about their care (in respect of NHS England, see section 13I of the NHS Act 2006; and, in respect of CCGs, see section 14R of the NHS Act 2006)

- the duty to act with a view to securing integration, including between health and other public services that impact on health,
- where this would improve health services (in respect of NHS England, see section 13N of the NHS Act 2006; and, in respect of CCGs, see section 14Z1 of the NHS Act 2006)

4.5.2 the duty to exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would:

- improve the quality of those services (including the outcomes that are achieved from their provision)
- reduce inequalities between persons with respect to their ability to access those services, or
- reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

(In respect of NHS England, see section 13N of the NHS Act 2006; and in respect of CCGs, see section 14Z1 of the NHS Act 2006.)

4.5.3 In many ways the considerations for these duties and the Promote Duties are the same. One difference is that while a Promote Duty can be met by encouraging others to achieve it (e.g. encouraging GP practices to make better use of telehealth devices), with the View To Duties the actions have to be carried out by the commissioner.

4.5.4 The View To duties are less onerous than the Promote Duties because they do not require the commissioner to achieve a particular outcome (although that would be desirable) – only to do something that aims to achieve it. This is in contrast to the Promote Duties, which require an outcome to be achieved.

4.5.5 The View To duties are most likely to affect strategic decisions taken at directorate level within NHS England. Provided the commissioner can show that within the totality of its activities there has been significant action taken with the intention of achieving the outcomes that the commissioner is required to have a view to, the duty is discharged.

4.5.6 As with the Promote Duties, decision-makers on the ground should be wary of doing something which actively goes against one of the goals set out in the View To duties. In this situation, if the decision is being made by NHS England or by a CCG on NHS England's behalf as part of co-commissioning, the NHS England legal team should be contacted for further guidance. Also, if there is a clear opportunity to help deliver one of the View To objectives, it is best to take it.

4.6 The Involvement Duty

Overview

- 4.6.1 Under sections 13Q of the NHS Act 2006, NHS England has a statutory duty to 'make arrangements' to involve the public in the commissioning services for NHS patients. (This duty is also placed directly on to CCGs under section 14Z2.)
- 4.6.2 Section 13Q applies to:
- the planning of commissioning arrangements
 - the development and consideration of any proposals that would impact on the manner in which services are delivered to individuals or the range of services available to them
 - decisions that would impact on the manner in which services are delivered to individuals or the range of services available to them
- 4.6.3 The section 13Q duty only applies to plans, proposals and decisions about services that are directly commissioned by NHS England. This includes GP, dental, ophthalmic and pharmaceutical services. However, under the co-commissioning Delegation Agreement CCGs must act in a way that enables NHS England to comply with the 13Q requirements.
- 4.6.4 (The section 14Z2 duty applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a CCG in the exercise of the CCG's own functions i.e. commissioning of secondary care.)

The commissioners' arrangements for public involvement

- 4.6.5 The statutory duty to 'make arrangements' under section 13Q of the NHS Act 2006 is essentially a requirement to make plans and preparations for public involvement.
- 4.6.6 NHS England has set out its plans as to how it intends to involve the public in the following publications:
- [The Patient and Public Participation Policy](#)
 - [The Statement of Arrangements & Guidance on Patient and Public Participation in Commissioning.](#)
 - [The Framework for Patient and Public Participation in Primary Care Commissioning](#)

4.6.7 These publications set out and explain the arrangements NHS England has in place:

- Corporate infrastructure – how public involvement is embedded in the way that NHS England is constituted and carries out its business
- Involvement initiatives – initiatives designed to involve the public in strategic planning and the development of policy or other aspects of NHS England's activities
- Monitoring arrangements – a step-by-step process to help commissioners identify whether the section 13Q applies and decide whether sufficient public involvement activity is already in place or whether additional public involvement is required
- Responsive arrangements – guidance to commissioners on how to make arrangements for public involvement where monitoring has indicated that such arrangements are required.

4.6.8 As well as setting out the above arrangements, which commissioners should follow, the documentation is regularly reviewed and updated and contains useful resources for commissioners, including:

- Details of existing corporate infrastructure and involvement initiatives that could be drawn upon by commissioners to involve the public in their commissioning activities.
- Reference to NHS England's framework for involving patients and the public in primary care commissioning, which includes resources developed especially for primary care.
- Resources to help commissioners identify whether section 13Q applies, put in place appropriate arrangements for public involvement and avoid legal challenges.
- Guidance on a variety of topics that often arise, such as what 'public involvement' means, how to involve the public, who to involve, when involvement should take place, urgent decisions and joint involvement exercises.
- Case studies based upon primary care scenarios.
- Summaries of related legal duties.
- Details of how to seek further advice if needed.

4.6.9 The documentation is intended to be used by both commissioners (who need to understand and comply with the arrangements when commissioning services)

and the public (to understand how NHS England involves the public in its commissioning of services). As noted, for CCGs co-commissioning under delegated authority from NHS England, these arrangements are supplementary to their own requirement to have in place arrangements for public involvement under section 14Z2 of the NHS Act 2006.

4.7 Duty to Act Fairly & Reasonably

- 4.7.1 Commissioners have a duty to act fairly and reasonably when making decisions. These duties come from case law that applies to all public bodies.

Acting fairly

- 4.7.2 Normally, to act fairly a commissioner will need to act in accordance with its own policies. and relevant policies published by NHS England. For CCGs co-commissioning under delegated authority from NHS England, this will include NHS England policies concerned with the commissioning of primary care. A commissioner can depart from guidance if there is good reason to do so. In this scenario, the commissioner will need to explain the situation fully to the people & organisations affected and give them a chance to provide their views on the procedure to be followed. This will include why it wants to depart from the usual policy and what it will do instead.
- 4.7.3 Commissioners also need to be careful about keeping promises made to contractors or the public e.g. that there will be a public consultation before any final decision is made on closing a particular pharmacy. It is sometimes (but not always) possible to depart from such promises. Therefore, care should be taken about giving any clear commitments to a particular course of action until the commissioner is sure that it is what it wants to do. If a commissioner is considering departing from a commitment it has given to do a particular thing or follow a particular type of process, then, if the decision is being made by NHS England or by a CCG on NHS England's behalf as part of co-commissioning, the NHS England legal team should be contacted for further guidance.

- 4.7.4 It is also important to act proportionately, taking into account any adverse impact on patients and/or contractors.

Acting reasonably

- 4.7.5 The Commissioner has to take all relevant factors into account when making its decisions and exclude irrelevant factors. It is up to the commissioner how much weight it gives competing considerations and may give a factor no weight at all. The key point is that all the relevant factors are identified and documented.

Example:

The Commissioner has to decide whether to approve a practice's application to stop opening on Wednesday evening and open on Saturday morning instead. The practice is based in an area with a high Jewish population. Relevant factors in this decision include whether services will become more or less accessible as a result of the change, any adverse impact on people with protected characteristics (is the Jewish population disadvantaged as Saturday falls on the Jewish rest day?) and any costs implications for the commissioner. An example of an irrelevant factor is that the commissioner has been promised some good publicity by the practice if it agrees to the change.

- 4.7.6 The reasons for the commissioner's decisions also need to "stack up". It is important for the commissioner to document its reasons for a decision as the commissioner needs not only to act reasonably but be able to show that it has acted reasonably by reference to contemporaneous documents. This means that, particularly where a controversial decision is being made the thinking behind the decision needs to be carefully documented.

4.8 The Duty to Obtain Advice

- 4.8.1 A commissioner has a duty to "obtain appropriate advice" from persons with a broad range of professional expertise (in respect of NHS England, see section 13J of the NHS Act 2006; and, in respect of CCGs, see section 14W of the NHS Act 2006)
- 4.8.2 This means that decision-makers need to collect appropriate information before making decisions. If the commissioner does not have the information

it needs, then it should seek out appropriate advice. In many cases, it will not be necessary to do this as all the necessary information is to hand.

- 4.8.3 The duty is most relevant to strategic decisions taken at the directorate level within NHS England, where decision-makers will need to document how they obtain advice from those with professional expertise (some of whom may be employees or secondees).

4.9 The Duty to Exercise Functions Effectively

- 4.9.1 The commissioner has a duty to exercise its functions effectively, efficiently and economically (in respect of NHS England, see section 13D of the NHS Act 2006; and, in respect of CCGs, see section 14Q of the NHS Act 2006).
- 4.9.2 This is a statutory reformulation of a duty that has been contained for many years in Managing Public Money and its predecessors. If the commissioner has complied with the other duties in this guidance – in particular, the duty to act reasonably – it is highly unlikely that it will breach this duty.

4.10 The Duty Not to Prefer One Type of Provider

- 4.10.1 NHS England must not try and vary the proportion of services delivered by providers according to whether the provider is in the public or private sector, or some other aspect of their status (section 13P). CCGs must also act in accordance with this duty when they are co-commissioning under delegated authority from NHS England.
- 4.10.2 This means that the commissioner must focus on the services delivered by an organisation and its sustainability. It should not make choices about contractors based solely on their status as e.g. company, partnership, public sector, private sector, charity or not for profit organisation.

Annex 1

Extracts from Legislation

The NHS ACT 2006 – SECTIONS 13C – 13Q

General duties of the Board

References to "the Board" are to NHS England and CCGs with delegated authority, by virtue of the terms and conditions laid out in the [delegation agreement](#)

13C Duty to promote NHS Constitution

- (1) The Board must, in the exercise of its functions--
 - (a) act with a view to securing that health services are provided in a way which promotes the NHS Constitution, and
 - (b) promote awareness of the NHS Constitution among patients, staff and members of the public.
- (2) In this section, "patients" and "staff" have the same meaning as in Chapter 1 of Part 1 of the Health Act 2009 (see section 3(7) of that Act).

13D Duty as to effectiveness, efficiency etc

The Board must exercise its functions effectively, efficiently and economically.

13E Duty as to improvement in quality of services

- (1) The Board must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with--
 - (a) the prevention, diagnosis or treatment of illness, or
 - (b) the protection or improvement of public health.
- (2) In discharging its duty under subsection (1), the Board must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services.
- (3) The outcomes relevant for the purposes of subsection (2) include, in particular, outcomes which show--

- (a) the effectiveness of the services,
 - (b) the safety of the services, and
 - (c) the quality of the experience undergone by patients.
- (4) In discharging its duty under subsection (1), the Board must have regard to--
 - (a) any document published by the Secretary of State for the purposes of this section, and
 - (b) the quality standards prepared by NICE under section 234 of the Health and Social Care Act 2012.

13F Duty as to promoting autonomy

- (1) In exercising its functions, the Board must have regard to the desirability of securing, so far as consistent with the interests of the health service--
 - (a) that any other person exercising functions in relation to the health service or providing services for its purposes is free to exercise those functions or provide those services in the manner it considers most appropriate, and
 - (b) that unnecessary burdens are not imposed on any such person.
- (2) If, in the case of any exercise of functions, the Board considers that there is a conflict between the matters mentioned in subsection (1) and the discharge by the Board of its duties under sections 1(1) and 1H(3)(b), the Board must give priority to those duties.

13G Duty as to reducing inequalities

The Board must, in the exercise of its functions, have regard to the need to--

- (a) reduce inequalities between patients with respect to their ability to access health services, and
- (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

13H Duty to promote involvement of each patient

The Board must, in the exercise of its functions, promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to--

- (a) the prevention or diagnosis of illness in the patients, or
- (b) their care or treatment.

13I Duty as to patient choice

The Board must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

13J Duty to obtain appropriate advice

The Board must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in--

- (a) the prevention, diagnosis or treatment of illness, and
- (b) the protection or improvement of public health.

13K Duty to promote innovation

- (1) The Board must, in the exercise of its functions, promote innovation in the provision of health services (including innovation in the arrangements made for their provision).
- (2) The Board may make payments as prizes to promote innovation in the provision of health services.
- (3) A prize may relate to--
 - (a) work at any stage of innovation (including research);
 - (b) work done at any time (including work before the commencement of section 23 of the Health and Social Care Act 2012).

13L Duty in respect of research

The Board must, in the exercise of its functions, promote--

- (a) research on matters relevant to the health service, and
- (b) the use in the health service of evidence obtained from research.

13M Duty as to promoting education and training

The Board must, in exercising its functions, have regard to the need to promote education and training for the persons mentioned in section 1F(1) so as to assist the Secretary of State in the discharge of the duty under that section.

13N Duty as to promoting integration

- (1) The Board must exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would--
 - (a) improve the quality of those services (including the outcomes that are achieved from their provision),
 - (b) reduce inequalities between persons with respect to their ability to access those services, or
 - (c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.
- (2) The Board must exercise its functions with a view to securing that the provision of health services is integrated with the provision of health-related services or social care services where it considers that this would--
 - (a) improve the quality of the health services (including the outcomes that are achieved from the provision of those services),
 - (b) reduce inequalities between persons with respect to their ability to access those services, or
 - (c) reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.
- (3) The Board must encourage clinical commissioning groups to enter into arrangements with local authorities in pursuance of regulations under section 75 where it considers that this would secure--
 - (a) that health services are provided in an integrated way and that this would have any of the effects mentioned in subsection (1)(a) to (c), or
 - (b) that the provision of health services is integrated with the provision of health-related services or social care services and that this would have any of the effects mentioned in subsection (2)(a) to (c).
- (4) In this section--

"health-related services" means services that may have an effect on the health of individuals but are not health services or social care services;

"social care services" means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).

13O Duty to have regard to impact on services in certain areas

- (1) In making commissioning decisions, the Board must have regard to the likely impact of those decisions on the provision of health services to persons who reside in an area of Wales or Scotland that is close to the border with England.
- (2) In this section, "commissioning decisions", in relation to the Board, means decisions about the carrying out of its functions in arranging for the provision of health services.

13P Duty as respects variation in provision of health services

The Board must not exercise its functions for the purpose of causing a variation in the proportion of services provided as part of the health service that is provided by persons of a particular description if that description is by reference to—

- (a) whether the persons in question are in the public or (as the case may be) private sector, or
- (b) some other aspect of their status.

13Q Public involvement and consultation by the Board

- (1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by the Board in the exercise of its functions ("commissioning arrangements").
- (2) The Board must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) –
 - (a) in the planning of the commissioning arrangements by the Board,
 - (b) in the development and consideration of proposals by the Board for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
 - (c) in decisions of the Board affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

- (3) The reference in subsection (2)(b) to the delivery of services is a reference to their delivery at the point when they are received by users.
- (4) This section does not require the Board to make arrangements in relation to matters to which a trust special administrator's report or draft report under section 65F or 65I relates before the Secretary of State makes a decision under section 65K(1), is satisfied as mentioned in section 65KB(1) or 65KD(1) or makes a decision under section 65KD(9) (as the case may be).

THE EQUALITY ACT 2010 - SECTION 149

Advancement of equality

149 Public sector equality duty

- (1) A public authority must, in the exercise of its functions, have due regard to the need to—
 - (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
 - (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
 - (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
- (2) A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).
- (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
 - (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
 - (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

- (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
- (4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.
- (5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
 - (a) tackle prejudice, and
 - (b) promote understanding.
- (6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.
- (7) The relevant protected characteristics are—
 - age;
 - disability;
 - gender reassignment;
 - pregnancy and maternity;
 - race;
 - religion or belief;
 - sex;
 - sexual orientation.
- (8) A reference to conduct that is prohibited by or under this Act includes a reference to—
 - (a) a breach of an equality clause or rule;
 - (b) a breach of a non-discrimination rule.
- (9) Schedule 18 (exceptions) has effect.

5 Working Together – Commissioning and Regulating

5.1 Introduction

- 5.1.1 This chapter is intended to inform commissioners of existing and ongoing work to establish a robust and practical joint working framework by CQC and NHS England, with wider clinical commissioners, in light of 98% of CCGs taking on delegation from 01 April 2020 and as CQC continues its phased inspection process.
- 5.1.2 In recognition of the Regulation of General Practice Programme Board's ambition to reduce the burden of regulation and assurance on GP providers, we are carrying out a programme of work to consider ways in which NHS England, clinical commissioners (CCGs) and CQC can work in a more aligned way at a regional and local level.

5.2 Background

- 5.2.1 Alongside the publication of the GP Forward View (NHS England, 2016), a [statement of intent](#) was published by the main national regulatory and assurance bodies, committing to working together with professional bodies and those using services in the development of a shared view of quality in general practice. This would provide the basis of a joined up approach to monitoring and improvement of quality.
- 5.2.2 The Regulation of General Practice Programme Board was established in June 2016 to take forward this commitment.
- 5.2.3 The purpose of the Board is to:
- Coordinate and improve the overall approach to the regulation of general practice in England by bringing together the main statutory oversight and regulatory bodies and delivering a programme of work which will streamline working arrangements and minimise duplication.
 - Provide a forum for sign-up by statutory bodies to a common framework – a shared view of quality – which will be co-produced with the professions and the public.

5.3 Implementation

- 5.3.1 [The Care Quality Commission \(CQC\), NHS England, and NHS Clinical Commissioners \(NHSCC\)](#), with the support of the General Medical Council (GMC), published a joint working framework in 2018.
- 5.3.2 The framework recognises that in many areas relationships between commissioners and CQC are working well; in other areas, the framework is intended to help provide structure and support for new relationships with examples of good practice.

5.4 Existing Good Practice and Interim principles

- 5.4.1 Significant steps have already been taken to streamline processes and share information:
- NHS England regularly share eDec data and information with CQC
 - NHS England will share eDec data with all commissioners, including analysis and outlier reports to help commissioners target support locally.
 - CQC share inspection rating updates every week with NHS England
 - CQC share inspection schedules with commissioners wherever possible
 - Commissioners share local information and intelligence with CQC and NHS England
 - In some areas commissioners work closely with GP practices prior to inspections to support them.
- 5.4.2 Collaborative working arrangements:
- 5.4.3 Positive working relationships are critical for ensuring successful partnership working. Commissioners and CQC have established some formal mechanisms for ensuring successful collaborative working but these should not be seen as the only means by which those relationships can be developed. We also recognise the role of Quality Surveillance Groups and other forums that have been established for information sharing in some areas of the country.
- 5.4.4 It is recognised that telephoning the right person at the right organisation at the right time is the best means of developing those relationships and avoiding duplication wherever possible. It is important that commissioners engage with and know their local contacts.

5.4.5 Existing good practice:

- All parties will be transparent and we will ensure information governance and data protection principles are adhered to without exception and we will ensure GP practices are fully sighted on this.
- Commissioners should actively and effectively communicate with each other and CQC to ensure GP practices are not overburdened e.g. to avoid the situation whereby a commissioner contract visit overlaps with a CQC inspection.
- Commissioners should keep in regular contact with CQC throughout the year and more targeted and regular communication on the run-up to inspection or annual review.
- Commissioners should actively engage with and support GP Practices pre and post-inspection.

5.5 Why:

5.5.1 The system of medical regulation has evolved over time, rather than having been designed from a single agreed blueprint. There is a perception within the medical profession that it is over-regulated, with too many bodies setting standards and imposing requirements with potential for regulatory overlap. A lack of clarity about which body is responsible for which areas of monitoring and regulation carries a risk of duplication, but also of potential gaps in the system which is designed to ensure **patient** safety.

5.5.2 These overlaps exist:

- between CQC GP practice requirements and GMC revalidation requirements
- between evidence sought by NHS England for contract compliance and CQC's regulatory requirements
- between NHS England in its oversight role of the National Performers List (NPL) and GMC's regulation of GPs on the GP register, and
- between NHS England in its oversight of national contracts and CCGs in their oversight of local contracts and accountability for system performance.

5.5.3 NHS England, CQC and GMC already work closely together to share data but there is more work to be done to align our processes and minimise the workload for general practice.

5.6 The ambition being delivered:

NHS England, CQC and GMC are committed to;

- identifying immediate actions to support GPs and GP practices to reduce the workload associated with regulation
- align and streamline regulatory and commissioning processes taking a more targeted and risk based approach to regulation and contract management;
- improved information gathering and intelligence about services - We need to ensure that the data and information we identify to collect, measure, and monitor, is clear and consistent, and proportionate to risk
- making it easier for commissioners and regulators to access and use shared information about quality, giving GPs time to focus on improving quality of care at the frontline

Part B – General Contract Management

1 Contracts Described

1.1 Comparison of Contract Types (Standard Medical and as part of models i.e. MCPs / PACS)

1.1.1 Throughout this document there are many references to standard contracts GMS, PMS and APMS. As new business models and related legislation are developed, this policy and guidance will be updated.

1.1.1.1 The GMS and PMS Consolidated Regulations 2015 can be viewed here:

- GMS: <https://www.legislation.gov.uk/ukxi/2015/1862/contents/made>
- PMS: <http://www.legislation.gov.uk/ukxi/2015/1879/contents/made>

1.1.2 Accountable Care Organisations (MCPs and PACS)

1.1.2.1 MCPs and PACSs are integrated delivery models which bring providers together to deliver services for a whole population. These models will be commissioned through a new ACO(MCP/PACS) contract. The contract will either require the holder to integrate its services with "core" primary medical services providers via an integration agreement (a "partially integrated" model), or may include those "core" services in its scope (a "fully integrated" model). With new legislation, GPs will have the opportunity to suspend their current "core" contracts for a period of time if they wish to join a fully integrated MCP or PACS, at which point the GPs may join the provider either as an employee or become a subcontractor to it whilst remaining in their practice.

Further information regarding MCPs can be found here

<https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf>

Further information regarding MCPs can be found here

<https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf>

	GMS Contract	PMS Agreement	APMS Contract
Who can hold the contract?	<ul style="list-style-type: none"> • Individual medical practitioner • Two or more individuals practising in partnership where: <ul style="list-style-type: none"> ○ at least one partner is a medical practitioner, and ○ any other partner is either an NHS employee; or an individual eligible under s88 of the NHS Act • A company limited by shares <p>The above is a summary only. Please refer to Annex 1 for more detail.</p>	<ul style="list-style-type: none"> • Medical practitioner • NHS employee • Health care professional • Individuals already providing services under a GMS, or GDS contract or equivalent (UK) • Individuals eligible under s93 of the NHS Act • Qualifying body (which is a company limited by shares with restrictions on share ownership) • NHS trust or foundation trust <p>The above is a summary only. Please refer to Annex 2 for more detail.</p>	<p>The APMS Directions do not state who can hold a contract. Instead it states that particular types of persons cannot hold a contract if they are not eligible. Please refer to Annex 3 for more detail.</p>

	GMS Contract	PMS Agreement	APMS Contract
Where two or more individuals are practising in partnership, is the contract treated as being made with the partnership?	Yes	No	No
Is the contract time limited?	No Except in certain circumstances when a temporary GMS contract can be used – see Urgent Contracts below	Yes Note that a PMS contractor providing essential services may apply for a GMS contract any time prior to the end of the PMS agreement	Yes
Can the Commissioner terminate at will?	No	Yes	If agreed by the parties and contained within the contract

	GMS Contract	PMS Agreement	APMS Contract
Must the contractor provide essential services?	Yes	No	No
Is there a standard form contract?	Yes	Yes	Yes
Does the standard form contract contain KPIs?	No	No	No
Can KPIs be added?	KPIs can be agreed between the parties in relation to supplementary quality based services	Yes	Yes
Payment arrangements	GMS SFE	As agreed by the parties and contained within the agreement – there may be reference to the GMS SFE	As agreed by the parties and contained within the contract

1.2 Urgent Contracts

1.2.1 Circumstances may arise that require the Commissioner to put in place an urgent contract. Such circumstances may include:

- the death of a contractor;
- the bankruptcy or insolvency of a contractor; or
- termination of an existing contract due to patient safety.

1.2.2 Where continuity of services to patients is required, the short timescales involved may not allow the Commissioner to undertake a managed closedown and transfer to a new provider (details of which are set out in the chapters on planned and unplanned practice closedown. Additional information can also be found in the Unplanned Closures chapter. The Commissioner may therefore, look to award a contract to a specific party that is able to provide the services to patients at short notice.

1.2.3 Prior to awarding a contract in this scenario, the Commissioner should consider a number of factors that are set out in the paragraphs below.

1.2.4 Procurement

1.2.4.1 A direct award of a contract, without considering whether a competitive process is required to determine the new contractor risks being a breach of procurement law, in which case the Commissioner could be challenged in Court or could be the subject of a complaint to NHS England and NHS Improvement (formerly Monitor).

1.2.4.2 The following factors will be relevant in determining the extent of the risk:

- value of the new contract and whether it is the best value for money;
- duration of the new contract (a shorter contract period would allow for a full competitive procurement to happen later, mitigating the risk) ;
- identity of the new contractor and whether it can be argued that the new contractor is the only provider capable of providing the services;
- number of potential new contractors;
- cross-border interest of the new contract;
- extent to which they need to procure a new contract was foreseeable.

1.2.4.3 Where the Commissioner determines that a contract for the immediate provision of services is required but time does not allow full consideration of the above factors (or for a competitive procurement process if required), the procurement risks can be mitigated by entering into a temporary contract that provides time for the proper action to be arranged and followed.

1.2.4.4 Having awarded a contract, the Commissioner must maintain a record of how, in awarding the contract, it complied with its duties in relation to effectiveness, efficiency, improvement in the quality of the services and promoting integration. Commissioners must also act in accordance with any national procurement protocol issued by NHS England, or other local protocol. CCGs with delegated authority should however, have due regard to their obligations as set out within the delegation agreement in regard to adherence with policies and guidance issued by NHS England.

1.2.5 Premises

1.2.5.1 The previous contractor may own or lease the premises which, as a result, may not be available for the provision of the services under a new contract. The availability of the premises must be ascertained before entering into a temporary contract.

1.2.6 Primary Care Networks

1.2.6.1 The commissioner should facilitate a discussion between the incoming contractor and the Primary Care Network to which the outgoing contractor was a member with the expectation that PCN membership should be maintained in order to ensure that patients continue to receive uninterrupted network services.

1.2.6.2 If the provider is not willing to join the PCN, or the PCN is not prepared to accept the provider as a member, the commissioner will liaise with the relevant LMC to facilitate discussions between the practice wishing to sign-up to the Network Contract DES and the appropriate PCN(s) taking all reasonable steps to reach agreement on the terms for the inclusion of the practice in a PCN. The commissioner can allocate a practice to a PCN if the LMC agrees that this is the right thing for the practice. Section 4.9 of the [Network Contract Directed Enhanced Services – Contract specification 20/21 PCN Requirements and entitlements](#) sets out the process for allocating a practice to a PCN.

1.3 Public Involvement

- 1.3.1 One of the general duties of Commissioners is to ensure there is public involvement where a decision leads to an impact on the provision of primary care services. If under a new contract, services are provided from a different location, this will be an impact on the services which may trigger the need to undertake a public involvement exercise.
- 1.3.2 Where there is no time for undertaking an exercise prior to entering into the contract, the Commissioner should ensure that as soon as possible after the contract is entered into, it arranges for such an exercise to be undertaken prior to the Commissioner making any decisions about the long term provision of services.
- 1.3.3 Commissioner SOs and SFIs
 - 1.3.3.1 The Commissioner may have organisational standing orders and standing financial instructions that require contracts to be procured in certain ways, e.g. securing three quotes for contracts up to a certain financial value. Where time does not allow the rules to be followed, there may be an emergency process that must be followed.

1.3.4 Other factors

1.3.4.1 Further factors may be relevant depending on the circumstances of the matter. Please refer to the chapters on planned and unplanned practice closures for a list of all factors that may be relevant.

1.3.4.2 Commissioners should also consider that if a practice has closed because of concerns in relation to patient safety, the incoming provider may need to be commissioned to undertake a review of systems and processes. This should include but is not limited to, undertaking audits to provide assurance around patient safety. This recognises the additional work that commissioners may need to reflect in the contract to provide assurance with regard to patient safety and public confidence

1.3.5 Which contract form?

1.3.5.1 A GMS contract can be used where the Commissioner has terminated a contract of another provider of primary medical services, and as a result of that termination, it wishes to enter into a temporary contract for a period specified in the contract for the provision of services.

1.3.5.2 A time limited PMS agreement may not be attractive in this scenario as the PMS contractor, if providing essential services, can request a non-time limited GMS contract at any time.

1.3.5.3 It is common for APMS contracts to be used in such a scenario due to the flexibility of:

- types of organisations that can enter into APMS contracts;
- flexibility of types of services and payment mechanism that can be agreed; and
- flexibility around duration and termination provisions.

1.3.5.4 The Commissioner should therefore consider what services and duration is required and whether there are any restrictions on the proposed contractor entering into different contract types to meet local diverse health needs.

1.4 Annex 1 Persons Eligible to Enter into a GMS Contract

1.4.1 Statutory Provisions

1.4.1.1 Section 86 of the NHS Act (extracted in paragraph 2 below) sets out the types of persons (including organisation types) that may enter into a GMS contract.

1.4.1.2 Regulations 3 to 5 of the GMS Regulations (extracted in paragraph 3 below) sets out the eligibility criteria that must be satisfied before any of the types of persons set out in Section 86 of the NHS Act can enter into the GMS contract.

1.4.1.3 The extracted legislation below is correct as of 1 July 2017.

1.4.1.4 By virtue of the delegation agreement, all references in legislation should be assumed to apply also to 'The Commissioner',

1.4.2 Section 86 of the NHS Act 2006

86 Persons eligible to enter into GMS contracts

- (1) The Board may, subject to such conditions as may be prescribed, enter into a general medical services contract with—
 - (a) a medical practitioner,
 - (b) two or more individuals practising in partnership where the conditions in subsection (2) are satisfied, or
 - (c) a company limited by shares where the conditions in subsection (3) are satisfied.
- (2) The conditions referred to in subsection (1)(b) are that—
 - (a) at least one partner is a medical practitioner, and
 - (b) any partner who is not a medical practitioner is either—
 - (i) an NHS employee,
 - (ii) a section 92 employee, section 107 employee, section 50 employee, section 64 employee, section 17C employee or Article 15B employee,

- (iii) a health care professional who is engaged in the provision of services under this Act or the National Health Service (Wales) Act 2006 (c. 42), or
 - (iv) an individual falling within section 93(1)(d).
- (3) The conditions referred to in subsection (1)(c) are that—
 - (a) at least one share in the company is both legally and beneficially owned by a medical practitioner, and
 - (b) any share which is not so owned is both legally and beneficially owned by a person referred to in subsection (2)(b).
- (4) Regulations may make provision as to the effect, in relation to a general medical services contract entered into by individuals practising in partnership, of a change in the membership of the partnership.
- (5) In this section—

“health care professional”, “NHS employee”, “section 92 employee”, “section 107 employee”, “section 50 employee”, “section 64 employee”, “section 17C employee” and “Article 15B employee” have the meaning given by section 93.

1.4.3 Regulations 4, 5 and 6 of the GMS Regulations (2015)

4. Conditions: general

4.—(1) The Board may only enter into a contract if the conditions specified in regulations 5 and 6 are met.

(2) Paragraph (1) is subject to the provisions of any scheme made by the Secretary of State under section 300 (transfer schemes) and section 303 (power to make consequential provision) of the Health and Social Care Act 2012(a).

5. Conditions relating solely to medical practitioners

5.—(1) Where the Board enters, or is proposing to enter, into a contract with—

(a) a medical practitioner, that medical practitioner must be a general medical practitioner;

(b) two or more persons practising in partnership—

(i) at least one partner (who must not be a limited partner) must be a general medical practitioner, and

(ii) any other partner who is a medical practitioner must be—

(aa) a general medical practitioner, or
(bb) employed by a Local Health Board, (in England and Wales and Scotland) an NHS trust, an NHS foundation trust, (in Scotland) a Health Board, or (in Northern Ireland) a Health and Social Services Trust; or (c) a company limited by shares—

(i) at least one share in the company must be both legally and beneficially owned by a general medical practitioner, and
(ii) any other share or shares in the company that are both legally and beneficially owned by a medical practitioner must be so owned by—

(aa) a general medical practitioner, or
(bb) a medical practitioner who is employed by a Local Health Board, (in England and Wales and Scotland) an NHS Trust, an NHS foundation trust, (in Scotland) a Health Board, or (in Northern Ireland) a Health and Social Services Trust.

(2) In paragraph (1)(a), (b)(i) and (c)(i) “general medical practitioner” does not include a medical practitioner whose name is included in the General Practitioner Register by virtue of being a medical practitioner to whom paragraph (3), (4) or (5) applies.

(3) This paragraph applies to a medical practitioner referred to in article 4(3) of the 2010 Order (general practitioners eligible for entry in the General Practitioner Register) who was exempt from the requirement to have the prescribed experience under—

(a) regulation 5(1)(d) of the National Health Service (Vocational Training for General Medical Practice) Regulations 1997(b);
(b) regulation 5(1)(d) of the National Health Service (Vocational Training for General Medical Practice) (Scotland) Regulations 1998(c);
or
(c) regulation 5(1)(d) of the Medical Practitioners (Vocational Training) Regulations (Northern Ireland) 1998(d).

(4) This paragraph applies to a medical practitioner who has an acquired right for the purposes of article 6(2) of the 2010 Order (persons with acquired

rights) by virtue of—

- (a) having been a restricted services principal; and
- (b) that medical practitioner's name being included, as at 31st December 1994, in—

- (i) a medical list which was, at that date, kept by a Family Health Services Authority(e), or
- (ii) any corresponding list which was, at that date, kept by a Health Board or by the Northern Ireland Central Services Agency for the Health and Social Services in Northern Ireland.

(5) This paragraph applies to a medical practitioner who has an acquired right for the purposes of article 6(6) of the 2010 Order (which relates to persons engaged or provided as a deputy or employed as an assistant) because, on at least ten days in the period of four years ending with 31st December 1994, or on at least 40 days in the period of ten years ending with that date, that medical practitioner was—

- (a) engaged as a deputy by, or provided as a deputy to, a medical practitioner whose name was included in—
 - (i) the medical list which was, at that date, kept by a Family Health Services Authority, or
 - (ii) any corresponding list kept, at that date, by a Health Board or by the Northern Ireland Central Services Agency for the Health and Social Services in Northern Ireland; or
- (b) employed as an assistant (other than as a trainee general practitioner) by such a medical practitioner.

(6) In paragraph (4)(a), “restricted services principal” means a medical practitioner who provided general medical services limited to child health surveillance, contraceptive services, maternity medical services or minor surgery.

6. General condition relating to all contracts

6.—(1) The Board must not enter into a contract with—

- (a) a medical practitioner to whom paragraph (2) applies; or

- (b) two or more persons practising in partnership, where paragraph (2) applies to any person who is a partner in the partnership; or
- (c) a company limited by shares where paragraph (2) applies to—
 - (i) the company,
 - (ii) any person both legally and beneficially owning a share in the company, or
 - (iii) any director or secretary of the company.

(2) This paragraph applies if—

- (a) the contractor is the subject of a national disqualification;
- (b) subject to paragraph (3), the contractor is disqualified or suspended (other than by interim suspension order or direction pending an investigation) from practising by any licensing body anywhere in the world;
- (c) the contractor has, within the period of five years before the signing of the contract or commencement of the contract (whichever is the earlier), been dismissed (otherwise than by reason of redundancy) from any employment by a health service body, unless—
 - (i) if the contractor was employed as a member of a health care profession at the time of the dismissal, the contractor has not subsequently been employed by that health service body or by another health service body, and
 - (ii) the dismissal was the subject of a finding of unfair dismissal by any competent tribunal or a court;
- (d) the contractor has, within the period of five years before the signing of the contract or commencement of the contract (whichever is the earlier), been removed from, or refused admission to, a primary care list by reason of inefficiency, fraud or unsuitability (within the meaning of section 151(2), (3) and (4) of the Act(a) (disqualification of practitioners)), or a performers list held by the Board by virtue of regulations made under section 91(3) (persons performing primary medical services) of the Act, unless the contractor's name has subsequently been included in such a list;

- (e) the contractor has been convicted in the United Kingdom of murder;
- (f) the contractor 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 longer than six months;
- (g) subject to paragraph (3), the contractor has been convicted outside of the United Kingdom of an offence which would, if committed in England and Wales, constitute murder and—
 - (i) the offence was committed on or after 14th December 2001, and
 - (ii) the contractor was sentenced to a term of imprisonment of longer than six months;
- (h) the contractor has been convicted of an offence, referred to in Schedule 1 to the Children and Young Persons Act 1933(a) (offences against children and young persons, with respect to which special provisions of this Act apply), or in Schedule 1 to the Criminal Procedure (Scotland) Act 1995(b) (offences against children under the age of 17 years to which special provisions apply), committed on or after 1st March 2004;
 - (i) the contractor has at any time been included in—
 - (i) any barred list within the meaning of section 2 of the Safeguarding Vulnerable Groups Act 2006(c) (barred lists), or
 - (ii) any barred list within the meaning of article 6 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007(d) (barred lists), unless the contractor was removed from the list either on the grounds that it was not appropriate for the contractor to have been included in it or as the result of a successful appeal;
 - (j) the contractor has, within the period of five years before the signing of the contract or commencement of the contract (whichever is the earlier), been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commission, the Charity Commission for Northern Ireland or the High Court, and that order was made on the grounds of misconduct or mismanagement in the

administration of a charity for which the contractor was responsible or to which the contractor was privy, or which was contributed to, or facilitated by, the contractor's conduct;

(k) the contractor has, within the period of five years before the signing of the contract or commencement of the contract (whichever is the earlier), been removed from being concerned with the management or control of any body in a case where the removal was by virtue of section 34(5)(e) of the Charities and Trustee Investment (Scotland) Act 2005(e) (powers of Court of Session);

(l) the contractor—

(i) has been adjudged bankrupt and has not been discharged from the bankruptcy or the bankruptcy order has not been annulled, or

(ii) has had sequestration of the contractor's estate awarded and has not been discharged from the sequestration;

(m) the contractor is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986(a) (bankruptcy restrictions order and undertaking), Schedule 2A to the Insolvency (Northern Ireland) Order 1989(b) (bankruptcy restrictions order and undertaking), or sections 56A to 56K of the Bankruptcy (Scotland) Act 1985(c) (bankruptcy restrictions order, interim bankruptcy restrictions order and bankruptcy restrictions undertaking), unless the contractor has been discharged from that order or that order has been annulled; (n) the contractor—

(i) is subject to moratorium period under a debt relief order under Part VIIA of the Insolvency Act 1986(d) (debt relief orders), or

(ii) is the subject of a debt relief restrictions order or an interim debt relief restrictions order under Schedule 4ZB to that Act(e) (debt relief restrictions orders and undertakings);

(o) the contractor has made a composition agreement or arrangement with, or granted a trust deed for, the contractor's creditors and the contractor has not been discharged in respect of it;

(p) the contractor is subject to—

- (i) a disqualification order under section 1 of the Company Directors Disqualification Act 1986(f) (disqualification orders: general) or a disqualification undertaking under section 1A of that Act(g) (disqualification undertakings: general),
 - (ii) a disqualification order or disqualification undertaking under article 3 (disqualification orders: general) or article 4 (disqualification undertakings: general) of the Company Directors Disqualification (Northern Ireland) Order 2002(h), or
 - (iii) a disqualification order under section 429(2) of the Insolvency Act 1986(i) (disabilities on revocation of an administration order against an individual);
 - (q) the contractor has had an administrator, administrative receiver or receiver appointed in respect of the contractor;
 - (r) the contractor has had an administration order made in respect of the contractor under Schedule B1 to the Insolvency Act 1986(j) (administration); or
 - (s) the contractor is a partnership and—
 - (i) a dissolution of the partnership is ordered by any competent court, tribunal or arbitrator, or
 - (ii) an event happens that makes it unlawful for the business of the partnership to continue, or for members of the partnership to carry on in partnership.
- (3) Paragraph (2)(b) or, as the case may be, paragraph (2)(g), does not apply to a person where—
- (a) that person—
 - (i) has been disqualified or suspended from practising by a licensing body outside of the United Kingdom, or
 - (ii) has been convicted outside of the United Kingdom of a criminal offence; and
 - (b) the Board is satisfied that the disqualification, suspension or, as the case may be, the conviction does not make that person unsuitable to be—
 - (i) a contractor,

(ii) a partner, in the case of a contract with two or more persons practising in partnership, or

(iii) in the case of a company limited by shares—

(aa) a person who both legally and beneficially owns a share in the company, or

(bb) a director or secretary of the company.

(4) For the purposes of paragraph (2)(c)—

(a) 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; and

(b) a health service body includes a Strategic Health Authority or a Primary Care Trust which was established before the coming into force of section 33 (abolition of Strategic Health Authorities) or 34 (abolition of Primary Care Trusts) of the Health and Social Care Act 2012(a).

(5) In this regulation, “contractor” includes a person with whom the Board is proposing to enter into a contract with.

1.5 Annex 2 Persons eligible to enter into a PMS Agreement

1.5.1 Statutory Provisions

1.5.1.1 Section 93 of the NHS Act (extracted in paragraph 2 below) sets out the types of persons (including organisation types) that may enter into a PMS agreement (referred to in the Act as section 92 agreements).

1.5.1.2 Regulations 3 and 5 of the PMS Regulations (extracted in paragraph 3 below) sets out the eligibility criteria that must be satisfied before any of the types of persons set out in section 93 of the NHS Act can enter into a PMS agreement.

1.5.1.3 The extracted legislation below is correct as of 1 July 2017.

1.5.1.4 By virtue of the delegation agreement, all references in legislation should be assumed to apply also to 'The Commissioner',

1.5.2 Section 93 of the NHS Act 2006

93 Persons with whom agreements may be made under section 92

- (1) The Board may make an agreement under section 92 only with one or more of the following—
- (a) an NHS trust or an NHS foundation trust,
 - (b) a medical practitioner who meets the prescribed conditions,
 - (c) a health care professional who meets the prescribed conditions,
 - (d) an individual who is providing services—
 - (i) under a general medical services contract or a general dental services contract or a Welsh general medical services contract or a Welsh general dental services contract,
 - (ii) in accordance with section 92 arrangements, section 107 arrangements, section 50 arrangements, section 64 arrangements, section 17C arrangements or Article 15B arrangements, or
 - (iii) under section 17J or 25 of the 1978 Act or Article 57 or 61 of the Health and Personal Social Services (Northern Ireland) Order 1972 (S.I. 1972/1265 (N.I.14)),

- or has so provided them within such period as may be prescribed,
- (e) an NHS employee, a section 92 employee, a section 107 employee, a section 50 employee, a section 64 employee, a section 17C employee or an Article 15B employee,
 - (f) a qualifying body.
- (2) The power under subsection (1) to make an agreement with a person falling within paragraph (d) or (e) of that subsection is subject to such conditions as may be prescribed.
- (3) In this section–
- “the 1978 Act” means the National Health Service (Scotland) Act 1978 (c. 29),
- “Article 15B arrangements” means arrangements for the provision of services made under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972 (S.I. 1972/1265 (N.I.14)),
- “Article 15B employee” means an individual who, in connection with the provision of services in accordance with Article 15B arrangements, is employed by a person providing or performing those services,
- “health care professional” means a person who is a member of a profession regulated by a body mentioned (at the time the agreement in question is made) in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002 (c. 17),
- “NHS employee” means an individual who, in connection with the provision of services in the health service, the Scottish health service or the Northern Ireland health service, is employed by–
- (a) an NHS trust, an NHS foundation trust or (in Northern Ireland) a Health and Social Services Trust,
 - (b) a Local Health Board,
 - (c) a person who is providing services under a general medical services contract or a general dental services contract or a Welsh general medical services contract or a Welsh general dental services contract,
 - (d) an individual who is providing services as specified in subsection (1)(d)(iii),

“the Northern Ireland health service” means the health service within the meaning of the Health and Personal Social Services (Northern Ireland) Order 1972,

“qualifying body” means a company which is limited by shares all of which are both legally and beneficially owned by persons falling within paragraph (a), (b), (c), (d), or (e) of subsection (1) ,

“the Scottish health service” means the health service within the meaning of the National Health Service (Scotland) Act 1978,

“section 17C arrangements” means arrangements for the provision of services made under section 17C of the 1978 Act,

“section 17C employee” means an individual who, in connection with the provision of services in accordance with section 17C arrangements, is employed by a person providing or performing those services,

“section 50 arrangements” means arrangements for the provision of services made under section 50 of the National Health Service (Wales) Act 2006 (c. 42),

“section 64 arrangements” means arrangements for the provision of services made under section 64 of that Act,

“section 107 employee” means an individual who, in connection with the provision of services in accordance with section 107 arrangements, is employed by a person providing or performing those services,

“section 92 employee” means an individual who, in connection with the provision of services in accordance with section 92 arrangements, is employed by a person providing or performing those services,

“section 50 employee” means an individual who, in connection with the provision of services in accordance with section 50 arrangements, is employed by a person providing or performing those services,

“section 64 employee” means an individual who, in connection with the provision of services in accordance with section 64 arrangements, is employed by a person providing or performing those services,

“Welsh general medical services contract” means a contract under section 42(2) of the National Health Service (Wales) Act 2006 (c. 42), and

“Welsh general dental services contract” means a contract under section

57(2) of that Act.

1.5.3 Regulations 4 and 5 of the PMS Regulations (2015)

3. Conditions: general

4.—(1) The Board may only enter into an agreement if the conditions specified in regulation 5 are met.

(2) Paragraph (1) is subject to the provisions of any scheme made by the Secretary of State under section 300 (transfer schemes) and section 303 (power to make consequential provision) of the Health and Social Care Act 2012(d).

5. General condition relating to all agreements

5.—(1) The Board must not enter into an agreement with—

(a) a person falling within section 93(1)(b) to (d) of the Act (persons with whom agreements may be made under section 92), to whom paragraph

(2) applies;

(b) a qualifying body if paragraph (2) applies to—

(i) the qualifying body,

(ii) any person both legally and beneficially owning a share in the qualifying body, and

(iii) any director or secretary of the qualifying body.

(2) This paragraph applies if—

(a) the contractor is the subject of a national disqualification;

(b) subject to paragraph (3), the contractor is disqualified or suspended (other than by interim suspension order or direction pending an investigation) from practising by a licensing body anywhere in the world;

(c) the contractor has, within the period of five years before the signing of the agreement or commencement of the agreement (whichever is the earlier) been dismissed (otherwise than by reason of redundancy) from any employment with a health service body, unless—

(i) if the contractor was employed as a member of a health care profession at the time of the dismissal, the contractor has not subsequently been employed by that health service body or by

another health service body, and

(ii) the dismissal was the subject of a finding of unfair dismissal by any competent tribunal or a court;

(d) the contractor has, within the period of five years before the signing of the agreement or commencement of the agreement (whichever is the earlier), been removed from, or refused admission to, a primary care list by reason of inefficiency, fraud or unsuitability (within the meaning of section 151(2), (3) and (4) of the Act(a) (disqualification of practitioners)), or a performers list held by the Board by virtue of regulations made under section 91(3) (persons performing primary medical services) of the Act, unless the contractor's name has subsequently been included in such a list;

(e) the contractor has been convicted in the United Kingdom of murder;

(f) the contractor has been convicted in the United Kingdom of a criminal offence other than murder committed on or after 1st April 2002 and has been sentenced to a term of imprisonment of longer than six months;

(g) subject to paragraph (3), the contractor has been convicted outside of the United Kingdom of an offence which would, if committed in England and Wales, constitute murder and—

(i) the offence was committed on or after 3rd November 2003; and

(ii) the contractor was sentenced to a term of imprisonment of longer than six months;

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

(i) the contractor has at any time been included in—

(i) any barred list within the meaning of section 2 of the Safeguarding Vulnerable Groups Act 2006(d) (barred lists), or

(ii) any barred list within the meaning of article 6 of the Safeguarding Vulnerable Groups (Northern Ireland) Order

2007(e) (barred lists), unless the contractor was removed from the list either on the grounds that it was not appropriate for the contractor to have been included in it or as the result of a successful appeal;

(j) the contractor has, within the period of five years before the signing of the agreement or commencement of the agreement (whichever is the earlier), been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commission, the Charity Commission for Northern Ireland or the High Court, and that order was made on the grounds of misconduct or mismanagement in the administration of a charity for which the contractor was responsible or to which the contractor was privy, or which was contributed to, or facilitated by, the contractor's conduct;

(k) the contractor has, within the period of five years before the signing of the agreement or commencement of the agreement (whichever is the earlier), been removed from being concerned with the management or control of anybody in any case where removal was by virtue of section 34(5)(e) of the Charities and Trustees Investment (Scotland) Act 2005(a) (powers of Court of Session);

(l) the contractor—

(i) has been adjudged bankrupt and has not been discharged from the bankruptcy or the bankruptcy order has not been annulled, or

(ii) has had sequestration of the contractor's estate awarded and has not been discharged from the sequestration;

(m) the contractor is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986(b) (bankruptcy restrictions order and undertaking), or Schedule 2A to the Insolvency (Northern Ireland) Order 1989(c) (bankruptcy restrictions order and undertaking), or sections 56A to 56K of the Bankruptcy (Scotland) Act 1985(d) (bankruptcy restrictions order, interim bankruptcy restrictions order and bankruptcy restrictions undertaking), unless the contractor has been discharged from that order or that order has been annulled;

(n) the contractor—

- (i) is subject to a moratorium period under a debt relief order under Part VIIA of the Insolvency Act 1986(e) (debt relief orders), or
 - (ii) is the subject of a debt relief restrictions order or an interim debt relief restrictions order under Schedule 4ZB to that Act(f) (debt relief restrictions orders and undertakings);
 - (o) the contractor has made a composition agreement or arrangement with, or granted a trust deed for, the contractor's creditors and the contractor has not been discharged in respect of it;
 - (p) the contractor is subject to—
 - (i) a disqualification order under section 1 of the Company Directors Disqualification Act 1986(g) (disqualification orders: general) or a disqualification undertaking under section 1A of that Act(h) (disqualification undertakings: general),
 - (ii) a disqualification order or disqualification undertaking under article 3 (disqualification orders: general) or article 4 (disqualification undertakings: general) of the Company Directors Disqualification (Northern Ireland) Order 2002(a), or
 - (iii) a disqualification order under section 429(2) of the Insolvency Act 1986(b) (disabilities on revocation of an administration order against an individual);
 - (q) the contractor has had an administrator, administrative receiver or receiver appointed in respect of the contractor; or
 - (r) the contractor has had an administration order made in respect of the contractor under Schedule B1 to the Insolvency Act 1986(c) (administration).
- (3) Paragraph (2)(b) or, as the case may be, paragraph (2)(g), does not apply to a person where—
- (a) that person—
 - (i) has been disqualified or suspended from practising by a licensing body outside of the United Kingdom, or
 - (ii) has been convicted outside of the United Kingdom of a criminal offence; and
 - (b) the Board is satisfied that the disqualification, suspension or, as the case may be, the conviction does not make the person unsuitable to be—

- (i) a party to the agreement; or
 - (ii) in the case of an agreement with a qualifying body—
 - (aa) a person who both legally and beneficially owns a share in the qualifying body, or
 - (bb) a director or secretary of the qualifying body.
- (4) For the purposes of paragraph (2)(c)—
 - (a) 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; and
 - (b) a health service body includes a Strategic Health Authority or a Primary Care Trust which was established before the coming into force of section 33 (abolition of Strategic Health Authorities) or section 34 (abolition of Primary Care Trusts) of the Health and Social Care Act 2012(d).
- (5) In this regulation, “contractor” includes a person with whom the Board is proposing to enter into an agreement.

1.6 Annex 3 Persons Eligible to Enter into an APMS Contract

1.6.1 Statutory Provisions

1.6.1.1 The NHS Act does not list persons who may (or may not) enter into an APMS contract.

1.6.1.2 The APMS Directions contain provisions relating to circumstances in which certain types of persons or organisation may not enter into an APMS contract (Direction 4 – extracted below). Provided Direction does not apply, any person or organisation may enter into an APMS contract.

1.6.1.3 The extracted legislation below is correct as of 1 July 2017.

1.6.2 Direction 4 and 5 of the APMS Directions

General conditions

4.The Board may only enter into an APMS contract if the conditions specified in direction 5 are met.

Provider conditions

5.—(1) The Board must not enter into an APMS contract with—

- (a) an individual, where paragraph (2) applies to that individual;
- (b) a company, where paragraph (2) applies to—
 - (i) the company, or
 - (ii) a director or secretary of the company;
- (c) two or more persons practising in a partnership, where paragraph (2) applies to—
 - (i) the partnership, or
 - (ii) any person who is a partner in the partnership;
- (d) an industrial and provident society(a), a friendly society, a voluntary organisation(b) or any other body where paragraph (2) applies to—
 - (i) the society, organisation or body, or
 - (ii) an officer, trustee or any other person concerned with the management of the society, organisation or body.

(2) This paragraph applies if—

(a) the APMS contractor is the subject of a national disqualification;

(b) subject to paragraph (3), the APMS contractor is disqualified or suspended (other than by an interim suspension order or direction pending an investigation) from practising by a licensing body anywhere in the world;

(c) the APMS contractor has, within the period of five years before the signing of the APMS contract or the commencement of the APMS contract (whichever is the earlier) been dismissed (otherwise than by reason of redundancy) from any employment with a health service body, unless—

(i) if the APMS contractor was employed as a member of a health care profession at the time of the dismissal, the APMS contractor has not subsequently been employed by that health service body or by another health service body, and

(ii) the dismissal was the subject of a finding of unfair dismissal by any competent tribunal or court;

(d) the APMS contractor has, within the period of five years before the signing of the APMS contract or the commencement of the APMS contract (whichever is the earlier), been removed from, or refused admission to, a primary care list by reason of inefficiency, fraud or unsuitability (within the meaning given by section 151(2), (3) and (4) of the Act(a) (disqualification of practitioners)), or a performers list held by the Board by virtue of regulations made under section 91(3) (persons performing primary medical services) of the Act, unless the APMS contractor's name has subsequently been included in such a list;

(e) the APMS contractor has been convicted in the United Kingdom of murder;

(f) the APMS contractor has been convicted in the United Kingdom of a criminal offence other than murder, committed on or after 1st April 2002, and has been sentenced to a term of imprisonment of longer than six months;

(g) subject to paragraph (3), the APMS contractor has been convicted outside of the United Kingdom of an offence which would, if committed in

England and Wales, constitute murder, and—

- (i) the offence was committed on or after 3rd November 2003, and
- (ii) the APMS contractor was sentenced to a term of imprisonment of longer than six months;

(h) the APMS contractor has been convicted of an offence referred to in Schedule 1 to the Children and Young Persons Act 1933(b) (offences against children and young persons, with respect to which special provisions of this Act apply), or in Schedule 1 to the Criminal Procedure (Scotland) Act 1995(c) (offences against children under the age of 17 years to which special provisions apply) committed on or after 1st April 2004;

- (i) the APMS contractor has at any time been included in—

- (i) any barred list within the meaning of section 2 of the Safeguarding Vulnerable Groups Act 2006(d) (barred lists), or

- (ii) any barred list within the meaning of article 6 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007(e) (barred lists), unless the APMS contractor was removed from the list either on the grounds that it was not appropriate for the APMS contractor to have been included in it or as the result of a successful appeal;

(j) the APMS contractor has, within the period of five years before the signing of the APMS contract or the commencement of the APMS contract (whichever is the earlier), been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commission, the Charity Commission for Northern Ireland or the High Court, and that order was made on the grounds of misconduct or mismanagement in the administration of the charity for which the APMS contractor was responsible or to which the APMS contractor was privy, or which was contributed to, or facilitated, by the APMS contractor's conduct;

(k) the APMS contractor has, within the period of five years before the signing of the APMS contract or the commencement of the APMS contract (whichever is the earlier), been removed from being concerned with the management or control of anybody in any case where removal

was by virtue of section 34(5)(e) of the Charities and Trustees Investment (Scotland) Act 2005(a) (powers of the Court of Session);

(l) the APMS contractor has—

(i) been adjudged bankrupt and has not been discharged from the bankruptcy or the bankruptcy order has not been annulled, or

(ii) had sequestration of the APMS contractor's estate awarded and has not been discharged from the sequestration;

(m) the APMS contractor is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986(b) (bankruptcy restrictions order and undertaking), or Schedule 2A to the Insolvency (Northern Ireland) Order 1989(c) (bankruptcy restrictions order and undertaking), or sections 56A to 56K of the Bankruptcy (Scotland) Act 1985(d) (bankruptcy restrictions order, interim bankruptcy restrictions order and bankruptcy restrictions undertaking), unless the APMS contractor has been discharged from that order or that order has been annulled;

(n) the APMS contractor—

(i) is subject to a moratorium period under a debt relief order under Part VIIA of the Insolvency Act 1986(e) (debt relief orders), or

(ii) is the subject of a debt relief restrictions order or an interim debt relief restrictions order under Schedule 4ZB to that Act(f) (debt relief restrictions orders and undertakings);

(o) the APMS contractor has made a composition agreement or arrangement with, or has granted a trust deed for, the APMS contractor's creditors and the APMS contractor has not been discharged in respect of it;

(p) the APMS contractor is subject to—

(i) a disqualification order or a disqualification undertaking under section 1 of the Company Directors Disqualification Act 1986(g) (disqualification orders: general),

(ii) a disqualification order or a disqualification undertaking under article 3 (disqualification orders: general), or article 4 (disqualification undertakings: general) of the Company Directors Disqualification (Northern Ireland) Order 2002(h), or

- (iii) a disqualification order under section 429(2) of the Insolvency Act 1986(i) (disabilities on revocation of an administration order against an individual);
- (q) an administrator, administrative receiver or receiver has been appointed in respect of the APMS contractor;
- (r) an administration order has been made in respect of the APMS contractor under Schedule B1 to the Insolvency Act 1986(a) (administration);
- (s) the APMS contractor is a partnership and—
 - (i) a dissolution of the partnership is ordered by any competent court, tribunal or arbitrator, or
 - (ii) an event happens that makes it unlawful for the business of the partnership to continue, or for members of the partnership to carry on in partnership.
- (3) Paragraph (2)(b) or, as the case may be, paragraph (2)(g), does not apply to a person where—
 - (a) that person—
 - (i) has been disqualified or suspended from practising by a licensing body outside of the United Kingdom, or
 - (ii) has been convicted outside of the United Kingdom of a criminal offence; and
 - (b) the Board is satisfied that the disqualification or suspension or, as the case may be, the conviction, does not make the person unsuitable to be—
 - (i) a party to an APMS contract;
 - (ii) in the case of an APMS contract with a company, a director or secretary of a company entering into an APMS contract; or
 - (iii) in the case of an APMS contract with—
 - (aa) an industrial or provident society,
 - (bb) a friendly society,
 - (cc) a voluntary organisation, or
 - (dd) another body, an officer, trustee or other person concerned with the management of such a society, organisation or other body entering into an APMS contract.

(4) For the purposes of paragraph (2)(c)—

(a) 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; and

(b) a health service body includes a Strategic Health Authority or a Primary Care Trust which was established before the coming into force of section 33 (abolition of Strategic Health Authorities) or 34 (abolition of Primary Care Trusts) of the Health and Social Care Act 2012(b).

(5) In this direction, “APMS contractor” includes a person with whom the Board is proposing to enter into an APMS contract.

1.7 Annex 4 Primary Care Support Services

Notifications

1.7.1 Commissioners should ensure that following any contract award or contract merger, GP performers are informed of their obligation to notify the Primary Care Support Services (PCSS) provider (currently Primary Care Support England (PCSE)) using the relevant online portal or forms issued by ‘the Board’ within 28 days.

1.7.2 Additionally and more generally, GP performers and indeed performers in all contractor groups are required to notify the PCSS provider of any changes relevant to their entry on the national performers list. Further information is available here <https://pcse.england.nhs.uk/services/performers-lists/gp-performers-list-for-england/>

2 Assurance Framework Contract Review

2.1 Introduction

- 2.1.1 Commissioners of Primary Medical Care are responsible for the quality, safety and performance of services delivered by providers, within their area of responsibility. This can be directly by NHS England (NHSE) local teams or CCGs through the delegation agreement. However, Commissioners have a statutory duty to conduct a routine annual review of every primary medical care contract it holds. This is covered through the annual GP Practice self declaration (eDec) collection which NHS England has established with providers. Therefore, commissioners should ensure they review the practices eDec returns following submission and any subsequent national analysis produced (e.g. NHS England's eDec outlier report which will usually be made available 6-8 weeks following eDec closure)
- 2.1.2 It is important to note that whilst exercising of the functions passes to the CCG, the liability for the exercise of any of its functions remains with NHS England.
- 2.1.3 Assurance of CCGs commissioning of Primary Care will be covered outside of this policy and guidance.
- 2.1.4 This chapter outlines the approach to be taken by commissioners when overseeing primary medical care contracts to ensure compliance with quality and safety standards and replaces the Primary Medical Services Assurance Management Framework guidance and policy documents first published April 2013.,
- 2.1.5 Commissioners are reminded that early engagement with LMCs presents the best opportunity to support practices in making effective and sustainable changes to support service improvement, should this be found to be appropriate and necessary.
- 2.1.6 This guidance provides an outline for assessing general practice through the normal contractual framework (i.e. Personal Medical Services (PMS), General Medical Services (GMS) or Alternative Provider Medical Services (APMS)).
- 2.1.7 This chapter **will not** re-cover details of the various types of contract or the contractual actions available as these are covered elsewhere within this

manual. It will aim to provide practical advice and guidance to support commissioners and contract managers.

2.2 Background

- 2.2.1 Whilst it is recognised that most health care professionals and providers of Primary Medical Care operate to a very high standard, it is essential that commissioners have robust monitoring arrangements in place.
- 2.2.2 Monitoring arrangements should create a balance of support, oversight and intervention where necessary. Furthermore, it should create a culture of openness and transparency and a vehicle to promote peer to peer improvement.
- 2.2.3 From 1 April 2015 the responsibility for monitoring quality and responding to concerns arising from General Practices has been delegated to CCGs in increasing numbers. The CCGs already had a statutory duty to assist and support NHS England with quality but most now have specific delegated authority for contracting primary care medical services.
- 2.2.4 Whilst Practices as providers are accountable for the quality of services and are required to have their own quality monitoring processes in place, NHS England and CCGs as Commissioners have a shared responsibility for quality assurance. Through the duty of candour and the contractual relationship with Commissioners, practices are required to provide information and assurance to Commissioners and engage in system wide approaches to improving quality.

2.3 Contract Review

- 2.3.1 Through the publication of this guidance, NHS England introduced a requirement on Commissioners to undertake a risk-based approach to reviewing contracts, along with a rolling programme of deep-dive contract reviews. Depending on the number of practices within the commissioning area and types of contract, a rolling programme could span one to three years.
- 2.3.2 For APMS contracts this would need to be more frequent owing to the length of contract and the variable KPIs within them. It is recommended that if new information becomes available to the Commissioner which suggests high levels of variation, a visit may be required and the contract reviewing further.

- 2.3.3 Commissioners will have varying resources available to effectively manage their range of contract. Nationally, there are (as Sept 2019) 6,867 practices in England with a prescribing cost centre 'GP Practice'¹, plus there are a small number of additional contracts not in this prescribing category.
- 2.3.4 Across these 6,867 practices, the latest workforce data² published by NHS Digital (table below) suggests that these break down into the following contract types:

England	Practice count, Full-Time Equivalent and Percentages		
	September 2018	March 2019	September 2019
Number of GP Practices	7,137	7,012	6,867
By Type of Contract:			
APMS	150	123	143
APMS by Limited Company	59	42	47
GMS	4,996	4,964	4,848
GMS by Limited Company	-	5	-
PMS	1,916	1,860	1,796
PMS by Limited Company	13	6	-
Unknown	3	12	20

- 2.3.5 However, this masks a range of GP Practice numbers across CCGs. The average number of GP Practices per CCG is c.36, however the range is currently between 6 – 165. There are ~60% of CCGs with no APMS contracts, and ~10% of CCGs that have no PMS contracts.
- 2.3.6 Across those CCGs that have APMS contracts in place, the average number is 2.2, although one CCG currently has 12 APMS contracts representing 13% of its total.
- 2.3.7 Commissioners should maintain accurate records of all contract reviews and will be required to demonstrate if requested, evidence of compliance, or otherwise support oversight of primary medical care commissioning arrangements. This may be for example, via NHS England's Primary Care Activity Report (PCAR) or internal and external audit functions.

¹ <https://digital.nhs.uk/services/organisation-data-service/data-downloads/gp-and-gp-practice-related-data>

² <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-30-september-2018-experimental-statistics>

2.4 Setting and Monitoring Key Performance Indicators

- 2.4.1 Commissioners should ensure key performance indicators (KPIs) are negotiated into relevant contracts. These should be specific, measurable, achievable, relevant and time-bound (SMART) and include relevant payment thresholds.
- 2.4.2 Primary Medical Care providers will then be required to submit evidence to the Commissioner in relation to those KPIs, against which payment will be considered. The Commissioner should be assured that the evidence submitted by the contractor is robust, relevant and proportionate.

2.5 Using data and information effectively

- 2.5.1 This section recognises that in a model for improvement, various data sets which are being used by commissioners to oversee the delivery of services provide only one part of a large picture and used in isolation presents not only a risk of inaccuracy, but anxiety amongst those providing services or those responsible for oversight of the delivery of those services. Data must be put into the context of the particular provider practice and used alongside other intelligence to gain a full understanding of any potential risk to quality and patient safety.
- 2.5.2 The use of measures and indicators to assess quality should not remove, diminish or unduly influence sound evidence based clinical decisions and judgements. Commissioners should take steps to ensure that indicators are not abused as perverse incentives to change clinical practice or ways of working which are inconsistent with the delivery of high quality patient centred care.
- 2.5.3 Whilst most health care professionals practise to a very high standard and it is recognised that there is excellence in general practice, it is essential that Commissioners have in place a robust assurance management programme to identify and share best practice, recognise where additional management may be needed and to highlight when things are going wrong at an early stage in primary medical services provision.

- 2.5.4 Through transparent measurement across practices within a CCG and CCGs within a regional area, the practice-Commissioner relationship provides a forum for collaborative and engaging discussions. Such engagement and collaboration recognises the contribution that each practice can make to both the quality of services to their registered patients and the wider impact to service delivery across the practice and wider CCG population.
- 2.5.5 The usage of measures and indicators is to act as a starting place for conversations, asking questions along the way as to why variation may be occurring and acknowledging that variation may be warranted or unwarranted depending on the context and wider supporting information available. A practice visit may be needed to support further understanding when high levels of variation are occurring.
- 2.5.6 If there are greater concerns about a practice, bordering on contractual failure, this will require a more formal conversation with the practice which should be led by the Commissioner. The focus will be the same for all practices: support to improve, with market exit as a last resort.
- 2.5.7 Recognising that practice specific data alone is not conclusive evidence of poor service provision and needs to be considered within the context of the practice, the Commissioner will use a collection of information including national data (clinical indicators, quality outcome standards, appraisals, complaints etc.) and local intelligence (including conferring with stakeholders) in order to assess and mitigate any potential risk to service provision and patient safety within a practice. Where a potential or actual risk is identified, the Commissioner will be expected to take the necessary steps to assure itself that adequate and effective support is being provided to reduce the risk, identify any ongoing areas for improvement and be able to demonstrate and measure that improvement.
- 2.5.8 NHS England provides Commissioners and GP practices with a centrally available set of pre-analysed data which the Commissioner must use as part of its assessment of variation in the provision of primary medical services. This information has been developed and made available through a restricted access web interface available at www.primarycareindicators.nhs.uk. Commissioners will be expected to use these sources of data and information to support contract monitoring.

- 2.5.9 Recognising the Commissioner retains contractual accountability and relying on the Practice/Commissioner /LMC relationship, supported by a centrally provided transparent and consistent suite of measures, in conjunction with robust, fair and consistent guidance for the management of service and performance improvement, will help to ensure risks to quality and patient safety are addressed in a timely and proportionate manner.
- 2.5.10 The approach described above provides for the Commissioner to assure the quality, safety and performance of each practice.
- 2.5.11 The Care Quality Commission is the independent regulator of health and adult social care in England. It seeks to ensure services are safe, effective, compassionate and delivered to a high quality, encouraging services to improve. The inspection of general practice includes five key questions of services i.e. whether services are: safe, effective, caring, responsive to people's needs and well-led. CQC rates each of the five questions to give an overall rating for a practice, the rating categories used include: Outstanding, good, requires improvement and inadequate. These ratings and practice reports are available on the CQC website.
- 2.5.12 CQC's report State of Care in General Practice 2014-2017 (<http://www.cqc.org.uk/publications/major-report/state-care-general-practice-2014-2017>) highlights that one of the key determinants of GP practice providing high quality care was, a practice that is proactive in identifying the needs of their patient population as well as people's health and care needs in the wider local population. Furthermore, practices that were good or outstanding proactively support people to live healthy lives, recognise social aspects such as employment, housing and finance and then target such support towards people who are vulnerable. As well as engaging with the needs of patients, meeting local needs also meant engaging with external agencies, and networks and including the voluntary sector. CQC rating data indicates that the majority of practices in England are rated as Good or Outstanding, with pockets of poor practice.
- 2.5.13 The standards set by the Care Quality Commission (CQC) describe the characteristics of 'good' quality primary medical care. These are available on the CQC website: <http://www.cqc.org.uk/guidance-providers/gps#care-standards>

2.5.14 Other definitions of good quality primary care which may also provide the starting point for discussions between practices and the Commissioner are outlined in the Health Foundation publication “Improving quality in general practice”³

2.5.15 As excellent service provision cannot be discerned from a single set of measures or indicators, NHS England primarily provide three sources of data and intelligence. Used alongside local knowledge, these may assist the Commissioner in assessing risk to service provision and patient safety and therefore adherence to the contract. This intelligence is currently provided through the Primary Care website at www.primarycareindicators.nhs.uk and through eDec which is collected by NHS Digital via the Strategic Data Collection Service (SDCS) on behalf of NHS England.

1. A Practice profile which describes the characteristics of each practice e.g. the demography of the population served. This information is updated regularly and whilst it is unlikely to change significantly over time, it may contain specific information which when presented alongside clinical indicators, would provide a more complete picture and potential impact on achievement of certain standards e.g. the effect of student practices or those that serve more discreet populations (homeless, high BME, highly deprived etc).
2. An annual GP practice electronic self-declaration (eDec). This includes information such as, operating policies, opening times and assurance of good workforce planning. This information will link with contractual requirements and may also contain responses to ‘reasonable requests for information’ e.g. from other governmental departments and bodies, parliamentary questions or freedom of information requests. The information declared will be shared with CQC, reducing the burden of separate information returns across organisations e.g. as part of pre-inspection information requests.
3. A suite of general practice measures and indicators supporting quality improvement, assurance and enabling benchmarking as these are shared transparently with all practices. This indicator set will apply to all GP practices in England, in order to allow for benchmarking comparisons to be made, within a CCG or wider regional areas, for example by grouping practices of other similar characteristics such index of multiple deprivation and list size, etc.

³ <http://www.health.org.uk/publication/improving-quality-general-practice>

2.5.16 These data should be used by Commissioners in the first instance, along with any new or emerging sources of intelligence to identify risk. These sources of data and information will direct commissioners to those areas where potential areas or pockets of highest risk exist.

2.5.17 It is acknowledged that these sources of data do not capture the full range of services provided by general practice, they are however an important starting point in helping individual practices, Commissioners and other stakeholders to build a rounded view of performance with a focus on objective service improvement and outcomes.

2.5.18 There are very few circumstances where data alone will determine Commissioner intervention. To ensure flexibility, Commissioners should review these three primary sources of data and any future published sources of data and information in order to understand whether a practice requires support to improve or intervention, for example, if the Commissioner considers there may be a risk to quality and patient safety. If necessary, the Commissioner should provide additional appropriate and adequate support to be agreed with the practice. If despite that support a practice is unable to demonstrate improvement within a reasonable period, the Commissioner must determine whether it considers there is an actual cause for concern. This will require scrutiny of any other relevant sources of intelligence or data for example;

- Additional and detailed practice data (PCCA tool)
- Local intelligence including the annual GP Practice electronic self-declaration (eDec) submission.
- CQC practice reports
- Public Health England GP practice profiles:
<http://fingertips.phe.org.uk/profile/general-practice>
- K041b complaints indicator set made by or on behalf of patients:
<http://content.digital.nhs.uk/datacollections/ko41b>
- Friends and Family Test:
<https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/>
- General Practice Patient Survey: <https://gp-patient.co.uk/>
- NHS Right Care future indicator sets for general practice:
<https://www.england.nhs.uk/rightcare/intel/>
- Performer performance/concerns (if appropriate)
- CCG engagement and relationship
- LMC intelligence

- Practice phone call or visit
- Medicines optimisation dashboard
<https://www.england.nhs.uk/medicines/medicines-optimisation/dashboard/>
- GP Workload tool and appointments data
<https://digital.nhs.uk/services/general-practice-gp-collections/service-information/gp-workload-collection>

2.5.19 Data alone (whether derived from the above or the three key sources) is not however a panacea. The Commissioner must consider the practice in the context of wider determining factors (e.g. social deprivation, health needs, population profile, resourcing, to name but a few).

2.5.20 There are numerous examples of data being used inappropriately and contrary to the purpose for which it was collected; one such non healthcare related example is provided below. This example is intended to reinforce the concept of using data appropriately, in context and as part of a wider suite of factual intelligence to make informed decisions.

The Bhoomi Project was an ambitious effort by the southern Indian state of Karnataka to digitize some 20 million land titles, making them more accessible. It was supposed to be a shining example of governance and open data that would benefit everyone and bring new efficiencies to the world's largest democracy. Instead, the portal proved a boon to corporations and the wealthy, who hired lawyers and predatory land agents to challenge titles, hunt for errors in documentation, exploit gaps in records, identify targets for bribery, and snap up property. An initiative that was intended to level the playing field for small landholders ended up penalising them and bribery costs and processing time actually increased.

2.5.21 Underlying this approach is the recognition that the best way of ensuring continued excellence lies in the consistent and proportionate application of an assurance framework which requires Commissioners to consider multiple sources of reliable and accurate information and intelligence against relevant and specific criteria.

2.6 Practice Visit – Best Practice

- 2.6.1 The Commissioner remains accountable for contract management, a co-ordinated practice / Commissioner / CQC / LMC relationship provides an opportunity for an engaging and collaborative discussion that covers each practice's quality and achievement across a range of agreed standards, be that in respect of the service provided by a practice or a practices use of for example, secondary care services.
- 2.6.2 By way of an example and to provide clarity, a Commissioner may have a conversation with a member practice, which from an initial view, appears to have a disproportionate number of emergency admissions for conditions usually managed in primary care. This in itself may not necessarily indicate a problem, but allows the Commissioner to understand the implications in the wider commissioning arrangements.
- 2.6.3 The Commissioner will not necessarily focus solely on the contractual requirements and may include quality improvement and health outcomes to ensure it is meeting its duties to improve quality and secure good public health in the population.

2.6.4 **Practice Visits – Practical Support**

2.6.5 **Understand the background**

- 2.6.6 To align with the commitment to reduce burden and bureaucracy, commissioners should consider whether other practice visits may be planned or recently undertaken to avoid unnecessary duplication. Such visits may be planned by CQC or Health Education England in relation to regulation or educational standards
- 2.6.7 Visits to practices may originate from many areas and may be formal or informal. The reasons for visiting a practice may be for:
- List closure application
 - CQC report
 - New contractor visits
 - Practice support

- Investigation of concerns raised (see sample practice review template at annex 3)
- Annual review of provider
- Contractual concerns e.g. boundary changes
- Practice mergers
- Performer concerns that may be impacting on contract

Note: In addition, Commissioners should still undertake a rolling programme of review as outlined at the start of this chapter but this should include a random sample of practices not identified through other intelligence led approaches.

2.6.8 **Gathering information**

2.6.9 Before visiting the practice, collate all relevant and available data and information (examples provided below):

- CQC report if available, or discussion with CQC data and/or inspection team
- Primary care web tool
- “Soft” intelligence
- QOF scores
- Complaints
- Any local profiling tools or dashboards
- Legal advice if required
- Ask the practice to complete template which may save time during your visit.

2.6.10 **Communications**

2.6.11 Early communication is key to a successful visit. Always contact the practice to advise them that you will be visiting the practice and the reason why. The agreed date must be followed up in writing. Give plenty of notice unless there is a patient concern (see sample practice visit letter at annex 2).

2.6.12 **Informal visits.**

2.6.13 If an informal visit is planned, the practice has usually instigated it themselves and therefore are aware of the reason i.e. practice merger. Ensure you have the right information available for the matter to be discussed. For example, if the visit is to discuss a list closure, ensure you know the practice list size, list variations, surrounding practice closures etc.

2.6.14 **Formal visits**

2.6.15 Concerns about a practice can be raised to commissioners through various routes. Depending upon the issues raised the Commissioners will need to make an informed decision on the extent to which it need to investigate.

2.6.16 Commissioners should:

- Establish a Task and Finish Group
- Establish Terms of Reference for Task and Finish Group (see sample at annex 5)
- Task and Finish Group agree the actions required
 - Practice visit
 - Breach / remedial notices issued where appropriate
 - Contract termination
 - Referral to QSAG / PAG
- Agree clear and specific terms of reference (ToR) for any visit, including a commitment to review / amend the ToR in light of any new / emerging evidence. Amendments should be agreed between parties.
- Investigation Team identified – to include, but inclusive of, GP, Primary Care Nurse Lead, Safeguarding Lead, Nursing and Quality Lead, Contract Manager. Admin support where appropriate.
- Initiate formal contact with Practice
- Communication with Practice, with recommendation of inclusion of LMC
- Practice visit with appropriate team
- Report / action plan drafted (see example at annex 4)
- Report / action plan submitted to Task and Finish Group
- Report / action plan finalised
- Report / action plan sent to Practice for comment
- Meeting with Practice to discuss taking action plan forward
- Monitoring meetings to ensure targets / deadlines are met
- Final meeting with Practice to close process
- Final Task and Finish Group to give assurance issue / concern is resolved.

2.6.17 If issues are not resolved then contract breach/termination notices may be served.

2.6.18 **Consultation with and support from the Local Medical Committee (LMC)**

2.6.19 If the commissioner is undertaking a targeted visit relating to concerns raised or known contractual underperformance, which may result in actions being imposed or considered, then it shall, whenever it is reasonably practical to do so, consult the Local Medical Committee.

2.6.20 The LMC has a role in supporting practices facing remedial, breach and termination notices or those undergoing performance investigations. The LMC can advise practices on how to complete actions required by remedial notices, how to address issues in order to avoid further contract breaches and appeal against termination notices if appropriate. The LMC can signpost practices to experts who can help, e.g. the practices' Medical Defence Organisation or consultants who can advise on practical issues such as practice policies, etc. For those practices undergoing performance investigations, the LMC can support practices in preparatory meetings with the investigating officers and the commissioners, assist with drafting terms of reference, guide practices through the investigation process and sit in on interviews with clinicians and staff to ensure that due process is followed.

2.6.21 Commissioners are encouraged to advise practices in these circumstances to make contact with their LMC as early as possible to ensure they have access to expert help and advice.

Annex 1: PCWT - Practice Profile / Data / User Guide

- [PCWT – Getting started guide](#)

Annex 2 A Sample Practice Visit Letter

- [A Sample Practice Visit Letter](#)

Annex 3 A Sample Clinical Governance and Practice Review

- [A Sample Clinical Governance and Practice Review](#)

Annex 4 A Sample Overview of Concerns - Investigation Plan

- [A Sample Overview of Concerns - Investigation Plan](#)

Annex 5 Sample Terms of Reference (ToR) For a Task & Finish Group Investigating Concerns

- (a) [Sample Terms of Reference \(ToR\) For a Task & Finish Group Investigating Concerns](#)

3 Managing Patient Lists

3.1 Introduction

- 3.1.1 Practices operate either an open or a closed list and patients have the ability to register with any local practice which operates an open list. Practices continue to have discretion over new patient registrations, although fair and reasonable grounds should be presented in the event of a refusal to accept a patient onto an open practice list.
- 3.1.2 Practices must ensure that they meet all general legal duties and must ensure that they are not directly or indirectly in breach of the public sector equality duty.
- 3.1.3 The Commissioner has an obligation to prepare and keep up to date a list of patients accepted by the contractor or assigned to its list of patients and who have not been removed from that list.
- 3.1.4 This policy sets out:
- 3.1.5 the arrangements for managing patient assignments (Part A);
- 3.1.6 list maintenance for primary medical services including general list maintenance by PCSE (Part B1) and targeted list cleansing by Commissioners (Part B2); and
- 3.1.7 managing closed lists (Part C).

3.2 PART A: Managing Patient Assignments

3.2.1 Scope

- 3.2.1.1 This Part A sets out the processes the Commissioner should follow in respect of patient assignment to practice lists. This Part A also provides information regarding the grounds for practice refusal to register a new patient and potential difficulties that may arise following removal from a practice list and the procedures that must be followed in the event that patient assignment to a practice list is required.
- 3.2.1.2 Where a practice list is open, a patient may apply for registration either in person or on behalf of another, whether or not they are resident in the practice area or are currently registered at another practice.

3.2.2 Refusing Patient Registration onto an Open List

- 3.2.2.1 In most circumstances, practices that are operating an open list do so effectively, and in a reasonable manner, accepting applications for new registrations on a daily basis. There are, however, a number of circumstances when a patient may find it difficult to obtain registration with their local practice and in these circumstances it is important that the Commissioner is fully aware of the grounds under which a practice may refuse registration and the processes that must be followed in order to demonstrate that this refusal has not been on prejudicial grounds.
- 3.2.2.2 A practice may only refuse to accept a patient onto an open list where it has reasonable grounds for doing so. Reasonable grounds will not relate to the patient's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. Reasonable grounds may include that the patient does not live in the practice area. Where a practice refuses to register a patient, the reason for this refusal must be made in writing to the patient within 14 days of the request for inclusion being made. The contractor must keep a written record of applications and reasons for refusal.
- 3.2.2.3 The operation of a waiting list for registrations is not appropriate. Where a practice feels that it cannot accept new registrations at the time of the patients' application to join the practice, they may need to consider whether the practice list should remain open and enter into discussions in this respect with the Commissioner. See Section C for more information.
- 3.2.2.4 In the event that the Commissioner is approached regarding any refusal of registration, it must make contact with the practice to confirm the situation and address the matter in line with the PMS Regulations, GMS Regulations or APMS Directions (as appropriate).

3.2.3 Removing a Patient from a Practice List

3.2.3.1 Where a practice wishes to remove a patient from its practice list, the practice must normally provide the reason for removal in writing to the patient. Removal may normally only be requested if, within the period of 12 months prior to the date of the request, the practice has warned the patient in writing that they are at risk of removal and reasons for this have been stated.

3.2.3.2 It may be justified that a written warning was not possible/appropriate in the circumstances that:

- the reason for removal relates to a change of address outside of the practice area including where a patient has been registered as a temporary resident elsewhere and has exceeded the three-month temporary residency period;
- the practice has reasonable grounds for believing that the issue of a warning would be harmful to the physical or mental health of the patient or put at risk one or more members of the practice team; or
- It is, in the opinion of the contractor, not otherwise reasonable or practical for a warning to be given. The practice must record in writing either the date of any warning given and the reasons for such a warning or the reason why no such warning was given.

- 3.2.3.3 All patient removals must be recorded by the practice, including the reasons and circumstances of the removal and this record must be made available to the Commissioner should it be requested.
- 3.2.3.4 Notifications by the contractor to the Commissioner (via PCSE) should be made on removals from the contractors' patient list. The Commissioner must refer to the relevant Regulations/Directions (set out at in Schedule 3 Part 3 of the GMS Regulations; Schedule 2 Part 3 of the PMS Regulations; the APMS Direction do not require APMS contracts to have provisions relating to patient lists – the Commissioner should refer to the wording of the relevant APMS contract).
- 3.2.3.5 Practices may remove a patient with immediate effect where the patient has committed an act of violence or behaved in such a way that the contractor, practice staff, other patients, or those present at the place the services were provided have feared for their safety. The incident leading to the request for immediate removal must have been reported to the police. It is highly likely that there are different ways in which violent patients are managed nationally as services were commissioned in different ways under a violent patient directed enhanced service scheme. For this reason, the Commissioner must refer to the relevant Regulations/Directions and the Special Allocation Scheme (SAS) chapter.
- 3.2.3.6 Patients may experience difficulties in registering where they have been removed from a practice list, although, (other than on the grounds of violence or threatening behaviour), this should not ordinarily be a factor considered by practices when approached by new patients. It should also be noted that patients have the right to choose to move from one practice to another, even within the same locality, without providing grounds for doing so.
- 3.2.3.7 In any type of patient deduction, consideration must be given to any potential safeguarding concerns. Where a patient is at risk of being removed for example for missed appointments, that may reflect on parenting / caring capacity (e.g. mental health) and consideration must be given to safeguarding either for children or vulnerable / at risk adults. Advice should always be sought from local Safeguarding leads and/or the commissioners' designated professional.

3.2.3.8 With regard to the deduction of Children (aged under 18) GP practices have the clinical expedient prerogative to retain children (under 18 years old) under the paramountcy of the child within The Children's Act 2014, until such time that they understand how the children might be cared for by another NHS or private GP, especially if vaccines or screening are still indicated.

3.2.3.9 It should also be noted that:

- Children and Young People (CYP) on a protection order or protection plan should not be de-registered on the grounds of behaviour including non attendance.
- CYP (not-protected) and adults with LD or with those with formal carer should not be de-registered on the grounds of behaviour including non attendance.

3.2.3.10 These citizens may need to be referred to safeguarding leads since they might be at risk either through behavioural problems or non attendance of their appointments.

3.2.3.11 These citizens should be allowed to sustain their GP Registration for continuity of care until such times as it can be established how the children might be cared for by another NHS or private GP.

Therefore:

- Children of parents or carers, who have been removed from the list for any reason, must not be left without access to primary care service.
- Where parents or carers have been removed from the list due to aggressive and or violent behaviour a risk assessment should be completed to identify any risk to their children and the appropriate safeguarding referrals made.

3.2.4 Where Patient Assignment to a Practice List is Required

3.2.4.1 Assignment to an open list

3.2.4.1.1 The Commissioner may assign a new patient to a practice whose list of patients is open and in making the assignment, the Commissioner shall have regard to:

- the wishes and circumstances of the patient to be assigned;
- the distance between the patient's place of residence and the practice premises;
- whether, during the six months ending on the date on which the application for assignment is received by the Commissioner, the patient's name has been removed from the list of patients of any practice in the area of the Commissioner, at the request of the practice;
- whether the patient's name has previously been removed from the list of patients of any practice in the area of the Commissioner owing to violent behaviour and, if so, whether the practice to which the patient is to be assigned has appropriate facilities to deal with such a patient; and
- other matters the Commissioner considers relevant.

3.2.4.1.2 A new patient is defined as a person who:

- has been refused inclusion in a contractor's list of patients or has not been accepted as a temporary resident by a contractor, and
- would like to be included in the list of patients of a contractor in whose outer boundary area (as specified in accordance with regulation 20(1)(d)) that person resides.

3.2.4.1.3 In making an assignment, the Commissioner will contact the practice by telephone, to which the patient is to be assigned, to inform them that an assignment is being made. Following this telephone contact, the Commissioner will send an assignment notification (example at Annex 1) to both the receiving practice and the PCSS provider for their information. A letter (Annex 2) will also be sent to the patient informing them of their registration and provide details as to how they may access the service. In the majority of cases this letter will be issued by the PCSS provider; however, the Commissioner should ensure that this process is satisfied either through this mechanism or through its own local arrangements.

3.2.4.1.4 PCSE are responsible for sending the standard patient letter in the case of allocations to open lists.

3.2.4.2 Assignment to a closed list

3.2.4.2.1 The Commissioner may not assign a new patient to a practice that has closed its list of patients except in the following circumstances:

- most or all of the providers of essential services (or their equivalent) whose practice premises are within the Commissioner's area have closed their lists of patients;
- the assessment panel (as will be detailed below) has determined that patients may be assigned to the practice in question, and that determination has not been overturned either by a determination of the Secretary of State or (where applicable) by a court; and
- the Commissioner has entered into discussions with the practice in question regarding the assignment of a patient, whereby additional support that the Commissioner can offer to the practice may be required. The Commissioner shall use its best endeavours to provide appropriate support and should discuss support in respect of the first assignment of a patient and any subsequent assignments made to that contractor during their list closure.

3.2.4.2.2 PCSE are responsible for sending the standard patient letter in the case of allocations to closed lists

3.2.5 Assignment Based on the Determination of a Commissioner Assessment Panel

3.2.5.1 Where the Commissioner has the need to assign a patient to a practice that has a closed list and most or all of the providers of essential services (or their equivalent) whose practice premises are within the locality of the Commissioner have closed their lists of patients, the Commissioner must:

- prepare a proposal to be considered by the assessment panel which must include details of those practices to which the Commissioner wishes to assign patients;
- ensure that the assessment panel is appointed to consider and determine its proposal and the members of the assessment panel must include:
 - a Commissioner director;
 - a patient representative who is a member of the local HWB or Local Healthwatch organisation; and
 - a member of an LMC but not a member of the LMC formed for the area in which the contractors who may be assigned patients as a consequence of the panel's determination provide services.
- Notify in writing that it has referred the matter of patient assignment to the assessment panel to the following:
 - the LMC for the area of the Commissioner; and
 - any contractors whose practice premises are within the Commissioner's jurisdiction that have closed their list of patients and may, in the opinion of the Commissioner be affected by the determination of the assessment panel.

3.2.5.2 In reaching its determination, the assessment panel shall have regard to relevant factors including:

- whether the Commissioner has attempted to secure the provision of essential

services (or their equivalent) for new patients other than by means of their assignment to contractors with closed lists of patients; and

- the workload of those contractors likely to be affected by any decision to assign such patients to their list of patients.

3.2.5.3 The assessment panel shall reach a determination within the period of 28 days beginning with the date on which the panel was appointed.

3.2.5.4 The assessment panel shall determine whether the Commissioner may assign patients to practices which have closed their lists of patients. If it determines that the Commissioner may make such assignments, it shall also determine those practices to which patients may be assigned.

3.2.5.5 The assessment panel may determine that the Commissioner may assign patients to practices other than those practices specified by the Commissioner in its proposal, as long as the practices were notified during the preparation stages of the assessment panel being held.

3.2.5.6 The assessment panel's determination must include the factors considered by the panel and be made in writing to:

- the LMC for the area of the Commissioner; and
- any contractors whose practice premises are within the Commissioner's jurisdiction that have closed their list of patients and may, in the opinion of the Commissioner be affected by the determination of the assessment panel.

3.2.6 NHS Dispute Resolution Procedure Relating to Determinations of the Commissioner Assessment Panel

3.2.6.1 Where an assessment panel makes a determination that the Commissioner 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. Please refer to the chapter on managing disputes.

3.2.7 Removal by a Contractor of Patients Assigned to the Practice

3.2.7.1 Historically, practices have often applied an unwritten agreement to the retention period of assigned patients. However, there are no formal arrangements in respect of timescales for patient retention in these circumstances. While the significant majority of practices continue to manage assigned patients in the same manner as an ordinarily registered patient, others may commence a formal removal process immediately following assignment. The Commissioner has a responsibility to ensure that all requests to remove a patient at the request of the contractor must be managed in line with the relevant Regulations/Directions.

Part A Annex 1 Example Assignment Notification

- [Example Assignment Notification](#)

Part A Annex 2 Example patient letter confirming registration

- [Example patient letter confirming registration](#)

3.3 Part B1: General List Maintenance for Primary Medical Services

3.3.1 Scope

3.3.2 This Part B sets out the processes for the Commissioner to ensure list maintenance is appropriately managed. It details the list maintenance and data quality measures to be undertaken and suggests additional measures to be taken. Where references are made to actions to be followed by the Commissioner, these actions should, where possible, be done together with the available support services or payment authority.

3.3.3 Medical service contracts are predominantly funded on a capitation basis. It follows, therefore, that if a patient list is overstated, the contractor will receive more funding than it is entitled to and this presents a significant financial burden on NHS resources.

3.3.4 While in most cases, primary care contractors endeavour to maintain their registered lists in a current and accurate state, patients often fail to notify their registered practice when leaving the area and/or country resulting in potential duplicate registrations, ghost and gone away patients remaining registered on the national patient registration systems.

3.3.5 Some degree of list inflation is inevitable, but manageable if kept within reasonable bounds. Current trends of inflation are excessive and in some regions, continue to rise. The Commissioner and PCSE are expected to engage in regular proactive list maintenance with general practices.

3.3.6 Ongoing and effective maintenance of lists is essential to ensure they are accurate. However, even with the most effective list maintenance procedures in place, a practice list can hold 3-8 percent of inaccuracy due to patient turnover alone.

3.3.7 Practices with robust systems in place to verify and record patient details at the point of registration, as well as regular systematic checking of details when patients contact the practice, have more accurate lists.

3.3.8 The accuracy of a practice's registration list is important for:

- the efficacy of ill-health prevention/screening programmes and total population capture;
- the assessment of performance and clinical outcomes which are often compared on a 'per patients' denominator; and

- the appropriate use of public funds, as allocations are made on a £ per patient basis.

3.3.9 **Operating Principles**

- 3.3.10 List maintenance processes should be designed with the proactive engagement of the Commissioner, patients (or their representatives), national PCS provider, and LMCs on behalf of GPs and practice managers. This should be through a continuous rolling programme, for example: working through the practice registers alphabetically over a one to three-year period, or by targeting specific patient cohorts, for example, choosing a cohort that supports a screening programme e.g. childhood immunisations, flu or cytology.
- 3.3.11 A "one-hit" approach in which a single practice is targeted should be avoided except in exceptional circumstances. This might include due diligence when transferring a full list to a new contract, for example. In all cases this should be carried out in discussion with the LMC.
- 3.3.12 Contractors have a crucial role to play in ensuring their staff access relevant training, are familiar with the FP69 process and are proactive partners in the list maintenance process, responding to requests from the national PCS provider.
- 3.3.13 When responding to an active FP69 (see Annex 1 and Annex 2) a practice declaration will be sufficient. The practice is responsible for ensuring all declarations made are accurate and should be made aware that these can be challenged where any inconsistencies are highlighted through a cluster-wide audit.
- 3.3.14 A list maintenance exercise is not designed to address performance failures. Where there are reasonable grounds for believing that list inflation is particularly high at an individual practice then concerns about this should be handled separately and in accordance with the performance management directions.
- 3.3.15 The Commissioner should ensure that where the PCS provider disputes the practice declaration, the practice is told why and is advised of any list actions that have been taken.

3.3.16 Minimising Inconvenience to Patients

3.3.16.1 Advance screening of the proposed cohort by practices means that fewer patients will be inconvenienced by having to respond to a letter. It will also reduce administrative costs and wasted resource associated with the exercise.

3.3.16.2 The Commissioner should maximise awareness in the patient population of list maintenance procedures by ensuring that an effective patient communication strategy is in place. The strategy should be tailored to local needs and build upon examples of what has worked well. For example:

- Letters to be addressed to named patients and not the occupier (Annex 3).
- Branded NHS envelopes with a return address are more likely to be opened as they are clearly directly in relation to the patients' health (Annex 4).
- Contractor teams alerting patients to registration checks well in advance – as part of the registration conversation, through display notices in a practice.
- The Commissioner and contractors making the process clear to patients through any letters and posters, for example – what the letter looks like, what to do when you get one, the steps in place to minimise deregistration errors, what to do if there is a de-registration error, what to do if a letter arrives for someone not living at that address.
- Communications must take into account the Accessible Information Standard which requires organisations to ensure that disabled patients receive information in formats that they can understand. For more information on the standard and guidance on its implementation, see the NHS England website: <https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/>
- Communications must be tailored for different languages and consideration of other support for patients whose first language is not English.

3.3.16.3 List maintenance is also an opportunity to improve other aspects of patients' registration including the accuracy of patient information held on the register. The Commissioner should ensure that contractors verify the details held on the practice system systematically as part of routine on-going maintenance.

3.3.17 Patient Registration Process

3.3.18 Appropriate and timely management of the patient registration process is essential in minimising the potential for list inflation.

3.3.19 The standard registration process requires all general practices to notify all registrations to NHAIS. The NHAIS user should then confirm the registration to the practice and take steps to arrange for the transfer of medical records from the patient's previous general practice. Electronic links are in place between NHAIS sites and all general practices that enable this process.

3.3.20 GP practices are required to monitor that all their registrations and patient deductions are acknowledged by NHAIS. This ensures that patients are correctly registered and will be included in NHS screening and immunisation programmes.

3.3.21 Practices should also check their list size of registered patients on a quarterly basis against Open Exeter (or its replacement). This ensures that payments to the practice remain accurate and any issues with the registration process are identified.

3.3.22 The process of confirming the new patient registration by NHAIS staff involves checking the patient details against the Personal Demographics Service (PDS) National Back Office (NBO) to confirm the patient's NHS number, where NHS numbers cannot be traced, the system provides for the user to request the allocation of a new NHS number.

3.3.23 Where it is not possible to trace an NHS number for a patient, rather than request allocation of a new NHS number the registration should be kept pending and the previous general practice contacted to obtain further details.

3.3.24 If the practice cannot provide further information to enable the NHS number to be traced it should be asked to contact the patient to obtain this. By taking these steps, the user will ensure that allocation of new NHS numbers is kept to a minimum and therefore minimises the potential for list inflation.

3.3.25 Where a new NHS number has been allocated then additional checks are undertaken by the PDS NBO to help ensure a duplicate NHS number has not been created for a patient. Monthly reports, identifying the number of duplicate NHS numbers allocated by PCSE are produced by the NHS Digital and these are split between those where the service provider should have been able to

trace the correct number and those duplicates that are considered unavoidable.

3.3.26 It is essential that robust procedures are in place to prevent the creation of duplicate registrations at the time of registration. The figures available on the volumes of duplicate numbers created by each service provider should provide valuable benchmark data to monitor this.

3.3.27 The Commissioner should ensure that the PCSE is processing routine registrations in a timely manner as this is also key to ensuring accuracy of practice lists.

3.3.28 Elements of a Rolling List Maintenance Programme

3.3.28.1 Routine business processes that involve sending letters to patients help reduce list inflation, as any letters returned undelivered⁴ by Royal Mail result in general practices being given the statutory six-month notice period to provide confirmation that the person is a patient to whom it is still responsible for providing essential services. Where confirmation is not provided then the patient is removed from the practice list (please also refer to the Patient Registration chapter for further information).

3.3.28.2 These letters to patients, using data sourced from the NHAIS system, are inclusive of, but not limited to, the following:

- Cervical screening invitation letters sent to all women aged 25-64.
- Cervical screening test results sent to all women attending for a test as part of the NHS cervical screening programme.
- Flu vaccination invitation letters sent to patients aged 65 and over together with any patients identified by general practices as being in an 'at risk' group.
- Chlamydia screening invitations letters sent to patients on behalf of certain local authorities.
- Bowel screening invitation letters are sent to all patients aged 60 and 74 where the source data used to identify patients to be invited is taken from the NHAIS system.

⁴ The FP69 flag in these circumstances will affect a breast screening invitation

- Letters sent to all patients registered with a specific general practice if there are any significant changes to practice arrangements.
- Medical cards or letters of confirmation of NHS number and registration.
- Verification by general practices of the vaccination status of all children aged two years and five years registered with the practice on the first day of each quarter.

3.3.28.3 In maintaining the NHAIS system specific tasks need to be undertaken to reduce list inflation and help maintain the accuracy of practice lists. The annual programme of checks to be undertaken is shown below together with the standard procedure which should be adopted for each. The flow chart illustrated within Annex 1 and Annex 2 indicates the standard process to be followed.

Patient group/cohort	Frequency	Process
Multiple Occupancy	After the initial month, PCSE will check the additional patients who appeared at MO addresses and reset annually	<p>The National PCSS must:</p> <ul style="list-style-type: none"> • compare Office of National Statistics (ONS) and NHAIS population figures at ward/super output area (SOA) level to enable prioritisation of work; • send the list of names to the relevant general practices. Each practice should confirm if patients have been seen in the last 15 months; • send letters to any patients that are recorded as being registered and have not been seen by their general practice in the past 15 months, taking into account the requirement to ensure that disabled patients receive information in a format that they can understand and they receive support to help them communicate (as mandated in the Accessible Information Standard).

Patient group/cohort	Frequency	Process
		<ul style="list-style-type: none"> • send reminder letters if no reply received after four weeks. • activate an FP69 for the practices if any letters return undelivered or where no response is received within two months of the date of the original letter being sent; • remove the patient from the list if the general practice does not confirm patient contact within six months.
University/college student/residential school	Annually October to December	<p>The National PCSS must:</p> <ul style="list-style-type: none"> • identify patients recorded on an NHAIS system as being registered with a general practice for four or more years in respect of a college/university address; • send the lists of names to the relevant general practices asking them to confirm the patients are still registered and are still attending the surgery for treatment. Any patients found to be no longer resident should be removed from the practice lists; • send letters to patients asking them to confirm their address where practices are unable to confirm registration, taking into account the requirement to ensure that disabled patients receive information in a format that they can understand and they receive support to help them communicate (as mandated in the Accessible Information Standard).; • send reminder letters if no reply received after four weeks. • activate an FP69 for the practices if any letters return undelivered or where no

Patient group/cohort	Frequency	Process
		<p>response is received within two months of the date of the original letter being sent;</p> <ul style="list-style-type: none"> • remove patients from the list in any cases where the general practice does not confirm the address within six months.
Patients aged 100 and over	Six monthly March and September checks	<p>The National PCSS must:</p> <ul style="list-style-type: none"> • check on NHAIS system for any patients aged over 100 years. • contact general practice to confirm patient still registered. • remove any patients no longer registered from practice lists.
Transient checks	Monthly	<p>The National PCSS must:</p> <ul style="list-style-type: none"> • send a letter to patients 12 months after their date of registration with a general practice, where at the time of registration they were recorded as having recently arrived from abroad, to ask the patient to confirm their current address. This sentence should be in several different languages depending on the reasonable needs of the practice's patient, and should take into account the requirement to ensure that disabled patients receive information in a format that they can understand and they receive support to help them communicate (as mandated in the Accessible Information Standard).; • send reminder letters if no reply received after [four] weeks; • if any letters are returned undelivered or where no response is received, remove patients from the list in any cases where

Patient group/cohort	Frequency	Process
		the general practice does not confirm the address within six months
Notification of demolished addresses ⁵	Quarterly	<ul style="list-style-type: none"> NHAIS systems receive regular updates to the PAF information to enable the accurate maintenance of patient addresses. Included in the updates are notifications of properties which have been demolished. PCSE should ensure that the correct address of patients registered regarding any of these addresses is checked with the registered general practices.
Patients not seen by general practice in previous five years	Annually	<p>The National PCSS should:</p> <ul style="list-style-type: none"> contact general practices to obtain a list of all those patients that have not had a consultation within the last five years; send a letter to all those identified patients to confirm address and registration, taking into account the requirement to ensure that disabled patients receive information in a format that they can understand and they receive support to help them communicate (as mandated in the Accessible Information Standard).; send reminder letters if no reply is received after four weeks; activate an FP69 for the practices if any letters return undelivered or where no response is received within two months of the date of the original letter being sent; remove patients from the list in any cases where the general practice does not confirm the address within six months.

⁵ The FP69 flag in these circumstances will affect a breast screening invitation

3.3.29 Additional Measures (see also Part B2 below)

3.3.29.1 Despite initiating a rolling programme of list maintenance measures, figures comparing ONS mid-year populations with NHAIS registered population may still show significant inflation in the NHAIS figures. These inflation rates may also differ significantly for local areas.

3.3.29.2 If the Commissioner has a particularly large variance it may wish to undertake a targeted campaign to reduce this in one large exercise. If so, the Commissioner is strongly urged to engage their general practices, LMC and CCGs.

3.3.29.3 Suggested work that could be undertaken is:

- Comparison of ONS mid-year stats with NHAIS figures at middle SOA level. This will identify localities within each area where inflation rates are highest and will therefore highlight specific areas to be targeted.
- Send mailshot to confirm residency to male patients aged 18-44 living in areas where inflation rates are highest. ONS/ NHAIS comparison at area level has previously shown that the highest inflation rates are related to male patients in this age group, possibly because there are no routine mailshots sent to this cohort.
- Undertake further immigrant checks three years after the date of first registration for persons who immediately before their current registration are recorded as having arrived from abroad.
- Issue guidance and clarification for general practices on the FP69 procedure. Greater awareness of the processes for removing patients within general practices could reduce the scale of list inflation. If guidance has not previously been given to practices on the FP69 process then this should be undertaken. Once in place, this could become part of a standard rolling programme.
- Test the effectiveness of undertaking checks for duplicate registrations between NHAIS systems. A check between several systems will confirm whether this type of check would identify duplicate registrations and if so could be developed as a standard procedure to be carried out at agreed intervals.

- 3.3.29.4 It is essential that work is carried out to reduce list inflation and verify practice lists but it is also important to recognise the resource implications of undertaking this work. It is equally essential that all work carried out is recorded and the outcomes monitored to evaluate the success of each initiative.
- 3.3.29.5 The Commissioner should ensure that the PCSS provider submits a monthly return to the Commissioner detailing the work undertaken and the outcome. A pro-forma is attached in Annex 5 to be used to submit the monthly returns. To streamline this process, standard reports available from the NHAIS system could be used to populate this pro-forma.
- 3.3.29.6 Given the requirement to allow a practice six months to confirm the address before patients can be removed from the practice list, it is recognised that any list maintenance exercise could take six to nine months before benefits are realised. This needs to be considered when assessing the effectiveness of interventions.

3.3.30 Annex 1 - Stage 1 of a List Maintenance Programme

[Stage 1 of a List Maintenance Programme](#)

3.3.31 Annex 2 - Stage 2 of a List Maintenance Programme

[Stage 2 of a List Maintenance Programme](#)

3.3.32 Annex 3 - Sample Letter to Patients

[Sample Letter to Patients](#)

3.3.33 Annex 4 - Standard Envelope Content

[Standard Envelope Content](#)

3.3.34 Annex 5 - Standard Monthly Return Pro-Forma

[Standard Monthly Return Pro-Forma](#)

3.4 Part B2: Targeted List Maintenance for Primary Medical Services

3.4.1 Background

3.4.1.1 The Office for National Statistics regularly publishes mid-year population estimates down to the level of CCG ([ONS CCG Mid-Year Population Estimates](#)) Middle Super Output Area ([ONS MSOA Populations](#)) and Lower Super Output Area ([ONS LSOA Populations](#)). Using these population estimates alongside the numbers of patients registered at a GP practice ([NHS Digital published GP Registered Populations](#)) and other sources of local intelligence such as patient postcode list, can assist in determining at a local level, whether the difference could warrant further investigation.

3.4.2 Scope

3.4.2.1 This short Part B2 sets out some considerations and investigations that could be undertaken to determine whether a targeted list validation exercise may be beneficial within the commissioning area and what that could involve.

3.4.2.2 A key line of enquiry in national counter fraud exercises, often relates to list maintenance and so GP practices may welcome support in proactively reviewing their registered list.

3.4.3 Available Data Sources

3.4.3.1 Of the data sources listed below, not all will be available to all organisations (e.g. patient level data cannot be held by NHS England)

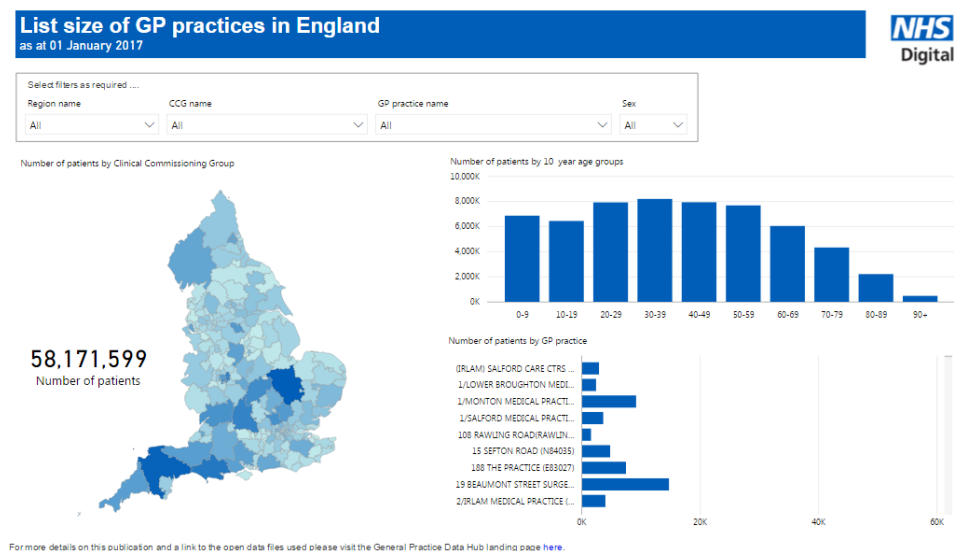
3.4.3.2 Data Providers:

3.4.3.2.1 NHS Digital

- Number of Patients Registered at a GP Practice
- Number of Patients Registered at a GP Practice (CCG Level)
- Number of Patients Registered at a GP Practice (NHS England Commissioning Region)
- Number of Patients Registered at a GP Practice mapped to LSOA
- From April 2017, NHS Digital began publishing these data monthly, prior to this the publication were quarterly on the first day of April, July, October

and January.

- Each of these data is available in both 5 year age groups and single year of age (by male, female and total). Files are available to download for onward analysis, but NHS Digital also provides an interactive platform called the General Practice Data Hub <https://www.digital.nhs.uk/gp-data-hub>
- Via NHS Digital's Data Hub, users can interact with the data to view the distribution and spread of data for specific geographies and GP Practices



3.4.3.2.2 Office for National Statistics

- Clinical Commissioning Group Mid-Year Population Estimates
- Middle Super Output Area Mid-Year Population Estimates
- Lower Super Output Area Mid-Year Population Estimates
- The Office for National Statistics publish these data annually, usually at the end of October each year, for the previous year.

3.4.3.2.3 Data.gov.uk

- Postcode to Output Area to Lower Layer Super Output Area to Middle Layer Super Output Area to Local Authority District Lookups for in England and Wales

3.4.4 What to consider, who and why?

3.4.4.1 Where a GP Practice list contains records of people who should no longer be on the list this is known as list inflation. There can be many reasons for this and commissioners and GP practices can work together to minimise this through list maintenance.

3.4.4.2 In some GP practices there can often be high turnover (leaving and joining) of patients, which can be challenging to monitor but benefits from timely processing.

3.4.4.3 There are records that link to patients who do not de-register and there are 2 principal reasons why an individual may not de-register

3.4.4.3.1 Some people may be slow to re-register at other GP practices, despite having moved away from the area, as they are relatively healthy and do not see re-registration as a priority

3.4.4.3.2 People who live abroad (who are required to de-register from their GP practice) fail to do so either because they do not see it as a priority when moving abroad or because they wish to have continued access to the NHS (often referred to as “ghost patients” (this affects list inflation at both the local and national level).

3.4.4.4 ONS suggests⁶ that, typically the following groups tend to be quicker to register a change of address:

- mothers with young children
- those with ongoing health conditions
- the very elderly

3.4.4.5 Additionally, the following tend to be slower to register a change of address:

- young healthy adults, especially males – including students
- highly mobile individuals
- healthier persons, especially males
- males – in general

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<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/methodologies/patientregisterqualityassuranceofadministrativeadatausedinpopulationstatisticsdec2016>

3.4.4.6 Parental home: Mobile young adults may choose or default to remaining registered at their parental address; this is similar to the lags issue above.

3.4.4.7 Shared custody: there is potential for a range of issues where there is shared custody of children at different addresses. These can potentially include:

- split residence not reflected in the record
- duplicate registrations
- use of different names (particularly surnames)

3.4.4.8 Care homes (and similar institutions): Where a patient moves into a care home this may not be recorded as a change in address, particularly if the intended stay is short. These stays may become longer so that there has in effect been a change in residence, although the GP register has not been updated. By contrast a move may be intended as long-term (and the move recorded on the Patient Register) but the patient may die soon after the move. There are 2 potential consequences for statistical use of data:

- a spell of residence away from the home address can be missed
- a death can be recorded with a place of residence given as different from that recorded on the Patient Register

3.4.4.9 Duplicate records: There are a number of occasions where duplicate records can occur. These can be classified as duplicates with the same NHS number, and duplicates with a different NHS number. Duplicate records with the same number could be:

- records for the same person, with the same number, held on 2 different lists – the Audit Commission said that the majority of these were temporary where a patient was in the process of transferring from one practice to another.
- records for 2 different people with the same number – the Audit Commission said that these were rare and the cause was not known; potential reasons could include error by the patient in writing an NHS number (and where a check is not undertaken or is passed by chance – for example, the same date of birth), clerical (typing or legibility) error on NHS number input, mismatching a patient to another with similar details on registration and allocating the wrong number or fraud. (Anecdotally there have been reports

of people “sharing” NHS numbers in certain communities.)

3.4.4.10 Duplicates with different numbers could be because:

- on registration with a GP, a patient is incorrectly identified as a new entrant to the NHS (returning emigrant, exit from armed forces, return from private practice)
- on registration with a GP, no match is traced to previous records
- on registration with a GP, a patient gives insufficient details to allow a match (as above, patients do not legally have to provide proof of identity).

3.4.4.11 Snapshot: The data that we currently use from the Patient Register is based on a (typically annual) snapshot. This gives the position at that point in time, as it occurs on the register. This approach means there is no “history” between snapshots of changes. For example, where there are 2 or more changes of address in a year only the first and last of these addresses are captured (implying a single move). Moves before exiting from the system (including emigration and death) can also be missed, as can moves shortly after entry to the system (including immigration and birth).

3.4.4.12 Coverage: The Patient Register is a broad coverage source, but some groups are not included (under-coverage of the total population) and there are also some over-coverage issues. Evidence from ONS shows that over-coverage tends to be the larger issue, with the Patient Register having 4.3% more people registered than the 2011 Census estimate of population, whilst we are aware in NHS England the range can be 3 to 8%

3.4.4.13 The following groups are not included in GP Practice Register, and may be the cause of statistical under-coverage:

- patients solely registered with private GPs
- babies that have yet to be registered at a GP practice
- migrants into the UK who have yet to register
- armed forces (though some remain on GP lists)
- some armed forces dependants

- prisoners (other than those with a sentence under 6 months)
- some prisoners with a short sentence who have received medical assistance in prison
- patients who have been removed through "no contact" measures
- patients with a temporary NHS number, where no "permanent" number exists or where their permanent number is not on a GP register

3.4.4.14 The following groups, for some statistical purposes, may be thought of as over-coverage:

- patients who are no longer resident in the UK (emigrants)
- patients who are staying in the UK for only a short period
- duplicate records

3.4.5 **What local checks could be undertaken**

3.4.6 Utilising the data sources and data listed section (3) above and the intelligence from ONS in section (4), Commissioners can determine where they may wish to focus attention and or support for the practice. Decisions should be made locally and on a case by case basis. Commissioners may wish to undertake analysis internally, or work with a partner such as a Commissioning Support Unit (CSU) who would work with their DSCRO (Data Services for Commissioners Regional Offices) should they wish to interrogate record level data that has been appropriately processed.

3.4.7 Comparing data sources and geographies

3.4.8 Trends in CCG resident population estimates compared to trends in GP registered populations

3.4.9 Are the proportions similar?

3.4.10 Are all the GP practices within the CCG areas increasing/decreasing with similar proportions?

3.4.11 Are there any practices significantly variant in comparison to other practices and the CCG trend?

3.4.12 Have there been any practice mergers or closures resulting in list dispersal?

3.4.13 Have there been any new and large scale property developments recently?

3.4.14 Trends in LSOA population (ONS estimates) compared to trends in GP registered populations (LSOA data from NHS Digital)

3.4.15 Are the proportions similar?

Which LSOAs fall within the practice boundary? (this may require the support of a 3rd party. Can you map record level patient data to determine in which LSOAs the practice has the majority of its patients .

3.4.16 Are the LSOA populations (resident and registered) mapped to GP practices, increasing/decreasing in broadly the same proportions as the GP practice as a whole?

3.4.17 How do they compare to other neighbouring practices?

3.4.18 Have there been any practice mergers, or closures resulting in list dispersal

3.4.19 Have there been any new and large scale property developments recently

3.4.20 Is there any in-depth work that could be undertaken by working with a partner (CSU) and record level record data?

3.4.21 These considerations provide a sample of checks that could be embarked on when undertaking a targeted list maintenance exercise.

3.5 PART C: MANAGING CLOSED LISTS

3.5.1 Scope

3.5.1.1 This Part C sets out the processes to be implemented when managing applications to close patient lists and to extend a closure period.

3.5.1.2 At all stages throughout these processes, it is essential that the Commissioner works with the contractor and the LMC to ensure clear and transparent decision making and that all decisions are made in line with internal governance arrangements.

3.5.2 Applications to Close a Patient List

3.5.2.1 Sometimes a contractor may wish to close its list to new registrations e.g. where there are internal capacity issues or premises refurbishments. The contractor must seek approval from the Commissioner by a written application (the "Application") before this may happen. A template Application for the contractor to complete is attached in Annex 1. The contractor should use the template Application to ensure it completes all the required information. The contractor may obtain the application itself (for example by accessing this policy) or it may be requested by the contractor. An example covering letter from the Commissioner to the contractor enclosing an application form is in Annex 2.

3.5.2.2 The Commissioner must acknowledge receipt of the Application within seven days of its receipt and may request further information from the contractor to enable it to consider the Application thoroughly.

3.5.2.3 With a view to possibly enabling the contractor to keep its list of patients open, the Commissioner and the contractor must talk openly to establish:

- what support the Commissioner may give the contractor; or
- changes the Commissioner or contractor may make.

- 3.5.2.4 The contractor or the Commissioner may at any time throughout these discussions invite the appropriate LMC to be included in the dialogue about the application.
- 3.5.2.5 The Commissioner should ensure compliance with the general duties of NHS England. Please refer to the chapter on General duties of NHS England for further information.
- 3.5.2.6 The contractor may withdraw the application at any time before the Commissioner makes its decision on the proposed list closure.
- 3.5.2.7 The Commissioner must make a decision, within a period of 21 days starting on the date of receipt of the Application (or within a longer period as the parties may agree):
- to approve the Application and determine the date the closure is to take effect and the date the list of patients is to reopen; or
 - to reject the Application.
- 3.5.2.8 The Commissioner must notify the contractor of its decision in writing as soon as possible after the 21 day period.

3.5.3 Approval of Patient List Closure: Closure Notice

- 3.5.3.1 Where the Commissioner has granted approval for closure of the patient list, a closure notice must be issued to the contractor as soon as possible after the decision is reached, with a copy to the LMC for its area (if any) and to any person consulted in the decision-making process. The Commissioner should use the template notice in Annex 4 to ensure it responds to the contractor with all the required information.
- 3.5.3.2 The contractor must close the list on the date in the notice and the list should remain closed for the time specified unless the Commissioner and the contractor agree that the list should be re-opened to patients before the expiry of the closure period.

3.5.4 Rejection of Application for List Closure

3.5.4.1 When the Commissioner decides to reject an application to close a list of patients, it must as soon as possible:

- provide the contractor with a notification including the reasons why the application was rejected. The Commissioner should use the template in Annex 5 to ensure it responds to the contractor with all the required information; and
- at the same time, send a copy of the notification to any affected LMC for its area and to any person it consulted in the decision-making process.

3.5.4.2 When the Commissioner decides to reject a contractor's application to close its list of patients, the contractor must not make a further application until:

- the end of the three-month period, starting on the date of the decision of the Commissioner to reject; or
- the end of the three months, starting on the date of the final determination regarding a dispute arising from the decision to reject the application made pursuant to the NHS dispute resolution procedure (or any court proceedings) (please refer to the chapter on managing disputes for further information on the NHS dispute resolution procedure),

whichever is the later.

3.5.4.3 A contractor may make a further application to close its list of patients where there has been a change in the circumstances of the contractor which affects its ability to deliver services under the contract.

3.5.5 Application to Extend a Closure Period

- 3.5.5.1 A contractor wishing to extend an agreed closure period must submit an application to the Commissioner no less than eight weeks before the closure period is due to end.
- 3.5.5.2 A template for completion by the contractor is attached in Annex 6. An example covering letter from the Commissioner to the contractor enclosing an application form is in Annex 7.
- 3.5.5.3 The Commissioner must acknowledge receipt of the application within seven days, then if necessary, discuss potential support that could be offered to the contractor, discuss with any affected LMC and consult other affected parties before reaching a decision on the application to extend within 14 days from receipt of the application. The Commissioner should use the template consultation letter in Annex 8.
- 3.5.5.4 If the decision is to accept the application the Commissioner must issue an extended closure notice as soon as possible after the decision is reached to the Contractor, with a copy to the LMC for its area (if any) and to any person it consulted in the decision-making process. The Commissioner should use the template in Annex 9 to ensure that the contractor receives all the relevant information.
- 3.5.5.5 If the decision is to reject the application then the Commissioner must provide the contractor with a notification, including the reasons for the rejection of the application, with a copy to the LMC for its area (if any) and to any person it consulted in the decision-making process. The Commissioner should use the template in Annex 10.
- 3.5.5.6 The contractor may re-open its list of patients before the closure period expires if Commissioner and contractor agree.
- 3.5.5.7 Where an application for the extension of the closure period has been made in accordance with this policy, and that application has been rejected, the list of patients will remain closed until such time as any dispute arising from the application has been resolved through the NHS dispute resolution procedure (or any court proceedings) or until such time as the expiry of the original closure notice. Please refer to the chapter on managing disputes for further information on the NHS dispute resolution procedure.

Annex 1 Example Application to Close Practice List of Patients – Sample Template for Completion by Contractor

- [Example Application to Close Practice List of Patients – Sample Template for Completion by Contractor](#)

Annex 2 Example Application to Close Patient List – Sample Letter from Commissioner to Contractor

- [Example Application to Close Patient List – Sample Letter from Commissioner to Contractor](#)

Annex 3 Example Consultation Letter from Commissioner to Affected Parties

- [Example Consultation Letter from Commissioner to Affected Parties](#)

Annex 4 Approval – Example Closure Notice

- [Approval – Example Closure Notice](#)

Annex 5 Rejection – Example Letter

- [Rejection – Example Letter](#)

Annex 6 Example Application to Extend a Closure Period – Sample Template for Completion by Contractor

- [Example Application to Extend a Closure Period – Sample Template for Completion by Contractor](#)

Annex 7 Example Application to Extend a Closure Period – Sample Letter from Commissioner to Contractor

- [Example Application to Extend a Closure Period – Sample Letter from Commissioner to Contractor](#)

Annex 8 Example Consultation Letter from Commissioner to Affected Parties Regarding Application for Extension

- [Example Consultation Letter from Commissioner to Affected Parties Regarding Application for Extension](#)

Annex 9 Approval – Example Extended Closure Notice

- [Approval – Example Extended Closure Notice](#)

Annex 10 Rejection of Extended Closure – Example Letter

- [Rejection of Extended Closure – Example Letter](#)

4 GP Patient Registration Standard Operating Principles for Primary Medical Care

4.1 Policy statement

4.1.1 There has not been any change in national policy in respect of patient registration for primary medical care services – this guidance clarifies the rights of patients and the responsibilities of providers in registering with a GP practice in particular issues in relation to:

- Who can access free healthcare
- the provision of documentary evidence of identity or residence on registration (in particular affecting migrants, refugees and asylum seekers (including ‘failed asylum seekers’) who may not have ID or documents such as household bills)
- the rights of patients who are temporarily resident in a specialist hospital away from their home address and access to their ‘usual’ GP practice
- Additional guidance relating to the temporary suspension of patient registration is already published and can be found [here](#)

4.2 Aims

4.2.1 In issuing these patient registration operating principles we aim to:

- Clarify the contractual rules in respect of patient registration for patients, practices, CCGs and NHS England’s regional teams
- Reduce the risk of worsening health inequalities for specific populations (for examples, asylum seekers or homeless people)
- Agree on a consistent approach across England to clarify, simplify and standardise the patient registration process for patients and practices
- Embed best practice approaches for patient registrations
- Ensure fairness, equity and transparency in the way general practice services are delivered across England

4.3 Context

4.3.1 The Health and Social Care Act 2012 places an obligation on NHS England to secure the provision of primary medical services for patients throughout England. In addition, the Health and Social Care Act 2012 introduced statutory

duties on the NHS to “have regard to the need to reduce inequalities” in access to and outcomes achieved by services

- 4.3.2 There are further duties imposed on NHS England under the Equality Act 2010 and NHS Act 2006 on equality and health inequalities.
- 4.3.3 NHS England wishes to establish operating principles for GP practices for patient registrations that promote equality, human rights and public health and reduce health inequalities.
- 4.3.4 In addition, the Care Quality Commission (CQC) in their guidance entitled; GP Mythbuster 29; Looking after Homeless Patients in General Practice can be found via the link below⁷
- 4.3.5 In 2014 [Homeless and health research](#) provided by ‘Homeless Link’ reported that 90% of the homeless people they surveyed were registered with a GP. However, many responded that they were not receiving the help they needed for their health problems, and 7% had been refused access to a GP or dentist in the previous 12 months. In some cases, these refusals were due to having missed a previous appointment or because of behaviour. Others reported that they were refused access if they did not have identification or proof of address.
- 4.3.6 Also the General Practitioners Committee (GPC) of the British Medical Association (BMA) has related guidance which can be found [here](#)

4.4 Who can register for free primary care services?

- 4.4.1 A patient does not need to be “ordinarily resident” in the country to be eligible for NHS primary medical care – this only applies to secondary (hospital) care. In effect, therefore, anybody in England may register and consult with a GP without charge.
- 4.4.2 Where a GP refers a patient for secondary services (hospital or other community services) they should do so on clinical grounds alone; eligibility for free care will be assessed by the receiving organisation.

⁷ <http://www.cqc.org.uk/content/gp-mythbuster-29-looking-after-homeless-patients-general-practice>

- 4.4.3 The absence of any reciprocal arrangements between the nation-states, a patient's nationality is therefore not relevant in giving people entitlement to register as NHS patients for primary medical care services.
- 4.4.4 From October 2017, we have agreed contractual changes that help to identify patients with a non-UK issued EHIC or S1 form or who may be subject to the NHS (Charges to Overseas Visitors) Regulations 2015.
- 4.4.5 Practices will be required to provide all new patients with a revised GMS1 form, which includes supplementary questions to determine a patient's eligibility for healthcare. For those patients who self-declare that they hold either a non-UK issued EHIC or a S1 form, the practice will be required to manually record that the patient holds either a non-UK issued EHIC or a S1 form in the patient's medical record and then send the form and supplementary questions to NHS Digital (for non-UK issued EHIC cards) or the Overseas Healthcare Team (for S1 forms) via email or post.
- 4.4.6 The Department of Health has agreed to provide practices with hard copy patient leaflets which will explain the rules and entitlements overseas patients accessing the NHS in England.
- 4.4.7 It is important to note that there is no set length of time that a patient must reside in the country in order to become eligible to receive NHS primary medical care services.
- 4.4.8 Therefore, all asylum seekers and refugees, students, people on work visas and those who are homeless, overseas visitors, whether lawfully in the UK or not, are eligible to register with a GP practice even if those visitors are not eligible for secondary care (hospital care) services.
- 4.4.9 The length of time that a patient is intending to reside in an area dictates whether a patient is registered as a temporary or permanent patient. Patients should be offered the option of registering as a temporary resident if they are resident in the practice area for more than 24 hours but less than 3 months.
- 4.4.10 An immigration health charge (or 'surcharge') is now payable by non-EEA nationals who apply for a visa to enter or remain in the UK for more than 6 months. People with indefinite leave to remain in the UK and those not subject to immigration control (e.g. diplomats posted to the UK) are not liable to pay the surcharge, but maybe ordinarily resident here and entitled to free NHS healthcare on that basis.

- 4.4.11 Payment of the health surcharge entitles the payer to NHS-funded healthcare on the same basis as someone who is ordinarily resident, from the date their visa is granted and for as long as it remains valid. They are entitled to free NHS services, including NHS hospital care, except for services for which a UK ordinary resident must also pay, such as dentistry and prescriptions in England.
- 4.4.12 Payment of the health surcharge is mandatory when making an immigration application, subject to exemptions for certain categories of people and the discretion of the Home Secretary to reduce, waive or refund all or part of a surcharge payment. Most of these groups also receive NHS-funded healthcare on the same basis as an ordinarily resident person.
- 4.4.13 Patients who have paid this surcharge as part of their visa application process should be registered as with any other patients.

4.5 Immediately necessary treatment

- 4.5.1 General Practices are also under a duty to provide emergency or immediately necessary treatment, where clinically necessary, irrespective of nationality or immigration status.
- 4.5.2 The practice is required to provide 14 days of further cover following provision of immediate and necessary treatment.

4.6 Determining if the patient lives in the practice area

- 4.6.1 All practices are required to have agreed an “inner” boundary with their commissioner (NHS England or CCG). Anyone who resides within the practice’s inner boundary is entitled to apply to register for primary care medical services and the practice boundary should be clearly advertised to patients on the GPs practice leaflet or website if they have one.
- 4.6.2 In addition, most practices have also agreed an “outer” practice boundary.
- 4.6.3 Patients who move out of a practice’s inner boundary area but still reside in the outer boundary area may be able to remain registered with the practice if they wish and the practice agrees.

- 4.6.4 GP practices are able to register new patients who live outside the practice area without any obligation to provide home visits or services out of hours when the patient is unable to attend their registered practice. It is for a practice to decide, at the point of registration, whether it is clinically appropriate and practical to register the individual patient in that way.

4.7 Access to registration

- 4.7.1 Practices should ensure there is equitable access for all patients who wish to register with them. Registration should be available to all patients every day rather than on particular days and throughout the practice's advertised opening hours.
- 4.7.2 Practices may find it helpful to let patients know the less busy times of the day when registration might be easier.
- 4.7.3 Where possible, it is good practice for practices to provide pre-registration documentation in advance e.g. online prior to a patient attending to register in person.
- 4.7.4 Patients have the right to change practices if they wish. If a patient is registered at another local practice this is not a reason to refuse registration but this would trigger the deregistration from the original practice

4.8 New patient health checks

- 4.8.1 It is a contractual requirement that once registered all patients must be invited to participate in a new patient check however neither registration nor clinical appointments should be delayed because of the unavailability of a new patient check appointment

4.9 Requesting documentary information from patients

- 4.9.1 Under the terms of their primary medical services contracts, GP practices cannot refuse an application to join its list of NHS patients on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

4.9.2 Practices can refuse an application to join a practice list if:

- The commissioner has agreed that they can close their list to new patients,
- the patient lives outside the practice boundary; or
- if they have other reasonable grounds

4.9.3 In practice, this means that the GP practice's discretion to refuse a patient is limited.

4.9.4 In addition, when applying to become a patient there is no regulatory requirement to prove identity, address, immigration status or the provision of an NHS number in order to register. However, there are practical reasons why a practice might need to be assured that people are who they say they are, or to check where they live. Seeing some form of ID will help to ensure the correct matching of a patient to the NHS central patient registry, thereby ensuring any previous medical notes are passed onto a new practice. It is legitimate therefore for the practice to apply a policy to ask for patient ID as part of their registration process.

4.9.5 Any practice that requests documentation regarding a patient's identity or immigration status must apply the same process for all patients requesting registration equally. A practice policy should not routinely expect a patient to present a photograph as this could be discriminatory.

4.9.6 The majority of patients will not find it difficult to produce ID / residence documentation, however there will be some patients who do live in the practice area, but are legitimately unable to produce any of the listed documentation. Examples of this may be;

- People fleeing domestic abuse staying with friends, family or in a shelter
- People living on a boat, in unstable accommodation or street homeless
- People staying long term with friends but who aren't receiving bills
- People working in exploitative situations whose employer has taken their documents
- People who have submitted their documents to the Home Office as part of an application
- People trafficked into the country who had their documents taken on arrival
- Children born in the UK to parents without documentation.

- 4.9.7 Reasonable exceptions therefore need to be considered and the individual registered with sensitivity to their situation.
- 4.9.8 As there is no requirement under the regulations to produce identity or residence information, the patient **MUST** be registered on application unless the practice has reasonable grounds to decline. These circumstances would not be considered reasonable grounds to refuse to register a patient and neither should registration or access to appointments be withheld in these circumstances. If a patient cannot produce any supportive documentation but states that they reside within the practice boundary then practices should accept the registration
- 4.9.9 Where necessary, (e.g. homeless patients), the practice may use the practice address to register them if they wish. If possible, practices should try to ensure they have a way of contacting the patient if they need to (for example with test results).
- 4.9.10 If a practice suspects a patient of fraud (such as using fake ID) then they should register and treat the patient but hand the matter over to the NHS Counter Fraud Authority (NHSCFA)
- the NHS Counter Fraud Authority Reporting Line: **0800 028 4060**
 - filling in an online form at <https://reportfraud.cfa.nhs.uk/reportFraud>
 - email at: generalenquiries@nhscfa.gsi.gov.uk
 - by post to the NHS Counter Fraud Authority, Skipton House, 80 London Road, London, SE1 6LH.

4.10 Refusing Registration

- 4.10.1 If a practice refuses any patient registration then they must record the name, date and reason for the refusal and write to the patient explaining why they have been refused, within a period of 14 days of the refusal.
- 4.10.2 This information should be made available to commissioners on request. Commissioners may ask practices to submit the numbers of registration refusals, age, ethnicity and reasons as part of their quality assurance process.

4.11 Patients who are temporarily resident in a specialist hospital away from home

- 4.11.1 There has been some confusion in respect of Part 5, 17 (4) of the
- 4.11.2 GMS regulations full reference to the regulations can be found in Appendix B
- 4.11.3 This regulation is not considered ‘reasonable grounds’ to refuse registration according to legal advice. 15(4)(b) relates to patients who are already registered with the GP practice and cannot be used as a reason/justification for not registering certain patients. These only become relevant AFTER a patient is registered it does not provide grounds for a refusal to register the patient in the first instance.
- 4.11.4 There are no legal grounds for refusing to register a patient because they are an inpatient in a hospital. Indeed, the “gatekeeper” role of the NHS GP for accessing secondary care services depends on patient registration.
- 4.11.5 Practices are not however expected to provide anything other than essential and additional services in these circumstances. If the resident requires any other services these must be arranged by the hospital or commissioned by the responsible CCG. CCGs who are responsible for securing specialist hospital services should ensure that all services over and above those normally associated with general practice are both agreed as part of the contract specification and actively monitored to ensure delivery against that specification
- 4.11.6 A template Memorandum of Understanding is appended to support GPs, commissioners and providers in clarifying the contractual requirements of primary care providers and those of the hospital, and the regulatory and professional obligations of the Clinicians to ensure safe care and example MOUs are also provided that describe ‘shared care’ arrangements/responsibilities so that patients receive holistic care.

4.12 Registering children

- 4.12.1 As a minimum requirement the arrangements above in respect of the registration of any patient with a GP surgery should be followed when the

person registering is a child. However, there are circumstances that practices should be aware of, in relation to safeguarding guidance.

4.12.2 The legal definition of a child is 0 to 18 years of age; however young people may be able to make independent decisions from as young as 13 year old, depending on their Gillick competency which can be found [here](#). Section 11 of the Children Act 2004 places a statutory duty on the NHS to safeguard and promote the welfare of all children up to the age of 18yrs. The Victoria Climbié Enquiry Report 2003 (9.104) stresses the importance of GP registration for every child. It sets out the importance of knowing the identity and name of those registering the child and their relationship to that child.

4.12.3 If a child under 16 attempts to register alone or with an adult that does not have parental responsibility, the Practice Child Safeguarding Lead should be alerted.

4.12.4 For purposes of safeguarding children, the following should be considered whilst recognising that patients must still be registered in the absence of documentation and policies must be applied in a non- discriminatory manner.

4.12.5 The practice should seek assurance through:

- Proof of identity and address for every child, supported by official documentation such as a birth certificate, (This helps to identify children who may have been trafficked or who are privately fostered.)
- An adult with parental responsibility should normally be registered at the practice with the child⁸. The ID of the adult is essential as it can be matched to the birth certificate details. However, the practice should not refuse to register a child if there is no-one with parental responsibility who can register, as it is generally safer to register first and then seek advice from the Practice Child Safeguarding Lead, Health Visitor or Practice Manager. (This situation may alert you to a private fostering arrangement which constitutes a safeguarding concern).

⁸ There may be legitimate exceptions to this, such as where both parents are serving in the armed forces and are registered with an 'armed forces' GP.

- Offering each child a new patient registration health check as soon as possible after registration
- Proof of parental responsibility or relevant guardianship agreements
- Seeking collaborative information (supported by official documentation) relating to
 - Current carers and relationship to the child
 - Previous GP registration history
 - Whether the child is registered with a school and previous education history
 - Previous contact with other professionals such as health visitors and social workers
- Children who have been temporarily registered with the practice should be reviewed regularly and proceed to permanent registration as soon as possible and ideally within three months of initial registration. Likely length of stay should be determined at initial registration and patient registered as temp/permanent as appropriate.
- Children of parents or carers, who have been removed from the list for any reason, must not be left without access to primary care services.
- Where parents or carers have been removed from the list due to aggressive and or violent behaviour a risk assessment should be completed to identify any risk to their children and the appropriate referrals safeguarding made.
- A 'think family' approach should be made when seeing either the adult(s) or child/children within the surgery. If you are aware that an adult has significant risk-taking behaviour, chronic mental health concerns or repeated episodes of stress and anxiety, safeguarding and support consideration should be made to the welfare and safety of the child/children being cared for by that adult.

4.12.6 Practices should be alert to potential risks such as those described above when young people aged between 16-18 years of age register alone and dealt with in line with practice safeguarding procedures and escalated outside of the practice through the local procedures if appropriate, 16-18 year olds are still

children by law of child protection but can also be parents and carers. It's imperative that we consider the risks and vulnerabilities within this age group.

- 4.12.7 There is nothing to stop a parent deregistering their family and not registering again. It is not compulsory to be registered with a GP whether an adult or a child. To amend this there would need to be legislative change. Such legislation would encroach on areas of personal freedoms and patient and parental rights so would likely attract resistance. In addition, it is difficult to see how to enforce or police as there is no jurisdiction or levers to ensure that all children are registered.
- 4.12.8 If a practice is concerned about a family who is deregistering their children with no plan to register with another general practice they need to consider whether this should be raised with the Local Authority as part of normal safeguarding processes.

4.13 Registration of those previously registered with Defence Medical Services (DMS) and Priority NHS care for Veterans

- 4.13.1 DMS have their own GP services that look after serving personnel, mobilised reservists and some families. These specific primary care services are commissioned separately by the DMS of the Ministry of Defence. When servicemen and women leave the armed forces, their primary healthcare reverts to the responsibility of the local NHS. As a minimum requirement, the arrangements set out above in respect of the registration of any patient with a GP surgery should be followed when the person registering is a veteran. Prior service should be recorded on registration and allocated the correct Read/Snomed Code. This should enable access to specialist or bespoke care or charity support as necessary for such patients and for the delivery of the armed forces covenant.
- 4.13.2 A veteran is an ex-service person or reservist who has served in the armed forces for at least one day. There are around 2.5m of these veterans in England at the time of drafting.
- 4.13.3 All veterans are entitled to suffer no disadvantage from their service and to receive priority access to NHS hospital care for any condition as long as it's

related to their service (subject to clinical need), regardless of whether or not they receive a war pension.

4.13.4 All people leaving the armed forces are given a summary of their medical records, which they are advised to give to their new GP when they register. The practice will also normally be advised automatically of prior registration with Defence Medical Services (with a summary of their in-service care).

4.13.5 More information on the duty of care owed to service personnel and specific services is contained in the armed forces covenant which can be found here; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf; <http://www.nhs.uk/NHSEngland/Militaryhealthcare/Pages/Militaryhealthcare.aspx>

4.14 Persons released from prisons, immigration centres or children's secure facilities

4.14.1 We have introduced a contractual change in October 2017 to allow patients who do not have a registered GP or are being released to a different area ability to register with a practice before they leave the detained estate. This agreement includes the timely transfer of clinical information, with an emphasis on medication history and substance misuse management plans, to the practice from the detained estate healthcare service to enable better care when a new patient first presents at the practice.

4.14.2 Those in contact with the Criminal Justice System may get a letter from the Youth Offending Service, the CRC or the National Probation Service

4.15 Temporary Residents

4.15.1 A contractor may, if the contractor's list of patients is open, accept a person as a temporary resident. This is provided the contractor is satisfied that the person is temporarily resident away from their normal place of residence and is not being provided with essential services (or their equivalent) under any other arrangement in the locality where that person is temporarily residing; or moving from place to place and not for the time being resident in any place.

4.15.2 It is of note that a notification to the Board of the acceptance of temporary resident on to the contractor's list only occurs at the end of the period of three months beginning with the date on which the contractor accepted that person as a temporary resident; or if the contractor's responsibility for that person as a temporary resident came to an end earlier, at that point. Any clinical records relating to the TR period of care can/should be submitted via PCSE for repatriation to the registered GP Practice or storage in archive.

4.15.3 As this type of registration does not get flagged with PCSE at the commencement of the temporary registration, there is potential for a contractor to accept as a temporary resident a patient who is actively registered with a Special Allocation Scheme (SAS). Should a contractor become aware that a patient is registered with a SAS, the contractor should contact their local commissioner who may seek to secure temporary primary medical care for the patient with a local SAS.

4.16 Sensitive Patient Registrations

4.16.1 GP Practices are required to work with PCSE and take actions on their clinical systems to ensure that the registration information for patients who undergo a change of identity is accurate and up to date. This is also the case for adoptions, gender transition and patients in witness protection schemes. This ensures data is kept up to date and held in line with Information Governance requirements on national demographics systems.

4.16.2 Commissioners must also work with PCSE in relation to managing escalations where there are potential blockages or delays in practices responding to PCSE requests.

4.17 Appendix A; Draft Framework for a Memorandum of Understanding between GP Practice and Private provider (MH facility)

- [Framework for a Memorandum of Understanding between GP Practice and Private provider \(MH facility\)](#)

Appendix B Regulation 15 of the GMS Regulations (2015)

Essential services

17.—(1) Subject to paragraph (2), for the purposes of section 85(1) of the Act (requirement to provide certain medical services), the services which must be provided under a contract (“essential services”) are the services described in paragraphs (4), (6), (7) and (9).

(2) Essential services are not required to be provided by the contractor during any period in respect of which the Care Quality Commission has suspended the contractor as a service provider under section 18 of the Health and Social Care Act 2008(87) (suspension of registration).

(3) Subject to regulation 20(2)(b) and (c), a contractor must provide the services described in paragraphs (4) and (6) throughout the core hours.

(4) The services described in this paragraph are services required for the management of a contractor’s registered patients and temporary residents who are, or believe themselves to be—

(a) ill, with conditions from which recovery is generally expected;

(b) terminally ill; or

(c) suffering from chronic disease,

which are delivered in the manner determined by the contractor’s practice in discussion with the patient.

(5) For the purposes of paragraph (4)—

“disease” means a disease included in the list of three-character categories contained in the tenth revision of the International Statistical Classification of Diseases and Related Health Problems(88); and

“management” includes—

(a) offering consultation and, where appropriate, physical examination for the purposes of identifying the need, if any, for treatment or further investigation; and

(b) making available such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services under the Act and liaison with other health care professionals involved in the patient’s treatment and care.

(6) The services described in this paragraph are the provision of appropriate ongoing treatment and care to all of the contractor's registered patients and temporary residents taking account of their specific needs including—

(a) advice in connection with the patient's health and relevant health promotion advice; and

(b) the referral of a patient for other services under the Act.

(7) A contractor must provide primary medical services required in core hours for the immediately necessary treatment of any person to whom the contractor has been requested to provide treatment owing to an accident or emergency at any place in the contractor's practice area.

(8) In paragraph (7), "emergency" includes any medical emergency whether or not related to services provided under the contract.

(9) A contractor must provide primary medical services required in core hours for the immediately necessary treatment of any person to whom paragraph (10) applies who requests such treatment for the period specified in paragraph (11).

(10) This paragraph applies to a person if—

(a) that person's application for inclusion in the contractor's list of patients has been refused in accordance with paragraph 21 of Schedule 3, and that person is not registered with another provider of essential services (or their equivalent);

(b) that person's application for acceptance as a temporary resident has been refused under paragraph 21 of Schedule 3; or

(c) that person is present in the contractor's practice area for a period of less than 24 hours.

(11) The period specified in this paragraph is, in the case of a person to whom—

(a) paragraph (10)(a) applies, 14 days beginning with the date on which that person's application was refused or until that person has been subsequently registered elsewhere for the provision of essential services (or their equivalent), whichever occurs first;

(b) paragraph (10)(b) applies, 14 days beginning with the date on which that person's application was rejected or until that person has been subsequently accepted elsewhere as a temporary resident, whichever occurs first; or

(c) paragraph (10)(c) applies, 24 hours or such shorter period as the person is present in the contractor's practice area.

5 Temporary suspension to patient registration

5.1 Formal List Closure

- 5.1.1 The GMS and PMS contracts allow for a Practice to request permission from its commissioner to close its list to new patients (Paragraph 33 of Schedule 3, Part 2 of the NHS (GMS Contracts) Regulations 2015). This option exists to give practices a degree of workload control over the management of their services, particularly when there is unusual and sustained demand from patients or in situations of workforce or recruitment difficulties that affect a practice's ability to provide services to an acceptable and safe standard.
- 5.1.2 As the commissioner also has a duty to ensure the availability of primary care services for the resident population it has certain powers with regard to these requests including agreeing to the length of the closure and the conditions that would need to exist to trigger a re-opening of the list. The commissioner will also need to consider the availability of alternative provision for new patients and any impact on neighbouring practices. Following changes to the formal list closure process in 2012, the commissioner does not have the power to halt practices' delivery of additional and/or enhanced services as a means to reduce practice workload thereby keeping the patient list open. Therefore, list closure no longer carries such financial consequences for the practice as it was once thought to have and allows practices to continue to deliver holistic care to registered patients.
- 5.1.3 When a practice does formally close its list, the requirement is to close between three and twelve months; not less than three months. An approved closure notice must specify the time period.

5.2 'Informal' or 'Temporary' List closure

- 5.2.1 While the GMS and PMS contracts do not allow for a 'temporary' or 'informal' list closure they do allow for a practice to refuse individual patient applications for inclusion in a contractor's list of patients providing there are reasonable non-discriminatory grounds to do so (paragraph 21 of Part 2 of Schedule 3). See appendix A. In this guidance we distinguish a patient refusal on a case by case basis, based on the *patient* circumstances, from a refusal to allow a

patient to join the list because of the circumstances surrounding the *provider* and so do not consider paragraph 17 to be appropriate in these circumstances.

- 5.2.2 Practices can however, suffer unforeseen pressures that can reasonably be predicted to be short term. In these circumstances there may be a real or perceived risk to 'safe patient care' by accepting more new patients onto the list and action to address this by the practice should be received by the commissioner as a trigger for support and help
- 5.2.3 NHS England has seen a significant rise in the number of practices suspending registration on a temporary basis causing a significant problem for patients, neighbouring practices and commissioners in some areas.
- 5.2.4 Practices do not exist in isolation so when a practice restricts new patient registration, this has an impact not only on patients but on neighbouring practices. It is for these types of circumstances that the formal list closure
- 5.2.5 procedure exists; to allow for a considered and managed approach to list management across all practices
- 5.2.6 Because of the potential impact of "temporary suspension" NHS England encourages practices to open a dialogue with their commissioner as early as possible when considering temporary suspension
- 5.2.7 These guidelines for commissioners describe the circumstances where a temporary suspension by the contractor of patient registration *may* be appropriate and the conditions that should govern that decision such that the roles and responsibilities of both parties are not compromised.

5.3 Overview of current activity

- 5.3.1 The increase in a temporary suspension of patient registration is a symptom of rising pressure in primary care, which creates a risk to patients, neighbouring practices and the commissioner; however, the risk to patients being registered with an oversubscribed practice should also be taken into account.

5.4 Facts/Principles

- 5.4.1 Addressing practices seeking to 'Informally' or 'Temporarily' suspend patient registration onto their list should be in the context of the General Practice Forward View and NHS England's commitment to supporting practices in difficulty.

5.4.2 However, NHS England has a duty to ensure that patients have access to primary care.

- Core services include operating an open list by the fact of regulation and is how NHS England ensures access to services; the NHS Act confers a duty on the commissioner to ensure the provision of services
- Any actions considered by the commissioner should ensure, system-wide, safe, quality and accessible core services to patients and be proportionate and sensitive to the providers concerned.
- NHS England and CCGs as Commissioners have a responsibility to address health inequalities
- Commissioners and providers must work together to ensure compliance with the Equality Act, ensuring the rights of those with protected characteristics are not directly or indirectly compromised.
- Good medical practice states that if a GP is aware that patient safety is being compromised, then they have a professional duty to act.
- The unintended impact of any action needs to be considered in relation to both registered patients and unregistered patients in the locality as well as the impact on other local providers both primary (GP and pharmacy) and secondary care

5.4.3 The commissioner has the right to assign patients throughout the period that the list is not formally closed having due regard to the quality and safety of services and the reasons behind the list closure in the first place

5.5 Issues to be taken into consideration

5.5.1 NHS England acknowledges that things can rapidly change within practices. These may include for example;

- An immediate and unpredicted shortfall in the availability of staff e.g. through sickness or a delay to a staff appointment
- An unpredicted surge in demand
- An unexpected event affecting a practice's ability in the short term to provide the full range of services normally available e.g. a flood or a fire (See Force Majeure provisions of the standard GMS, PMS and APMS contracts).

- Impact on a practice of an unfavourable CQC inspection where remedial action temporarily affects normal service provision

- 5.5.2 In some circumstances the action required to remedy a problem may take several months and in others just a few weeks, for example, a planned short term suspension of registration as part of a recovery plan through the vulnerable practice programme. Alternatively, practice capacity may be temporarily compromised by premises development or IT upgrades. Under these circumstances, it would be usual to expect planning and communication with patients in advance with a specific start and end date and disruption measured in weeks not months
- 5.5.3 In all but exceptional circumstances Practices should approach the commissioner in advance so that an action plan that minimises the impact on patients can be considered jointly at the earliest opportunity and so that immediate support from the commissioner can be put into action. A request to temporarily suspend patient registration should be considered by the commissioner as a trigger for support as it should for a formal application to close the list
- 5.5.4 This guidance does not prescribe what length of time approval of a temporary list suspension is appropriate as this will vary depending on the circumstances. The keywords are unpredictable and/or short term. In circumstances where there is a known history of difficulty in recruitment including the availability of locums or the circumstances affecting the practice can be predicted to last longer e.g. a planned refurbishment or a rebuilding programme scheduled to last month's say following a flood or a fire, the formal list closure procedure should be encouraged.
- 5.5.5 In both cases the practice's eligibility for support through the Practice Resilience Programme should be considered by the commissioner.

5.5.6 Circumstances in which an 'informal' or 'temporary' list closure is not appropriate (list not exhaustive)

- When the practice considers its list is full (a formal application should be made)
- For long term sickness absence (a formal application should be made)
- For issues expected to be longer term (e.g. over 3 months)
- Because a formal closure application has been declined

5.6 Process to be adopted

- 5.6.1 All practices should be encouraged to contact their commissioner at the earliest possible opportunity i.e. at the point that suspension to registration is being considered so that the provider and commissioner can work together to agree on what support is required.
- 5.6.2 At this point commissioners should
- seek to understand the reasons behind the action
 - engage the LMC at the time of a decision as the LMC also carries a responsibility for representing all their affected parties
 - Facilitate what action needs to take place by the practice and/or by the commissioner for the list to be re-opened. If actions can reasonably be expected to take longer than 3 months then the Practice should be asked to make a formal application to close its list.
- 5.6.3 Actions should trigger consideration of the practice resilience programme or use of section 96 e.g. a diagnostic/review of the difficulties faced and recommended action
- 5.6.4 At the end of the agreed period where a temporary suspension of patient registration has occurred, the list would normally re-open. There are only two alternative outcomes;
- If the situation is almost resolved for example an appointment has been made but the post not yet filled (for example by a week or two later) an extension to the temporary arrangement can be negotiated
 - Despite support to deliver an action plan the practice continues to feel compromised. The commissioner should then consider an application for formal list closure, which will require wider consultation. The parties will need to agree on the status of the practice list during the formal process, whether, having regard to all local circumstances, the practice should continue to operate a temporary suspension to patient registration.

5.6.5 These guidelines have been drafted in recognition of the immediate pressures facing some practices; they do not however sanction the term 'open but full'. Where a practice is failing to engage with the commissioner, and unilaterally seeking to determine its own restrictions on patient access, without consideration of the impact on patient access generally or the implications for neighbouring practices, then contractual action may need to be considered

5.7 Appendix A; GMS paragraph 21 of Part 2 of Schedule 3

Refusal of applications for inclusion in the list of patients or for acceptance as a temporary resident

21.—

(1) The contractor may only refuse an application made under paragraph 18 or 20 if the contractor has reasonable grounds for doing so which do not relate to the applicant's age, appearance, disability or medical condition, gender or gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sexual orientation or social class.

(2) The reasonable grounds referred to in sub-paragraph (1) may, in the case of an application made under paragraph 18, include the ground that the applicant—

(a) does not live in the contractor's practice area; or

(b) lives in the outer boundary area (the area referred to in regulation 20(3)).

(3) Where a contractor refuses an application made under paragraph 18 or 20, the contractor must give notice in writing of that refusal and the reasons for it to the applicant (or, in the case of a child or an adult who lacks capacity, to the person who made the application on their behalf) before the end of the period of 14 days beginning with the date of its decision to refuse.

(4) The contractor must—

(a) keep a written record of—

(i) the refusal of any application made under paragraph 18, and

(ii) the reasons for that refusal; and

(b) make such records available to the Board on request.

6 Special Allocation Scheme (SAS)

(To note and for information only: Other terminology previously used in relation to special allocations of this type have been included but are not limited to, Violent Patient Scheme (VPS) or Zero Tolerance Scheme (ZTS))

6.1 Executive Summary and Key Messages

This chapter provides guidance to Commissioners and providers of essential primary medical care services in relation to the removal of patients who are violent from their practice list and the Special Allocation Schemes (**SAS**) intended to ensure such patients receive primary care services. Provision for SAS is set out in the GMS Regulations and the PMS Regulations (together, the **Regulations**).

This guidance focuses on a number of key themes (which are intended to support the implementation of, and commissioning and monitoring of a SAS:

- [Introduction](#)
- [Commissioning a robust SAS](#)
- [Provider and service requirements and monitoring.](#)
- [The scope of / eligibility criteria for a SAS.](#)
- [The process for requesting immediate removal of a patient.](#)
- [What happens after removal, including returning choice to patient \(see also section 3.11.2\)](#)

Given the importance of the interests that SAS seeks to balance, two key messages are emphasised at the outset.

The first relates to the scope of SAS. The Regulations regarding the removal of patients who are violent is specific in terminology and the Regulations require that GMS and PMS contracts provide for "Removal from the list of patients who are violent".

However, within the Regulations it is further specified that the grounds on which a contractor may request that a person be removed from its list of patients with immediate effect are that "the person has committed an **act of violence against** any of the persons specified in subparagraph (2) **or has behaved in such a way that any of those persons has feared for their safety**".

The Commissioner should therefore be clear that violence does not have to be physical or actual. It can be perceived, threatened or indeed a perceived threat of violence. A person's fear for their safety can also be actual or perceived. If a patient's behaviour is such that it warrants removal from the patient list and placing them on a SAS (if they wish to continue receiving primary medical care),

then the Regulations require that the incident is reported to the police.

In the case of the patients whose behaviour is disruptive but falling short of the above grounds, Commissioners should discuss with the practice if the patient should instead be removed from the practice on the alternative ground of irrevocable breakdown in the relationship between the person and the contractor see paragraph 24, Schedule 3, Part 2 of the GMS Regulations and paragraph 23, Schedule 2, Part 2 of the PMS Regulations).

The second key message is that we want all providers to be fully aware of and understand the process for immediate removal of a patient. In summary, where a patient's behaviour is deemed within the scope of this chapter (i.e. SAS):

The Regulations require that, for a patient to be removed from a practice list, the practice must report the incident to the police. The following 10 point process is designed to work in all but very exceptional circumstances. Those infrequent and exceptional cases relate solely to commissioner instigated allocations (for example a patient that falls within the remit of a SAS allocation, but with no recent removal from a GP Practice i.e. previously unregistered) and must be discussed and agreed with NHS England in advance.

1. The Practice calls the police to report the incident (which is required under the regulation) and obtain a response (if required) and police incident number. Where possible this should be at the time of reporting but in any case, a police incident number must be included within the written report provided by the practice within 7 days (a contractual requirement under 'reasonable requests for information'). **Practice Action **

Note: Practices should be reminded of the requirement to notify the Care Quality Commission (CQC) about any incident related to their service that is reported to, or investigated by the police.

Furthermore, where appropriate the practice should consider if the incident and subsequent removal from its list warrants notification to any other agency (e.g. Local Authority) where there may be concern for welfare or safeguarding concern as a result of the incident (e.g. the deducted patient has children or is a carer for another vulnerable person including elderly relatives).

2. The Practice requests an immediate removal from NHS England's Primary Care Support England ("PCSE") service provided by Capita. This request can be by phone (visit <https://pcse.england.nhs.uk/contact-us/> for contact details) or email pcse.patientremovals@nhs.net. PCSE will request the police incident number [Note: this is different from a crime reference number, which can only be allocated by the police once it has been established that a crime has been committed. The police will

however record an incident number on police systems for all incidents according to Home Office Counting Rules ("HOCR")). If the Practice does not have a police incident number at this point (which should be in exceptional circumstances only), the Practice will be asked to provide details of the date, time and mechanism (i.e. 999, 111, local number) via which the incident was reported to the police. **The absence of an incident number will not delay the immediate removal of a patient.**

**** Practice and PCSE Actions ****

3. PCSE removes the patient from the Practice list and informs the appropriate Commissioner. **** PCSE Action ****
4. The Regulations require that the Practice notifies the patient in writing that a request for removal has been made, unless to do so would harm the patient's physical or mental health or put others on the Practice premises at risk. **** Practice Action ****
5. PCSE allocates the patient to a local SAS provider. Commissioners are responsible for commissioning SAS either from GPs or another provider. **** PCSE Action ****
6. PCSE notifies the patient in writing (standard letter at appendix 7) that they have been removed from the Practice list (as per the Regulations (25.7)) and also, allocated to the SAS provider. **** PCSE Action ****
7. The Practice provides a followup report in writing to the Commissioner (sample available at appendix 1), within 24 hours where possible but before the end of a period of seven days beginning with the date on which notice was given. Where the Practice was unable to provide a police incident number initially; the practice will be asked to include this in the report (under the contractual requirement for reasonable requests for information). **** Practice Action ****
8. Following 7 days from the incident, the Commissioner and PCSE will liaise to ensure an incident number has been received (either by PCSE or via the written practice report to the Commissioner). In the event an incident number has not been provided, the Commissioner will contact the provider to ensure one has been obtained and provided. **** Commissioner Action ****
9. The SAS provider will ensure risk assessment and regular monitoring is in place to enable the patient to be repatriated back into mainstream Primary Care as soon as is feasible. **** SAS Provider Action ****
10. The SAS provider will notify PCSE when choice has been returned to the patient and they have been removed from the SAS. This will ensure the patient's records are amended accordingly by PCSE (i.e. VP flag

removed from patient record) allowing them to re-register at their chosen practice. [Note: Commissioners should ensure this is included in any future SAS contracts awarded and where possible, seek to make arrangements for this to be added to existing contracts]. ** SAS Provider and PCSE Action **

11. Where a patient on the SAS moves address and between commissioners and a change in SAS provider is required, the previous SAS provider must ensure a safe transfer (e.g. by secure email) of an electronic summary of the patient record to the new provider as soon as possible but not later than 5 days following deduction, to ensure continuity of care while the new provider awaits the transfer of the patient's full medical records.

6.2 Introduction

6.2.1 Purpose of this document

6.2.2 There will undoubtedly be instances when practices have to deal with patients who are difficult, challenging, aggressive and abusive, as well as in some cases, violent. In order to protect GP's and practice staff and to allow them to carry out their roles, Commissioners, in collaboration with the wider stakeholders, have developed this guidance.

6.2.3 Under the SAS, designated GP practices will provide services to patients by prior appointment and at specific locations and times as detailed in individually agreed contracts. Patients are allocated to SAS following a process of immediate removal as a result of an incident that was reported to the police.

6.2.4 Where this document refers to NHS England, the Commissioner or Commissioners, this encompasses NHS England local teams that retain commissioning of primary medical services and CCGs with delegated authority.

6.2.5 The purpose of this document is to provide Commissioners with consistent national guidance to support good commissioning of SAS. It aims to provide a steer on the implementation of SAS in practice and how to work with Primary Care Support England (PCSE), which is delivered on behalf of NHS England, by Capita Plc.

6.2.6 Background to this work

6.2.7 The SAS was introduced as a Directed Enhanced Service in 2004 to provide general primary care medical services in a secure environment to patients who meet the criteria for inclusion into the scheme. The SAS cannot be used

in any other circumstances without express and prior agreement with NHS England

6.2.8 This SAS allows Commissioners to balance the rights of patients to receive services from GPs with the need to ensure that specified persons, including GPs, their staff, patients and others on the premises, deliver and receive those services without actual or threatened violence or other reasonable fear for their safety.

6.2.9 Removing a patient under the regulations should only be used as a last resort when all other ways of managing the patient's behaviour have been exhausted.

6.2.10 **Context: Rules, Regulations and Existing Arrangements**

6.2.11 **Rules and Regulation**

6.2.12 **The GMS / PMS Contract Regulations**

6.2.13 The National Health Service (General Medical Services Contracts) Regulations 2015

- [The National Health Service \(General Medical Services Contracts\) Regulations 2015](#)

6.2.14 The National Health Service (Personal Medical Services Agreements) Regulations 2015 - Schedule 2 – Part 2

- [The National Health Service \(Personal Medical Services Agreements\) Regulations 2015 - Schedule 2 – Part 2](#)

6.2.15 The Primary Medical Services (Directed Enhanced Services) Directions (2016)

- [The Primary Medical Services \(Directed Enhanced Services\) Directions \(2016\)](#)

6.2.16 **Police Incident Reporting – The Home Office Counting Rules**

6.2.17 Excerpt from the Home Office Counting Rules (HOCR) For Recorded Crime and from Her Majesty's Inspectorate of Constabulary

- [Excerpt from the Home Office Counting Rules \(HOCR\) For Recorded Crime and from Her Majesty's Inspectorate of Constabulary](#)

6.2.18 Existing Arrangements

6.2.19 The administrative arrangements of the existing SA scheme across England have been disparate and varied. This has created challenges when trying to apply the Regulations consistently and the practical application of SAS through a single delivery partner (Primary Care Support England)

6.2.20 Particular issues are as follows.

- 6.2.21 First, the Regulations provide for immediate removal of a patient from a practice list on a phone call from the practice, yet some SAS require Commissioner intervention of some sort before a removal is actioned. This is out with the provisions as set out in the Regulations.
- 6.2.22 Secondly, the Regulations require a practice to report an incident to the police but do not mandate the acquisition of a police incident number or crime number before a removal is actioned. NHS England's stakeholders (including GPC) acknowledge that the provision of an incident number (but not a crime number) is a 'reasonable request for information' in accordance with the contract. However, an incident number should not be a prerequisite to the immediate removal of a patient whose behaviour is such that they meet the criteria for removal.

6.3 Commissioning a robust SAS

- [Commissioning a robust SAS](#)

6.4 When to request a removal of this type under the Regulations (Information on eligibility for Commissioners and Providers)

- 6.4.1 **It is important that these regulations are not misused or used lightly but that it is** only reserved for those patients who meet the criteria for removal and resulting in an incident being reported to the police, or for patients who are deemed a future safety risk to themselves or others within the primary care setting.
- 6.4.2 It is not the intention to encourage a situation where patients are immediately removed for comparatively minor offences (e.g. that have not been reported to the police) or for behaviour that could be ascribed to a health condition and which is capable of being alleviated through careful management, care and treatment.
- 6.4.3 We therefore provide the following comprehensive guidance that outlines circumstances deemed appropriate to remove a patient from the patient list (although this is a guide and not exhaustive) and emphasises the importance of applying this procedure when strictly necessary. The overarching objectives behind a SAS is to ensure any patient removed under the violent patient regulations have access to essential and additional medical services. Also, to communicate behavioural expectations to patients and educate them to behave responsibly wherever possible, while at the same time minimising the risks to the safety of health professionals and others.

6.4.4 Types of behaviour covered by this guidance?

6.4.4.1 The Health Circular 2000/01 defined violence in the primary care context as:

6.4.4.2 *“Any incident where a GP, or his or her staff, are abused, threatened or assaulted in circumstances related to their work, involving an explicit, or implicit, challenge to their safety, wellbeing, or health”.*

6.4.4.3 The main kinds of behaviour which are considered to bring a patient within the regulations covered by this guidance are (these are only intended to be used as a guide and therefore the list is not exhaustive):

6.4.5 Assault

6.4.5.1 For an assault to fall within the scope of removal from the list, it should involve a person intentionally or recklessly causing another to apprehend the immediate infliction of unlawful force on an individual in a manner which either results in injury or causes that individual to fear injury or some other immediate threat to their safety.

6.4.6 Threatening behaviour

6.4.6.1 Any verbally threatened harm towards others, with or without accompanying gestures, will fall within the scope of a removal. Threats of nonviolent acts are unlikely to do so (e.g. use of offensive language without threats).

6.4.7 Behaviour resulting in damage to property

6.4.7.1 Any behaviour resulting in damage to property, whether accompanied by verbal threats or not and whether that damage is intentional or not, is likely to be within the scope of the scheme if the behaviour was intended to terrorise or intimidate individuals or is seen as a precursor to a personal assault.

6.4.8 Further considerations in relation to 6.4.5 – 6.4.7

6.4.8.1 Examples of the cases referred to above would include any incident in which the patient has:

6.4.8.1.1 struck, grabbed or punched a GP, member of staff or other individuals, either within the practice premises or elsewhere in a targeted attack

6.4.8.1.2 thrown an inanimate object at a GP, member of staff either within the practice premises or elsewhere in a targeted attack

6.4.8.1.3 struck, grabbed, punched or thrown an inanimate object at another patient(s) within the practice premises

6.4.8.1.4 wielded a weapon, or used an object as one, in an actual or intended assault or in a manner intended to intimidate or terrorise staff, patients or other persons on the practice premises

6.4.8.1.5 threatened to assault or physically harm a primary care worker

6.4.8.1.6 threatened to damage property or to 'seek revenge' in a menacing way

6.4.8.1.7 caused damage to property with an intention to intimidate or cause harm.

This list is not exhaustive

6.4.9 What behaviour this scheme does not ordinarily cover?

6.4.10 Below are some examples of the types of behaviours that would not ordinarily fall within the scope of the Regulations covered by this guidance. These are only intended to be used as a guide and therefore the list is not exhaustive. Any person felt threatened or fearful of their own safety, should still report the incident. These removal regulations cover all persons on the practice premises.

- 6.4.10.1 verbal abuse including swearing, either of a specific or non-specific nature, if not accompanied by any genuine (including perceived) threatening behaviour, e.g. when it can reasonably be seen as merely venting frustration or 'blowing off steam'. Practices should exercise discretion when considering whether a perceived fear or belief that behaviour is threatening is reasonable.
- 6.4.10.2 invasion of another person's personal space
- 6.4.10.3 shouting or banging the reception desk
- 6.4.10.4 behaviour that was not appropriate to report to the police (e.g. a patient who has never been aggressive before and who is clearly suffering mental or physical anguish). In such circumstances, it might be more appropriate to use the standard procedure for a breakdown in practice/patient relationship by writing to them after the event, requesting an explanation or apology and warning that a continuation of such behaviour could result in them being removed from the practice's list. Patients must not be immediately removed for minor offences not reported to the police, nor should they be removed for behaviour which can be ascribed to a condition capable of being rapidly alleviated by treatment e.g. mental health illness or medical/acute conditions with known behavioural changes (e.g. head injury) Therefore, careful consideration of any mitigating circumstances must be given as to whether a referral to this scheme is in the best interests of the patient.
- 6.4.11 Incidents that occur outside of the primary care setting and have no connection with the practice, such as community or hospital-based incidents. These would ordinarily default to and dealt with by that specific settings policy.
- 6.4.12 It is important to recognise that the SAS does not provide for the ongoing treatment of the families of those patients allocated to the scheme for incidences of violence. A practice must not unilaterally remove all family members unless they have also behaved in a way as to require allocation to a SAS and each patient must be referred separately. However, careful consideration will need to be given to the ongoing arrangements of any dependants of the family member who has been removed from the practice. These should be considered on a case by case basis.

6.4.13 Where a breakdown in relationship had occurred with non-dependant family members as a result of one family member being placed on the SAS, then they should be removed using a more relevant process e.g. 8 day removal.

NB – where a practice is unsure how to proceed having read these examples, they can contact the commissioner for support, advice and guidance. The practice may also choose to seek guidance from the Local Medical Committee.

6.4.14 Please note that within the 'Managing Patient Lists' chapter there is sub section 'Removing a Patient from a Practice List' which describes a route to be taken in the event of an irrevocable breakdown in GP/patient relationship, which can be the more appropriate route, however, a patient must be sent a warning letter within the proceeding rolling twelve month period and given the opportunity to moderate their behaviour. Removal can only be effected if the behaviour is repeated and then the patient can be given 8 days' notice to find a new GP. Less serious circumstances are suitable for this method of removal by the contractor. Patients must not be removed using the 'immediate removal' process unless the matter has resulted in the incident being reported to the police.

6.4.15 **Once satisfied that a patient's behaviour warrants removal from the practice list, in order to remove a patient immediately, the practice is required under GMS and PMS regulations to:**

6.4.16 **Notify the Police**

6.4.16.1 In order to remove a patient immediately for cases of serious violent assault, threat or damage, the situation has to be serious enough to justify reporting the incident to the police in an appropriate timeframe, due to the incident having left the person feeling sufficiently threatened for their own safety, or that of another.

6.4.16.2 The practice, where appropriate, should dial 999 on the day of the incident and if necessary, summon police assistance/attendance. When contacting the police, it is important that the practice makes it clear that an incident has occurred about which the practice wants to make a formal statement as soon as possible, so as to support the situation that is to qualify for immediate removal.

6.4.16.3 Due to the nature of incidents requiring an immediate removal under these regulations, it would not be expected that the practice notify the police days after the incident. A further contact to the police within 7 days may be required if the incident number for the call wasn't recorded, retained or provided at the time of the call. The SAS policy is in place for urgent incidences and as such, this information and evidence may be used for local audit purposes.

6.4.17 Notify the Commissioner (via PCSE)

6.4.17.1 The practice is required to notify the Commissioner via PCSE either by telephone (0333 014 2884) or emailing Pcse.patientremovals@nhs.net. At this point there will be a reasonable expectation that practices will be able to evidence contact with the police by passing on details of an incident number or detail why this has not been possible and if possible call back with an incident number as soon as practical. The practice will be required to follow up the call with a written report of the incident (including police incident number), preferably within 24 hours but no more than 7 days after the incident occurring and via email to the Commissioner. A sample reporting form for recording the incident can be found in Appendix One.

6.4.17.2 The practice must notify the patient that it has requested their removal from the patient list, as set out in the regulations, unless an exception applies under the Regulations (see section 2.14).

6.4.17.3 PCSE will ensure the patient removal process commences. Following the removal and in conjunction with the commissioners as necessary, PCSE will decide on the best arrangement to ensure continuity in primary care service for the patient. This may include allocation to the SAS (but recognises the patient retains the right to choose not to be registered at all). A flag is placed on the patient record which prevents the patient from registering at other GP Practices.

6.4.17.4 PCSE will write to the patient to notify them of the removal and ongoing management arrangements (standardised letter at appendix 7). It is expected that this process will be completed within a 24 hour working period from the initial notification.

NB After removal, all patients must be allocated to and accepted by the CCG commissioned SAS. Subsequently, all patients allocated to SAS should be reviewed by a SAS Panel. The panel will monitor the ongoing appropriateness of the patients continued registration with the SAS and their rehabilitation.. This is with a view to safely returning choice to the patient in timely way and reintegration to mainstream Primary Care.

6.4.18 Registered providers and managers of NHS GP and other primary medical services must also comply with their regulatory obligations. For example, to

notify CQC about certain incidents that took place “while an activity is actually being provided or as “a consequence of its being provided” (CQC, 2013) and when an incident is reported to or investigated by the police. For more information, [click here](#).

6.4.19 For further information relating to the process following an allocation to the scheme, please refer to Appendix Two.

6.4.20 The practice should notify the patient that it has requested their removal from the list unless an exception applies under the Regulations (see section 2.14)

6.4.21 **Patient Appeals Process**

6.4.22 It is recognised that GP practices report incidents to the police and request immediate removal where there is due cause and to protect the safety of practice staff, patients and visitors.

6.4.23 The appeals process must recognise that a practice has already fulfilled its obligation under the Regulations by reporting the incident to the police and notifying the Commissioner.

6.4.24 The patient referred to the SAS has a right of appeal and should they wish to do so, can appeal against the decision by putting this in writing within 28 days of the notification of the referral, addressing it to the Commissioner's SAS Liaison Team. The Commissioner will contact the practice to notify them of the appeal and invite them to provide any supplementary information in relation to the removal.

6.4.25 **The appeals process does not delay the immediate removal of a patient following an incident that has been reported to the police and the commissioner (via PCSE).**

6.4.26 The appeal should be reviewed by a panel convened by the Commissioner (a ‘SAS Panel’) within 28 days of receipt of the patient’s appeal. The panel should include appropriate representations (including LMCs and if appropriate, a patient representative or patient representative group, (when requested by or agreed with the patient). A **sample** terms of reference for an appeal panel is provided in appendix 8.

6.4.27 The Commissioner will notify the patient of the decision in writing within 14 days of the SAS Panel decision, having first discussed the outcome with the practice from which the patient was removed.

6.4.28 It is the responsibility of the SAS panel to review the evidence provided by the patient in support of their appeal. The SAS Panel will uphold or reject the appeal where it has reasonably considered if a removal under the regulations was made in error, or inappropriately.

6.4.29 Pending the outcome of any appeals process, should the patient need to access Primary Medical Care, this would have to be provided by the SAS to which the patient had been allocated

6.4.30 **Patient Appeals – Additional information**

6.4.30.1 To support appeal panels in their reaching a determination some sample considerations are provided below (these lists are not exhaustive).

6.4.30.1.1 The panel should be assured that:

- The identity of the removed patient and that of the patient that was involved in the incident should be confirmed as the same and be without any doubt.
- Where the reported incident occurred during a clinical consultation, the removed patient had an appointment at the practice on the same day.
- A police incident number has been provided, either at the time of the removal or within 7 days as part of the written report.
- That a written report has been submitted to the Board (usually via PCSE)
- The information provided in the report is consistent with the requirements for immediate removal, as set out in the GMS/PMS regulations.
- The content and strength of any evidence provided by the removed patient does not wholly support their claim that they should not have been removed (for example – clear and incontrovertible evidence that they were out of the country at the time of the incident or at another location e.g. in-patient in a hospital).

6.4.30.1.2 The panel should also:

- Invite the patient to submit any further relevant information or a statement in relation to the alleged incident. This will ensure all parties are considered to have been treated fairly and equally should the matter be escalated to the PHSO or through a legal route.
- Seek confirmation from the practice, which member of staff was involved in the incident

- Seek confirmation from the practice which member of staff requested the deduction
- Discuss the incident with the practice
- Re-confirm with the practice, the details of the patient involved in the incident and cross-check this with the details of the patient making the appeal.

6.4.30.2 In reaching a determination the panel may conclude that the patient appeal should be upheld. In this case, the SAS flag on the patient records should be removed (by the commissioner notifying PCSE) and choice returned to the patient. This presents a number of options to the panel and the commissioner and will depend entirely on the reason for upholding the appeal.

6.4.30.3 If for example a case of mistaken identity is confirmed, the panel in consultation with the commission may (if agreed in advance with the removing practice) seek to return the patient to the practice they were removed from.

6.4.30.4 Return choice to the patient enabling them to choose another local practice. This could be an option where the practice that removed the patient under the immediate removal process considers there has also been an irrevocable breakdown in relationship.

6.4.30.5 In reaching a determination that the patient appeal should be rejected, the patient should remain on the SAS and be reviewed in accordance with policy

6.4.30.6 In all cases the patient must be notified within 14 days of the appeal hearing

6.5 Working with Primary Care Support England (PCSE) (delivered on behalf of NHS England by Capita)

6.5.1 Brief Introduction to PCSE

[\(https://pcse.england.nhs.uk/organisations/general-practices/\)](https://pcse.england.nhs.uk/organisations/general-practices/)

6.5.1.1 In September 2015, PCSE took on responsibility for the delivery of NHS England's primary care support services. PCSE provides support services to GP Practices, Pharmacies, Dentists and Opticians. For General practices they provide services covering:

- Registrations and List Maintenance (Exeter and PDS);
- Medical Records – Responsible for moving hard copy patient medical records and temporary patient records between practices and into storage;
- Supplies – Providing NHS stationery, pre-printed forms, needles and syringes via an online portal;
- GP Payments and Pensions – Administering monthly contracts and reimbursements to GP practices;
- The National Performers List (NPL) – Administering entry and changes to Performers Lists on behalf of NHS England;
- Cervical Screening – Delivering prior notification lists of patients eligible for screening to GPs, sending out call;
- Open Exeter – Providing access control support for Open Exeter.
- Practice Mergers and Closures – Administering the mergers and closures of GP practices.

6.6 Appendices

6.6.1 Appendix One – Sample Violence Reporting Form

- [Sample Violence Reporting Form](#)

6.6.2 Appendix Two – What happens to the patient following allocation?

6.6.2.1 **All** patients immediately removed from a GP practice **must** be allocated to and accepted by the SAS service commissioned by the CCG. This is because the regulations allow for a GP practice to remove a patient, if it transpires that they were previously removed under the violent patient regulations from another practice, and have either not successfully appealed that allocation, or been allocated to, reviewed and discharged by the SAS.

6.6.2.2 Once a patient has been allocated onto the SAS and notified, they will usually remain on the scheme for a minimum of 12 months, with the exception of an upheld appeal or the break clause of six months, which is considered by the provider, only when the patient has been reviewed on a minimum of three occasions within the previous six months.

6.6.2.3 At this point, the patient could be removed from the scheme if there is clear evidence of changed behaviour, with the aim being to try and tackle the underlying causes of their behaviour, and rehabilitate them, as far as possible, through counselling and/or other forms of treatment.

6.6.2.4 Patients who do not co-operate, or show no signs of change in behaviour, will remain registered with the designated practice for a minimum of 12 months. This will be the case even if the patient changes address but remains within the commissioning area.

6.6.2.5 In any case, a patient who has not engaged with the SAS following their immediate removal and allocation to a SAS should remain on the SAS until they do and have been assessed by the SAS provider. Registration with a SAS prevents the patient from being able to freely register with a mainstream, thus protecting the safety of NHS Staff.

6.6.2.6 Where the patient changes address and moves out of the commissioning area relevant to the practice they were immediately removed from, the patient will be transferred to a provider of the SAS in the area where they have moved into. Commissioners should ensure that their SAS providers are aware that they should notify PCSE if a SAS patient moves outside of the CCG.

6.6.2.7 SAS providers should be encouraged to support patients (if requested) in finding an alternative GP Practice upon discharge from the scheme. In doing so, this may help to break a cycle of registration and removal, as patients are supported with the transition. In addition, the SAS provider can allay any concerns a newly registering practice may have about registering the patient.

6.6.2.8 SAS patients should not ordinarily be removed from a SAS for non attendance. In relation to patients that become subject to a term of imprisonment during their SAS registration, currently application of the usual regulations pertaining to the 'Removal from the list of patients absent from the United Kingdom etc' should be applied.

6.6.3 Appendix Three – SAS Sample Good Conduct Guide

- [SAS Sample Good Conduct Guide](#)

6.6.4 Appendix Four – Sample Data Sharing Agreement

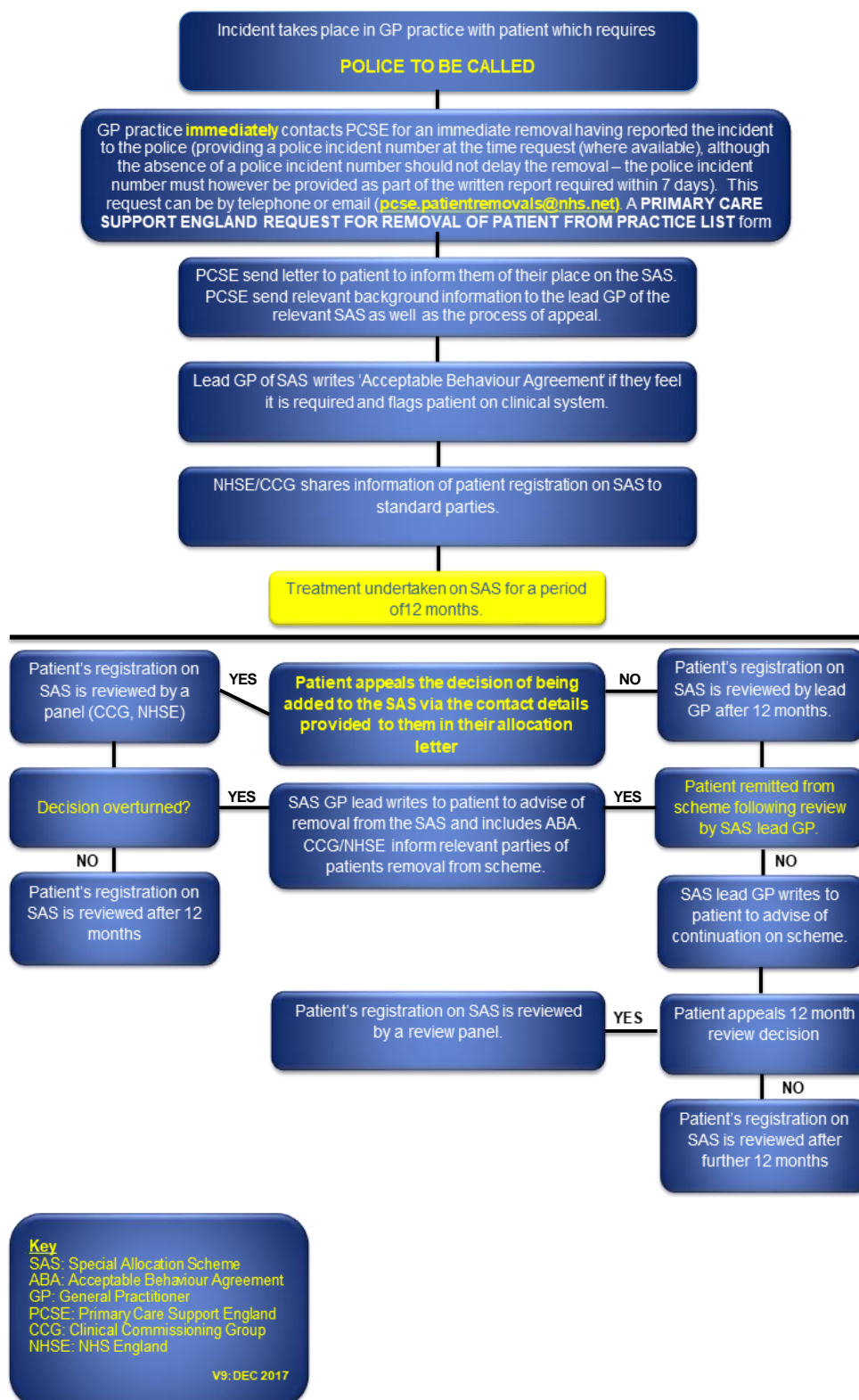
- [Sample Data Sharing Agreement](#)

6.6.5 Appendix Five – Risk Assessment approach

- [Risk Assessment approach](#)

Appendix Six: SAS Allocation and Appeals Flow Chart

Special Allocation Scheme Process Flow Chart (including appeals)



Note: Where a patient has been on a SAS for 2 years or more, they should be reviewed by an exceptional discharge panel every 6 months. **ALL** patients immediately removed from a GP practice **must** be allocated to and accepted by the SAS service commissioned by the CCG (see 6.6.2.1 above).

6.6.5.1 Each Commissioner's SAS Panel should consider any patient appeal. The panel's decision with regard to the removal and SAS allocation does not affect the patient's right to escalate the matter to NHS England via the customer contact centre (<https://www.england.nhs.uk/contact-us/complaint/>) or the Parliamentary and Health Service Ombudsman (PHSO).

N.B. If a patient's appeal is upheld, the Commissioner MUST notify PCSE via pcse.patientremovals@nhs.net

6.6.5.2 The Commissioner should note that when a matter is referred to NHS England for consideration, NHS England will require information regarding the process followed in the patient's appeal and the reasons for the determination of the panel.

6.6.6 **Appendix Seven: Standardised Patient Communication from PCSE**

- [Standardised Patient Communication from PCSE](#)

NHS England is committed to working with its partners, patients and patient representative groups to refine and improve this standardised letter further. We are also committed to making this communication available in alternative languages.

6.6.7 **Appendix Eight – Appeal Panel Terms of Reference (ToR)**

[Appeal Panel Terms of Reference \(ToR\)](#)

Appendix Nine – Sample Patient Letter: Appeal Upheld

[Sample Patient Letter: Appeal Upheld](#)

6.6.8 **Appendix Ten – Sample Patient Letter: Appeal Rejected**

[Sample Patient Letter: Appeal Rejected](#)

7 Contract Variations (templates available)

7.1 Introduction

- 7.1.1 This policy 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 legislation so as to maintain robust contracts.

7.2 Types of Contract Variation

- 7.2.1 Variations to contracts fall broadly within four categories:
- 7.2.1.1 changes due to legislation or regulatory change;
 - 7.2.1.2 changes to the contracting party;
 - 7.2.1.3 changes to services; or
 - 7.2.1.4 changes to the payment arrangements.
- 7.2.2 Where a GMS contract or PMS agreement is varied, the Commissioner is required by the Regulations to notify relevant patients where such variation:
- 7.2.2.1 changes the range of services provided to the contractor's registered patients; or
 - 7.2.2.2 where patients who are on the contractor's list of patients are to be removed from that list.
- 7.2.3 The Commissioner must inform those patients of the steps they can take to obtain elsewhere the services in question or register elsewhere for the provision of essential services (or their equivalent).
- 7.2.4 The Commissioner should consider whether any such provision is contained within an APMS, MCP or PACS contract.

7.3 Legislation / Regulatory Changes

- 7.3.1 Usually both parties to a primary medical contract must agree on a variation in order for it to take effect. The Commissioner may, however, 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 NHS Act or any direction given by the Secretary of State

pursuant to the NHS Act. This right is contained within all GMS, PMS, APMS and where appropriate MCP/PACS contracts.

- 7.3.2 The Commissioner must notify the contractor in writing of the wording of the variation and the date it will take effect. Where it is reasonably practicable to do so, the date the variation will take effect must not be less than 14 days after the notice is served.
- 7.3.3 There is no need for the Commissioner to seek agreement or require a signature of acceptance for this type of variation, as there is no right of refusal or negotiation.
- 7.3.4 The process for issuing a variation notice due to legislation / regulatory changes is:

- 7.3.4.1 a regulatory amendment to existing Regulations or new Directions are issued under statutory instrument. Commissioners should ensure arrangements are in place to take the appropriate action as quickly as possible after the issue of an amendment.
- 7.3.4.2 Where the GMS regulations, PMS regulations and/or APMS Directions are amended, there may be centrally issued GMS, PMS and APMS variation notices. These should be used to update the relevant contracts and ensure contractors are informed of the changes.
- 7.3.4.3 the Commissioner must notify contractors of the variation and its effective date. A template variation notice is provided in Annex 1 for GMS contracts and Annex 2 for PMS/APMS contracts.
- 7.3.4.4 for GMS contractors, the notification should include the GMS variation and the relevant pages of the amended contract document for completeness. For PMS and APMS contractors, the Commissioner will be required to ensure the regulatory amendments become a contractual amendment, citing the correct clause numbers affected within the individually held contracts and including the relevant pages of the document for completeness.
- 7.3.4.5 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.
- 7.3.4.6 commissioners should retain a copy of the notice on file for completeness. Each contract file should contain a variation log and commissioners should ensure that this is updated accordingly.

7.4 Changes to the Contracting Party

7.4.1 Changes to the contracting party may be due to:

7.4.1.1 partnership changes;

7.4.1.2 company changes;

7.4.1.3 retirement (including 24-hour retirement);

7.4.1.4 novations, mergers and splits; and/or

7.4.1.5 death of a contractor

7.4.1.6 Joining an MCP or PACS

7.4.2 There are specific processes to follow on the death of a contractor. Please refer to the chapter on the death of a contractor for further information.

7.4.3 The GMS and PMS Regulations and the APMS Directions contain provisions relating to the remaining scenarios listed above which are considered in more detail below.

7.5 Partnership Changes

7.5.1 Changes to the composition of a partnership will require variation to the contract and may require a variation to the standard registration conditions with the CQC.

7.5.2 Procurement law may be relevant as, in some circumstances, the admittance of a new contracting party may give rise to procurement obligations. Commissioners should refer to relevant published guidance and should take appropriate advice at an early stage. Commissioners must also act in accordance with any procurement protocol issued by NHS England.

7.5.3 The GMS Regulations, the PMS Regulations and the APMS Directions place restrictions on the organisational structures that are eligible to enter into different types of primary medical contracts. Please refer to the 'Contracts Described' chapter for details on the eligibility criteria.

7.5.4 Contracts may be varied in a number of ways with relation to partnership matters, including the following which are looked at in more detail below:

- 7.5.4.1 individual contractors changing to more than one individual (which may be a partnership which requires a different process depending on whether it is a GMS contract or not); and
- 7.5.4.2 changes to the parties of contracts with more than one individual (which may be from a partnership to an individual contractor or changes to the composition of partnerships).
- 7.5.5 There may be many reasons for partnership changes including disputes between parties which are considered further below.

Individual to partnership – GMS contracts

7.5.6 If a GMS contractor is currently an individual medical practitioner who wishes to enter into partnership with one or more individuals under that contract, the contractor is required to notify the Commissioner in writing and provide the following information:

- 7.5.6.1 the name of the person or persons with whom the contractor proposes to practice in partnership;
- 7.5.6.2 confirmation that the person or persons is either a medical practitioner or a person who satisfy the conditions specified in section 86(2)(b) of the NHS Act;
- 7.5.6.3 confirmation that the person or persons satisfies the conditions imposed by regulations 4 and 5 of the GMS Regulations (please refer to the 'Contracts Described' chapter for further information);
- 7.5.6.4 whether or not the partnership is to be a limited partnership and if so, who is a limited and who is a general partner; and
- 7.5.6.5 the date on which the contractor wishes to change its status (which shall not be less than 28 days from the date on which the notice was served on the Commissioner).
- 7.5.7 The notice must be signed by the individual contractor and by the person or persons with whom the individual contractor is proposing to practise in partnership. Where the contractor contacts the Commissioner about such a change, the Commissioner should send Annex 3A.

- 7.5.8 The Commissioner must ensure the accuracy of the information provided. 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.
- 7.5.9 Where the change is agreed, the Commissioner will confirm in writing that the contract will continue with the partnership and issue a variation notice accordingly to amend the relevant sections of the contract. The Commissioner 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 contractor, or the nearest date to it (Annex 3B).
- 7.5.10 A variation notice must include the wording of the proposed variation and the date upon which the variation will take effect. The contractor would then be required to return a signed copy of the variation notice. The Commissioner should ensure that the electronically held contract documentation is amended accordingly.
- 7.5.11 If the new partner is not accepted as eligible the Commissioner should 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 notice is provided by the contractor proposing an alternative eligible partner.

Individual to more than one individual – PMS agreement

- 7.5.12 The PMS Regulations do not allow PMS agreements to be treated as made with a partnership. Where individuals are practising in partnership, the PMS agreement will be entered into with each individual (which may or may not be in partnership). The individual signatories to a PMS agreement collectively form the contractor.
- 7.5.13 The PMS Regulations do not require a PMS agreement to define a specific process for any variation to the signatories. The Commissioner must, therefore, review the relevant PMS agreement to determine whether any provisions have been added relating to this and prior to following any process for variation.
- 7.5.14 If the contractor is currently an individual medical practitioner and they wish to have one or more individuals join them under that agreement, then they must

seek the Commissioner's consent in writing for any such variation to the contract. Where the contractor contacts the Commissioner about such a change, the Commissioner should send Annex 4A. The Commissioner must have consideration of any procurement implications, along with other influencing factors, when considering such an application. commissioners must also act in accordance with any procurement protocol issued by NHS England.

- 7.5.15 The Commissioner must ensure the proposed individual(s) meet the eligibility criteria for holding a PMS agreement (Please refer to the 'Contracts Described' chapter for further information).
- 7.5.16 The Commissioner should confirm its decision on the variation in writing to the contractor detailing the reasons for the decision and details of any information that they have relied upon in the process (Annex 4B).
- 7.5.17 If the decision is to consent to the variation, then the Commissioner shall issue a variation notice accordingly to amend the relevant sections of the contract. A variation notice should include the wording of the proposed variation and the date upon which the variation will take effect. The contractor would then be required to return a signed copy of the variation notice. The Commissioner should ensure that the electronically held contract documentation is amended accordingly.
- 7.5.18 If the contractor does not return a signed copy of the variation notice, then no amendment to the agreement can take place.
- 7.5.19 If the new partner is not accepted as eligible the Commissioner should 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 as it was until the matter can be resolved or a further notice is provided by the contractor proposing an alternative eligible partner.

Individual to more than one individual – APMS contract

- 7.5.20 APMS contracts can be entered into with a partnership and the Commissioner should consider the wording of the relevant contract to determine whether there are any specific provisions covering a request from the contractor to have one or more individuals join them under the contract. Where there are no such provisions, a similar process to PMS agreements could be followed.

Changes to contracts with more than one individual – GMS contracts

7.5.21 Changes to the contracting parties may occur where a partnership dissolves or terminates or where the composition of the partnership changes. Both scenarios are explained below.

7.5.22 Where a partnership is dissolved or terminated and the contractor consists of two or more individuals practising in partnership, the contract may continue with one of the former partners if the following conditions apply:

7.5.22.1 the former partner must be nominated by the contractor; and

7.5.22.2 the former partner must be a medical practitioner that meets the condition in regulation 4(2)(a) of the GMS Regulations.

7.5.23 The nomination of the former partner by the contractor must:

7.5.23.1 be in writing and signed by all of the persons who are practising in partnership. Where the contractor contacts the Commissioner about such a change, the Commissioner should send Annex 5A;

7.5.23.2 specify the date on which the contractor proposes to change its status from that of a partnership to that of an individual medical practitioner;

7.5.23.3 be provided to the Commissioner at least 28 days in advance of the date on which the contractor proposes to change its status from that of a partnership to that of an individual medical practitioner; and

7.5.23.4 specify the name of the medical practitioner with whom the contract will continue, which must be one of the partners.

7.5.24 Where the Commissioner receives such a nomination, it must acknowledge receipt in writing before the date specified in the nomination as the date on which the contractor proposes to change its status from that of a partnership to that of an individual medical practitioner.

7.5.25 Where the Commissioner agrees the nomination, the Commissioner may vary the contract but only to the extent that it is satisfied it is necessary to reflect the change in status of the contractor from a partnership to an individual medical practitioner. The Commissioner must notify the contractor in writing of the wording of the proposed variation and the date upon which that variation is to take effect.

- 7.5.26 A template notice is provided at Annex 5B. A variation notice will need to be included with this letter.
- 7.5.27 The Commissioner should be satisfied that the arrangements in place for continuity of service provision to the contracts registered patients are robust.
- 7.5.28 In circumstances where the Commissioner 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, to explore potential solutions.
- 7.5.29 These might include the partners nominating an alternative partner to continue with the contract, in which circumstances a new notice should be issued to the Commissioner to include these details and propose a new date on which the changes will occur.
- 7.5.30 Where the contractor consists of two or more individuals practising in partnership and the composition of the partnership changes, either by a partner leaving (but without the partnership terminating) or a new partner joining, the contract will need to be amended to recognise the new partnership composition. For the variation to have effect, it must be in writing and signed by all parties to the contract.

Changes to contracts with more than one individual – PMS agreements

- 7.5.31 As stated in paragraph 7.5.13, the PMS Regulations do not require a PMS agreement to define a specific process for any variation to the signatories. The Commissioner must, therefore, review the relevant PMS agreement to determine whether any provisions have been added relating to this and prior to following any process for variation.
- 7.5.32 If the contractor is currently two or more individuals and wish to change to an individual contractor, then they must seek the Commissioner's consent in writing for any such variation to the contract. Where the contractor contacts the Commissioner about such a change, the Commissioner should send Annex 6A. The Commissioner must consider any procurement implications, along with other influencing factors, when considering such an application. commissioners must also act in accordance with any procurement protocol issued by NHS England.

- 7.5.33 The Commissioner must ensure that the proposed individual(s) meets the eligibility criteria for holding a PMS agreement (Please refer to the 'Contracts Described' chapter for further information).
- 7.5.34 The Commissioner should confirm its decision on the variation in writing to the contractor detailing the reasons for the decision and details of any information that they have relied upon in the process (Annex 6B).
- 7.5.35 If the decision is to consent to the variation, then the Commissioner shall issue a variation notice accordingly to amend the relevant sections of the contract. A variation notice should include the wording of the proposed variation and the date upon which the variation will take effect. The contractor would then be required to return a signed copy of the variation notice. The Commissioner should ensure that the electronically held contract documentation is amended accordingly.
- 7.5.36 If the contractor does not return a signed copy of the variation notice, then no amendment to the agreement can take place.
- 7.5.37 If the new individual is not accepted as eligible the Commissioner should advise the contractor in writing of the reasons they believe the individual is ineligible and confirm that the contract status will remain as it was until the matter can be resolved or a further notice is provided by the contractor proposing an alternative eligible individual.
- 7.5.38 The principles outlined in paragraphs 7.5.31 to 7.5.37 will also apply where the contractor consists of two or more individuals and the composition of the contractor changes, either by an individual wishing to leave the agreement or a new individual joining the agreement. The contract will need to be varied to recognise the new contractor composition.
- 7.5.39 The Commissioner should ensure that it is satisfied that the contractor will remain eligible to hold the agreement after the variation. For the variation to have effect, it must be in writing and signed by all existing (and new) individuals to the contract.
- 7.5.40 The Commissioner should also 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 post-variation contractor's ability and capacity to fulfil the obligations of the contract and their proposals for the future of the service.

7.5.41 APMS or PMS contracts are not required to contain a right of termination where one or more persons have left the practice during the existence of the contract. The Commissioner should review the relevant contract to determine whether any such provisions have been included.

Changes to contracts with more than one individual – APMS contracts

7.5.42 The Commissioner should consider the wording of the relevant APMS contract to determine whether there are any specific provisions relating to changes to the composition of the contractor. Where there are no such provisions, a similar process to PMS agreements could be followed.

Partnership splits/members dispute – GMS and PMS

7.5.43 Where the contractor to a GMS contract is a partnership and the partnership dissolves due to an internal partnership dispute, the contract will terminate unless the parties agree for the contract to continue with one partner (see paragraph 7.5.22 of this policy). The Commissioner may have little time to make arrangements to ensure service continuity.

7.5.44 It is, therefore, desirable that the partners of a GMS contract are able to resolve disputes internally where possible, with the support of the LMC and/or mediation services.

7.5.45 If the partnership holding a GMS contract does not dissolve or terminate but the partnership no longer wishes to be a party to the contract, then the contractor will need to terminate on notice, which must not be less than six months unless agreed by the Commissioner. Failure to give six months' notice of termination is a breach of contract and the appropriate action will be taken in line with the chapter on contract breaches, sanctions and terminations.

7.5.46 Under PMS agreements, subject to the terms of the individual agreements, partnership matters (including dissolution or termination of the partnership) do not affect the continuation of the agreement. This is because where the agreement is with two or more individuals that are practising in partnership, the agreement is not entered into with the partnership but instead with the individuals (who collectively make up the contractor).

7.5.47 If a PMS contractor is practising in partnership and, following termination of a partnership, the contractor no longer wishes to be a party to the contract, the

contractor will need to give notice to terminate the contract, such notice being a minimum of six months unless agreed with the Contractor.

7.5.48 Where partnerships or membership are formalised through a partnership agreement, 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.

7.5.49 Unfortunately, many partnership organisations do not have agreements in place or have insufficient or outdated documents which can often lead to very protracted and acrimonious disputes between the partners.

7.5.50 The Commissioner should not get involved in endeavouring to resolve the dispute between the partners, instead insisting that the parties notify the Commissioner of their final decision when it is reached.

7.5.51 It is likely that the Commissioner will have numerous contacts from different partners and their staff about the dispute but the Commissioner should try to maintain a detached position in this respect. Any accusations of inappropriate behaviour or concerns should be considered, however, this should not be used as a means to endeavour to resolve the dispute.

7.5.52 Throughout the dispute the commissioners should maintain open dialogue with the LMC and implement contract performance management protocols, if and when necessary.

7.6 Retirement of a Contractor – Single Handed

7.6.1 There is no specific reference to retirement in the GMS Regulations, the PMS Regulations or the APMS Directions. The Commissioner should deal with a request to retire as a request to terminate the contract by the contractor on notice.

7.6.2 The contractor must provide the Commissioner with a written notification of the intended retirement date which will be the termination date of the contract. This notice period must not be less than three months for GMS contracts held by an individual medical practitioner or less than six months for GMS contracts that are not held by an individual and for PMS/APMS contracts. Leaving MCP and PACS contracts are subject to different arrangement and commissioners should seek legal advice.

- 7.6.3 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.
- 7.6.4 For PMS/APMS contracts, there is no such requirement. The Commissioner must calculate the date of termination, based on the terms in the individual contract and from the date of the notice.
- 7.6.5 In exceptional circumstances, such as ill health, the Commissioner 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 is unwell to the full notice term may have on the contractor, the practice's patients and colleagues.
- 7.6.6 In either case the Commissioner should 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.
- 7.6.7 Although not required by the GMS Regulations, the Standard GMS Contract clearly sets out the arrangements that must be made on termination of a contract, which include (but are not limited to) the contractor having to:
- 7.6.7.1 cease performing any work or carrying out any obligations under the contract;
 - 7.6.7.2 co-operate with the Commissioner to enable any outstanding matters under the contract to be dealt with or concluded satisfactorily;
 - 7.6.7.3 co-operate with the Commissioner to enable the contractor's patients to be transferred to one or more other contractors or providers of essential services (or their equivalent); and
 - 7.6.7.4 deliver up to the Commissioner 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.
- 7.6.8 The Commissioner 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 the Commissioner 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.

- 7.6.9 On termination of the contract, the Commissioner shall perform a reconciliation of the payments made by the Commissioner to the contractor and the value of the work undertaken by the contractor under the contract. The Commissioner 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.
- 7.6.10 Each party shall pay the other any monies due within three months of the date on which the Commissioner 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.
- 7.6.11 PMS/APMS contracts must make suitable provision for arrangements on termination (or leaving and MCP or PACS), including the consequences (whether financial or otherwise) of the contract ending, subject to any specific requirements in the regulations. While these terms are likely to mirror those set out in GMS contracts, the individual contracts must be checked by the Commissioner to ensure that no additional or alternative terms were included. This is especially important when considering termination of an APMS contract, which often included very specific additional terms in this respect.
- 7.6.12 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.
- 7.6.13 For a list of considerations relating to termination, please refer to the chapter on contract breaches, sanctions and terminations.

7.7 Retirement of a Contractor – Two or More Partners/Individuals

- 7.7.1 Where a partner wishes to retire from a GMS partnership, as constituted from time to time, the contractor will need to notify the Commissioner that it wishes to vary the contract. The Commissioner should follow the process in paragraphs 7.5.21 to 7.5.30 of this policy.
- 7.7.2 Where an individual wishes to retire from a PMS agreement, where that agreement is also held by one of more other individuals, the contractor will need

to notify the Commissioner that it wishes to vary the agreement. The Commissioner should follow the process in paragraphs 7.5.31 to 7.5.40 of this policy.

- 7.7.3 Where a partner of a partnership holding an APMS contract wishes to retire, the Commissioner should follow any process defined within the contract, or in the absence of any defined process, the consent of the Commissioner must be sought through a contract variation.
- 7.7.4 The Commissioner should always keep in mind the possible implications on procurement and competition when applying the guidance in this policy.
- 7.7.5 Any changes to the partners within a contract may require a new registration with the CQC.

7.8 Twenty-Four Hour Retirement

- 7.8.1 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).
- 7.8.2 24-hour retirement usually involves resigning from all involvement in an NHS contract, not returning to the NHS in any capacity for at least 24 hours and not working for more than 16 hours a week in the first month of retirement. The Commissioner should ensure that it is aware of the current conditions around 24-hour retirement.
- 7.8.3 If the Commissioner is approached by a contractor wishing to take 24-hour retirement, it must not offer advice relating to pension arrangements.
- 7.8.4 Where a contractor confirms that 24-hour retirement requires "resignation" from the contract, steps will need to be taken to ensure that the contractor is removed from the contract, either by:
 - 7.8.4.1 termination on notice in the case of a single-handed contractor; or
 - 7.8.4.2 variation of the contracting party in the case of a partnership.
- 7.8.5 The Commissioner may wish to suggest single-handed practitioners take independent advice, as 24-hour retirement using the method described above would necessitate the termination of the contract as set out in paragraphs 7.6.1 to 7.6.13.

- 7.8.6 The Commissioner must make clear to the contractor that there is no guarantee that the Commissioner would commission services from that individual following termination.
- 7.8.7 Please refer to the NHS England Legal Team for further information on procurement implications england.legal@nhs.net.

7.9 Variation Provisions Specific to a Contract with a Company Limited by Shares (GMS) or a Qualifying Body (PMS)

- 7.9.1 A GMS contract may be held by a company limited by shares (subject to certain conditions). PMS agreements 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 into a PMS agreement).
- 7.9.2 APMS contracts, in principle, have fewer restrictions on the types of organisations that may enter into the contracts and therefore the Commissioner can enter into APMS contracts with any individual or organisation that meets the provider conditions detailed in the APMS Directions.
- 7.9.3 For further information on what types of organisations can enter into the different types of contracts (please refer to the 'Contracts Described' chapter for further information).

7.10 Contracts and Incorporation/Dis-incorporation

- 7.10.1 It is possible for individual GPs or partnerships holding a GMS, PMS or APMS contract to seek commissioner approval to operate and deliver services through a company limited by shares (called a "qualifying body" in PMS) - this process is known as "incorporation". A change from a single-handed or partnership contract to a limited company is a complete change of the identity of the contracting party, regardless of whether the company is owned and/or run by the original contractors.

7.10.2 Dis-incorporation is the same process in reverse.

7.10.3 There is no right for a contractor to incorporate or dis-incorporate. They need agreement from the Commissioner, which does not have to be given. In reaching their approval or rejection decision, a commissioner should consider carefully the proposal including assessing the application for its benefits, for example to patients, but also the opportunities including strategic alignment with local priorities to transform services and improve care quality. A commissioner should also consider the risks.

7.10.4 There are a range of incorporation scenarios that commissioners may be asked to consider. The most straightforward scenario is a request for the existing individual contractor(s) to form a company and continue to run the business themselves as the shareholders and directors of that company (or vice versa on dis-incorporation). There are also scenarios that might seek to change the nature of the contractor:

- a request to form or become part of a company in which one or more existing contractor(s) will hold some shares but they may not have overall control of that company – this should be carefully assessed for procurement and other risks; and
- a request to transfer the contract to an existing or new company controlled by completely separate third parties in which the existing contractor(s) hold no interest – this is a request to transfer the contract to an apparently completely unrelated third party and should be carefully assessed for procurement and other risks.

To note: In scenarios that include a plan to merge practices there are a further set of considerations as set out in paragraph 7.11

7.10.5 A commissioner may conclude that a proposal, and the associated benefits, is worth supporting provided that there is alignment with local strategic priorities and identified risk can be mitigated and/or minimised. If so, the contract will need to transfer from the old to the new contractor. A legal document called a novation agreement is used - its primary function is to change the parties to

the contract. In practice, it ends the contractual relationship between the commissioner and old contractor and creates a contractual relationship between the commissioner and new contractor. The agreement must be signed by each of the three parties. (To note: signing a novation agreement counts as the award of a new contract for procurement purposes – as such there may be procurement law implications. Commissioners must also act in accordance with any procurement protocol issued by NHS England). A contract variation cannot be used in place of a novation agreement.

7.10.6 The novation agreement can also capture what has been agreed at the point of novation including the nature of any controls, including pre-conditions to be satisfied, that have been placed upon the contractor. Any such provisions can be added to the template novation agreement in Annex 17. This is likely to require legal advice.

7.10.7 In some incorporation scenarios, it may involve a contractor selling its business and as part of the sale it is transferring its contracts, including its list of registered patients, to the buyer. In the event the request is approved and the contract is novated, the buyer is agreeing to take over the seller's responsibilities for performing the contract, along with any associated debts and obligations.

7.10.8 It is anticipated that GP practices operating on a PCN footprint may seek to incorporate. The drivers for this may include strengthening their collaboration with their PCN partners to deliver primary medical services, the 'network' contract and potentially other locally commissioned services.

7.10.9 Scenarios involving 'at scale' providers of primary medical services⁹ would create systemically important companies if those requests are approved.

7.10.10 Incorporation toolkit

⁹ At scale in this context can be defined in a number of ways: a) by the size of the population served, for example, on PCN footprint b) by the number of contracts held and c) by the extent to which they operate across multiple commissioner areas. Only one of these needs to be present but, in some cases, one or more may be present.

7.10.11 To support effective decision making in these scenarios, NHS England and Improvement has, in collaboration with regional and CCG colleagues, co-developed a toolkit that includes a standardised approach for assessing the requirements and considerations set out in this chapter. The toolkit includes:

- A standardised assessment framework to support commissioner decision making processes
- A supporting guidance document to help commissioners apply the framework and consider essential checks and risk mitigations including for the 'at scale' provider of primary medical services scenarios
- An application template for providers aligned to this framework
- An example due diligence procedure that CCGs and their regional NHS England and Improvement teams can adapt and tailor according to local arrangements.

7.10.12 The objective of that toolkit is to support commissioners to:

- undertake their due diligence in a structured and consistent way including a standardised approach for assessing the requirements and considerations set out in this chapter;
- reach an approval or rejection decision based on assessed levels of risk; and
- apply approval conditions as necessary to mitigate identified risks and issues

7.10.13 The assessment framework has been designed to be comprehensive in scope and to support commissioners to assess all incorporation scenarios. The framework should be applied in full when assessing 'complex' or novel incorporation proposals, for example, those involving 'at scale' providers of primary medical services. For more straightforward incorporation applications, commissioners should use their discretion as to whether the assessment framework should be applied in full. For all applications, Commissioners should be able to audit and justify their approval or rejection decision.

7.10.14 The toolkit is intended to supplement – not replace - the considerations and guidance set out further in the remainder of this chapter. improved and refined in light of feedback from commissioners and kept under review by NHS England and NHS Improvement.

7.10.15 **Annexes**

7.10.15.1 Annex 1 The Common Assessment Framework for Incorporation requests: Support and Guide

[The Common Assessment Framework for Incorporation requests: Support and Guide](#)

7.10.15.2 Annex 2 Acknowledgement of requests to incorporate and incorporation Application – Template and Guide

[Acknowledgement of requests to incorporate and Incorporation Application – Template and Guide](#)

7.10.15.3 Annex 3 Assessment Framework

[Assessment Framework](#)

Procurement considerations

7.10.16 Contractors should be made aware that on incorporation or dis-incorporation the Commissioner could potentially decide to competitively tender any new contract in accordance with procurement law, instead of agreeing to award it to the proposed new contractor. The existing or proposed new contractor may not be successful in winning the new contract.

7.10.17 The Public Contracts Regulations 2015 (PCR 2015) provide protection from a procurement challenge in relation to some requests for incorporation or dis-incorporation. The relevant parts of regulation 72 of the PCR 2015 provide that:

Contracts may be modified without a new procurement procedure where a new contractor replaces the one to which the contracting authority had initially awarded the contract as a consequence of –

- an unequivocal review clause or option in conformity with the regulations (but note that the standard GMS, PMS and APMS contracts do not provide such a clause or option), or
- universal or partial succession into the position of the initial contractor, following corporate restructuring, including takeover, merger, acquisition or insolvency, of another economic operator that fulfils the criteria for qualitative selection initially established, provided that this does not entail other substantial modifications to the contract and is not aimed at circumventing the application of the regulations.

7.10.18 Regulation 72 of PCR2015 goes on to confirm that a change of contractor outside of the above exemption is a change that requires a new procurement process.

7.10.19 This means that the Commissioner should consider whether the proposed incorporation or dis-incorporation of an above-threshold contract falls within the above exemption. If it does, there would be no requirement for a new procurement and so no risk of procurement challenge if the Commissioner agreed to the request.

For example, if there is a change in structure from a body corporate to a partnership consisting of the directors of the body corporate then this would not require a new procurement as long as the following criteria are met:

- The new contractor fulfils the criteria for qualitative selection initially established.
- The change does not entail other substantial modifications to the contract.
- The change is not aimed at circumventing the application of the Regulations.

7.10.20 It is important to be aware that the procurement exemption described above covers only a change to the contractor party. It does not allow for other substantial changes to be made to the contract on novation. Among other things, extension of the scope of the contract, or altering the economic balance in favour of the contractor, are things which usually require a new

procurement, unless they fall within a particular exemption in the PCR2015. This means that in agreeing a change of contractor, the Commissioner should not ordinarily agree any significant changes to the contract in favour of the contractor.

7.10.21 The contractor may be unwilling to relinquish its original contract, unless it receives assurances from the Commissioner that the Commissioner will commission an equivalent (or mutually agreed) level of activity from the proposed new contractor under the new contract. As set out below, there are factors that the Commissioner should consider before providing any such assurance or agreeing to a contract novation.

Managing a request for Incorporation or Dis-incorporation

7.10.22 On receipt of a request from a contractor to incorporate or dis-incorporate, the process below should be followed.

7.10.22.1 the Commissioner should acknowledge the request and send the contractor an assessment template. A letter and the assessment template for incorporation are provided in Annex 7 with a form for internal Commissioner use provided in Annex 8. A letter and assessment template for dis-incorporation is provided in Annex 9.

7.10.22.2 the Commissioner should make the contractor aware of the potential implications of the incorporation or dis-incorporation as outlined in paragraph Contractors should be made aware that on incorporation or dis-incorporation the Commissioner could potentially decide to competitively tender any new contract in accordance with procurement law, instead of agreeing to award it to the proposed new contractor. The existing or proposed new contractor may not be successful in winning the new contract.

7.10.22.3 On receipt of the information, the Commissioner should review the application using the toolkit and decide whether or not to agree the request.

7.10.23 The Commissioner should first consider whether the proposed new contractor is eligible to enter into the contract. If it is not eligible, the Commissioner must refuse the request. A template letter of refusal of a request to incorporate is provided at Annex 10 and in respect of dis-incorporation at Annex 11.

7.10.24 Where the proposed contractor is eligible, the Commissioner should undertake further essential checks (including that they are satisfying their own statutory duties) and undertake a risk based assessment when assessing any request.

7.10.25 These matters are outlined further in this section and detailed in the incorporation toolkit. In considering these matters, the Commissioner is required to act reasonably and in accordance with public law principles. Matter to consider include:

- 7.10.25.1 the Commissioner's obligations under procurement law to determine whether there is a risk of challenge in agreeing the request and whether a competitive tender process should be carried out to select any new contractor (see also procurement section above);
- 7.10.25.2 the effect of the proposal on the statutory duties of NHS England, particularly the involvement duty under section 13Q¹⁰ of the NHS Act 2006 (although this is not usually triggered by a change solely to the identity of the contractor), duty under section 13K (duty to promote innovation) and section 13P (duty as respects variation in provision of health services) (see chapter 4, general duties);
- 7.10.25.3 the value of the contract – both in terms of whether it represents value for money and whether it would be a contract of interest to others;
- 7.10.25.4 the likely level of market interest in the contract;
- 7.10.25.5 the potential for innovation;
- 7.10.25.6 the need to protect services in the core contract – Commissioners should ensure that if novation goes ahead it will not result in any reduction in services to patients;
- 7.10.25.7 whether the Commissioner is satisfied that there will be continuity of patient care;
- 7.10.25.8 the extent to which the original contractor(s) will be controlling and giving instructions to the proposed contractor to comply with contractual obligations;
- 7.10.25.9 the extent of change to the terms of the existing contract (e.g. contract value or services) – this is important in assessing both procurement risk (see procurement section above) and whether there is a service change requiring patient and public involvement;
- 7.10.25.10 payments under the existing contract and value for money;

¹⁰ Note: In the coming months, supplementary information and guidance will be made available to commissioners in the form of FAQs.

7.10.25.11 benefits to patients of the proposal – these should be outlined by the contractor and, as a minimum, there should be no detrimental impact on patients or reduction in services;

7.10.25.12 opening hours (including evening and weekend) required – note that any reduction may trigger the patient and public involvement duty (see general duties, s13Q) and in any case, is unlikely to be acceptable unless there are exceptional reasons justifying such a change;

7.10.25.13 sustainability – the Commissioner should be assured that the proposed novation will ensure ongoing sustainability of the practice and patient services in the area going forward;

7.10.25.14 any impact on patient choice;

7.10.25.15 any impact on competition between providers (see procurement section above);

7.10.25.16 whether the Commissioner requires that the existing contractor guarantees the performance of the proposed contractor (for example, this may be appropriate where on incorporation the new company will not have any assets) – any such requirement must be proportionate to the risks associated with the novation and reasonable with a clear rationale for placing such a responsibility on the existing contractor – legal advice should be sought;

7.10.25.17 whether the Commissioner has any concerns about the proposed contractor's financial standing and financial stability – serious concerns are likely to suggest they are unsuitable as a contractor, whereas minor concerns could for example be a factor in deciding to seek a guarantee;

7.10.25.18 whether the Commissioner is satisfied with the proposed contractor's plans for managing and operating the practice, including any proposed changes from current arrangements;

7.10.25.19 whether the proposed contractor is a company¹¹:

- but is not registered with Companies House (the contractor may take the view that this cannot be finalised until agreement in principle has been given by the

Commissioner);

- and any director of the company has been disqualified from another registered company (check Insolvency Website and Companies House Disqualified Directors);

7.10.25.20 an unsatisfactory Disclosure and Barring Scheme;

7.10.25.21 whether the existing contractor has outstanding debts and whether novation is made conditional on repayment being made;

7.10.25.22 whether the existing contractor has received any breach or remedial notices or contract sanctions and whether novation is made conditional on the proposed contractor taking on the consequences of the notices, e.g. action the remedial activity; and/or

7.10.25.23 whether the existing contractor has outstanding issues regarding CQC inspection or practice inspection by the Commissioner and whether the novation should be made conditional on those issues being resolved – or in some circumstances it may not be appropriate to agree to a novation until those issues are resolved.

Making a decision

7.10.26 Each of the above factors, along with any other relevant information about the particular request, should be carefully considered in deciding whether or not the Commissioner will consent to the incorporation or dis-incorporation request. If there are concerns about the level of risk of challenge, legal advice should be sought.

7.10.27 Requests for incorporation or dis-incorporation should be agreed with or without conditions unless there are concerns that the request will not benefit patients or will create a significant risk of successful procurement law or other challenge.

¹¹ **Note:** In the coming months, supplementary information and guidance will be published in the form of FAQs, alongside the PGM. The material will be published on NHS England website at the same location as this document.

7.10.28 In practice, if the Commissioner does not agree to novate the contract, the existing contractor may decide not to incorporate/dis-incorporate but to keep the existing contract in place. Where this happens, there will be no new contract to put out to procurement¹².

Agreeing the request

7.10.29 Where the Commissioner agrees the request, the original contract will be novated. A template letter is provided at Annex 12 and a template novation agreement at annex 17.

7.10.30 As a contract novation is technically termination of the original contract and replacing it with a new contract, the Commissioner must make appropriate arrangements for termination of the contractual relationship with the outgoing contractor including:

7.10.30.1 carrying out a financial reconciliation; and

7.10.30.2 any other requirements in the contract relating to termination.

7.10.31 The novation process, and the discretion commissioners have in approving the request, provides an opportunity for commissioners to negotiate and agree a range of controls with the contractor. Those controls can take the following forms (these are not mutually exclusive):

- Contractual requirements: there is some, although limited, scope to agree local contract variations that would bind contractors into a course of action and be enforceable using the core contractual levers.
- Non-contractual requirements: these are declarative statements of intent that describe expected behaviours and/or actions but are not enforceable through the core contract

7.10.32 There are opportunities and limitations in implementing both type of controls. The supporting guidance that forms part of the toolkit set out further advice on how the contract novation process can be used by the

¹² **Note: In the coming months, supplementary information and guidance will be made available to commissioner in the form of FAQs.**

commissioner to address identified risks and issues should they wish to approve the request.

7.10.33 Contractual requirements are the most binding form of control that can be placed on a contractor. They must be agreed between, and signed by, both parties in line with local contractual variation processes.

7.10.34 As the contractor has to agree to them, negotiating local contract variations at the same time as considering novation puts the commissioner in a good negotiating position. The value of documenting them in the novation agreement is to confirm and emphasise what has been agreed contractually at the point of novation.

7.10.35 However, there are rigid national rules and processes governing the core GP (GMS/PMS) contractual framework that limit the scale and nature of what local contractual variations are implementable outside of the national requirements (which cannot be changed).

7.10.36 The nature of what is permissible when seeking to vary the contract needs to be considered on a case by case basis. In summary, the following broad principles act as parameters as to what might be suitable:

- Variations are targeted, proportionate, and can be justified on reasonable grounds - these can be linked to either contractor performance, their capabilities and contractual management arrangements
- Variations must not seek to alter or extend the agreed core GMS service provision requirements - these are negotiated nationally with the BMA and are reflected in the relevant GMS/PMS contract regulations and statement of Financial Entitlements (SFE).

7.10.37 There are a practical set of local contract variations that are pre-cautionary, support provider sustainability and can help mitigate for the occurrence and consequences of provider failure in line with good practice. For example, as the new contractor will be a body corporate, it will be appropriate to require that the new contract contains a change of control

clause. Such a clause requires the contractor to notify the Commissioner where there is a change in ownership or control of the contractor and can include a requirement to obtain the Commissioner's consent. If the Commissioner does not consent to the change but the contractor proceeds anyway, the Commissioner may issue a Remedial Notice.

7.10.38 The supporting guidance that forms part of the toolkit describes the different types of controls in more detail including the circumstances in which they might apply.

7.10.39 Commencement of the new contract must be made conditional on the new contractor being CQC registered. The CQC cannot provide the Notification of Decision until the date of commencement is agreed. The contractor should, however, provide the Commissioner with written confirmation from the CQC that the CQC does not intend to impose any restrictions on registration of the new contractor.

Disputes

7.10.40 Where the contractor does not agree with the Commissioner's decision, the contractor may appeal the decision. Please refer to the chapter on managing disputes for further information.

Payment system requirements

7.10.41 Following the commissioner's decision, any changes to the contracts must be made on the relevant payment and contract management systems.

7.11 Practice Mergers and/or Contractual Mergers

7.11.1 A GP or partnership may hold more than one form of primary care contract with a Commissioner. For example, a GMS contractor can also be a party under a PMS agreement and vice versa and/or a company may, for example, hold several GMS contracts.

7.11.2 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 coming together.

7.11.3 The overarching issues for the Commissioner to consider when any such proposal is made are the benefits to patients and the financial implications of the practice merger.

Note: Where a proposed merger involves one or more dispensing practices, contract managers should also refer to the Pharmacy Manual

<https://www.england.nhs.uk/commissioning/primary-care/pharmacy/manual/>

Practice merger models

7.11.4 There are many ways in which practices may seek to come together. The most common are listed below but Commissioners should recognise that a proposed practice merger may fall into one or more of the models below or may propose a different approach:

7.11.4.1 Model 1: GP providers agree loose arrangements such as sharing back office functions or management staff or may even create a new legal entity to manage and oversee the delivery of services under the GP contracts. This is not a formal merger and the contracts with the Commissioner will not change (this model is often referred to as a contractual joint venture).

7.11.4.2 Model 2: The GP partners from Practice A may join the partnership of Practice B and vice versa. The new partnership may continue to hold the two separate contracts but will have merged at an operational level.

7.11.4.3 Model 3: GP partners from Practice A join the partnership of Practice B and Practice A ceases trading. The Commissioner terminates Practice A's contract and varies Practice B's contract to include the services originally provided by Practice A. This may happen with more than two practices so that the larger partnership holds one larger contract for services originally provided by a number of practices under a number of contracts. The parties are likely to enter into a business transfer agreement for the transfer of assets and staff.

7.11.4.4 Model 4: GP providers come together to create a new legal entity (for example, the GP partners become shareholders of a new company limited by shares). This may involve:

- novating the existing GP contracts to the new entity (see also 7.10 (incorporation));
- terminating the majority of the existing GP contracts and varying one to include all existing services; or
- terminating the existing GP contracts and directly awarding a new contract to the new entity.

7.11.5 Practice mergers can be complex matters which should not be approached lightly by either the contractors or the Commissioner. Where a practice merger requires amendments to the practice contracts, the final commissioning decision on whether contracts should be amended to effect the proposed merger, lies with the Commissioner. The Commissioner does not have to agree to change the existing contracts and there are a number of

important issues that would need to be considered, prior to giving consent. An overview of the potential issues is set out below. This is by no means an exhaustive list and the Commissioner should refer to and seek appropriate guidance in each case to ensure that all relevant matters are considered. Some of the factors set out in 7.10 in deciding on whether to agree to a novation are likely to be relevant here too, so please refer to that section for more information.

Benefits to patients

7.11.6 The Commissioner should consider the following matters in relation to the effect of the proposed practice merger on patients:

- 7.11.6.1 how patients would access a single service;
- 7.11.6.2 what would the practice boundary be (inner and outer);
- 7.11.6.3 assurances that all patients will access a single service with consistency across provision, i.e. home visits, booking appointments, essential and additional services, opening hours, extended hours, and so on, single IT and phone system;
- 7.11.6.4 premises arrangements and accessibility of those premises to patients;
- 7.11.6.5 proposed arrangements for involving the patients about the proposed changes, communicating the change to patients and ensuring patient choice throughout;
- 7.11.6.6 the impact on patient choice; and
- 7.11.6.7 how the proposed merger is intended to benefit patients.

Costs/value for money

7.11.7 A contract merger is likely to merge two contracts with differing values, this would have an 'averaging' effect, possibly resulting in a higher cost per head of population under a single contract than the Commissioner would have expected. For example:

- 7.11.7.1 practice A attracts £120 per patient with a list size is 1,400;
- 7.11.7.2 practice B attracts only £90 per patient but has a list size of 5,000;
- 7.11.7.3 practice A's contract value by registered population = £168,000;
- 7.11.7.4 practice B's contract value by registered population = £450,000;
- 7.11.7.5 total cost to the Commissioner = £618,000;
- 7.11.7.6 a merger would result in a list size of 6,400 patients and as result the per patient cost would require renegotiation. From a procurement perspective, the Commissioner should not usually enter into a new contract at a higher value than that covering the existing contracts.
- 7.11.8 There may be other financial arrangements that need to be considered including but not limited to:
 - 7.11.8.1 the impact of directions under the Statement of Financial Entitlements, or any specific terms included in the individual contracts;
 - 7.11.8.2 QOF - merging contracts midway through a financial year in respect of QOF achievements and payments is enormously complex and requires significant safeguards to be built in to ensure there is no duplication of payments at year-end. There will also be an averaging of the arrangements and achievements in this respect too. For example:
 - 7.11.8.3 practice A has always achieved highly against each indicator of QOF;
 - 7.11.8.4 practice B has struggled to meet the criteria under several of the indicators;
 - 7.11.8.5 the results of a merger might be a single practice with mediocre achievement against aspirations and this would affect the aspirational payment that the single contract would attract; and
 - 7.11.8.6 premises reimbursements.

General duties of NHS England

- 7.11.9 The general duties of NHS England/the Commissioner are likely to be relevant to a decision by the Commissioner to approve a practice merger that results in changes to the way services are delivered.
- 7.11.10 As set out in chapter 4 on NHS England's general duties, section 13Q of the NHS Act 2006 requires NHS England to make arrangements to involve the public in the commissioning of services (see the box at the end of this section in relation to CCG duties). The requirements are triggered if there are proposals that mean that patients would experience a change to the range of services available or the manner in which they are delivered (e.g. if a practice is closed following a practice merger).
- 7.11.11 As set out in the chapter on NHS England's general duties, NHS England has published guidance on section 13Q in the form of "The Statement of Arrangements & Guidance on Patient and Public Participation in Commissioning" (the "Statement").
- 7.11.12 The Statement sets out that a change in the GP delivering the service is not usually enough to trigger the duty but that care must be taken if a change in personnel makes services less accessible to patient groups (e.g. because patients wish to be treated by someone of the same religion and gender as them). Where a practice merger may result in a change of the personnel delivering the service, the Commissioner should be alert to this.
- 7.11.13 In practice, what will be sufficient in terms of patient involvement is very context specific. The extent of the patient engagement activities required will depend on a number of factors including the extent of the impact any changes will have. As a general rule, the greater the extent of changes and number of people affected, the greater the level of activity that is likely to be necessary to achieve an appropriate level of public involvement.
- 7.11.14 Generally speaking, to meet the section 13Q duty, involvement needs to apply to and inform the whole decision making process, but this does not mean that patients need to be actively involved at every moment. Provided involvement is suitably built into the overall process, its timing can be arranged at stages to suit the Commissioner's decision-making processes. In particular, it is not necessary to involve patients immediately at the outset of any planning/consideration/decision making process in relation to any proposals of the commissioning of new services, provided patient involvement is planned

for some early stage in the process. The plans for patient involvement should be clearly documented from the outset and the Commissioner should consider liaising with patient representative groups, such as local Healthwatch or the practices' patient participation group.

7.11.15 The timing of public involvement is again a matter of broad discretion for the Commissioner. However, any involvement should be meaningful. As such, the Commissioner should involve patients at the time proposals are developed and considered. Overall, it is helpful to bear in mind the "Gunning" principles (these are used to judge whether or not a consultation exercise has been "fair" but are useful when making arrangements for patient and public involvement), as follows:

7.11.16 Involvement should take place when the proposal is still at a formative stage;

7.11.17 Sufficient information regarding the proposals should be provided, to allow meaningful involvement;

7.11.18 Adequate time should be given for consideration of the information provided and for response;

7.11.19 The product of the involvement should be conscientiously taken into account by the decision-maker.

7.11.20 Separately, bearing in mind the Commissioner's equalities responsibilities, the Commissioner should consider carrying out an Equality Impact Assessment, to check whether any specific groups of people require specific or enhanced forms of involvement.

Competition

7.11.21 It is important to consider the competition impact of a proposed merger. It is possible that the Competition and Markets Authority ("CMA") may take an interest in merger control, where practices are brought under some form of common ownership or common control. This could happen under certain types of merger model (for example, via a corporate structure), but by no means all.

7.11.22 If no one party has a sufficient degree of ownership or control over the practice merger (usually via a shareholding exceeding 25%) then the whole arrangement would remain a contractual one. However, if a party has a 25% or more shareholding, a "relevant merger situation" could be created, meaning that the CMA would then have the right to examine the practice merger, and

whether it poses the risk of a substantial lessening of competition in any market in the UK. Commissioners should be aware that as practice mergers move towards the creation of more and larger “super-practices”, it becomes more likely that the CMA may take an interest in competition in the market for these services.

- 7.11.23 The outcome of any examination by the CMA is not easy to predict. However, in NHS hospital mergers the issue is usually whether, if the CMA identifies a risk of a substantial lessening of competition, that risk is counterbalanced by benefits for patients. Therefore, the commissioner should clearly articulate the benefits of delivering Primary Care at scale in its Primary Care strategy and should always consider whether a proposed merger will benefit patients. If the Commissioner considers that there will not be any benefit to patients, it may be reasonable to refuse its consent to the merger.
- 7.11.24 Additionally, there are competition law prohibitions on anti-competitive agreements and practice and the abuse of a dominant position. There is, however, some uncertainty as to how competition law applies in detail to the activities of GPs operating solely within an NHS contractual framework.
- 7.11.25 Commissioners should take advice if they are considering a large scale merger where they are concerned about the potential competition implications.
- 7.11.26 The NHS (Procurement, Patient Choice and Competition) Regulations 2013 ("PPCC") (enforced by NHS Improvement) require Commissioners not to engage in "anti-competitive behaviour" when commissioning health care services for the purposes of the NHS, unless to do so is in the interests of people who use the services. This includes where services are provided in an integrated way and when providers co-operate in providing the services to improve their quality. The Commissioner should therefore consider, case by case, whether a merger is likely to improve the quality of the services and record this decision.
- 7.11.27 "Arrangements" for the provision of health care services for the purposes of the NHS must not include terms or conditions restricting competition which are not necessary to attain outcomes beneficial for the users of services, or to the general objective of procuring high quality health care services. Again, the Commissioner can assure itself that it is not in

breach of this by always considering the impact on the quality of the services following a merger and ensuring that any changes to existing contract terms of the merging practices are appropriate and justifiable. As a minimum, Commissioners should in any case be assured that there will be no detriment to patients if a merger goes ahead.

7.11.28 The PPCC require the Commissioner to have regard to how it enables providers to compete to provide the services and allow patients a choice of provider of the services. Providing that the Commissioner considers this against the overall duty to improve the quality of services it will satisfy this requirement – this is not an absolute obligation to ensure that patients have a choice of provider.

7.11.29 The Commissioner will be aware of its duty to ensure that it maintains a record of any contract award detailing how the award complies with its duties under sections 13D, 13E and 13N (for NHS England) and sections 14Q, 14R and 14Z1 (for CCGs) of the NHS Act 2006 (i.e. duties as to effectiveness, efficiency etc., improvement in quality of services and promoting integration). It is essential for the Commissioner to keep an audit trail of decisions made and have a clear approval process for mergers.

7.11.30 In addition to considering the changes that GP mergers bring to the provision of core primary care, the Commissioner also needs to consider the (potentially) dominant or strong market position of such GP providers in the market in respect of future opportunities. Currently, core primary care services and locally enhanced services are dominated by GP providers but as new business models ("NBM") (for example, Multispecialty Community Providers (MCP) and Primary and Acute Care Systems (PACS)) are developed and put out to procurement, large GP providers will be in a strong position to bid for these opportunities or partner with Trusts or other potential providers to form joint ventures to hold such contracts, restricting the available opportunities for other providers to provide services in that area.

7.11.31 Not only could NBM contract-holders provide the majority of services in an area but they will be able to control the way that services are delivered, appointing subcontractors as required, and changing the scope of services to meet the contractual outcomes. This could put them in strong market positions, possibly creating local situations of dominance or monopoly. Under

these circumstances, either NHS Improvement or the CMA may be alert to possible abuses of dominance, like long term exclusivity or discriminatory behaviour. The Commissioner will need to continue to monitor this position.

Procurement

7.11.32 Practice mergers often require the Commissioner to either:

- mutually agree the termination of existing contracts and directly award a new contract to a new legal entity; or
- terminate existing contracts and then significantly vary one contract to add all of the terminated services.

7.11.33 The Commissioner's consent is required to vary any terms (e.g. the services, performance standards or pricing etc.) of any GP contract.

7.11.34 The Public Contracts Regulations ("PCR") 2015 are clear that a material variation to a public contract is likely to require a new procurement procedure as the varied contract will be deemed a new contract for procurement purposes.

7.11.35 There are a number of exceptions to the basic principle that a modified contract will be a new contract requiring a procurement process. These are set out in Regulation 72 of the PCR 2015.

7.11.36 The most relevant exception is at Regulation 72(1)(d) which enables the Commissioner to vary public contracts "where a new contractor replaces the one to which [NHS England] had initially award the contract as a consequence of...universal or partial succession into the position of the initial contractor, following corporate restructuring, including takeover, merger....etc." The new contractor will need to fulfil the criteria for qualitative selection (i.e. the PQQ) initially established (we appreciate that this may not be the case for GP contracts which are not always procured and may have been in place for a considerable number of years)), there must be no other substantial modifications to the contract and this exemption cannot be relied on if the aim is to circumvent the procurement rules.

7.11.37 Where this exemption applies, it means that where the initial contractors (here, the individual GP practice contractors) merge with each other, their contracts can be varied to enable the new entity (which may be a new corporate entity or a wider group of partners) to hold the larger, varied

contract and the Commissioner may not need to procure this new / varied contract.

7.11.38 Pursuant to the PPCC, the Commissioner must consider appropriate means of improving the quality and efficiency of services which may include allowing providers to compete and giving patients a choice of provider. When GP practices merge, this may reduce patient choice and can be problematic in small towns where there has been an irrevocable breakdown in the relationship between the patient and contractor. In these circumstances, if all of the local GP practices merge then that contractor will be a provider of all of the available GP services in the locality which may cause an issue for that particular patient. In considering the application, it is reasonable for the Commissioner to ask the contractors how they propose to address this issue.

Other matters

7.11.39 This may include but is not limited to the effect of the practice merger on:

- the provision and/or contracting of additional services such as locally commissioned services; and
- out of hours opt-outs.

Mergers generally

7.11.40 In general terms contractual mergers should only be considered in cases of like-for-like contracts, i.e. GMS with GMS and PMS with PMS because of the differences in terms and financial arrangements. However, this does not remove the ability of a PMS provider to request to merge its business with a GMS provider and eventually work under one form of contractual terms.

7.11.41 Commissioners should advise contractors to seek guidance from their representative bodies in this instance to ensure they follow due process and are fully aware of the implications.

7.11.42 It is essential that patients from the terminating contract are included under the remaining contract through bulk transfer where possible to avoid additional cost pressure.

7.11.43 The Commissioner must bear in mind that even avoiding this additional cost, once patients are under the new contract, the Carr-Hill formula will be

applied and may even then increase the cost of the transferring patients based on one of the other factors, such as rurality, when it may not have applied to the terminating contract.

7.11.44 The Carr-Hill allocation formula is used to adjust the global sum payment for a number of local demographic and other factors, which may affect a practice workload. For example, a practice with a large number of elderly patients may have a higher workload than one that primarily cares for commuters.

7.11.45 The factors included in the Carr-Hill formula are:

- patient age and gender (used to reflect frequency of home and surgery visits);
- additional needs: standardised mortality ratio and standardised long-standing illness for patients under the age of 65 years;
- number of newly registered patients (generate 40% of work in first year);
- rurality;
- costs of living in some geographical areas; and
- patient age/gender for nursing/residential consultations.

7.11.46 The Commissioner may request that practices proposing to merge collectively submit a business case (a sample business case is provided at Annex 12A) which the Commissioner can use to base its decisions on whether to approve the merger and the consequential contract variations. A template mobilisation plan for practices to tailor and submit with their business case is provided at Annex 12B.

7.11.47 The Commissioner will need to amend the template business case to ensure it requests all the relevant information in respect of the merger. The Commissioner should therefore seek to engage with the practices early in the development process to shape the business case and to liaise with the practices on any amendments or updates to the business case to enable the business case to be as comprehensive as possible prior to the Commissioner making its decision.

“Super-practices”

7.11.48 Some mergers involve the creation of so-called “super-practices”.

Where such a merger is approved by the Commissioner in accordance with this chapter 7.11, it may be that the merger is bringing together the partners of multiple practices by adding them as partners to each other’s existing contracts. This will result in a large group of partners holding a number of primary medical contracts. For this specific scenario, and provided that partners are only being added (with none leaving any of the contracts), commissioners may use the simplified Variation Agreement for super-practices at [Annex 16]. This allows the various partners to sign a single document so as to effect the addition of all of the partners to all of the contracts. It can also be used to designate a small number of the partners as authorised signatories in relation to contractual matters going forward. The document is not for use in any other scenario.

7.11.49 In addition, this Variation Agreement includes agreement for future changes to the partnership to take effect via a single notification to the Commissioner for all of the contracts. This applies only where the simplified Variation Agreement for super-practices is used and in all other cases a change of partners must be dealt with in accordance with chapter 7.5 of this PGM.

7.11.50 The simplified Variation Agreement for super-practices/partnerships at Annex 16] is only for use where multiple contracts will be held by a partnership. Whilst there is no definition or criteria of a super-practice/partnership, to avoid inappropriate use, NHS England require that this variation agreement should only be used where a super-partnership is being formed, usually to cover a large geographical area and registered patient population (min 30k), a minimum of three contracts (at least one must be GMS) and at least 10 - partners. For the avoidance of doubt this variation agreement should not be used for example, when merging two PMS contracts, regardless of the number of partners.

Co-commissioning - delegated commissioning arrangements

A CCG that has delegated commissioning arrangements will have entered into a Delegation Agreement with NHS England setting out the scope of those arrangements.

The Delegation Agreement includes a section on approving GP practice mergers and closures. When carrying out such actions, the CCG is required to act in accordance with the Delegation Agreement which includes but is not limited to:

- undertaking all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the LMC;
- prior to making any decision, clearly demonstrating the grounds for such a decision and fully considering any impact on the GP practice's registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed; and
- in making any decisions, taking account of the CCG's obligations as set out in the Delegation Agreement in relation to procurement, where applicable.

7.11.51 Annex A - Template Business Case for Practice Merger

• [Template Business Case for Practice Merger](#)

1. Explanation of the practice merger

Practices should provide an overview below of how the practices are merging. Paragraph 11.4 of the Contract Variations chapter provides common models of practice mergers and may be helpful here but practices should recognise that mergers are not restricted to one of the models listed and proposed mergers may adopt elements of more than one model or may adopt an entirely different approach.

If appropriate some context is required here in relation to how and why the arrangements for a merger have come about.

2. Practices' characteristics and intentions for the merged practice

	Current Practice 1	Provision –	Current Practice 2	Provision –	Merged Practice
Name and address of practice (provide name and address)					
Contract type (GMS, PMS, APMS)					
Name of contractor(s)					
Location (provide addresses of all premises from which practice services are provided)					
Practice area (provide map of area)					
List size (provide both, raw and weighted list and date provided)					
Number of GPs and clinical sessions (provide breakdown and the number of wte)					

GPs)			
Number of other practice staff (provide breakdown)			
Number of hours of nursing time (provide breakdown and number of wte nurse and nurse practitioner) Sessions/hours of other health care professionals such as HCA, PA and PCN resources.			
CCG area(s) (list CCG(s) in which practices are located)			
PCN Areas List PCN(s) in which practices are located)			
Please confirm if current and future agreement to sign up to the PCN Network DES			
Which computer system/s (list system(s) used)			
Clinical governance/ complaints lead and systems (provide names)			
Provide organisational chart showing roles and responsibilities including workforce, corporate governance and finance			
Training practice (yes/no)			
Opening hours (list days and times)			
PCN Extended hours delivered by the practices (list days and times)			
Extended hours			

(list days and times)			
Other PCN services delivered by the practice			
Enhanced services (list all enhanced services delivered whether they are commissioned by NHSE, CCG or LA)			
Premises the address for each premises and confirmation of main/branch status			
Premises indicate whether premises are owned or leased and when the lease is due to expire			
Premises For leased premises please confirm length of lease remaining including and break clauses.			

2. Patient benefits

<p>Please explain below the consequences of the proposed practice merger for patients. You should include comments on any benefits or adverse effects on patients in relation to matters such as access to services and service delivery arrangements.</p>

3. Financial considerations

<p>Please provide comments <u>from a financial perspective</u> on the following matters if they are relevant to the proposed practice merger.</p>	
Premises	

Please provide comments **from a financial perspective** on the following matters if they are relevant to the proposed practice merger.

<p>Business case should consider the following where applicable</p> <ul style="list-style-type: none"> • Legal fees • SDLT payments • Rent reimbursement • Any potential savings due to site closure • Or potential increase in rent reimbursement if the newly merged practice will change premises utilisation 	
<p>IT</p> <ul style="list-style-type: none"> • Cost associated with merging different clinical systems • Moving servers • Upgrading telephony system 	
TUPE	
Redundancy	
QOF	
Pension/seniority	
MPIG/PMS Premium	
Dispensing	

4. Service delivery

Please provide comments **from an improving service delivery perspective** on the following matters if they are relevant to the proposed practice merger.

QOF	
Access	
Primary Care Web Tool	
Recent or ongoing breaches of contract	
Recent or pending CQC matters	
If one practice's service delivery is of a lower standard, is there a proposal to improve performance	
Will there be any cessation of services post-merger?	
Will there be a reduction of hours for which services are provided post-merger?	
Will there be a change in the hours at which services are provided?	
Will there be a reduction in the number of locations or a change in the location of premises from services are provided?	
Resilience – where the merged patient list is over 10,000, how will the	

Please provide comments <u>from an improving service delivery perspective</u> on the following matters if they are relevant to the proposed practice merger.	
practices ensure resilience to ensure that performance and patient experience is maintained and improved.	
Primary Care Networks (PCN) – what are the benefits of the proposed merger for the PCN? e.g. offer space for PCN services, taking leadership of delivering services on behalf of the PCN	
Primary Care Networks (PCN) – what are the implication of the proposed merger for the PCN? e.g. where two practice premises is located in two different PCNs	

5. Patient and stakeholder engagement

Please provide comments on the following matters.	
Have the practices engaged with patients and/or stakeholders on the practice merger? Stakeholders may include local LMC, Healthwatch, PCN members, Community and voluntary services	

Please provide comments on the following matters.	
Note: Practices must engage with patients/stakeholders	
When did/will you engage with patients/stakeholders?	
In what form did/will you engage with patients/stakeholders?	
With whom did/will you engage?	
If you have already carried out engagements, what was the outcome? Please provide evidence	

6. Contractual actions

Please provide below an explanation of any contractual variations that you consider are necessary to effect the proposed practice merger.

7. Procurement and competition

Please provide below any comments on the procurement and/or competition matters that may arise as a result of the proposed contract merger.

8. Merger mobilisation

Please set out below a step by step plan to the mobilisation of the merger if the business case is approved including what actions are required of the practices and third parties, such as commissioners, the order in which the actions need to be undertaken and timescales for the actions to be completed. A template mobilisation plan that can be used but will need to be amended to fit the proposed practice merger is set out at Annex 12B.

8. Additional information

Please provide any additional information that will support the proposed practice merger.

9. Signatures

Please ensure all Contractors under the current practice contracts sign below to indicate they agree with the information provided in this business case.

[name]	[signature]
--------	-------------

[name]	[signature]
--------	-------------

[name]	[signature]
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7.11.52 **Annex B Template Mobilisation Plan for Practice Merger**

- [Template Mobilisation Plan for Practice Merger](#)

7.12 Changes to Services

- 7.12.1 commissioners will need to consider changes to local service provision as a consequence of a health needs assessment of the local community with particular regard to the diverse nature of the community and reducing health inequalities in access and outcomes.
- 7.12.2 The Commissioner and the contractor shall only agree to any change to the delivery of services after all legal obligations in respect of consultation, engagement or involvement of the public, patients and other organisations have been fulfilled.
- 7.12.3 The paragraphs below outline the principles and steps required to process the most commonly occurring service changes.

7.13 Open and Closed Lists

- 7.13.1 There are circumstances where a contractor may wish to close their list to new registrations, e.g. internal capacity issues or premises refurbishments. A contractor may also seek to extend a closed list period or open their list again before the end of an agreed period.
- 7.13.2 Further details on how to manage patient lists are set out in the chapter on managing patient lists.

7.14 Boundary Changes

- 7.14.1 There may be circumstances when a contractor wishes to change their main practice boundary to either expand or contract the practice area for new registrations due to new redevelopment, local authority compulsory purchase schemes and/or road developments.
- 7.14.2 Most practices will also have within their contracts a defined outer boundary to allow those patients, who move home a relatively short distance outside of the main boundary and who would prefer to stay with their existing practice with whom they may have a well-established relationship, to remain registered.

- 7.14.3 For the purposes of service provision, the full range of contractual services must be made available to those patients registered with the practice within the outer boundary and the outer boundary area must be treated as part of the practice's contracted area.
- 7.14.4 Any changes to the practice area (main and outer boundary) must be considered a variation to the contract and the definitions of these areas amended under a variation notice. The contractor must notify the Commissioner of its intent to vary its area in writing setting out the reasons for the change and full details of the proposed practice area, with any additional supporting evidence that may assist the Commissioner in reaching its decision (a template application notice is set out in Annex 13 A).
- 7.14.5 The contractor and the Commissioner must engage in open dialogue concerning the circumstances that have led to the request to change their boundary and discuss the possible implications of the action, i.e. a reducing patient register, an expanding patient register, the financial implications of both and any possible alternative actions that may be taken by either party to enable the practice to maintain its existing practice area.
- 7.14.6 Commissioners must consider the application having regard to other practices' boundaries, patient access to other local services and other health service coverage within a location and may seek to involve the public to seek their views.
- 7.14.7 Once a decision is reached on whether to accept or reject the application, the Commissioner should notify the contractor of its decision in writing (a template letter is provided in Annex 13B).
- 7.14.8 If the Commissioner accepts the proposed changes to the practice area, the contractor should be notified, as soon as possible, in writing of:
- the acceptance;
 - the date upon which the changes will take effect; and
 - a requirement of the contractor to publish the details of the new practice area within their patient information leaflet and on their website (if they have one).
- 7.14.9 If the Commissioner declines the proposed changes to the practice area, the contractor should be notified, as soon as possible, in writing of that decision and to include:

- the reasons for the decision;
- the right of the contractor to appeal and the process for doing so; and
- specify any period within which the Commissioner would not consider a further application from this contractor to vary its practice area.

7.14.10 Practices who are intending to reduce their practice area must be advised that registered patients who subsequently fall outside of the new agreed area, but who are within the original practice area (main and outer boundary) can only be removed from the list if one or more of the provisions of the relevant regulations/directions that relate to removal of patients from the practice's patient list apply.

7.15 Premises

7.15.1 A contractor may wish to make changes to its contracted practice premises (including branch surgeries – for further information, see paragraphs 7.15.10 to 7.15.28 below) from which services are provided.

7.15.2 This would likely be a significant change to services for the registered population and as such, the Commissioner and the contractor must engage in open dialogue in the first instance to consider the consequences and implications of the proposed change and discuss any possible alternatives that may be agreed between them.

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

7.15.4 Once, and if, the final date for closure is confirmed, the Commissioner will issue a variation agreement notice to remove the registered address from the contract, and as in other variations under this policy, include the wording of the variation and the date on which it will take effect. The commissioner must also inform PCSE for changes to the main site location.

7.15.5 The contractor will be fully responsible for the cessation or assignment of the lease for any rented premises and any disposal of owner-occupied premises.

7.15.6 While it is likely that a PMS/APMS contract would reflect the terms as laid out in the GMS contract example above, it is essential that the Commissioner

reviews the individual contract for relevant provisions that relate to removing the closing premises and any rights associated with that premises.

7.15.7 Where the premises relocation is in relation to a dispensing doctor's practice, contract managers should also refer to the Pharmacy Manual, as moving the site may have significant implications for which patients are eligible to be dispensed to by the practice.

7.15.8 The practice should also apply separately for permission to relocate the dispensing rights of the practice elsewhere, and the timeframes involved in getting approval for that relocation may influence the broader relocation plans and timetable

Branch Surgeries

7.15.9 It is important to note that unless there are specific reasons for variation, branch surgeries should be held to the same standard of service level as a 'main surgery', unless there is specific reason for a lesser service provision. An example of this may be in rural areas, where the principle is ensuring local access and this would be for local commissioning determination.

Branch Closure

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

7.15.11 In the circumstances that the Commissioner is instigating a branch closure, the Commissioner must be able to clearly demonstrate the grounds for such a closure and fully considered any impact on the contractors registered population and any financial impact on the actual contractor. The Commissioner will be expected to demonstrate that they have considered any other options available prior to instigating a branch closure and entering into a dialogue with the contractor as to how the closure is to be managed. The Commissioner will need to have complied with the duty (under section 13Q of the NHS Act) to involve patients in decision-making before any final decision to close a branch is made.

7.15.12 Where a contractor wishes to close a branch surgery, the contractor should have preliminary discussions with the Commissioner to determine appropriate and proportionate patient involvement requirements prior to the consideration of such a service provision change. Even though the closure is being instigated by the contractor, the Commissioner will still need to comply with the section 13Q duty to involve patients in decision-making before any final decision is made.

7.15.13 The closure of a branch surgery would be a significant change to services for the registered population and as such the Commissioner and the contractor should engage in open dialogue in the first instance to consider the consequences and implications of the proposed change and discuss any possible alternatives that may be agreed between them. At this stage, the duty to involve the public in proposals for change is triggered and the Commissioner and contractor should work together on fair and proportionate ways to achieve this. The Commissioner should ensure clarity on what involvement activities are required by the contractor.

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

- financial viability;
- registered list size and patient demographics;
- condition, accessibility and compliance to required standards of the premises;
- accessibility of the main surgery premises including transport implications;
- the Commissioner's strategic plans for the area;
- other primary health care provision within the locality (including other providers and their current list provision, accessibility, dispensaries and rural issues);
- dispensing implications (if a dispensing practice);
- whether the contractor is currently in receipt of premises costs for the relevant premises;
- other payment amendments;
- possible co-location of services;
- rurality issues;
- patient feedback;
- any impact on groups protected by the Equality Act 2010 (for further detail see chapter 4 (General duties of NHS England));
- the impact on health and health inequalities; and

- any other relevant duties under Part 2 of the NHS Act (for further detail see chapter 4 (General duties of NHS England)).

7.15.14 The Commissioner and contractor, through their dialogue, may establish that there is a need to retain medical service provision in the locality and must find a solution, which could include tendering for a new provider within that locality though not necessarily within the same premises. Note that most changes in premises will trigger the commissioner's duties to involve patients in decision-making.

7.15.15 The Commissioner should confirm any such arrangements and agreements in writing to the contractor as soon as is practicably possible after the agreement is reached and **must** notify PCSE of any branch closures.

7.15.16 If the Commissioner and the contractor are unable to reach an agreement to keep the branch surgery open, then the contractor, based upon their previous discussions with the Commissioner regarding appropriate and proportionate involvement, will continue to involve patients in the proposed changes.

7.15.17 The contractor is required to follow The Patient and Public Participation Policy, The Statement of Arrangements & Guidance on Patient and Public Participation in Commissioning and The Framework for Patient and Public Participation in Primary Care Commissioning process as appropriate to the arrangements agreed with the Commissioner, with support and advice as appropriate from the Commissioner. Adherence to the PPP involvement process will help ensure that an appropriate involvement exercise is carried out, that meets the legal obligations on the Commissioner.

7.15.18 Once this involvement exercise has been undertaken and the results provided to the Commissioner, the contractor would then submit a formal application to close the branch surgery to the Commissioner for consideration (Annex 14A).

7.15.19 The Commissioner will then assess the application regarding the closure and the outcome of the patient involvement exercise with a view to either accepting or refusing the proposal. These assessments will need to again consider all the relevant factors, including those listed in paragraph 7.15.13. The Commissioner should document how it has taken the various factors into account.

- 7.15.20 Either the contractor or the Commissioner may invite the LMC to be a party to these discussions at any time.
- 7.15.21 Where the Commissioner refuses the branch closure through its internal assessment procedure, the contractor shall be notified in writing within 28 days following the internal assessment and the contractor may then follow the relevant resolution process as referenced in the contract. Please refer to Annex 14B.
- 7.15.22 Where the Commissioner approves the branch closure, the Commissioner will need to ensure that it retrieves all NHS owned assets from the premises.
- 7.15.23 The contractor remains responsible for ensuring the transfer of patient records (electronic and paper Lloyd George notes) and confidential information to the main surgery, having full regard to confidentiality and data protection requirements, Records Management: NHS Code of Practice guidance and any relevant guidance from the Health & Social Care Information Centre or the Information Commissioner's Office. Where a third party contractor is being used to handle records, they must be vetted and appropriate contractual arrangements put in place. Further information is contained in Annex 15.
- 7.15.24 The contractor remains responsible for carrying out public involvement in accordance with the instructions given by the Commissioner and informing the registered patients of the proposed changes. However, ultimately it is the Commissioner's responsibility to ensure that involvement activities have met legal requirements, even if carried out by the contractor. Further guidance can be found in the NHS England documents [The Patient and Public Participation Policy](#), [The Statement of Arrangements & Guidance on Patient and Public Participation in Commissioning](#), and [The Framework for Patient and Public Participation in Primary Care Commissioning](#)
- 7.15.25 Once the final date for closure is confirmed, the Commissioner will issue a standard variation notice to remove the registered address of the branch surgery from the contract, including the amended sections of the contract for completeness.
- 7.15.26 Where the contractor has previously been granted premises consent to dispense, and these rights are only associated with the closing premises in

question (that is listed on the relevant dispensing contractor list), the contractor's consent to dispense will cease.

7.15.27 The Commissioner shall update its records and ensure that the relevant dispensing contractor list is updated appropriately to reflect the removal of the premises.

7.15.28 It is possible that a PMS or APMS contract will reflect the terms as set out above. It is however essential that the Commissioner reviews the individual contract for these or any other relevant provisions to allow a variation to effectively remove the closing premises and any rights associated with that premises alone.

7.15.29 Where the commissioner is operating under delegated authority and is considering a branch closure, the commissioner must have regard to the matters set out in the Delegation Agreement as indicated in section 11.14 of this policy.

7.16 Opt Outs

7.16.1 Services under primary medical contracts are categorised as:

7.16.2 Essential services – these are the services described in regulation 15 of the GMS Regulations which a GMS contractor must provide. Essential services are not mandatory for PMS or APMS contractors;

7.16.3 Additional services and out of hours – these are specific services that are additional to essential services. It is not mandatory for contractors to provide these services but where GMS and PMS contractors provide such services, the contracts must contain terms relating to the procedure for opting out of those services. It is not a requirement that APMS contracts contain such opt out provisions but the Commissioner should review the relevant APMS contract to determine whether any such provisions have been included; or

7.16.4 Enhanced services - these are any services that go beyond essential, additional or out of hours services that the contractor may have agreed to be included.

7.16.5 Where a contractor has opted out of delivering any or all of the additional or out of hours services, the Commissioner must commission these services from an alternative source for the registered patients under that contract.

- 7.16.6 Prior to any opt out taking effect, the Commissioner and the contractor shall discuss how to inform the contractor's patients of the proposed opt out. The Commissioner can request the contractor to inform its registered patients of an opt out and the arrangements made for them to receive the additional service or out of hours services by either placing a notice in the practice's waiting rooms; or including the information in the practice leaflet.
- 7.16.7 The Regulations do not refer to opt-ins, i.e. where a contractor wishes to provide services which it previously opted out of providing. If the Commissioner receives a request to opt-in, it should refer to their Legal Team (england.legal@nhs.net) for consideration of the procurement implications.

Opt out of additional services

- 7.16.8 Where a contract wants to opt out of providing additional services, the contractor must notify the Commissioner in writing stating the reasons for wishing to opt out. This notice is referred to as a preliminary opt-out notice.
- 7.16.9 As a next step, the Commissioner must discuss with the contractor what support the Commissioner may give the contractor to enable the contractor to continue to provide the additional service. The parties must also discuss other changes which with party could make to enable the contractor to continue providing the service. These discussions must be started as soon as is reasonably practicable and in any event within seven days beginning with the receipt of the preliminary opt-out notice. The Commissioner and the contractor must use reasonable endeavours to achieve this aim of enabling the contractor to continue to provide the additional service.
- 7.16.10 The discussions must be completed within ten days beginning with the date of the receipt of the preliminary opt-out notice or as soon as reasonably practicable after the ten days.
- 7.16.11 If, after the discussions, the contractor still wishes to opt out, the contractor must send an opt-out notice to the Commissioner which must include:

- 7.16.11.1 the additional service concerned;
- 7.16.11.2 whether the contractor wishes to temporarily or permanently opt out;
- 7.16.11.3 the reasons for wishing to opt out;
- 7.16.11.4 the date from which the contractor would like the opt out to commence, which must:
- in the case of a temporary opt out, be at least 14 days after the date of service of the opt-out notice; and
 - in the case of a permanent opt out, must be the day either three or six months after the date of service of the opt-out notice; and
- 7.16.11.5 in the case of a temporary opt out, the desired duration of the opt out.
- 7.16.12 The Contract Regulations do not allow contractors to temporarily opt out of providing additional services more than twice. Where a contractor has given two previous temporary opt-out notices within the period of three years ending with the date of the service of the latest opt-out notice (whether or not the same additional service is concerned), the Commissioner must treat the latest opt-out notice as a permanent opt out (even if the notice says that it wishes to temporarily opt out).

Temporary opt out of additional services

- 7.16.13 Where the contractor has provided a temporary opt-out notice, the Commissioner must follow the process below:
- 7.16.13.1 The Commissioner must, as soon as is reasonably practicable and in any event within the period of seven days beginning with the date of receipt of a temporary opt-out notice, either:
- approve the opt-out notice and specify both the date on which the temporary opt out is to commence (which wherever reasonably practicable must be the date requested by the contractor in its opt out notice) and the date that it is to come to an end (“the end date”); or
 - reject the opt-out notice on the ground that the contractor:
 - is providing additional services to patients other than its own

registered patients or enhanced services, or

- has no reasonable need temporarily to opt out having regard to its ability to deliver the additional service;

7.16.13.2 The Commissioner must notify the contractor whether it has approved or rejected the opt-out notice as soon as possible, including reasons for its decision (Annex 7B).

7.16.14 The Commissioner or the contractor may have concerns about the ability of the contractor to provide the services at the end of the temporary opt out. If the Commissioner considers that the contractor will be unable to satisfactorily provide the additional service at the end of the temporary opt out, the Commissioner can agree with the contractor to extend the end date. If such extension is not possible, the Commissioner may notify the contractor in writing at least 28 days before the end date that a permanent opt out shall immediately follow the temporary opt out. Similarly, a contractor who has temporarily opted out may, at least three months prior to the end date, notify the Commissioner in writing that it wishes to permanently opt out of the additional service in question.

Permanent opt out of additional services

7.16.15 Where the contractor has provided a permanent opt-out notice, the Commissioner must approve or reject it. The Commissioner must do so as soon as is reasonably practicable and in any event within the period of 28 days beginning with the date of receipt of a permanent opt-out notice. The only ground on which the Commissioner may reject the notice is that the contractor is providing an additional service to patients other than its registered patients or enhanced services. The Commissioner must notify the contractor of its decision as soon as possible, including reasons for its decision where its decision is to reject the opt-out notice.

7.16.16 If, after the Commissioner approves a permanent opt-out, the contractor wishes to withdraw the notice, it can only do so if the Commissioner agrees. This is because after approving the opt-out, the Commissioner must use reasonable to make arrangements for the

contractor's registered patients to receive the additional service from an alternative provider.

7.16.17 It may be difficult for the Commissioner to find an alternative provider to deliver the service from the date on which the contractor proposed to opt out. Where this is the case, the Commissioner must notify the contractor one month before the proposed opt out date requiring the contractor to continue to provide the services for a certain period of time as set out below.

7.16.18 Where the proposed opt out date is three months after service of the opt-out notice (if six months, see paragraph 7.16.20), the contractor shall continue to provide the additional service until the day six months after the service of the opt-out notice. If, during this period, the Commissioner, despite using its reasonable endeavours, is still unable to find an alternative provider, it can provide a further notice to the contractor requiring the contractor to provide the additional service until the day nine months after the date of service of the permanent opt-out notice.

7.16.19 The contractor may find it difficult to continue providing the services for a further nine months. Therefore, as soon as is reasonably practicable and in any event within seven days of the Commissioner serving a further notice to the contractor to continue providing the service until nine months after the date of service of the permanent opt-out notice, the Commissioner must enter into discussions with the contractor. These discussions must consider what support the Commissioner may give to the contractor or other changes which either party may make in relation to the provision of the additional service until the actual opt out date. The requirement to enter into discussions only arises where the Commissioner requires the contractor to provide the services until the date nine months after service of the opt out notice. It does not apply where the Commissioner requires the contractor to provide the services until the day six months after service of the opt-out notice.

7.16.20 Where the proposed opt out date is six months after service of the opt-out notice, the contractor shall continue to provide the additional service until the day nine months after the service of the opt-out notice.

Opt out of Out of Hours

- 7.16.21 If a contractor wishes to terminate its obligation to provide out of hours services, it must provide the Commissioner with an out of hours opt-out notice specifying the date from which the contractor would like the opt out to take effect, which must be either three or six months after the date of service of the out of hours opt-out notice.
- 7.16.22 As soon as is reasonably practicable and in any event within 28 days of receiving the out of hours opt-out notice, the Commissioner shall approve the notice and confirm the date on which the out of hours opt out is to commence. The Commissioner cannot reject an out of hours opt-out notice.
- 7.16.23 If, after the Commissioner approves an out of hours opt-out notice, the contractor wishes to withdraw the notice, it can only do so if the Commissioner agrees. This is because after approving the opt-out, the Commissioner may have made arrangements for the contractor's registered patients to receive the out of hours service from an alternative provider.
- 7.16.24 If the Commissioner cannot find an alternative provider, paragraphs 7.16.17 to 7.16.20 will apply as if the reference to an additional service was a reference to the out of hours service.
- 7.16.25 Once the terms of any permanent or temporary opt out are agreed, a variation notice must be issued in accordance with the principles laid out in this policy to amend the relevant section of the contract.
- 7.16.26 The Commissioner should follow the same process for PMS contractors. For APMS arrangements, the Commissioner should review the contract to determine whether it contains any relevant provisions.

7.17 Financial Changes – Statement of Financial Entitlements

- 7.17.1 The contract will contain the terms of any payments due. Any change to those terms will require a notice of variation which should be provided no less than 28 days before the proposed variation takes effect.
- 7.17.2 For GMS contracts, the financial terms must reflect those set out in the GMS SFE. There is no such requirement under PMS or APMS contracts which have been locally agreed. Any changes under the GMS SFE should be

reviewed against the terms of each of the individual contracts to ascertain what, if any, affect those changes have on local financial terms.

7.18 Annex 4 Primary Care Support Services

Notifications

7.18.1 Commissioners should ensure that following any contractual merger, GP performers are informed of their obligation to notify the Primary Care Support Services (PCSS) provider (currently Primary Care Support England (PCSE)) using the relevant online portal or forms issued by 'the Board' within 28 days.

7.18.2 Additionally and more generally, GP performers and indeed performers in all contractor groups are required to notify the PCSS provider of any changes relevant to their entry on the national performers list. Further information is available here <https://pcse.england.nhs.uk/services/performers-lists/gp-performers-list-for-england/>

7.19 Annexes

Annex 1 - Template Variation Notice for Legislation / Regulatory Change – GMS Contracts

- [Template Variation Notice for Legislation / Regulatory Change – GMS Contracts](#)

Annex 2 Template Variation Notice for Legislation / Regulatory Change – PMS/APMS Contracts

- [Template Variation Notice for Legislation / Regulatory Change – PMS/APMS Contracts](#)

Annexes 3 - 6 Requests for Information – Changes to the Contracting Parties

The following Annexes contain requests for information to be sent to the contractor and corresponding acknowledgements for completion by the Commissioner. The Annexes include:

Annex 3A – Request for information relating to change from individual to partnership – GMS contracts

- [Request for information relating to change from individual to partnership – GMS contracts](#)

Annex 3B – Acknowledgement of information relating to change from individual to partnership – GMS contracts

- [Acknowledgement of information relating to changes from individual to partnership – GMS contracts](#)

Annex 4A – Request for information relating to change from individual to more than one individual – PMS agreements

- [Request for information relating to change from individual to more than one individual – PMS contracts](#)

Annex 4B – Acknowledgement of information relating to change from individual to more than one individual – PMS agreements

- [Acknowledgement of information relating to change from individual to more than one individual – PMS contracts](#)

Annex 5A – Request for information relating to change from partnership to individual – GMS contract

- [Request for information relating to change from partnership to individual – GMS contracts](#)

Annex 5B – Acknowledgement of information relating to change from partnership to individual – GMS contract

- [Acknowledgement of information relating to change from partnership to individual – GMS contracts](#)

Annex 6A – Request for information relating to change from more than one individual to an individual - PMS agreement

- [Request for information relating to change from more than one individual to an individual – PMS contracts](#)

Annex 6B – Acknowledgement of information relating to change from more than one individual to an individual - PMS agreement

- [Acknowledgement of information relating to change from more than one individual to an individual – PMS agreements](#)

Annex 7 Acknowledgement of Request to Incorporate and Medical Incorporation Assessment Template

- [Acknowledgement of request to incorporate and medical incorporation assessment template](#)

Annex 8 – Assessment Template for Incorporation for Commissioner

- [Assessment template for Incorporation for Commissioner](#)

Annex 9 – Acknowledgement of Request to Dis-incorporate and Medical Dis-incorporation Assessment Template

- [Acknowledgement of request to Dis-incorporate and Medical Dis0incorporation assessment template](#)

Annex 10 – Refusal of Request to [Incorporate / Become a Company Limited by Shares / Qualifying Body]

- [Refusal of Request to \[Incorporate/Become a Company Limited by Shares/Qualifying Body\]](#)

Annex 11 – Refusal of Request to Dis-incorporate

- [Refusal of Request to Dis-incorporate](#)

Annex 12 – Template Agreement Letter

- [Template Agreement Letter](#)

Annex 13A – Template Application to Change the Practice Area

- [Template Application Notice to Change the Practice Area](#)

Annex 13B – Acknowledgement of Application to Change the Practice Area

- [Acknowledgment of Application to Change the Practice Area](#)

Annex 14A – Template Application Notice to Close Branch Premises

- [Template Application to Close Branch Premises](#)

Annex 14B – Acknowledgement of Application to Close Branch Premises

- [Acknowledgment of Application to Close Branch Premises](#)

Annex 15 – Records Management: NHS Code of Practice

- [Records Management: NHS Code of Practice](#)

Annex 16 – Super-practice template variation agreement

[Super-practice template variation agreement](#)

Annex 17 – Template novation agreement

- [Template novation agreement](#)

8 Managing a PMS Contractor's Right to a GMS Contract

8.1 Introduction

- 8.1.1 The aim of this policy is to ensure that all parties to the contract understand the process and procedures that must be followed when a contractor requests a transfer from a PMS agreement to a GMS contract.
- 8.1.2 Subject to the contractor's eligibility to hold a GMS contract and the requirement to provide essential services, then there should be no variation in the application of this policy.

8.2 Roles and Responsibilities

- 8.2.1 Commissioners will need to ensure that the finance department and relevant persons are made aware of the change to the contracting arrangements as there will be long term financial implications. A GMS contract is not time limited and exists in perpetuity. Anyone with delegated authority can sign off the transfer.
- 8.2.2 The payment and contract management system must be updated by the officer managing the transfer.

8.3 Background

- 8.3.1 A contractor holding a PMS agreement which is providing essential services, has the right to a GMS contract in accordance with Regulation 19 of the PMS Regulations which states:
- 8.3.2 "A contractor which is providing essential services and which wishes a general medical services contract to be entered into pursuant to this regulation shall notify [the Commissioner] in writing at least three months before the date on which it wishes the general medical services contract to be entered into."
- 8.3.3 This policy sets out the decision making process that the Commissioner will follow, together with refusal (where eligibility is not satisfied), appeal processes and discussions regarding any actions that are required.

8.4 Notification from a Contractor

8.4.1 The Commissioner should receive at least three months' notice in writing from the contractor requesting a GMS contract.

8.4.2 The contractor's notice must:

- state that the contractor wishes to terminate the PMS agreement;
- state the date on which the contractor wishes the PMS agreement to terminate which must be at least three months after the date of service of the notice;
- give the name of the person(s) with whom the contractor wishes the Commissioner to enter into a GMS contract (a person's name may only be given in a notice if that person is a party to the PMS agreement); and
- confirm that the person(s) named meet the conditions set out in section 86 of the NHS Act (persons eligible to enter into GMS contracts) and regulations 4 and 5 (where applicable) of the GMS Regulations or, where the contractor is not able to confirm, the reason why it is not able to do so and confirmation that the person(s) immediately prior to entering into the GMS contract will meet those conditions.

8.5 Process for PMS Agreements

8.5.1 The Commissioner must acknowledge receipt of the notice within seven days beginning on the day it received the notice.

8.5.2 While it is not a requirement of the PMS Regulations, when the Commissioner receives such a notice it should discuss the full implications of this action with the contractor to ensure the contractor has fully understood the necessary changes to the contractual income streams (see paragraph 8.5.4) and should advise the contractor to seek their own independent advice.

8.5.3 The Commissioner will check that all necessary information has been provided in the contractor's notice and undertake a review of the PMS agreement to establish if the contractor provides essential services; and if they are eligible to hold a GMS contract (as set out in section 86 of the NHS Act (persons eligible to enter into GMS contracts) and regulations 4 and 5 of the GMS Regulations. This information can also be found in the 'Contracts Described' chapter.

- 8.5.4 The Commissioner must apply the GMS SFE on first setting up a GMS contract and calculating the global sum monthly payment. Whilst a PMS contractor has the right to a GMS contract, there is no entitlement for the contractor to carry the same funding arrangements it had under the PMS agreement into that GMS contract. GMS contracts are funded according to terms set out in the GMS SFE while PMS agreements are funded through local agreement. There is the discretion to agree additional payments under GMS arrangements outwith the GMS SFE which are not necessarily payable under the GMS SFE. It is essential that the Commissioner has ascertained the financial impact of this decision of the contractor to move to a GMS contract.
- 8.5.5 If the contractor does not provide essential services, the Commissioner must notify the contractor that they are not entitled to transfer to a GMS contract. A template letter is provided in Annex 1.
- 8.5.6 If the contractor is not eligible to hold a GMS contract the Commissioner must refuse to enter into a GMS contract. A template letter is provided in Annex 2.
- 8.5.7 If the Commissioner confirms that the contractor provides essential services and is eligible to hold a GMS contract under section 86 of the NHS Act and regulations 4 and 5 of the GMS Regulations, the Commissioner will acknowledge receipt of the notice and outline the next steps within seven days of receipt of the notice. A template letter is provided in Annex 3.
- 8.5.8 The GMS contract will start immediately after the termination of the PMS agreement. The GMS contract start date should be the date set out in the notice to the Commissioner unless a different date is agreed by the parties. The GMS contract will include all the terms required by the GMS Regulations.
- 8.5.9 The new GMS contract must require the provision of the same services that were commissioned by NHS England (or a CCG under co-commissioning arrangements) under the PMS agreement and were provided by the contractor immediately prior to the PMS agreement terminating, unless the parties otherwise agree.
- 8.5.10 The names of the patients included in the contractor's list of patients immediately before the PMS agreement termination must be included in the first list of patients prepared and maintained by the Commissioner.

- 8.5.11 The out of hours services must be the same as were provided under the PMS agreement before it terminated.
- 8.5.12 The Commissioner must use the current standard GMS contract ensuring that it is amended to the specific contractor.
- 8.5.13 Once a GMS contract is agreed and entered into and the PMS agreement has terminated, the Commissioner must ensure all nationally held records of the contractor's status are adjusted appropriately. This must include, but not be limited to, changing the contractor's status on QMAS/CQRS, from PMS to GMS, to ensure that the correct quality and outcomes framework calculations are completed at year end and any contractual payment systems used, (i.e. Exeter).
- 8.5.14 The calculation of the contractor's first Initial Global Sum Monthly Payment must be made in accordance with Part 1 of the GMS SFE.

8.6 Disputes

- 8.6.1 Where there is a dispute about whether or not a person satisfies the conditions set out in section 86 of the NHS Act or regulations 4 and 5 of the GMS Regulations, the contractor may appeal to the First-Tier Tribunal.
- 8.6.2 Any other dispute about the GMS contract shall be determined by the Secretary of State (NHS Resolution (NHSR) – Primary Care Appeals (PCA)) in accordance with regulation 9(2) and (3) of the GMS Regulations (pre-contract disputes). NHSR
- 8.6.3 The Commissioner can identify whether the contract is an NHS contract or not by reviewing the agreement. This will enable the Commissioner to identify whether they can apply for NHS dispute resolution (with or without the need for the written consent of the contractor) if appropriate.

**Annex 1 - PMS Agreement Transfer to GMS Contract – Template Letter
(Essential Services)**

- [PMS Agreement Transfer to GMS Contract – Template Letter \(Essential Services\)](#)

**Annex 2 - PMS Agreement Transfer to GMS Contract – Template Letter
(Eligible Persons)**

- [PMS Agreement Transfer to GMS Contract – Template Letter \(Eligible Person\)](#)

Annex 3 - PMS Agreement Transfer to GMS Contract – Template Letter

- [PMS Agreement Transfer to GMS Contract – Template Letter](#)

9 Practice Closedown (Planned / Scheduled)

9.1 Introduction

- 9.1.1 This policy outlines the approach to be taken when a time-limited primary medical services contract is coming to an end. Where an urgent contract needs to be put in place (please refer to the 'Contracts Described' chapter for further information).

9.2 Scope

- 9.2.1 Time-limited contracts can be in place regarding GMS, PMS, APMS and where appropriate MCP/PACS contract types. GMS contracts, however, do not usually have an end date but a temporary GMS contract can be put in place for a period not exceeding 12 months, for the provision of services to the former patients of a contractor following the termination of that contractor's contract.
- 9.2.2 PMS agreements may be in perpetuity or for a time limited period. Commissioners should review the relevant PMS agreement to establish if there is a defined end-date.
- 9.2.3 APMS contracts tend to be for a fixed-term period of three to five years, often with an option to extend for a maximum of a further two years. The main purpose of time limiting these contracts was to provide commissioners the scope for testing the market and ensuring value for money.
- 9.2.4 In each of the cases above there are generic principles that will apply and individual circumstances that will need to be considered. This policy covers the steps to be taken in advance of the end of any contract and will support the Commissioner in planning procurement cycles and future service provision.
- 9.2.5 The Commissioner must consider whether the expiring contract contains provisions relating to the end of the contract that impacts on any practice closedown actions. The NHS England Standard GMS Contract 2014/15 and the NHS England Standard APMS Contract 2014/15 contain provisions relating to the consequences of termination including a requirement that the contractor co-operates with the Commissioner and arrangements for a financial reconciliation exercise.

9.2.6 Contracts may come to an end by reasons other than by expiry including by:

9.2.6.1 being terminated by either the Commissioner or the contractor (in which case refer to the chapter on contract breaches, sanctions and terminations);

9.2.6.2 an adverse event (in which case refer to the chapter on adverse events);

9.2.6.3 the death of the contractor (in which case refer to the chapter on the death of a contractor); or

9.2.6.4 retirement of the contractor (in which case refer to the chapter on contract variations).

9.3 Timetable for Managing Contracts Coming to an End

9.3.1 The Commissioner needs to be aware of the end dates of all contracts held so that advance planning can be undertaken to ensure both capacity and timescales can be aligned with the key stages outlined below.

9.3.2 It is essential that the Commissioner ensures continued communication with contractors throughout the stages to enable them to have a clear understanding of the processes, expectations and obligations. Outlined in Annexes 1 and 2 are guides to communications with contractors and a proposed checklist for documentation recording.

9.3.3 In each of the stages below there is a range of activities that may need to be undertaken, depending on the Commissioner's preferred route, and the Commissioner may usually discuss with the appropriate LMC throughout.

9.4 Summary of Key Stages

9.4.1 There are three key stages:

9.4.2 **Stage 1 – minimum 9 to 15 months before contract end (all essential):**

9.4.3 Needs assessment;

9.4.4 Impact; and

9.4.5 Engagement proposal.

9.4.6 **Stage 2 – 12 months before contract end:**

9.4.7 Notice period – exit plan;

9.4.8 Commence procurement and either:

9.4.9 Begin negotiations for continuation with contractor; and

9.4.10 Begin exit arrangements of incumbent provider and mobilisation of any new provider.

9.4.11 **Stage 3 – at contract end:**

9.4.12 Contract end – possible dispersal of patient list:

9.4.13 Variation to contract/extension: and

9.4.14 Commencement of new provider.

9.5 Stage 1 – 9 – 15 Months before Contract End

9.5.1 The considerations that should be given when completing each action are provided below. This list is not exhaustive but does provide a platform for commissioners to fully assess the existing and future service needs of its population. Commissioners should ensure that all appropriate stakeholders are given the opportunity to input into the needs assessment for their population, including but not limited to public health.

9.5.2 Needs assessment

9.5.3 Is there still a demand for this service in this locality and a requirement for it to continue? For example, to reduce inequalities in access or health outcomes

9.5.4 Does the contract specification still address current local priorities?

9.5.5 Has the contract delivered on the expected outcomes?

9.5.6 Has it provided added value to the local population and service provision?

9.5.7 Have you assessed the potential service needs for any forthcoming new developments?

9.5.8 What is the capacity of other local providers and the market for other providers to deliver services?

9.5.9 Have you given consideration to any specialist services needs in the locality?

9.5.10 Are there any needs that are not met by the contract, which could be delivered?

9.5.11 Impact

9.5.12 Have you considered available outcome and delivery data held nationally and locally, regarding the current service and impact on other providers?

9.5.13 Have you compared the cost of the current service against other providers i.e. cost per head of population whilst taking into account any differences in the scope of the services provided?

9.5.14 Is the current service still affordable within projected future budgets?

- 9.5.15 Has the contract delivered on the expected financial outcomes?
- 9.5.16 What other objectives might be set within the existing budget?
- 9.5.17 Have you considered the potential impact on service users/patients?
- 9.5.18 Have you considered the potential impact on other service providers, e.g. GPs, pharmacy, local trust, out of hours, community services?
- 9.5.19 Have you considered the potential impact on the current provider, i.e. continued viability within the locality?
- 9.5.20 Have you considered patient choice and equality?
- 9.5.21 Have you considered the potential risks i.e. reputational (adverse publicity, Commissioner/provider relationship), market testing, timescales and financial?
- 9.5.22 Have you considered how the expiry of the contract affects compliance with the general duties? For further information, please refer to the chapter covering General duties of NHS England.
- 9.5.23 Engagement proposal
- 9.5.24 Each situation will need to be managed regarding each individual circumstance and the nature of the procurement process to be followed, if at all. However, where it has been deemed appropriate to complete a form of engagement before taking action, the Commissioner should consider:
- 9.5.25 have arrangements been made for the involvement of patients and the public (please refer to the chapter covering General duties of NHS England) for more information on this requirement)?
- 9.5.26 have other local providers and other interested parties i.e. LMC, local members of parliament, review and scrutiny committee, etc been engaged?
- 9.5.27 have the local CCGs been engaged?
- 9.5.28 If the answer is 'no' regarding any of the above, the Commissioner should be able to identify the grounds under which they felt engagement was unnecessary and these should be included in the report defined below.
- 9.5.29 Completion of Stage 1
- 9.5.30 Completion of stage 1 will provide all the information required to enable the Commissioner to make an informed commissioning decision on whether to re-commission, procure or allow the service to end. At this stage, the Commissioner should develop a detailed report (a template is provided in Annex 3) about the investigations undertaken, engagement and outcomes.

This report shall demonstrate that the Commissioner has considered all possible options and the rationale behind the decision taken.

9.6 Stage 2 - 12 Months before Contract End

- 9.6.1 Below are the potential next stages following stage 1 based upon the Commissioner's decision regarding the proposed way forward. It is important to note that where a contract has a duration or an end date specified, and the intention is to allow the contract to naturally expire, there is no requirement to issue a formal termination notice. It would be best practice to issue a formal letter of notice detailing the Commissioner's intentions and the obligations on the contractor throughout the remainder of the contract period.

Notice period – exit plan

- 9.6.2 Issue a letter of notice of intentions.
- 9.6.3 Develop an exit plan (a template is provided in Annex 4) with the contractor with clearly defined Commissioner/contractor responsibilities. This should be developed whether the contract is to cease or transfer to a new provider. Commissioner should review the contract and ensure any exit arrangements detailed in the contract are followed.
- 9.6.4 Procurement
- 9.6.5 Ensure any new contract is procured in accordance with procurement law. Commissioners must also act in accordance with any procurement protocol issued by NHS England.
- 9.6.6 Once a preferred provider is established, agree an operational management plan (a template is provided in Annex 5 – this template should only be used where the contract does not contain exit arrangements as any such arrangements take precedence over the template).
- 9.6.7 Begin negotiations for continuation of the contract with the existing contractor, if appropriate.
- 9.6.8 Extending any contract beyond a previously agreed end date could be considered a material change to the terms of that contract which could lead to a procurement challenge.
- 9.6.9 If there is no extension period already included in the contract, the Commissioner will need to consider carefully whether such an extension

should instead be subject to a full procurement process to ensure best value and mitigate the risk of challenge from previous and/or potential alternative service providers. If the Commissioner's decision is that no procurement process is necessary then it must ensure it is aware of the necessary steps which must be taken to satisfy procurement law and any procurement protocol issued by NHS England.

9.6.10 Once the decision to extend has been reached and all correct processes have been followed the Commissioner will need to consider:

- the length of the extension;
- any alterations to the existing contract (including the financial arrangements); and
- any agreement of new key performance indicators.

Completion of stage 2

9.6.11 Completion of stage 2 will provide the Commissioner with the firm foundations and detailed preparations ready to manage the end of the contract.

9.7 Stage 3 – At Contract End

9.7.1 Below are the possible outcomes culminating from stages 1 and 2.

9.7.2 Contract end

9.7.3 Service ceases.

9.7.4 Dispersal of list if applicable (please refer to comments on managing patient lists in the termination section of the chapter on contract breaches, sanctions and terminations and section 2.5 of the unplanned closures chapter regarding orphan data.

9.7.5 Communication to be sent out to all those parties involved e.g. management of patient communication working with provider, management of the press, notification of contract end to relevant stakeholders.

9.7.6 Variation to contract – extension

9.7.7 Contract variation issued and signed off by both parties.

9.7.8 Commencement of the new provider

9.7.9 Issue of a new contract.

9.7.10 Operational management plan implemented.

9.7.11 Relevant communications undertaken, internally and externally.

- 9.7.12 On completion of stage 3, the Commissioner will have reached an agreed, structured outcome about the management of contract end.
- 9.7.13 As part of any practice close down, PCSE makes a site visit to remove, store and forward patient records to a new provider(s). Patient records should contain reprints of electronic records for patients who have not re-registered at the point of practice closure and will need to be individually placed in transit polytopes. Records will only be collected from the closing practice site. Records are held in archive until the patient re-registers or the retention period expires and they are securely destroyed.
- 9.7.14 Commissioner should also refer to PCSE practice mergers and closures process. Further information is available here
<https://pcse.england.nhs.uk/services/practice-mergers-and-closures-notifications/>

9.8 Primary Care Networks

- 9.8.1.1 When new services are procured, the commissioner should facilitate a discussion between the incoming contractor and the relevant Primary Care Network, to ensure uninterrupted network services for the incoming contractor's registered patients.
- 9.8.1.2 If the provider is not willing to join the PCN, or the PCN is not prepared to accept the provider as a member, the commissioner will liaise with the relevant LMC to facilitate discussions between the practice wishing to sign-up to the Network Contract DES and the appropriate PCN(s) taking all reasonable steps to reach agreement on the terms for the inclusion of the practice in a PCN. The commissioner can allocate a practice to a PCN if the LMC agrees that this is the right thing for the practice. Section 4.9 of the [Network Contract Directed Enhanced Services – Contract specification 20/21 PCN Requirements and entitlements](#) sets out the process for allocating a practice to a PCN.

9.9 Links to relevant PCSS information and documentation

- Performer list <https://pcse.england.nhs.uk/services/performers-lists/>
- Practice Mergers and Closure <https://pcse.england.nhs.uk/services/practice-mergers-and-closures-notifications/>

Annex 1 Guide to Communication with Contractors

- [Guide to Communication with Contractors](#)

Annex 2 Checklist for Documentation Recording when Contract Ends

- [Checklist for Documentation Recording when Contract Ends](#)

Annex 3 Template Detailed Report

- [Template Detailed Report](#)

Annex 4 Template Exit Plan

- [Template Exit Plan](#)

Annex 5 Template Operational Management Plan

- [Template Operational Management Plan](#)

Annex 6 PCSE practice mergers and closures notification form

- [PCSE Practice Mergers and Closures Notification Form](#)

10 Discretionary Payments (made under Section 96)

10.1 Introduction

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10.1.1 Section 96 of the NHS Act (2006) (as amended) makes provisions for commissioners to provide assistance and support to primary medical services contractors, including financial support:

96 Assistance and support: primary medical services

(1) The Board may provide assistance or support to any person providing or proposing to provide–

- primary medical services pursuant to section 83(2),*
- primary medical services under a general medical services contract, or*
- primary medical services in accordance with section 92 arrangements.*

(2) Assistance or support provided by the Board under subsection (1) is provided on such terms, including terms as to payment, as the Board considers appropriate.

(3) “Assistance” includes financial assistance.

Full details of Sections 83, 93 and 96 of the National Health Service Act 2006 can be found at [appendix 1](#)

10.1.2 Section 96 expressly states that NHS England may provide financial assistance, on terms as it considers appropriate. As a result, NHS England has discretion as to the type and level of financial assistance and the payment mechanism that it may choose to employ.

10.1.3 However, NHS England is increasingly being expected to demonstrate publicly what it is spending its money on, what it is getting for its money and of that funding that is allocated to support initiatives that this is done fairly and in the best interests of the organisation and public funds. As such when providing any financial assistance, you must be able to demonstrate that you have acted with propriety, that you have understood and complied with any wider financial requirements as set out in the latest NHS England Standing Financial Instructions, that you have followed all steps to provide best value for money and that you have followed requirements in relation to public sector

bodies as stipulated in Managing Public Money (January 2015), available at:
<https://www.gov.uk/government/publications/managing-public-money>

10.2 Key Principles

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- 10.2.1 All financial assistance must be provided within the principles of openness, fairness, probity and accountability.
- 10.2.2 The provision of financial assistance should not conflict with UK or EU policies and actions including the rules on bribery, corruption, competition, state aid, or and other equality duties.
- 10.2.3 It must be demonstrated how the financial assistance supports NHS England functions and strategic objectives of NHS England as well as any policy objectives
- 10.2.4 Financial Assistance must demonstrate value for money and be in the best interests of NHS England and the patients.
- 10.2.5 Financial Assistance must be proportionate to the identified need and represent better value for the taxpayer than alternative solutions.
- 10.2.6 Financial Assistance will only be made available in exceptional circumstances.

10.3 Programme and Non Programme Financial Assistance

- 10.3.1 Section96 exceptional discretionary funding is generally used to safeguard patients' interests by providing additional funding to support practices facing a crisis situation.
- 10.3.2 Often, financial assistance was made available through formal programmes such as the [General Practice Resilience Programme \(GPRP\) or the current Covid Support Fund](#).
- 10.3.3 However, formal national programmes of support do not cover or replace all circumstances where there is a need for support and agreement on eligibility for funding support from local primary care budgets. Their proposed use - and

the amount provided - will still generally need to be managed by individual local commissioners.

10.3.4 The pressures on general practice mean that requests for support are being received more frequently with a consequent need to have a more structured approach to considering and approving such expenditure outside of formal programmes.

10.3.5 It is also important to ensure that ad hoc requests are minimised through proactive work with practices via appropriate programmes of support that may be in place.

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10.4 Process for Financial Assistance for individual Provider

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Stage		Action
1	The practice raises its sustainability issue with its CCG and NHSE Contract Officer to discuss issues. Verify contract payments are correct.	Practice, CCG, Commissioning
2	Practice submits Section 96 application (Appendix 1) accompanied by the level of support requested, for what period, and for the type of expenditure with evidence provided to support application and CCG support	Practice & CCG
3	Primary Care team review submission and if necessary request for further information / supporting documentation in order to produce a Business Case.	Commissioning
4	<p>Following review and validation of the practice information, a Business Case for the proposed financial assistance must be completed. This must confirm:</p> <ul style="list-style-type: none"> - The Name and reference code of practice for whom discretionary payment request is being made - The level of financial assistance being requested and the level being recommended - How the financial assistance will be paid. - How long is the support anticipated to be needed (either to achieve a resolution or to prepare a business case for long term support) generally no more than a maximum of £200,000 or 3 months funding should be considered (apart from in exceptional circumstances). - The practice need for financial assistance has been validated; - Description of what precipitated the request for discretionary funding - Confirmation of what practical and financial support the <u>practice has</u> already invested to resolve these issues 	Commissioning

Stage		Action
	<ul style="list-style-type: none"> - Confirmation that the practice agrees to receiving the support and any conditions placed on the support including confirmation of any conditions; - details of the practices plan to recover the position and demonstrate that the short term support will deliver a sustainable solution in the long term to ensure that the support is non recurrent. - Performance Management arrangements in respect of the financial assistance - The case represents value for money; - Financial assistance is a better option than any alternatives - Confirmation that the expenditure is in the “normal course of business” for primary medical care. - Confirmation that there is no reason why greater transparency is required in respect of the payment - Whether the contractor is already identified under any national or local programme providing support. - Whether the contractor has applied for and/or received any funding (whether from any NHS or government body, or commercially) that relates to same subject matter of the s.96 application. - Confirmation that there is no additional obligation being placed on NHS England as a result of the financial assistance, that this financial assistance does not arise out of a dispute or claim nor is there any fault or issue which a court may hold requires a payment must be made. 	
5	<p>Review of financial evidence including certified accounts for the previous year and management accounts for the current year, cash flow, declared earnings etc.</p> <p>Consideration of whether the financial assistance will be sufficient to achieve the objectives.</p> <p>Consideration of value for money vs alternatives</p> <p>Total likely overall financial risk to NHS England.</p>	Finance
6	<p>Before the application and Business Case is passed for authorisation the application must be considered and recommended by local arrangements as required.</p>	

Stage		Action								
	<p>Where, in exceptional circumstances, the financial assistance is above £200,000 the business case must be endorsed by:</p> <ul style="list-style-type: none">•The Management accounts team to confirm the availability of funding within the existing budget.•Budget holders for confirmation of the use of this financial assistance, and•legal advice to confirm the correct use of the Financial Assistance power.									
7	All Financial Assistance provided must be in compliance with NHS England SFIs. As such, any application for financial assistance must be authorised as set out in the SFIs. The authority levels should be confirmed at the time the financial assistance is provided.	LPCDOG								
8	<p>Following approval from the LPCDOG, the application from the Provider along with Commissioner business case containing operational and financial reviews set out above will be passed to the NHS England officer with delegated authority to approve the financial assistance.</p> <p>At the date of publication any financial assistance must be approved as follows:</p> <table><tr><th>Below £50k</th><th>£50k to £200,000k</th><th>>£200,000k to Below £1m</th><th>Above £1m</th></tr><tr><td>Deputy appointed by Director of Primary Care and System Transformation</td><td>Director of Primary Care and System Transformation</td><td>Chief Financial Officer</td><td>Department Care/HMT</td></tr></table>	Below £50k	£50k to £200,000k	>£200,000k to Below £1m	Above £1m	Deputy appointed by Director of Primary Care and System Transformation	Director of Primary Care and System Transformation	Chief Financial Officer	Department Care/HMT	Commissioning
Below £50k	£50k to £200,000k	>£200,000k to Below £1m	Above £1m							
Deputy appointed by Director of Primary Care and System Transformation	Director of Primary Care and System Transformation	Chief Financial Officer	Department Care/HMT							
9	All decisions reported as set out below and logged for central reporting and consistency checking	Commissioning								
10	The practice is advised of outcome	Commissioning								
11	MOU populated and signed by the practice, CCG and NHSE	Practice, CCG, Commissioning								

Stage		Action
	<p>The MoU must set out:</p> <ul style="list-style-type: none"> • Name and reference code of practice (the “practice code”) for whom discretionary payment request is being made • aims and objectives of the funding; • outputs agreed and longterm outcomes are defined, wherever possible, to enable active performance management; • clawback provisions included unless NHSE authorised officer confirms that they are not appropriate; • regular reviews and adjustments are included where deemed necessary; • eligible expenditure is stated where necessary; • where appropriate, regular checkpoint meetings will be held to discuss progress against pre-agreed schedule; and • supporting documentation and other evidence required to be provided from the recipient as appropriate. 	
12	Payment set-up on a non-recurrent basis	Finance
13	Review of MOU objectives mid-way through period of support	Practice, CCG, Commissioning
14	Routine reporting via the Primary Care Activity Report (PCAR) and/or National Primary Care Delivery Oversight Group (PCDOG) (see section 7 below)	Commissioning
15	Advise practice of continuation or further review of support depending on MOU progress	Commissioning
16	Final Review and reporting to Local arrangement (as required)	Commissioning

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10.5 Process for CCG and NHS England Proposed Financial Assistance Programmes

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10.5.1 NHS England and CCGs under delegated authority may only enter into contracts within the statutory powers delegated to it by the Secretary of State for Health and must comply with the following:

- NHS England Scheme of Delegation and Standing Financial Instructions; and
- EU Directives and other statutory provisions

10.6 Reporting

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10.6.1 The Primary Care Activity Report

10.6.2 A primary care commissioning activity report (PCAR) was introduced in 2016/17 as a new bi-annual collection to support greater assurance and oversight of NHS England's primary care commissioning responsibilities. It seeks to replace what have often been variable and ad hoc requests for information with a more systematic approach.

10.6.3 The report is managed through UNIFY2 and focuses on key operational areas for commissioned general practice services. It collects information on local commissioning activity regardless of the commissioning route (e.g. NHS England or CCGs with delegated authority) including Financial assistance to providers covered under the section of PCAR 'Equitable funding'

10.6.4 PCAR – Equitable funding

10.6.5 Section 96 payments (sometimes referred to as discretionary payments or funding locally) are a legacy from the NHS Act 2006, which provided PCTs with the facility to support (including financially) GP practices outside of standard contractual arrangements. This regulation still stands and was transferred to the NHS Commissioning Board (NHS England) 'the Board' under the Health and Social Care Act 2012 and subsequent amendments.

10.6.6 When providing a value for this question please consider all payments that are not covered under standard arrangements such as the global sum, a DES or other enhanced services (ES). Support funded from the Vulnerable Practice Programme and the General Practice Resilience Programme has sometimes been covered under this umbrella by some DCOs (i.e. in previous PCAR return). However, it is essential that DCO's DO NOT include payments funded from either fund in their returns as we want to measure genuine discretionary spend by local commissioners. If you are unsure as to whether a payment should be included, CCGs should contact their NHS England local team and DCOs should contact the national team.

10.7 Maintaining Records

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- 10.7.1 A clear audit trail of all financial assistance authorised, along with any expenditure incurred under this arrangement, must be maintained and reported. Summary information will be collected biannually via PCAR but you should also maintain adequate records such that you are able to respond to any other routine financial reporting arrangements. Please refer to section 10.6 for authorising and recording individual applications.
- 10.7.2 All applications for financial assistance should be recorded using the application (Appendix 1) and as set out above.

10.8 Addendums

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10.8.1 Annex 1 – S.96 Application

- [Functional Excel Template Application](#)

Hard Copy of Template Application

FORM REF:

(NHSE use)

Commissioner: Insert NHS England DCO / or Delegated CCG

GP Practice Application for Discretionary Funding Support (Section 96 NHS Act 2006)

1	Date of application:	
2	Practice Name:	ABC practice
3	Practice Identifier Code:	
4	Contract type: GMS/PMS/APMS	
5	Member of GP Federation (formal/informal?)	Yes / No
6	CCG Name:	Name:
7	Practice Address (of all contract sites)	1
		2
		3
8	Practice Raw List Size - Last Quarter	
9	Practice Weighted List Size - Last Quarter	
10	Reason for application (describe the issues to be resolved)	
	<p><i>e.g. May be a GP recruitment issue - IMPACT is high cost of locum support - What are the circumstances that led to the situation? e.g. retirement, partnership split etc. How long has the vacancy existed? Describe recruitment attempts with dates and salary offered.</i></p> <p><i>CONSEQUENCES: describe effect on practice staff, patient services & access</i></p>	
11	Purpose of support requested and itemised value (non-recurrent) - above the practice budgeted level	

	<i>e.g. Support with cost of locums whilst further recruitment is attempted: e.g. Need X sessions per week covered with a premium of £X per week above budgeted cost of £Y per week. Difference of £Z for X weeks sought initially, TOTAL £X. (Practice has funded X weeks but cannot cover this cost much longer and may need to reduce service provision)</i>			
12	Period of support and profile of costs (taper-off)	Period 1	<i>insert dates</i>	<i>insert £</i>
		Period 2	<i>insert dates</i>	<i>insert £</i>
		Period 3	<i>insert dates</i>	<i>insert £</i>
		Period 4	<i>insert dates</i>	<i>insert £</i>
		Period 5	<i>insert dates</i>	<i>insert £</i>
		Period 6	<i>insert dates</i>	<i>insert £</i>
		TOTAL REQUESTED		£0
13	Supporting information - required for ALL applications at the outset			
13.1	Practice Recovery Plan (with actions and milestones to track success)	Yes	No	An MOU will detail agreed actions
13.2	Current AND proposed staff establishment - budgeted with salary & WTE	Yes	No	State drawings for partners
13.3	Evidence of recruitment attempts	Yes	No	e.g. advertisement invoices
13.4	Annual income (all sources) & expenditure analysis OR Practice Accounts	Yes	No	to validate sustainability issue
13.5	Cash flow forecast 12 months ahead	Yes	No	to understand predicted trend

	Sustainability analysis	Support Rationale			Practice Response
14	Negative impact of Carr-Hill formula? (weighted list vs raw list)	Atypical population: adverse impact of Carr-Hill	Yes	No	<i>insert any comments</i>
15	Does the practice have an ' atypical ' population e.g. university, rural or new town which is not adequately reflected in the contract payment? Please explain:	'Atypical' criteria: Must evidence that local demographics dictate workload is not adequately reflected in Carr-Hill	Yes	No	Details required:
16	Are practice expenses greater than 65% of primary medical services (including Local Authority/CCG and NHS England) income?	South East average ratio of expenses: earnings is 65:35	Yes	No	Please state expenses:%
16b	If yes, can this be sufficiently evidenced?		Yes	No	<i>insert any comments</i>
17	Please state individually declared pensionable earnings per GP within the practice (pro-rata'd for part time) for the YEAR [2018/19] (It is noted this may include non-GMS/PMS/APMS income & 'non-NHS' income.) (£110.7k / £93.7k figures per NHS Digital GP Earnings and Expenses Estimates 2017/18 – average income before tax in England Contractor/combined contractor and salaried averages. Add 1%/yr – which for 2018/19 earnings would be £117,981.k for contractors / £94.6k) https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2016-17	No doctor in the practice should have declared pensionable earnings in excess of Contractor = £117,981. Or combined contractor & Salaried GP average not in excess of = £100.6k Support not designed to increase pensionable income.		1 2 3 4 5 6 7 8 9	<i>insert £</i> <i>insert £</i> <i>insert £</i> <i>insert £</i> <i>insert £</i> <i>insert £</i> <i>insert £</i> <i>insert £</i> <i>insert £</i>
	Local Context Information	Practice to complete			Practice to complete
18	Practice Total number of GP sessions worked/week?	Understand GP access	GP sessions		X sessions/week

19	Number of patients per WTE GP	Understand GP access	Patients/GP		XXXX patients/WTE GP
20	Total no. of clinical (GP & Qualified Nursing) hours offered per week (incl. concurrent hours)	Understand total clinical access	a) GP		hrs/week
			b) Nurse		hrs/week
			c) Other		state e.g. Pharmacist hours/week
			Total		hrs/week
21	Has the practice received any contract breaches since 1 April 2013?	Potential marker of poorer quality practice	Yes	No	<i>Details not required</i>
22	Are any of the GP performers being investigated by NHS England Medical Directorate or GMC?	Potential marker of poorer quality practice	Yes	No	<i>Details not required</i>
23	What was the Practices published CQC overall rating ?	Understanding of practice quality issues	Please state		Outstanding / Good / Requires Improvement / Inadequate?
24	Has the practice applied for a formal list closure at any point since 1 April 2013?	Marker of demand/practice issues	Yes	No	Details not required
24b	If yes, was this granted?		Yes	No	
24c	If application was approved how long was the list closed in total?		Please state		3 months / 6 months / 9 months / 12 months
25	Number of practices within a 1-mile radius of practice	insert number			

To be completed by Commissioner - NHS England

	Local Context Information	NHS England complete			NHS England complete
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26	Any previous S96 support received?		Yes	No	Detail..
27	Any GP Resilience funding received?		Yes	No	Detail..
28	Overview of deprivation - IMD Score?	IMD is a marker of deprivation with consequential impact on workload			Practice Area: CCG Area: County Average: England Average:
29	A review of General Practice Indicators used by NHS England to assess quality and safety	Potential marker of poorer quality practice	Yes	No	
30	Annual contractual 'e-declaration' - non-compliance issues?	Potential marker of poorer quality practice	Yes	No	
31	Patient satisfaction survey - outlier areas?	Potential marker of poorer quality practice	Yes	No	Detail issues:

Please return to: <insert local email> @nhs.net (ALL INFORMATION WILL BE HELD SECURELY)

CCG Support required in all cases:	Contractor name	insert	Practice signature (Contractor):	
	CCG Lead Name	insert	CCG signature	or attach CCG email of support
NHS England Contract Officer reviewer - NHSE insert name		insert		

10.8.2 Appendix 1 – Sections 83, 93 and 96 of the National Health Service Act 2006

- [Sections 83, 93 and 96 of the National Health Service Act 2006](#)

[\(return to contents page\)](#)

11 NHS England Procurement Support Contract and National Procurement Tool

11.1 Background

11.1.1 NHS England holds a contract, which is available for use by its commissioners and CCGs, for procurement services with a collaboration of commissioning support units (CSUs) lead by NHS Arden and GEM CSU. The collaboration covers all parts of England as follows:

- Arden and GEM - Midlands and East region
- North East London CSU - London region
- South Central and West CSU - South region
- North of England CSU – North region

11.1.2 The collaboration deploys over 40 procurement staff as dedicated resource to the contract and has access to over 100 more from its activities across the commissioning landscape. The knowledge and experience of the teams deployed is built on undertaking 80 to 100 primary care procurements each year utilising a strategic 7 step process that provides a framework to support commissioners from identification of need to contract award and mobilisation.

11.2 The Offer

11.2.1 This service provides standard process guidance and expertise ensuring best practice and sustainable outcomes through the following phases.

11.2.2 Pre-Procurement activity – Including baselining, project initiation, market analysis and engagement, development of procurement or market intervention strategies ensuring compliance with the regulatory framework(s) and guidance on the production of business cases to meet with the requirements set out in NHS England the Standing Financial Instructions.

11.2.3 Procurement facilitation – working alongside commissioners, we provide a full auditable solution that is compliant with the regulatory framework(s) and includes e- commerce solutions for all aspects of the procurement process, from advert, to invitation to tender, evaluation and award.

11.2.4 Mobilisation support – we provide a full mobilisation support or advice and guidance throughout the process. We have procurement professionals on hand to

support the mobilisation of the contract and ensure a seamless transition to a new contract.

11.3 Contacts

11.3.1 For Primary Care requirements please use the contacts below:

CSU	Contact	Email
NHS Arden and GEM CSU	Gavin Bennett	Gavin.Bennett2@nhs.net
NHS South Central and West CSU	Chris Fuller	chris.fuller1@nhs.net
NHS North East London CSU	Barend Henning	barend.henning@nhs.net
NHS North of England CSU	Julie Parkinson	julie.parkinson5@nhs.net

11.3.2 Further commissioning support services can be provided by CSU's to support processes. Should you require further information contact your local CSU Procurement lead.

11.4 APMS Purchasing System - national procurement tool for APMS and Caretaker GP services

11.4.1 Building on the primary care procurement services that are available to commissioners from the collaboration of Commissioning Support Units (CSUs), NHS England and Improvement has worked with the CSUs to introduce a new online procurement tool to support more streamlined approach to the procurement of GP services, including caretaker services.

11.4.2 The APMS Purchasing System is mirroring many of the elements of a Dynamic Purchasing System. Key features include:

- Building over the next four years an electronically held list of pre-approved providers of GP services
- Providers able to apply join this list almost at any time (unlike a traditional procurement framework)
- Providers able to join for substantive and/or caretaker service, and in the areas they wish to operate in
- An online "call off" process where listed providers will be invited to bid to deliver commissioners local contracting needs.

11.4.3 North and East London (NEL) Commissioning Support Unit (CSU) has established the new system and are running the process including managing application rounds to join the list.

11.4.4 You can find out more by reading commissioner and provider factsheets available at annexes one and two below

11.4.5 Commissioners are free to use the system but application will be dependent on the list of pre-approved GP providers. Equally GP providers application to join the system may be dependent on commissioners use of the system. Commissioners can support the system by:

- Signalling to the GP provider market intentions to use the system – this could include on individual procurement basis as and until there is a developed provider base to adopt it use routinely.
- Sharing details of substantive APMS contracts/procurement pipelines with their CSU so that there is transparency for prospective GP providers on possible future opportunities: this information would be made available to providers through the system.

11.5 Annexes

11.5.1 [Annex 1 – APMS Purchasing System – Commissioner Factsheet](#)

11.5.2 [Annex 2 – APMS Purchasing System – Provider Factsheet](#)

12 Premises Running Costs and Service Charges

POLICY FOR CONSIDERATION OF APPLICATIONS FROM GP CONTRACTORS FOR FINANCIAL ASSISTANCE TOWARDS PREMISES RUNNING COSTS & SERVICE CHARGES

PURPOSE OF THE POLICY: To provide a consistent methodology that is fair, transparent and equitable, for primary care commissioners to consider formal applications for financial assistance towards premises running costs and service charges in line with the NHS (GMS – Premises Costs) Directions 2013, Part 5 Directions 46 and 47.

12.1 Introduction

- 12.1.1 The NHS (GMS – Premises Costs) Directions 2013, dated 28 March 2013, Part 5 Directions 46 and 47 enable GP contractors to request financial assistance from the Commissioner towards premises running costs and service charges that are not reimbursable elsewhere under the Directions. The Commissioner is required to consider such applications and, subject to budgetary targets, to approve them.
- 12.1.2 Applications for financial assistance, under direction 46, in respect of premises running costs, may include costs relating to fuel and electricity charges, building insurance costs, costs of internal or external repairs and/or plant, building and grounds maintenance costs.
- 12.1.3 Direction 47 offers two methods for calculating the amount of financial assistance towards service charges that the Commissioner may consider:
- 12.1.4 GP contractors are required to declare their previous year's average premises running costs (for the same period for which service charge support is applied for), which are then deducted from the financial assistance to be paid by the Commissioner towards service charges.
- 12.1.5 There's a 40% deduction, where information regarding the previous year's average premises running costs is not given/available, from the service charge costs otherwise payable by the Commissioner.
- 12.1.6 Directions 46 and 47 are produced in full at Annex 1.

12.1.7 What the above provisions take no account of is the period in which financial assistance should be provided; what the trigger(s) for a review might be; applications that the Commissioner might prioritise over others in light of other budgetary targets; or whether the financial assistance being requested can be mitigated.

12.1.8 This policy seeks to address these issues.

12.2 Principles

12.2.1 In order for an application for financial assistance to be considered by a primary medical care commissioning organisation, the following principles need to be accepted and adopted by specified stakeholders:

12.2.2 **Commissioners will:**

- 12.2.2.1 Prioritise formal applications from GP contractors that have already been made or those from practices proposing to occupy LIFT, NHS PS (Property Services), or NHS Trust buildings on a head or sub/under lease basis, in recognition of the Commissioner's budgetary targets. This does not preclude GP contractors in other tenancy arrangements or those considering entering into new tenancy arrangements making an application to primary care commissioners for financial assistance towards their premises running costs or service charges, but recognises that higher service charge costs are more typically evidenced by practices occupying or proposing to occupy NHS owned or head leased premises. This prioritisation is further evidenced within the local estate's strategies, developed by CCGs with a wide range of local stakeholders, which seek to the maximise use of the existing public estate.
- 12.2.2.2 Only consider applications that pass through the eligibility criteria check gateway (section 12.3.1 refers). This enables primary care commissioners to prioritise applications that demonstrate they have the greatest need, which in turn ensures that a GP contractor does not waste their time on completing and providing information when ultimately, primary care commissioners are unable to support their application.
- 12.2.2.3 Make recommendations on applications that have passed through all gateways (please refer to section 12.3.3 below) to the relevant CCG Part 2 Primary Care Commissioning Committee. Applications can take a considerable time to process, should they be subsequently approved, back claims will be with effect from the date that the original application was made.
- 12.2.2.4 Offer short term financial support towards premises running costs and/or service charges to GP contractors where there is evidence that their practice expenses are significantly higher than the latest published averages, as a result of high service charge costs and other practice expenses. In this eventuality, a GP contractor must be prepared to put in place a clear action plan, demonstrating that over the next 12 months, it will optimise its income and reduce its expenditure. A further assessment as to whether a GP contractor should remain entitled to further financial support will be undertaken one year on by re-running the financial assistance model, subject to a GP contractor's wish to continue to request such support.

- 12.2.2.5 Discontinue financial support to GP contractors towards premises running costs and/or service charges after a 12 month period, where the true cost pressure does not relate to service charge expenses. GP Contractors can apply for further support under Section 96 of the National Health Services Act 2006.
- 12.2.2.6 Have no direct involvement in managing service charge costs but will require evidence that GP contractors and landlords/head leaseholders have taken appropriate steps to mitigate costs. Steps taken by the incumbents may include, but are not limited to: a formal meeting or correspondence with the landlord or head leaseholder during which the service charge costs were explained and justified. GP contractors should also seek assurance from the landlord/head leaseholder that the service charge costs demonstrate value for money and deliver soft and hard maintenance, in the interests of good estate management and following the principles within the RICS' Code of Practice – Service charges in commercial property. The current GP contractor should also show that they have analysed their own service expenditure to identify areas where costs can be reduced.
- 12.2.2.7 Have interest both in maintaining the viability of its practices and safeguarding tax payer's monies to ensure value for money is delivered.
- 12.2.2.8 Use the latest available GP Earnings and Expenses report currently published by NHS Digital¹³ to benchmark average PMS/GMS GP contractor's earnings to expenses ratios, which are used as a yardstick to ensure fair and reasonable application.
- 12.2.2.9 Take into account changes in income and expenditure, advising GP contractors about any outlying (based on the above NHS Digital report) costs in the process.
- 12.2.2.10 Always use the average previous year's annual service charge costs (where applicable) as the practice's starting contribution to new service charge costs, should a case be made for service charge support. Whilst there is a provision to assume 40% of service charge cost is paid by a GP Contractor in the event where no historical information is available, the model assesses financial assistance required by the GP Contractor based on actual cost projections and Expenses and Income ratios.
- 12.2.2.11 Test a range of alternative inputs to its model to establish which variables provide the best match to enable the GP contractor to attain average PMS/GMS contract earnings.

12.2.3 In light of the number of variables that can impact upon a GP contractor's ongoing need for financial support towards premises running costs and service charges, these would normally be reviewed on an annual basis, when the relevant information is available, reconciling costs back to the last review period.

12.2.4 GP Contractors will:

- 12.2.4.1 Agree to full disclosure of income and expenditure on an open book and annual basis. Should GP contractors not wish to be a party to an annual review, they will need to propose a one-off fixed term support package, which demonstrates a phasing out of financial assistance, taking into account the known variables.
- 12.2.4.2 Not seek to occupy an unreasonable amount of space, taking into account their potential list size; and undertake to share space to mitigate costs, wherever this is practicable.
- 12.2.4.3 Take responsibility for assessing the potential for growing their practice list and develop the associated trajectory over the relevant time period.
- 12.2.4.4 Agree to negotiate and sign a lease at the earliest opportunity, whilst seeking assurance from the landlord/head leaseholder that the service charge costs being levied are fair and reasonable, in compliance with section 12.2.2.6.
- 12.2.4.5 Take responsibility for maximising their NHS income by providing GP services commissioned by local and national NHS and Local authority commissioners within their sphere of competence, resources and affordability, so that the burden of use of public monies for service charge assistance is reduced.
- 12.2.4.6 Take responsibility for minimising their practice expenditure by ensuring cost effectiveness and value for money spend.
- 12.2.4.7 Demonstrate through a clear action plan agreed with support from the LMC (as necessary), how they intend, over a reasonable period of time (deemed to be 12 months), to optimise their income and reduce expenditure, where there is evidence that their practice expenses are significantly higher than the latest published averages.

12.2.5 Landlords/Head Leaseholders will be expected to:

¹³ <https://digital.nhs.uk/data-and-information/publications/statistical/gp-earnings-and-expenses-estimates/2017-18>

12.2.5.1 Ensure the proposed service charge costs being levied are fair and reasonable, and they have a clear strategy to drive down service costs; and provide associated evidence to their prospective tenant/occupier in accordance with the RICS' Code of Practice – Service charges in commercial property.

12.2.5.2 Enable space to be used flexibly to enable GP contractors to mitigate costs, where possible.

12.2.5.3 Allow GP contractors to procure their own services (such as cleaning) where it is practicable to do so, subject to the former providing assurance that their specification will comply with life cycle requirements.

12.2.6 Expectation management:

12.2.6.1 Should there be evidence that a landlord is not prepared to fulfil the expectations detailed in 12.2.5.1 to 12.2.5.3, this will not – in principle - prejudice a GP contractor's application for financial support towards premises running costs and service charges. However, it is likely to delay the processing of an application until the information required to complete it is available.

12.2.7 Evidence required to demonstrate application of Principles:

12.2.7.1 An expression of interest or application shall normally be considered when the steps identified in 12.2.7.1.1 to 12.2.7.1.4 have been evidenced:

12.2.7.1.1 Meetings and/or correspondence between the landlord/head leaseholder and the GP contractor which include full disclosure of soft FM costs backed up with supporting evidence

12.2.7.1.2 Agreement that the footprint that the GP contractor occupies or wishes to occupy is sufficient to meet their current service provision and future potential provision

12.2.7.1.3 Confirmation that key support service related matters such as cleaning services have been discussed and agreed

12.2.7.1.4 Evidence that the impact of procured soft FM services has been discussed in the context of value for money

12.3 The Model

12.3.1 Eligibility criteria:

12.3.1.1 Questions to help establish eligibility should be answered on Tab 2 in Annex 2 of the FMT (Financial Model Template).

12.3.1.2 Total practice expenses to total practice income (expressed as a percentage) for the most recent financial year must be greater than the published average 2017/18 Expenses to Earnings ratios for GP Contractors in the UK for a similar contract type (see FMT, Annex 2, Tab 5). It is reasonable to recognise that the average Expenses to Earnings ratios for GP Contractors in London are higher than those for the UK. “The expenses to earnings ratio is a measure of the proportion of an individual’s gross earnings that is consumed by business expenses. For ease of understanding it is expressed as a percentage throughout this report.” Note: “Full time and part time GPs are included. Figures are irrespective of working hours except in Chapter 3 - Earnings and Expenses Estimates by Weekly Working Hours and Gender for GPs in England’.” “Earnings and expenses results relate to both NHS and private work. It is not possible to provide an NHS/private split using HMRC as a data source as most GPs submit a Self-Assessment tax return which contains information on all of their self-employment earnings while practising as a GP, but which cannot differentiate between NHS and private earnings. GPs can perform both NHS and private work both inside and outside of practice, including the NHS Out of Hours service.” Private income is identified as a very small percentage of average GP income – based on the England data collection “As a guide to NHS/private earning proportions, the average NHS superannuable income for GPMS contractor GPs was 94 per cent of income before tax in 2014/15 which is the latest year for which pensions data are available.” If the value of work being undertaken by a GP partner outside of their contractual commitment affects the total practice expenses to total practice income ratio, such that it is significantly greater than the relevant GMS, PMS or APMS benchmark ratio (as appropriate), The Commissioner reserves the right to exclude additional practice expenses relating to this (e.g. locum costs to cover GP partner’s practice sessions). The value of outside clinical work/advice should be included in the expenditure incurred by the practice. Primary Care commissioners recognise that there may be circumstances that impact on the expenses/income ratio that could exclude a practice’s application for consideration for financial assistance towards service charges; these issues will always be evaluated on a case for case basis.

12.3.1.3 The practice should have had no serious contract breaches for any reason since 1 April 2013. The practice can make a statement for mitigation if they have had any serious contract breaches since 1 April 2013.

12.3.1.4 Should the above criteria not be met, or the practice has not yet provided acceptable explanations for mitigation, an application will not be considered any further.

12.3.2 Financial Model template:

12.3.3 Notes for completion of the template file can be found in Tab 1 in the Financial Model Template (FMT, Annex 2).

12.3.4 For the purpose of this exercise, a contract is considered as a whole. In other words, where a practice operates from more than one site, the combined income and expenses should be entered on the template. Similarly, where two or more practices are merging, the estimated combined income and expenses of the new practice should be entered on the template.

12.3.5 The practice is required to populate the attached “I&E” template (Tab 3 in the FMT) declaring their income and expenditure for the most recent financial year, including full disclosure of service charge cost paid during the most recent financial year. Evidence of payment of service charges must be provided. If no service charges were paid, a statement is required stating the reasons why no service charge costs were paid during the most recent financial year. Applications where this applies will be evaluated on a case by case basis.

12.3.6 The practice must show baseline income separate from other income such as income received from QOF, Enhanced Services, non-NHS organisations, reimbursements, etc.

12.3.7 The practice income and expenditure will be compared with the published 2017/18 (or later when available) UK/London averages (Tab 5 in the FMT) for GMS and PMS practices to determine if the practice is performing broadly in line with these averages. An adjustment may be made for service charges based on the information provided by the practice since the UK/London average for service charge cost is not available.

12.3.8 On the “I&E” template (Tab 3 in the FMT), the practice should demonstrate through a clear action plan how it intends, over a reasonable period of time, as agreed with the commissioner, to optimise its income and reduce its expenditure, where applicable, to align broadly with the published UK/London averages for 2017/16 (Tab 5 in the FMT) (or more recent when available).

12.3.9 On the Service Charge template (Tab 4 in the FMT), the practice should further demonstrate how it plans to increase its share of the service charge cost and reduce the liability of the primary care commissioner to provide financial assistance. This can be done in fixed percentage/value increments each year or based on list growth or another plan tailored for the practice. The practice is advised to note the impact of its projections on its Expenses to Earnings ratios. Where a practice cannot increase its share of the service charge cost, it must give reasons why this is not possible. Note that the primary care commissioner's liability for financial assistance for Service Charge support can never be higher than the total Service Charge cost to the practice.

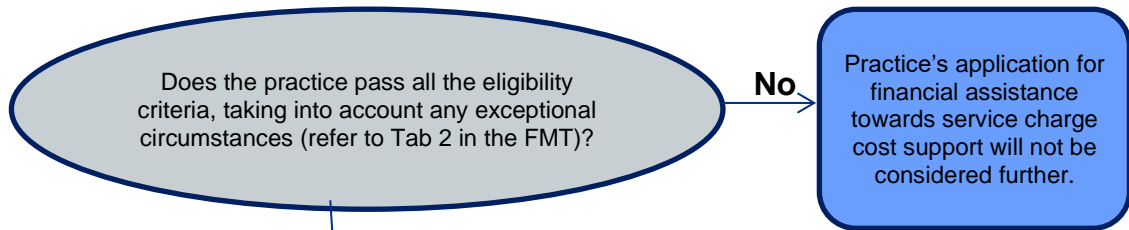
12.3.10 The figures mentioned above will be reviewed on an annual basis in the interest of the practice, primary care commissioner as well as the taxpayer. This includes the income and expenditure, service charge cost as well as the comparison with UK/London averages where applicable. The projected reduction in primary care commissioner's liability for financial assistance for service charge cost will also be assessed annually to evaluate whether it is viable or not for the practice to be responsible for a larger share, and ultimately 100%, of the total service charge cost. The practice should notify the primary care commissioner of any significant changes and provide an updated FMT to enable the re-evaluation of financial assistance for service charge cost. If there are no significant changes, the practice must provide the primary care commissioner with proof of payment of the most recent years' service charge costs in order to compare that with the FMT submitted previously. Primary care commissioners will reconsider financial assistance for service charge cost support to a practice if there are significant changes to the FMT as well as actual service charge costs.

12.3.11 Where a practice chooses not to disclose its income and expenditure information on an annual basis, it will need to propose a fixed term financial assistance package for service charge costs. The practice will still be required – in the first instance – to demonstrate that it meets the eligibility criteria to access financial assistance, and must also provide proof of payment of the most recent years' service charge costs (where applicable). The practice will need to demonstrate a reduction in required service charge support taking into account known variables such as changes in weighted list size, baseline price, other income, actual service charge costs, other expenditure, national averages and other variables that may impact the financial viability of the proposal. At the start of each financial year and while financial assistance is required, the practice must

provide proof of payment of the most recent years' service charge costs to the commissioner in order to compare that with the proposed financial assistance package, regardless of its agreement to a fixed term package. The commissioner will reconsider its financial assistance for service charge costs to the practice if there are significant changes to the proposed package and actual service charge costs. Financial assistance towards service charge costs will only be reimbursed based on actual service charge cost paid by the practice and not while there is a dispute between the practice and the landlord, and/or there is no lease in place and/or the service charge costs have not been agreed with the landlord following an increase in this cost.

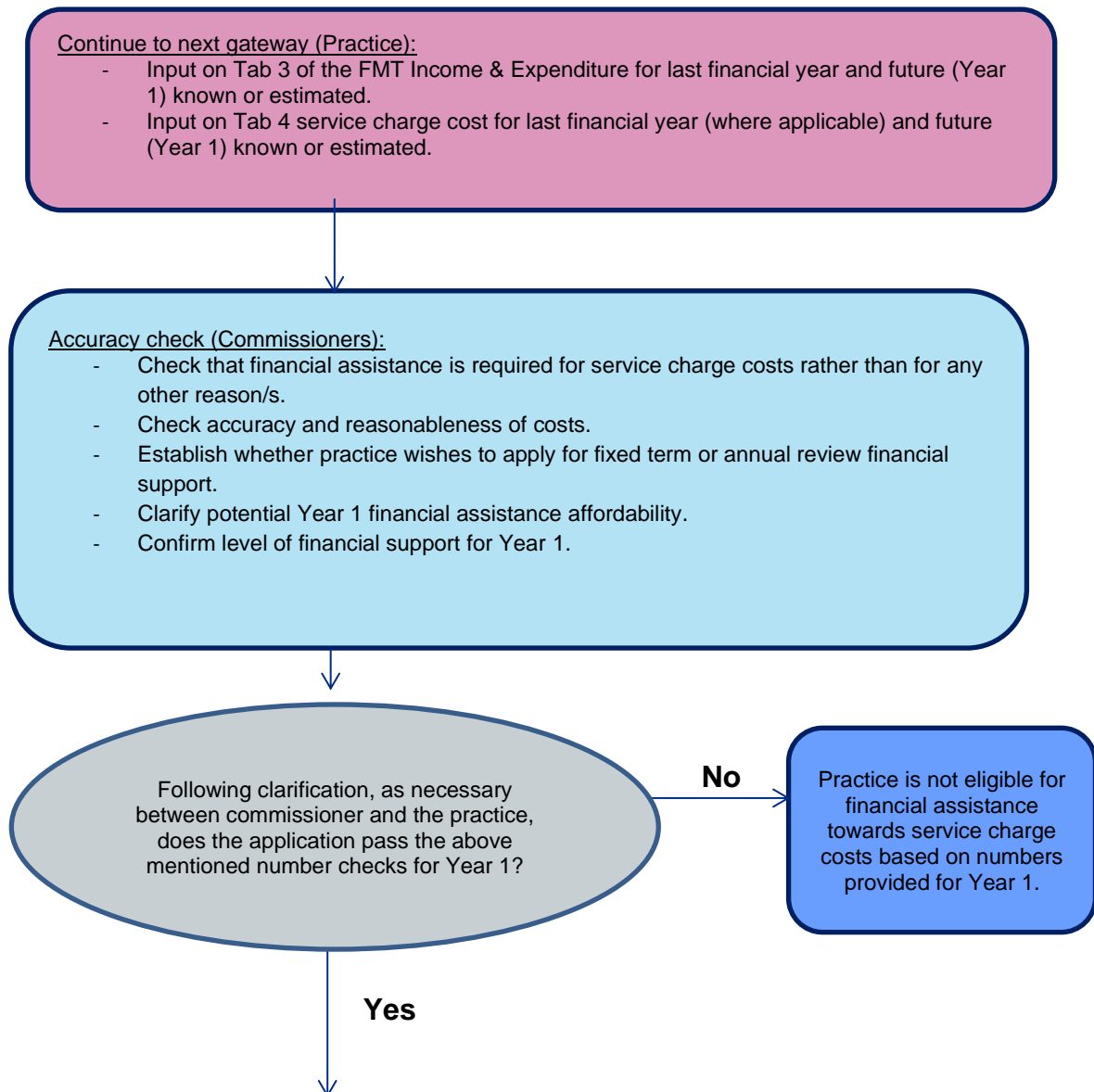
12.4 Process flowchart

GATEWAY 1

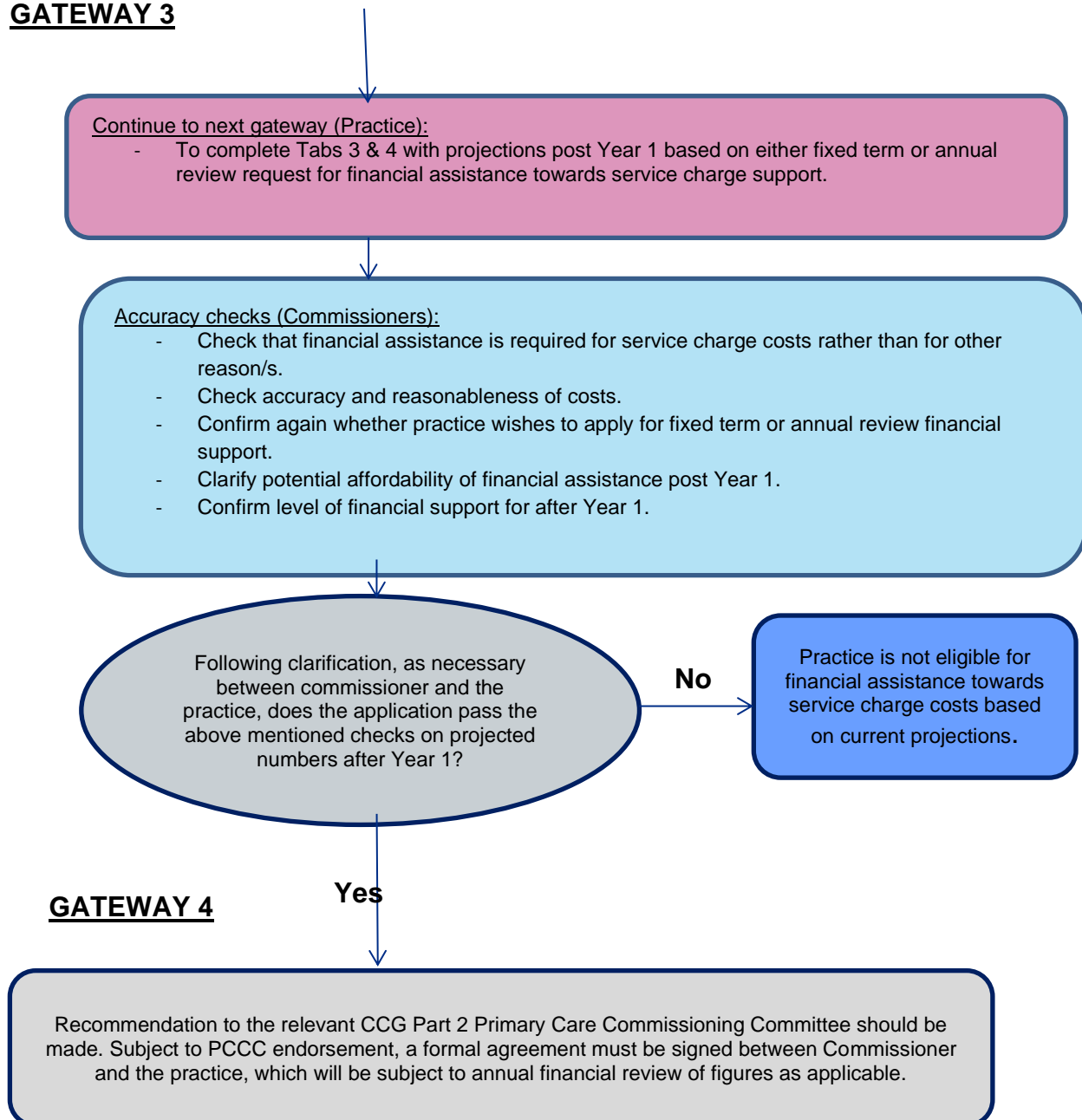


Yes

GATEWAY 2



GATEWAY 3



12.5 Annexes

12.5.1 Annex 1 - Directions

Extract from NHS (GMS – Premises Costs) Directions 2013, dated 28 March 2013

Payments in respect of running costs

46. – (1) Where–

- (a) a contractor is in receipt of payments pursuant to this Part in respect of leasehold rental costs or borrowing costs, or by way of notional rent payments;
- (b) the contractor actually and properly incurs the costs which are or relate to–
 - (i) business rates,
 - (ii) water and sewage charges,
 - (iii) charges in respect of the collection and disposal of clinical waste, or
 - (iv) a utilities and services charge which covers the matters in paragraph (2);

(c) those costs are not covered in other payments that the contractor is receiving pursuant to these Directions, and

the contractor makes an application to the Board for financial assistance towards meeting any or all of these costs, subject to direction 47, the Board must consider that application and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

(2) The utilities and service charges in paragraph (1)(b)(iv)-

- (a) may include a service charge under a lease or a charge levied under separate arrangements made by a contractor which is an owner-occupier,
- (b) must cover–
 - (i) fuel and electricity charges,
 - (ii) building insurance costs,
 - (iii) costs of internal or external repairs, and
 - (iv) plant, building and grounds maintenance costs.

Financial assistance towards service charges

47. The Board must deduct from any amount that it would otherwise be required to pay in respect of a service charge pursuant to an application of the type mentioned in direction 46–

(a) an average (calculated on the basis of the previous year's costs) amount that the contractor paid in respect of–

- (i) fuel and electricity charges,
- (ii) insurance costs,
- (iii) costs of internal or external repairs, and
- (iv) building and grounds maintenance costs,

calculated by reference to the same time period as the period in respect of which the service charge is payable; or

(b) if suitable and sufficient information is not (or does not become) available to calculate the average referred to in paragraph (a), 40% of the amount otherwise payable.

12.5.2 Annex 2 – FMT Service Charge Support 17-18

[FMT Service Charge Support 17-18 Application v2](#)

12.5.3 Annex 2A – FMT Service Charge Support 17-18 (GUIDE)

[FMT Service Charge Support 17-18 \(GUIDE\)](#)

12.5.4 Annex 2B – Commissioners and Finance Officers Guide to Tab 2 of FMT

[Commissioners and Finance Officers Guide to Tab 2 of FMT](#)

12.5.5 Annex 3 - Commissioner-GP Formal Agreement

[Commissioner-GP Formal Agreement](#)

12.6 NHS Resolution guidance note on Premises costs (Current Market Rent) disputes

12.6.1 The aim of this guidance note (link below) is to provide information which should be used in conjunction with the Regulations, Directions, Protocol, Determinations and Guidance Note for Parties Involved in Dispute Resolution (see paragraph 11). It is not its function to summarise these documents, which should be referred to before making any referral to Primary Care Appeals in relation to CMR reimbursement.

<https://resolution.nhs.uk/resources/guidance-note-on-premises-costs-current-market-rent-disputes/>

12.7 PCN Workforce and Estates Guidance

12.7.1 The Network Contract Directed Enhanced Service (DES) Contract Specification 2020/21 – PCN Entitlements and Requirements ('the Contract') paves the way for around seven additional new full-time clinical support staff for an average PCN in 2020/21. This figure rises to 20 full-time staff by April 2024. It is predicted that the introduction of these new staff, under the Additional Roles Reimbursement Scheme (ARRS), will transform service delivery for patients, and ease the mounting pressures on existing clinical staff, including GPs and practice nurses.

12.7.2 The 'Update to the GP Contract Agreement 2020/21 – 2023/24' (published 6th February 2020) makes reference to ensuring sufficient space is available for additional staff employed under the ARRS (paragraph 1.34).

12.7.3 These documents offer advice and guidance to providers (PCNs and constituent practices), as well as to commissioners in receipt of applications for additional funding to accommodate additional staff. The documents are set out below and can be accessed [here](#):

Annex 1 Advice note for providers

[Advice note for providers](#)

Annex 2 Supplementary guidance for providers

[Supplementary guidance for providers](#)

Annex 3 Guidance for commissioners in receipt of an application for funds (including annexes 1-4)

- [Guidance for commissioners in receipt of an application for funds \(including annexes 1–4\)](#)

13 Sub-contracting of Clinical Services

13.1 Assurance Framework: Sub-contracting of Clinical Services Under GMS Contracts

13.2 Introduction

13.2.1

13.2.2 This framework was primarily developed to support commissioners assurance of proposals by a GMS contractor to expand into new areas across the country by sub-contracting clinical services to a separate company to deliver services to 'out of area' patients, both through the provision of 'digital-first' services and face-to-face consultations in sub-contractor's premises located outside of the practice's area.

13.2.3 The framework is particularly useful to commissioners when considering such proposals; however it can be of use in relation to any proposal by a contractor to sub-contract clinical services.

13.2.4 The framework is provided as a resource to support commissioners and consists of:

- Guidance on assuring sub-contracting of clinical services under GMS contracts;
- Annex A – Assurance Checklist;
- Annex B – Mandatory contract terms regarding sub-contracting.

The following are outside the scope of this framework:

- sub-contracting of non-clinical matters;
- sub-contracting of out of hours services;
- entering into a contract for services with a health care professional for the provision by that professional personally of clinical services.

13.3 Guidance on assuring sub-contracting proposals

13.3.1 Preliminary discussion and co-operation

13.3.1.1 It can assist both commissioners in assuring proposals for sub-contracting, and providers in developing their proposals and addressing potential issues, to enter into preliminary discussions and co-operate with one another, prior to formally serving a notice of sub-contracting.

13.3.1.2 Doing so avoids the considerable time pressures associated with the 28 day period for commissioners to formally to object to a notice of sub-contracting under a GMS contract.

13.3.1.3 However, under the GMS contract, the contractor has the right to serve a notice of sub-contracting at any time. Where a contractor does so, commissioners must act rapidly to undertake assurance of the proposals and (where appropriate) serve any notice of objection within a 28 day period.

13.3.2 Step 1 – identify the relevant contract and terms

13.3.2.1 In all cases the commissioner should identify the relevant primary medical services contract in place with the contractor and review its terms regarding sub-contracting. These terms set out the respective rights and obligations of the parties in relation to sub-contracting and must be adhered to by both parties.

13.3.2.2 This guidance and the checklist focus upon GMS contracts only and reflect the mandatory terms regarding sub-contracts that must be included in all GMS contracts.

13.3.2.3 PMS and APMS contracts have fewer mandatory terms regarding sub-contracting, and may also have bespoke sub-contracting arrangements agreed within the contract. Therefore not all aspects of this guidance and checklist will apply to such contracts. See **Annex B** for a summary of the mandatory terms for each type of contract and seek legal advice where required.

13.3.3 Step 2 – notice of sub-contracting

13.3.3.1 The contractor must give notice in writing of its intention to sub-contract as soon as reasonably practicable before the date on which the proposed sub-contract is intended to come into effect (**'notice of sub-contracting'**).

13.3.3.2 Upon receipt of such a notice, the commissioner should check if it is valid.

A valid notice must include:

- the name and address of the proposed sub-contractor;
- the duration of the proposed sub-contract;
- the services to be covered by the proposed sub-contract; and
- the address of any premises to be used for the provision of services under the proposed sub-contract.

13.3.3.3 If the notice is valid, the commissioner should then calculate a period of 28 days beginning with the date on which the notice of sub-contracting was received. The last day of that 28 day period is the last date upon which the commissioner may serve a notice of objection (see Step 5). The commissioner should take into account the notice provisions of the contract to ensure that the date is correctly calculated and any such notice is served in time.

13.3.3.4 If the notice is invalid, the commissioner should advise the contractor of this and that the proposed sub-contract will be unlawful unless and until a valid notice of sub-contracting has

13.3.3.5 been served. Upon receipt of a valid notice, the commissioner has a further 28 days to object starting on the date it was received.

13.3.4 **Step 3 – notification of novel, contentious or repercussive proposals**

13.3.4.1 The commissioner should take an initial view upon whether any of the following criteria are met:

- the sub-contracted services will be delivered wholly or partly via a 'digital-first' service (i.e. care delivery models through which a patient can receive the advice and treatment they need via online symptom checking and remote consultation);
- the sub-contracted services will be provided to 'out of area' patients (i.e. patients who reside outside of the practice area);
- the premises to be used for the provision of services under the proposed sub-contract are outside of the contractor's practice area; or

- the proposed sub-contract is otherwise considered to be novel, contentious or repercussive.

13.3.4.2 Where any of the above criteria are met, the commissioner should immediately notify its regional NHS England and Improvement primary care team. The purpose of this notification is to enable:

- monitoring of the rollout of such sub-contracting arrangements;
- notification of commissioners affected by the proposed sub-contract;
- provision of additional guidance and support to the commissioner, where appropriate; and
- in the case of a CCG commissioning primary medical services under delegated arrangements with NHS England, determining whether the decision requires additional approval by NHS England.

13.3.4.3 In such cases, NHS England and Improvement regional team will advise, having consulted with NHS England and Improvement national primary care team, the commissioner of any additional procedures to be followed.

13.3.5 Step 4 – assurance of the proposed sub-contract

13.3.5.1 The commissioner must then assure the proposed sub-contract and decide:

- whether the proposed sub-contract is unlawful (i.e. not permitted under the GMS contract);
- whether there are any safety or financial grounds to object to the proposed sub-contract.

13.3.5.2 Where the contractor has served a valid notice of sub-contracting, it is essential that this process is completed (and any notice of objection given) before the 28 day period ends (see Step 2).

13.3.5.3 Unlawful sub-contracting

13.3.5.4 The contractor is not permitted to sub-contract clinical services unless:

- it has given notice in writing to the commissioner of its intention to sub-contract as soon as reasonably practicable before the date on which the proposed sub-contract is intended to come into effect (see Step 2, above);
- it is satisfied that the sub-contractor has in force in relation to it an indemnity arrangement which provides appropriate cover;
- it has taken reasonable steps to satisfy itself that:

- o it is reasonable in all the circumstances to sub-contract clinical matters; and
 - o the person to whom clinical matters are sub-contracted is qualified and competent to provide the service;
- the sub-contractor would be able to meet the contractor's obligations under the contract;
- the sub-contract prohibits the sub-contractor from sub-contracting any of the clinical services that it has agreed with the contractor to provide under the sub-contract.

13.3.5.5 The proposed sub-contract will also be unlawful if it involves the sub-contracting of essential services to a company or firm which is or was formed wholly or partly for the purpose of avoiding the restrictions on the sale of goodwill of a medical practice. Seek legal advice if this is a concern.

13.3.5.6 Objections on safety or financial grounds

13.3.5.7 The grounds of objection are that the sub-contract would:

- put the safety of the contractor's patients at serious risk; or
- put NHS England at risk of material financial loss.

13.3.5.8 These are the only grounds of objection available.

13.3.5.9 Assurance process

13.3.5.10 The assurance of the proposed sub-contract is at the discretion of the commissioner.

13.3.5.11 The assurance process should be proportionate and undertaken within the 28 day period to enable objections to be served if necessary.

13.3.5.12 What is proportionate in any particular case will depend upon the circumstances and the commissioner's assessment of the potential safety, financial and compliance risks associated with the proposal. Proposals that have been identified as novel, contentious or repercussive under Step 3 are likely to require the most detailed level of assurance.

13.3.5.13 Without prejudice to the discretion of commissioners, NHS England has prepared an Assurance Checklist which sets out a series of matters which could be interrogated as part of such an assurance process – see **Annex A**.

13.3.5.14 Additional information

13.3.5.15 The commissioner may request further information relating to the proposed sub-contract as appears to it to be reasonable and the contractor must supply such information to the commissioner promptly.

13.3.5.16 This is particularly likely to apply where the contractor has not engaged with the commissioner in advance of giving notice of sub-contracting, as the commissioner is unlikely to have all of the information required to undertake an appropriate assurance exercise.

13.3.5.17 The 28 day period is not 'paused' when requests for information are made, therefore any requests for information should be made promptly to allow sufficient time to receive and scrutinise such information.

13.3.5.18 Decision

13.3.5.19 A decision on the above matters must be taken within the 28 day period based upon the information available at that time.

13.3.5.20 The decision should be taken in accordance with relevant decision-making processes and (in the case of a CCG commissioning primary medical services under delegated arrangements with NHS England) in accordance with the relevant delegation agreement.

13.3.6 Step 5 – implementation

13.3.6.1 No objections

13.3.6.2 If the commissioner considers that that the proposed sub-contract is permitted under the terms of the contract, and that there are no safety or financial grounds to object, no further formal steps are necessary. The contractor will be permitted to proceed with the sub-contracting once the 28 day has expired.

13.3.6.3 In these circumstances, the commissioner may indicate to the contractor that it does not presently have any objections, however it is recommended that the commissioner states that this is without prejudice to its rights under the contract, including to object to the sub-contract in future, where appropriate.

13.3.6.4 Unlawful sub-contracting

13.3.6.5 If the commissioner considers that the proposed sub-contract is unlawful (i.e. not permitted under the terms of the contract), it should notify the contractor of this in writing.

13.3.6.6 If the contractor nonetheless proceeds with the sub-contract, this should be treated as a breach of contract and appropriate contractual action should be taken. What action is appropriate will depend upon the circumstances and legal advice should be obtained if necessary.

13.3.6.7 Objection on safety or financial grounds

13.3.6.8 Where NHS England is satisfied that there are grounds to object on safety or financial grounds, the commissioner must give notice in writing of its objection to the sub-contract within the 28 day period ('**notice of objection**').

13.3.6.9 The notice must specify the specific grounds relied upon (see Step 4) and include a statement of reasons for NHS England's objections.

13.3.6.10 Where a valid notice of objection has been served on the contractor within the 28 day period, the contractor must not proceed with the sub-contract. If the contractor disagrees with the notice of objection, it must follow usual dispute resolution procedures.

13.3.6.11 If the contractor nonetheless proceeds with the sub-contract, this should be treated as a breach of contract and appropriate contractual action should be taken. What action is appropriate will depend upon the circumstances and legal advice should be obtained if necessary.

13.3.7 Step 6 – review

13.3.7.1 Where sub-contacting proceeds, commissioners should continue to monitor the arrangements. Where issues arise, appropriate contractual action should be taken. What action is appropriate will depend upon the circumstances and legal advice should be obtained if necessary.

13.3.7.2 In some cases a proposed sub-contract may be unlawful or objected to on safety or financial grounds within the 28 day period, but is capable of being permitted following a further period of development and assurance of the proposal. If so, the commissioner may wish to schedule a future review of the decision to assess if any objections can be lifted.

13.4 Annex A – Assurance Checklist

Assessment Checklist

13.5 Annex B – Mandatory terms regarding sub-contracting

Mandatory terms regarding sub-contracting

13.6 GP and NHS provider (NHS trusts or FTs) sub-contracting checklist

13.6.1 There are also various emerging arrangements in which NHS trusts or FTs (or their subsidiary companies) are becoming involved in primary medical services contracts (including GMS contracts) through either:

- subcontracting of services
- contract award (PMS agreements and APMS contracts).

13.6.2 This (sub) section provides an overview of some key and emerging issues that commissioners may wish to assure themselves where such arrangements are proposed. It is structured into four parts:

- Part A – issues that the NHS England and Improvement regional teams will need to consider, to ensure that its own statutory responsibilities are upheld
- Part B – issues that a CCG would need to consider to meet its responsibilities
- Part C – issues that would need to be considered by the NHS England and Improvement regional team or the CCG, depending on whether primary care commissioning responsibilities are delegated
- Part D – issues on which the commissioner may need to seek assurance that the provider has considered.

13.6.3 Part A: Issues for consideration by the NHS England and Improvement regional teams:

Issue: Responsible officers (RO)

The Medical Profession (Responsible Officers) Regulations 2010 establish the role of the 'Responsible Officer'. Organisations with a responsibility to appoint a responsible officer include NHS England (for example, for an individual on the Performers List) and organisations 'designated' under the regulations.

Those who wish to perform primary medical services on behalf of the NHS must generally be included in the national performers list (except in certain specified circumstances), and NHS England has a responsibility to provide a Responsible Officer for those on the Performer's List – this includes in instances where that person(s) on the performers list are employed by another organisation (such as a NHS trust or FT) – this is likely to encapsulate the types of arrangements described given that they are performed under a GMS (sub)contract.

There may be circumstances in which it is appropriate for the NHS trust/FT to provide a RO for someone providing primary medical services – for example, if they have employed an overseas GP who is not required to be on the performers list.

Considerations

There may be a risk of either:

- potential duplication between NHSE and providers – ie that both may provide a RO inappropriately; or
- that both the provider and NHSE may assume that the other party is providing the role.

Action required

NHS England should ensure its responsible officer (RO) responsibilities are upheld. In practice, NHS England regional/local teams should confirm which organisation is taking responsibility for appointing a responsible RO and check that each GP employed/operating the subcontract has a RO appointed.

13.6.4 Part B: Issues for consideration by the CCG

Issue: Potential conflicts of interest

CCGs are expected to manage any conflicts that may arise in relation to CCG membership and decision-making.

Considerations

There is potential that a direct relationship between GPs and trusts/FTs may raise additional conflicts of interest for CCG decision-making. In particular, it is possible that GP practices affiliated with one NHS trust/FT could become dominant within a CCG's membership, and then potentially (dependant on its constitution), have an ability to influence other aspects of CCG policy which may benefit that trust.

Action required

Commissioners should consider this issue and refer to NHSE's Managing Conflicts of Interest guidance for CCGs.

13.6.5 Part C: issues on which the commissioner may need to seek assurance that the provider has considered

Issue: Following due process

There are set rules that govern the nature and circumstances in which primary medical services can be sub-contracted. It is worth noting that those rules differ slightly between GMS, PMS and APMS contractual frameworks. Further guidance on assuring sub-contracting arrangements is covered in [] of this section:

Those rules specify that where a GMS contractor wishes to subcontract clinical matters, they must give notice in writing to NHS England of its intention to subcontract as soon as is reasonably practicable before the date on which the proposed subcontract is intended to come into effect (note that there is an exception in relation to sub-contracting out of hours services).

The contractor must not proceed with a subcontract or, if the subcontract has already taken effect, the Contractor must take steps to terminate it, where:

- NHS England gives notice in writing of its objection to the subcontract on the grounds that the sub-contract would:
 - (i) put the safety of patients at serious risk, or
 - (ii) put NHS England at risk of material financial loss;and notice is given by the NHS England before the end of the period of 28 days beginning with the date on which the NHS England received a notice from the Contractor, or
- the subcontractor would be unable to meet the Contractor's obligations under the Contract.

A statement of reasons for an objection must be provided and should set out a clear rationale for the decision.

Considerations

Commissioners must ensure that commissioned services continue to be delivered in accordance with the GMS contract.

In considering any such proposals to subcontract, commissioners will wish to consider whether the GMS contract will continue to be delivered to the nationally agreed terms and requirements. This may include seeking assurance of, for example, matters such as how services will be delivered in accordance with the GMS Contract and quality of care will be ensured.

Action required

Commissioners should consider whether the GMS contract, under sub-contract, will continue to be delivered to the nationally agreed requirements. This may include seeking assurance of, for example, matters such as how services will be delivered in accordance with the GMS Contract and quality of care will be ensured.

Commissioners should also identify whether, because of the particular delivery model, the GMS contract holder – and therefore the person to whom the CCG should be escalating performance management concerns – could have a conflict of interest with their responsibilities to the NHS trust/FT. If any conflict is identified, the commissioner should ensure that measures are in place to manage them.

As part of the assurance process, commissioners may wish to seek confirmation from the contractor that they have updated their CQC registration, and to understand the detail of this registration.

Throughout the duration of any subcontracting arrangements, commissioners should continue to seek assurance about the delivery of the GMS Contract through the lead contractor.

13.6.6 Part D: issues on which the commissioner may need to seek assurance that the provider has considered:

There is a range of issues that contractors will need to properly consider and seek appropriate advice. These include but are not limited to:

- indemnity – for example, whether there is appropriate indemnity coverage for flexible use of workforce in the delivery of more integrated services
- implications for regulation – for example, to ensure that the provider's registration with the Care Quality Commission has been appropriately updated where applicable
- pensions – in particular, staff employed by subcontractors are not able to access the NHS Pension Scheme (unless otherwise eligible in their own right e.g. employees of Trust/FT). This is particularly an issue where primary care contracts are subcontracted to subsidiary companies with individuals becoming employed by the subsidiary rather than the Trust / FT directly.

Part C – When things go wrong

1 Contract Breaches, Sanctions and Terminations

1.1 Introduction

- 1.1.1 This policy chapter outlines the approach to be taken by the Commissioner when a contract is considered to have been breached. Where processes differ with regards to GMS, PMS and APMS contracts, these are highlighted.

Primary Care Networks

While network services are delivered by the member practices they are commissioned from the individual member practices

Circumstances of non delivery of network services may result in the issue of a Breach Notice, a Remedial Notice, Contract Sanction, or exceptionally lead the Commissioner to consider termination and will be applied to individual member practices as those circumstances dictate or are clear eg. breach at network or practice population level.

- 1.1.2 Given that any decision to issue a Breach or Remedial Notice, apply sanctions or terminate a contract or agreement can be challenged by the contractor under appeal, it is essential that the Commissioner follows, and can demonstrate that it has followed, due process in investigating, communicating and implementing actions in this respect and that the Commissioner has acted fairly and reasonably throughout.
- 1.1.3 It is essential that the Commissioner maintains thorough and accurate records of all communications and discussions in respect of all notices under this policy.
- 1.1.4 Commissioners should maintain accurate records of all breaches sanctions and terminations and will be required to demonstrate if requested, evidence of compliance, or otherwise support oversight of primary medical care commissioning arrangements. This may be for example, via NHS England's Primary Care Activity Report (PCAR) or internal and external audit functions.

1.2 Contract Breaches

Where the Commissioner considers that a breach has occurred, there are a number of options on how to proceed. The Commissioner can:

- take no action;
- agree on an action with the contractor;
- issue a Remedial Notice;

- issue a Breach Notice;
- apply a Contract Sanction; or
- terminate the contract.

- 1.2.1 In many cases, it will be appropriate as a minimum, to serve a breach or remedial notice to formally document a breach as part of routine contract management. Where issues with a contractor then escalate, it is helpful if the pattern of breaches to date is already evidenced by appropriate breach and/or remedial notices. However, doing nothing or informally agreeing on an action with the contractor are options that the Commissioner may consider appropriate for a very minor or technical breach. The Commissioner should be aware of the implications of this decision, in that there will be no formal record of the breach to rely on as part of future contract management.
- 1.2.2 The following paragraphs set out the circumstances in which a Remedial Notice or a Breach Notice may be issued, a Contract Sanction may be applied or the contract may be terminated with an explanation of the relevant process that the Commissioner must follow.
- 1.2.3 The Commissioner must ensure that, when issuing a Remedial or Breach Notice, applying a Contract Sanction or terminating a contract, it follows the proper internal processes around the approval of the action, compliance with any standing orders and due consideration of all relevant factors in the decision making process.

Co-commissioning - delegated commissioning arrangements

A CCG that has delegated commissioning arrangements will have entered into a Delegation Agreement with NHS England setting out the scope of those arrangements.

The Delegation Agreement reserves primary medical services functions that relate to performers lists to NHS England. Circumstances that may result in the issue of a Breach Notice, a Remedial Notice, a Contract Sanction or may lead the Commissioner to consider termination may relate to or include reference to performers lists matters. Where this is the case, the Delegation Agreement requires the CCG to work collaboratively with NHS England and support and assist NHS England to carry out its performers lists functions.

1.3 Remedial Notices and Breach Notices

- 1.3.1 The GMS Regulations, the PMS Regulations and the APMS Directions make a clear distinction between the process to be followed where a breach is capable of remedy and the process where a breach is not capable of remedy.
- 1.3.2 **GMS/PMS** - Where a breach is capable of remedy, a Remedial Notice must be issued before the Commissioner takes any other action under the contract (such as termination). Where a breach is not capable of remedy, a Breach Notice must be issued before the Commissioner takes any other action under the contract (such as termination).
- 1.3.3 **APMS** - Contracts are not required to contain provisions relating to Remedial or Breach Notices. The NHS England Standard Alternative Provider Medical Services Contract 2014/15 does, however, contain these provisions. Where there is a potential breach of an APMS contract, the Commissioner should always review the actual wording of the contract to ensure the right process is followed.

Remedial Notice

- 1.3.4 Where a contractor has breached the contract and the breach is determined to be capable of remedy, the Commissioner may issue a Remedial Notice to the contractor setting out the actions that must be taken to remedy the breach.
- 1.3.5 A flowchart highlighting the main steps that the Commissioner should take when issuing a Remedial Notice is set out in Annex 1.
- 1.3.6 The Commissioner must issue a Remedial Notice before it takes any other action it is entitled to take under the contract, except where the breach relates to the rights of termination set out below. This is because the Commissioner has a right to terminate the contract immediately for a breach of any of the circumstances set out below. These rights of termination are explained in more detail in paragraph 1.7 of this policy:
- provision of untrue information;
 - fitness to practise matters;
 - a serious risk to patient safety or risk of financial loss to NHS England;
 - unlawful sub-contracting; and
 - in the case of a GMS contract, issues relating to the contractor's eligibility to hold the contract.

1.3.7 A breach capable of remedy is where the breach continues but the contractor could take action to stop the breach. Examples of breaches that may be capable of remedy include:

- failure to compile a practice leaflet; or
- failure to provide information to the Commissioner.

1.3.8 Where the breach creates a serious risk to patient safety, the Commissioner can take more immediate action, regardless of whether the breach is capable of remedy or not. For further information on this, please refer to paragraph 1.7.32 of this policy.

1.3.9 Where the Commissioner has determined that a breach is capable of remedy, the Commissioner may, depending on the nature and circumstances of a breach take the following steps. These steps do not prejudice or delay a Commissioner's right to issue a Remedial Notice at any point before or during any of these steps being taken where the Commissioner reasonably considers it is appropriate to do so:

1.3.9.1 The Commissioner should contact the contractor to discuss the breach and the action that they may be entitled to take, i.e. the issue of a Remedial Notice.

1.3.9.2 This discussion should provide the contractor with an opportunity to provide an explanation as to the circumstances that led to the breach. An accurate minute of any discussions should be retained.

1.3.9.3 The Commissioner should review the evidence related to the breach including any information received during the discussion or in representations.

1.3.9.4 If the Commissioner is satisfied that the matter is a breach which is capable of remedy, then the Commissioner may issue a Remedial Notice to the contractor, requiring the contractor to remedy the breach.

1.3.9.5 It is important that when the steps above are undertaken, this is completed as quickly as is reasonably possible as long delays between the breach occurring, or the Commissioner becoming aware of the breach, and the Remedial Notice being issued, could lead to an argument that the Commissioner has accepted the breach and waived its right to take action. The Commissioner will need to decide what action it considers would be reasonable to take before issuing a Remedial Notice taking into account the circumstances of an individual breach.

1.3.10 A Remedial Notice must specify:

- 1.1.1 details of the breach, which led to the Remedial Notice being issued and any evidence gathered in respect of the breach;
- 1.1.2 the steps the contractor must take in order to remedy the breach to the Commissioner's satisfaction;
- 1.1.3 the period in which the steps must be taken;
- 1.1.4 any arrangements for reviewing the matter to ensure that the requirements of the Remedial Notice have been met; and
- 1.1.5 the actions that the Commissioner shall take if the contractor fails to satisfactorily remedy the breach.

1.3.11 The Commissioner may wish to include in the Remedial Notice how the contractor may appeal against the decision to issue a Remedial Notice.

1.3.12 A template Remedial Notice is provided in Annex 2. Where NHS England is the Commissioner, the finalised Remedial Notice should be signed off by the Head of Commissioning or their nominated deputy. Where the Commissioner is a CCG operating under delegated commissioning arrangements, the CCG should ensure the finalised Remedial Notice is signed off by the Chief Operating Officer (COO) or an individual authorised by the COO.

1.3.13 The period during which the steps to remedy the breach must be taken must not be less than 28 days from the date that notice is given, unless the Commissioner is satisfied that a shorter period is necessary to protect the safety of the contractor's patients or protect NHS England from material financial loss. In setting an appropriate remedial period, the Commissioner should ensure that it would be possible for the breach to be remedied within that timescale. For example, if a premises breach required major building works to remedy the issue, 28 days will not be reasonable if it seems likely that it would be impossible to meet this deadline.

1.3.14 The Remedial Notice must be delivered to the contractor in accordance with the notice provisions of the contract. This usually requires hand delivery or postal delivery (first class or registered post). Delivery of a notice by fax or email may be permissible. The Commissioner should review the relevant provisions to the contract to ensure proper delivery. Where the notice is hand delivered, the template Receipt Notice in Annex 3 can be used.

1.3.15 The Commissioner should ensure that arrangements are in place to follow up a Remedial Notice appropriately and in a timely fashion.

- 1.3.16 Where the Commissioner is satisfied that the contractor has taken the required steps to remedy the breach within the required period, a letter should be issued to the contractor informing them that the terms of the Remedial Notice have been satisfied and that no further action will be taken at this stage. A template Remedial Notice Satisfaction letter is provided in Annex 4.
- 1.3.17 Where the Commissioner is satisfied that the contractor has not taken the required steps to remedy the breach by the end of the required notice period, the Commissioner may inform the contractor that they have failed to meet the terms of the Remedial Notice and that the Commissioner may terminate the contract with effect from such date as the Commissioner may specify in a further notice to the contractor.
- 1.3.18 Where the Commissioner intends to terminate the contract, please refer to paragraphs 1.5 to 1.7 of this policy.
- 1.3.19 If, following the issue of a Remedial Notice, a contractor either repeats a breach that was the subject of a Remedial Notice or otherwise breaches the contract that results in a further Remedial Notice or a Breach Notice, then the Commissioner has the right to terminate the contract by serving notice on the contractor.
- 1.3.20 For GMS and PMS, the right to terminate in paragraph 1.3.19 above must only be used where the Commissioner is satisfied that the cumulative effect of the breaches is such that the Commissioner considers that to allow the contract to continue would be prejudicial to the efficiency of the services to be provided under the contract. The Commissioner does not usually have to establish this when terminating an APMS contract, although check the contract wording. Where the Commissioner intends to terminate the contract under this right, please refer to paragraph 1.7.46 of this policy.
- 1.3.21 If the contractor is in breach of any obligation and a Remedial Notice in respect of that default has been given to the contractor, the Commissioner may withhold or deduct monies that would otherwise be payable under the contract in respect of that obligation which is the subject of the default.
- 1.3.22 Where a Remedial Notice is issued, the Commissioner should submit a Notice Return to the NHS England primary care inbox (england.primarycareops@nhs.net) as soon as practicable after issue. A template Notice Return is set out Annex 13.

Breach Notice

1.3.23 Where the contractor has breached the contract and that breach is not capable of remedy, the Commissioner may serve a Breach Notice on the contractor requiring the contractor not to repeat the breach.

1.3.24 A flowchart highlighting the main steps that the Commissioner should take when issuing a Breach Notice is set out in Annex 5.

1.3.25 Breach Notices cannot be issued where the breach relates to the following rights of termination:

- provision of untrue information;
- fitness to practice matters;
- a serious risk to patient safety or risk of financial loss to NHS England;
- unlawful sub-contracting; and
- in the case of a GMS contract, issues relating to the contractor's eligibility to hold the contract.

For further information on these rights of termination, please refer to paragraph 1.7.

1.3.26 A breach that is not capable of remedy is where a breach occurs but either does not continue prior to a notice being issued or there is no action that can be taken to remedy the breach.

1.3.27 Examples of breaches that are not capable of remedy include:

- a practice closing during its contracted opening times in the previous week with no access for the contractor's registered patients to access essential services; or
- failure to store vaccines correctly and such vaccines have already been provided to patients.

1.3.28 Where the breach creates a serious risk to patient safety, the Commissioner can take more immediate action, regardless of whether the breach is capable of remedy or not. For further information on this, please refer to paragraph 1.7.32 of this policy.

1.3.29 Where the Commissioner has determined that a breach is not capable of remedy, the Commissioner may, depending on the nature and circumstances of a breach take the following steps. These steps do not prejudice or delay a Commissioner's right to issue a Breach notice at any point before or during any of these steps being taken where the Commissioner reasonably considers it is appropriate to do so:

- 1.3.29.1 Initially the Commissioner should contact the contractor to discuss the breach and the action that they may be entitled to take, i.e. the issue of a Breach Notice. This does not prejudice or delay a Commissioner's right to issue a Breach Notice.
- 1.3.29.2 The discussion will afford the contractor the opportunity to provide an explanation as to the circumstances that led to the breach and this discussion should be recorded accurately in writing.
- 1.3.29.3 The Commissioner should review the evidence related to the breach including any information received during the discussion or in representations.
- 1.3.29.4 If the Commissioner is satisfied that the matter is a breach which is not capable of remedy, then the Commissioner may issue a Breach Notice to the contractor, requiring the contractor not to repeat the breach.
- 1.3.30 The Breach Notice must specify:
- details of the breach;
 - the requirement that the contractor must not repeat the breach again; and
 - the consequences of the contractor further breaching the contract;
- 1.3.31 A template Breach Notice is provided in Annex 6. Where NHS England is the Commissioner, the finalised Breach Notice should be signed off by the Head of Commissioning or their nominated deputy. Where the Commissioner is a CCG operating under delegated commissioning arrangements, the CCG should ensure the finalised Remedial Notice is signed off by the Chief Operating Officer (COO) or an individual authorised by the COO.
- 1.3.32 The Breach Notice must be delivered to the contractor in accordance with the notice provisions of the contract. This usually requires hand delivery or postal delivery (first class or registered post). Delivery of a notice by fax or email may be permissible. The Commissioner should review the relevant provisions to the contract to ensure proper delivery. Where the notice is hand delivered, the template Receipt Notice in Annex 3 can be used.
- 1.3.33 If, following the issue of a Breach Notice, a contractor either repeats a breach that was the subject of a Breach Notice or otherwise breaches the contract that results

in a further Remedial Notice or a Breach Notice, then the Commissioner has the right to terminate the contract by serving notice on the contractor.

- 1.3.34 For GMS and PMS, this right to terminate can only be used where the Commissioner is satisfied that the cumulative effect of the breaches is such that the Commissioner considers that to allow the contract to continue would be prejudicial to the efficiency of the services to be provided under the contract. The Commissioner does not usually have to establish this when terminating an APMS contract, although check the contract wording. Where the Commissioner intends to terminate the contract under this right, please refer to paragraph 1.7.46 of this policy.
- 1.3.35 If the contractor is in breach of any obligation and a Breach Notice has been issued, the Commissioner may withhold or deduct monies that would otherwise be payable under the contract in respect of that obligation.
- 1.3.36 Where a Breach Notice is issued, the Commissioner should submit a Notice Return to the NHS England primary care inbox (england.primarycareops@nhs.net) as soon as practicable after issue. A template Notice Return is set out Annex 13 (see also 1.4)

1.4 Contract sanctions

- 1.4.1 **GMS / PMS** - The Commissioner must follow the process set out in this section. PMS agreements refer to "agreement sanctions" rather than Contract Sanctions. Reference to Contract Sanctions in this policy should be read as including reference to agreement sanctions.
- 1.4.2 **APMS** – APMS contracts are not required to contain provisions relating to Contract Sanctions. The NHS England Standard Alternative Provider Medical Services Contract 2014/15 does not contain references to Contract Sanctions. The Commissioner must check the relevant contract to determine whether Contract Sanctions can be applied.
- 1.4.3 Contract Sanctions must not be applied to a contract unless the Commissioner has the right to terminate. Where Contract Sanctions are applied, this is instead of terminating the contract. The Commissioner cannot apply Contract Sanctions and later decide to terminate the contract based on the breach that triggered the Contract Sanction.

1.4.4 The circumstances in which the Commissioner may apply Contract Sanctions are those circumstances set out below where a right of termination arises. Please refer to the relevant right of termination in paragraph 1.7 for further information on how these rights of termination arise:

- provision of untrue information;
- fitness to practice matters;
- where there is a serious risk to patient safety or NHS England is at risk of material financial loss;
- where the Commissioner is satisfied that the contractor has not taken the steps required by a Remedial Notice to remedy a breach within the required period;
- where, after a Remedial Notice or Breach Notice has been issued, the contractor: repeats a breach that was the subject of a Remedial Notice or a Breach Notice; or otherwise breaches the contract resulting in a further Remedial Notice or Breach Notice.
- where the contractor carries on business detrimental to the contract; and/or
- for GMS contracts only, where changes in the membership of the partnership are likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform obligations under the contract.

1.4.5 Contract Sanctions must not be applied if they terminate or suspend any obligation that relates to essential services.

Contract Sanctions may involve:

- termination of specified reciprocal obligations;
- suspension of specified reciprocal obligations for a period of up to six months; or
- withholding or deducting monies otherwise payable under the contract.

1.4.6 The choice of which Contract Sanction to use would ordinarily depend on the nature of the breach, or cumulative effect, and what is felt to be the most appropriate and proportionate action in those circumstances. For example, if the breaches have occurred in relation to a specific service element under the contract, it might be most appropriate to move to terminate that specific service, such as an additional service.

1.4.7 Where the Commissioner is considering imposing a Contract Sanction and the contractor has a GMS contract, it is a statutory requirement that the Commissioner consults the relevant LMC before it imposes the Contract Sanction, where it is

reasonably practicable to do so. There is no such statutory requirement in respect of PMS or APMS contracts and the Commissioner should ensure it considers any relevant wording in the contract.

- 1.4.8 Where the Commissioner decides that the most appropriate sanction would be to withhold or deduct monies, this must be calculated to establish a consistent, fair and measured approach. Annex 7 provides further information on calculating a financial Contract Sanction.
- 1.4.9 Where the Commissioner decides to impose a Contract Sanction, the Commissioner must issue a notice of its intent to apply a sanction to the contractor which must include:
- the nature of the sanction to be applied;
 - if withholding or deducting monies, how this has been calculated and the duration of any such sanction;
 - if services are to be terminated, which services and from what date;
 - if a suspension of specified reciprocal obligations under the contract or agreement, the period of that suspension and its end date;
 - an explanation of the effect of the imposition of the Contract Sanction; and
 - the contractor's right to appeal the decision to apply a Contract Sanction.
- 1.4.10 A template Contract Sanctions Notice is provided in Annex 8. Where NHS England is the Commissioner, the finalised Contract Sanction Notice should be signed off by the Head of Commissioning or their nominated deputy. Where the Commissioner is a CCG operating under delegated commissioning arrangements, the CCG should ensure the finalised Remedial Notice is signed off by the Chief Operating Officer (COO) or an individual authorised by the COO.
- 1.4.11 The date that the Contract Sanction takes effect must not be until at least 28 days after the notice was served unless the Commissioner is satisfied that it is necessary to impose the Contract Sanction earlier to protect the safety of patients or protect NHS England from material financial loss.
- 1.4.12 Where a Contract Sanction is imposed, the Commissioner can charge the contractor reasonable administration costs of imposing the Contract Sanction.
- 1.4.13 After imposing the Contract Sanction on a contractor with a GMS contract, it is a statutory requirement for the Commissioner to, as soon as reasonably practicable, notify the relevant LMC in writing of the Contract Sanction imposed. There is no

such statutory requirement in respect of PMS or APMS contracts and the Commissioner should ensure it considers any relevant wording in the contract.

- 1.4.14 If the contractor disputes the imposition of a Contract Sanction, the Commissioner must not impose the Contract Sanction until the dispute has been determined unless the Contract Sanction is necessary to protect the safety of patients or protect NHS England from material financial loss.
- 1.4.15 Where a dispute arises in relation to the imposition of Contract Sanctions, please refer to the chapter on managing disputes.
- 1.4.16 The Commissioner should ensure that arrangements are in place to monitor the contractor's compliance with a Contract Sanction notice.
- 1.4.17 Where a Contract Sanction notice is issued, the Commissioner should submit a Notice Return to the NHS England primary care inbox (england.primarycareops@nhs.net) as soon as practicable after issue. A template Notice Return is set out Annex 13 (see also 1.4).

1.5 Termination

- 1.5.1 Termination is a very significant action to take both on the part of the Commissioner and the contractor and is an area of high risk for both parties in respect of financial impact and continuity of services. Where the Commissioner considers that a Termination Notice may be issued, the Commissioner should seek legal advice early in the process to confirm the appropriateness and lawfulness of taking such a step. It is essential that the Commissioner maintains thorough and accurate records of all communications and discussions in respect of all notices.
- 1.5.2 Contractors have the right to appeal so it is essential that the Commissioner follows, and can demonstrate that they have followed due process in investigating, communicating and implementing actions leading to termination.
- 1.5.3 It is essential that prior to moving to terminate a contract, the Commissioner is satisfied that they are fully within their rights to do so.
- 1.5.4 Legislation sets out certain rights of termination that are required to be in each type of primary medical contract. These mandatory termination rights are set out below and explained more fully in paragraph 1.7. Where the termination relates to a matter that is contained within an alternative policy, this is highlighted.

1.5.5 GMS/PMS may only be terminated using mandatory termination rights. An APMS contract may contain additional termination rights. The Commissioner should consider the relevant contract to ensure it is fully aware of all termination rights.

1.5.6 **GMS / PMS** - The following circumstances relating to rights of termination are required to be in GMS and PMS contracts:

- death of a contractor;
- contractor serving notice;
- late payment;
- provision of untrue information;
- fitness to practice issues;
- patient safety;
- material financial loss;
- unlawful sub-contracting;
- remedial Notices and Breach Notices; and
- carrying on business detrimental to the contract.

1.5.7 **GMS** - GMS contracts are required to contain additional rights of termination relating to:

- breach of Regulation 4 (Conditions relating solely to medical practitioners) of the GMS Regulations; and
- certain partnership matters.

1.5.8 **PMS** - PMS agreements are required to contain additional rights of termination relating to:

- commissioner serving notice;
- contractor's exercise of the right to a GMS contract; and
- agreement of the parties.

1.5.9 **APMS** - The following circumstances relating to rights of termination are required to be in APMS contracts:

- death of a contractor;
- provision of untrue information;
- fitness to practice issues;
- patient safety;
- material financial loss; and
- unlawful sub-contracting.

1.5.10 **APMS** - APMS contracts are likely to have further rights of termination. Where the Commissioner wishes to terminate for a reason other than those set out in paragraph 1.5.9 above, the Commissioner must review the contract to determine if any further rights of termination apply.

1.5.11 Contracts may also terminate by:

- reaching their natural end dates, without the need for termination notice (in which case, please refer to the chapter on practice closedown for more information); or
- retirement of the contractor (in which case, please refer to the chapter on contract variation).

1.5.12 Where the Commissioner has considered all the relevant factors and has decided to proceed with termination, it must send a Termination Notice to the contractor.

1.5.13 A template Termination Notice is provided in Annex 9. Where NHS England is the Commissioner, the finalised Termination Notice should be signed off by the Director of Commissioning Operations or their nominated deputy. Where the Commissioner is a CCG operating under delegated commissioning arrangements, the CCG should ensure the finalised Remedial Notice is signed off by the Chief Operating Officer (COO) or an individual authorised by the COO.

1.5.14 Where the termination relates to:

- for GMS and PMS contracts:
- provision of untrue information;
- fitness to practice issues;
- patient safety;
- material financial loss; or
- remedial Notices and Breach Notices;
- for GMS agreements:
- certain partnership matters;
- for PMS agreements:
- carrying on business detrimental to the agreement,

the notice usually specifies a date on which the contract terminates that is not less than 28 days after the date on which the Commissioner has served the notice on the contractor. The Commissioner may state a date less than 28 days where this is necessary to protect the safety of the contractor's patients or protect NHS England from material financial loss. APMS contracts are not required to contain any such

provisions and the Commissioner should consider the wording of the particular APMS contract.

- 1.5.15 Where the contractor disputes the Commissioner's decision to terminate the contract, the contractor may invoke the NHS dispute resolution procedure. In such circumstances, the Commissioner should refer to the chapter on managing disputes.
- 1.5.16 Where a Termination Notice is issued, the Commissioner should submit a Notice Return to the NHS England primary care inbox (england.primarycareops@nhs.net) as soon as practicable after issue. A template Notice Return is set out Annex 13 (see also 1.4).

1.6 Key Considerations on Termination

- 1.6.1 The Commissioner must establish that grounds exist under the terms of the contract to terminate. The Commissioner must follow due process and investigation of the facts and provide the contractor with the opportunity to provide a response to allegations, wherever possible.
- 1.6.2 A flowchart highlighting the main steps that the Commissioner should take when issuing a termination notice is set out in Annex 10.
- 1.6.3 The Commissioner must consider all relevant information available and decide on the appropriate course of action and whether the contract should be terminated.
- 1.6.4 Apart from considerations regarding whether the right to terminate arises, there are a number of common factors that the Commissioner should consider when termination is a proposed course of action. These factors are set out below.
- 1.6.5 This list is not exhaustive and there are likely to be other issues that need due consideration under these provisions. These considerations will also apply following the sudden death of a contractor (see the chapter on the death of a contractor) and in some part on the closure of a branch surgery (see the chapter on contract variations).
- 1.6.6 **Continuity of service provision**
- 1.6.7 NHS England has a statutory duty to ensure the continuity of provision of primary care services. Termination of existing service provision may result in some persons not being able to access primary care services. The Commissioner must therefore

consider how this duty will be discharged if it decides to terminate the contract. This should be considered as soon as the Commissioner starts to think about terminating.

1.6.8 If the Commissioner envisages that a new contract will be entered into with a provider, the Commissioner must consider how to procure that contract and to ensure it is in accordance with procurement law and any procurement protocol issued by NHS England.

1.6.9 PMS to GMS

1.6.10 PMS agreements provide a right for certain contractors to request to enter into a GMS contract. Such a request can only be refused where the contractor fails to meet the conditions set out in the PMS Regulations.

1.6.11 For further information on this, please refer to the chapter on managing a PMS contractor's right to a GMS contract.

General duties

1.6.12 NHS England has a number of statutory duties relating to the exercise of its functions including reducing health inequalities and public involvement. The Commissioner must ensure that its actions in terminating a contract and any consequential actions ensure compliance with these duties. In an urgent situation, it may be necessary to balance the duty to involve with the public interest in maintaining continuity of care and protecting the health, safety and welfare of patients or staff. Please refer to the full chapter on general duties for further information.

1.6.13 NHS England has set out its plans as to how it intends to involve the public in the following publications:

- [The Patient and Public Participation Policy](#)
- [The Statement of Arrangements & Guidance on Patient and Public Participation in Commissioning.](#)
- [The Framework for Patient and Public Participation in Primary Care Commissioning.](#)

1.6.14 LMC consultation (GMS Contracts)

1.6.15 For GMS contracts, the Commissioner must consult the LMC for the area in which the contractor provides services where the Commissioner is considering:

- terminating the contract;
- which alternative notice to issue where there is a right to terminate for unlawful sub-contracting; or
- imposing a contract sanction.

1.6.16 Whether or not the LMC has been consulted, whenever the Commissioner imposes a Contract Sanction or terminates a GMS contract, the Commissioner must as soon as reasonably practicable, notify the relevant LMC in writing of the sanction or termination. PMS and APMS contracts are not required to contain such provisions. The Commissioner should review the relevant contract to determine whether any requirement has been included.

1.6.17 Premises

1.6.18 The Commissioner should ascertain who owns the premises and what arrangements apply to the premises. Where the outgoing contractor owns the premises, a future service provider may not be able to use those premises for the delivery of services. The Commissioner should consider what arrangements need to be put in place to ensure continued service provision. Commissioner should also ensure they consider any Premises Cost Directions or guidance published by NHS England in relation to Premises.

1.6.19 TUPE

1.6.20 The Commissioner should consider the impact of termination on the staff currently employed under the terminating contract. Where a new contract is entered into with a new provider, TUPE may apply to transfer the staff to the new provider.

1.6.21 TUPE can be complex, risky and time consuming for any incoming provider and is likely to have a financial impact on the cost of any service. The Commissioner should consider whether the potential for TUPE to apply may be considered a significant risk to any incoming provider.

1.6.22 Equipment

1.6.23 All equipment, including associated software, issued through GP IT are owned by NHS England and these are being managed on its behalf by the CCGs as responsible commissioners of GP IT services. Arrangements should be put in place

to retrieve this equipment, together with other kits issued by the CCG, to ensure it is available to a future service provider.

1.6.24 Patient lists – See also PCSE <https://pcse.england.nhs.uk/services/practice-mergers-and-closures-notifications/>

1.6.25 Patients have a right of choice meaning the Commissioner must not routinely transfer all of the registered patients to an alternative provider. Patients should be provided with a detailed list of other local practices that are currently accepting new patients and offered the opportunity to register with one of them.

1.6.26 The Commissioner should consider what steps will be taken in regard to patients who have not registered elsewhere at the end of the contract. It is often the case that the majority will voluntarily seek alternative registration; however, there are usually a number of patients who do not, some of whom may no longer be resident in the UK 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. Some may have died. In these circumstances, the Commissioner must be clear on the process of dispersal or allocation that they will follow in order to avoid the risk of challenge from other local providers. Please refer to the chapters on planned and unplanned closure for more information.

1.6.27 Patient records – See also PCSE <https://pcse.england.nhs.uk/services/practice-mergers-and-closures-notifications/>

1.6.28 The Commissioner should consider management of NHS patient paper records (Lloyd George notes) and any subsequent clinical mail – it is very likely that the contractor 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. The Commissioner must be able to securely retrieve these records and communications, having full regard of data protection and confidentiality in order that these can be distributed accordingly to any 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 Commissioner to manage (dispose of) any confidential information on their

behalf. Please refer to the chapters on planned and unplanned closure for more information.

1.6.29 Prescriptions

1.6.30 The Commissioner should consider prescription pads, electronic prescriptions and any uncollected completed prescriptions – these will also need to be retrieved and dealt with accordingly. The Commissioner may wish to decide on a specified age of a current prescription (such as one month) and make appropriate arrangements for the handling of these and disposal of any that are older. – See also PCSE <https://pcse.england.nhs.uk/services/practice-mergers-and-closures-notifications/>

1.6.31 Drugs and medicines

1.6.32 The Commissioner should consider practice held drugs – these will need to be disposed of but are technically likely to be owned by the contractor whose contract is terminating. The Commissioner should seek assurances about the safe and effective disposal of such drugs.

1.7 Rights of Termination

1.7.1 Death of a contractor

1.7.2 Please refer to the chapter on the death of a contractor for further information.

1.7.3 Termination where both parties agree

1.7.4 PMS agreements are required to contain a provision stating that both parties may agree to terminate a contract. Although GMS or APMS contracts are not required to contain such a provision, all types of contracts may be terminated where both parties agree.

1.7.5 Where the parties agree to terminate, the parties must agree on the date from which termination will take place and any further terms relating to the termination. Before agreeing on the termination date, the Commissioner should ensure any proposed timescale allows the Commissioner to consider any other factors or actions that may be required prior to termination.

1.7.6 The contractor party may be composed of more than one person. The Commissioner must agree to the same termination arrangements with all persons that constitute the contractor.

1.7.7 NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to the chapter covering General Duties of NHS England

1.7.8 Termination where the contractor serves notice

1.7.9 GMS and PMS contracts can be terminated by the contractor by serving notice in writing at any time. APMS contracts may also contain this right of termination.

1.7.10 Where a contractor serves notice to terminate a GMS contract, it shall terminate six months after the date on which the notice is served, except where the contractor is an individual medical practitioner in which case the contract shall terminate three months after the date on which the notice is served.

1.7.11 If the date on which the GMS contract will terminate 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.

1.7.12 Where a contractor serves notice to terminate a PMS agreement, the period of notice shall not be less than six months (unless both parties agree in which case please refer to paragraph 1.7.3 – termination where both parties agree).

1.7.13 NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to paragraph 1.1.6.12.

1.7.14 Termination where the Commissioner serves notice

1.7.15 PMS agreements can be terminated by the Commissioner by serving notice in writing at any time, without needing to establish any breach by the contractor. APMS contracts may also contain this right of termination.

1.7.16 Where the Commissioner serves this type of notice to terminate a PMS agreement, the period of notice shall not be less than six months (unless both parties agree in which case please refer to paragraph 1.7.3 – termination where both parties agree). Commissioners should bear in mind the right of some PMS contractors to request a GMS contract. For further information on this, please refer to the chapter on managing a PMS contractor's right to a GMS contract.

1.7.17 NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to 1.6.12.

1.7.18 GMS contracts are usually contracts in perpetuity without any right for the Commissioner to terminate on notice.

1.7.19 Termination where the contractor exercises the right to a GMS contract

1.7.20 Please refer to the chapter on managing a PMS contractor's right to a GMS contract for further information.

1.7.21 Termination due to late payment

1.7.22 The contractor may give notice in writing to the Commissioner if the Commissioner has failed to make any payment due to the contractor under the contract. If the Commissioner has failed to make any such payment within 28 days of the notice, the contractor may terminate the contract by a further written notice.

1.7.23 Where the NHS dispute resolution procedure has been invoked by the Commissioner, within 28 days of the initial notice, the contractor may not terminate the contract until either the NHS dispute resolution determination allows termination or the Commissioner ceases to pursue the NHS dispute resolution process.

1.7.24 For further information on the NHS dispute resolution process, please refer to the chapter on managing disputes.

1.7.25 NHS England's general duties may be triggered by termination in these circumstances. For further information, refer to paragraph 1.6.12 of this chapter and also the full chapter on General Duties of NHS England.

1.7.26 Termination for provision of untrue information

1.7.27 The Commissioner may serve notice to terminate the contract immediately (or from any date set out in the notice) if, after the contract has been entered into, it comes to the attention of the Commissioner that written information provided to the Commissioner:

- before the contract was entered into; or
- for GMS contracts, pursuant to paragraph 50(1)(a) or (b) or 51(1) of Schedule 3 of the GMS Regulations; or
- for PMS agreements, pursuant to paragraph 46(1)(a) or (b) of Schedule 2 of the PMS Regulations,
- in relation to:
 - for GMS contracts, Regulations 5 and 6 of the GMS Regulations
 - for PMS agreements, Regulation 5 of the PMS Regulations; and
 - for APMS contracts, Direction 6 of the APMS Directions,

- was, when given, untrue or inaccurate in a material respect.

1.7.28 NHS England's general duties may be triggered by termination in these circumstances. For further information, refer to paragraph 1.6.12 of this chapter and also the full chapter on General Duties of NHS England.

1.7.29 Termination due to fitness to practice issues

1.7.30 The Commissioner may serve notice in writing on the contractor terminating the contract immediately (or from any date set out in the notice) where a person connected with the contract (such as a medical practitioner, a partnership, a company or a director) falls within any circumstances set out in the relevant regulations/directions. Those circumstances include where the person:

- is disqualified from practising by a licensing body;
- has been convicted of certain offences;
- has been adjudged bankrupt; or
- has been subject to a disqualification under the Company Director Disqualification Act 1986.

The full list of circumstances is set out in Annex 11. Part A of Annex 11 refers to GMS contracts, Part B of Annex 11 refers to PMS agreements and Part C of Annex 11 refers to APMS contracts.

1.7.31 NHS England's general duties may be triggered by termination in these circumstances. For further information, refer to paragraph 1.6.12 of this chapter and also the full chapter on General Duties of NHS England.

1.7.32 Termination where there is a serious risk to patient safety

1.7.33 The Commissioner may serve notice in writing on the contractor terminating the contract immediately (or from such date set out in the notice) where the contractor has breached the contract and, as a result of that breach, the safety of the contractor's patients is at serious risk if the contract is not terminated.

1.7.34 NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to paragraph 1.6.12 of this chapter and also the full chapter on General Duties of NHS England.

1.7.35 Termination where there is a material financial loss

1.7.36 The Commissioner may serve notice in writing on the contractor terminating the contract immediately (or from such date set out in the notice) where the contractor's financial situation is such that the Commissioner considers that NHS England is at risk of material financial loss.

1.7.37 NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to paragraph 1.6.12 of this chapter and also the full chapter on General Duties of NHS England.

1.7.38 Termination due to unlawful sub-contracting

1.7.39 The Commissioner will have a right of termination where it comes to the Commissioner's attention that the contractor has sub-contracted any of its rights or duties under the agreement in relation to the provision of essential services to a company or firm:

- owned wholly or partly by the contractor, or by any former or current employee of, or partner or shareholder in, the contractor;
- formed by or on behalf of the contractor, or from which it derives or may derive a pecuniary benefit; or
- formed by or on behalf of a former or current employee of, or partner or shareholder in, the contractor, or from which such a person derives or may derive a pecuniary benefit,

where that company or firm is or was formed wholly or partly for the purpose of avoiding the restrictions on the sale of the goodwill of a medical practice in section 54 of the NHS Act or any regulations made wholly or partly under that section.

1.7.40 Where this occurs, the Commissioner may serve notice in writing on the contractor terminating the contract immediately or instructing the contractor to terminate the relevant sub-contract.

1.7.41 It is a requirement under GMS contracts that, whenever reasonably practicable to do so, the Commissioner must consult with the relevant LMC when considering which alternative notice to issue (for further information on LMC consultation requirements, refer to paragraph 1.6.15). PMS and APMS contracts are not required to contain such provisions. The Commissioner should review the relevant contract to determine whether any requirement has been included.

1.7.42 If the contractor fails to terminate the sub-contract, the Commissioner may serve a notice in writing on the contractor terminating the contract immediately.

1.7.43 NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to paragraph 1.6.12 of this chapter and also the full chapter on General Duties of NHS England.

1.7.44 Termination relating to Remedial Notices and Breach Notices

1.7.45 The Commissioner has a right to terminate the contract where the Commissioner is satisfied that the contractor has not taken the required steps to remedy the breach by the end of the required period as stated in the Remedial Notice.

1.7.46 The Commissioner has a further right of termination where, following the issue of a Remedial Notice or Breach Notice, a contractor:

- repeats a breach that was the subject of a Remedial Notice or Breach Notice; or
- otherwise breaches the contract that results in a further Remedial Notice or Breach Notice.

1.7.47 The further breach must have occurred after the breach which was the subject of the Remedial Notice or Breach Notice. The Commissioner may intend to issue a further Remedial Notice or Breach Notice for a breach that occurred prior to the original breach with the need to investigate or gather information delaying the issue of the notice. In these circumstances, the Commissioner cannot then rely on this right of termination as the further breach did not occur following the issue of the original Remedial Notice or Breach Notice.

1.7.48 For GMS and PMS, this further right to terminate can only be used where the Commissioner is satisfied that the cumulative effect of the breaches is such that the Commissioner considers that to allow the contract to continue would be prejudicial to the efficiency of the services to be provided under the contract. The Commissioner does not usually have to establish this when terminating an APMS contract, although check the contract wording.

1.7.49 NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to paragraph 1.6.12 of this chapter and also the full chapter on General Duties of NHS England

1.7.50 Termination due to the contractor carrying on business detrimental to the contract

1.7.51 For GMS and PMS, where the contractor is a company that is carrying on business which the Commissioner considers is detrimental to the contractor performance of the contract, the Commissioner may give notice to the contractor requiring that it ceases carrying on the relevant business within a specified period (which must not be less than 28 days from the date the notice was given). This termination right does not have to be included in an APMS contract so please check the specific contract to see whether it is included.

1.7.52 Where the contractor has not satisfied the Commissioner that it has ceased carrying on the business by the end of the notice period, the Commissioner may by further written notice terminate the contract immediately (or from such date set out in the notice).

1.7.53 NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to paragraph 1.6.12 of this chapter and also the full chapter on General Duties of NHS England.

1.7.54 Termination due to partnership matters

1.7.55 A Commissioner has a right to terminate a GMS contract where:

- the contractor is two or more persons practising in partnership;
- where one or more partners have left the practice during the contract; and
- if the Commissioner reasonably considers that the changes in the membership of the partnership are likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform its obligations under the contract.

1.7.56 Where this occurs, the Commissioner may terminate the contract by notice in writing on such date as is set out in the notice. The notice must contain the Commissioner's reasons for considering that the change in the membership of the partnership is likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform its obligations under the contract.

1.7.57 NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to paragraph 1.6.12 of this chapter and also the full chapter on General Duties of NHS England

1.7.58 Termination due to breach of regulation 5

1.7.59 Regulation 5 sets out conditions that the contractor must satisfy in order to enter into a GMS contract. There are a number of rights of termination relating to these conditions. Annex 12 sets out the termination rights and conditions in detail.

1.7.60 NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to paragraph 1.6.12 of this chapter and also the full chapter on General Duties of NHS England

1.8 Consequences of Termination

1.8.1 Contracts usually contain certain obligations on both parties on termination of the contract. The GMS Regulations, PMS Regulations and APMS Directions do not set out any requirements for primary care contracts to contain such provision but the Standard GMS Contract contains a number of obligations including provisions relating to:

- co-operation in dealing with any outstanding matters;
- delivering up property owned by the other party; and
- carrying out a financial reconciliation.

1.8.2 It is likely that PMS and APMS contracts will contain similar provisions. The Commissioner should consider the relevant contract to determine what obligations are set out on termination.

1.9 Dealing with CQC issues

1.9.1 Commissioners may become aware of potential contract breaches when the CQC takes action following an inspection. CQC action may include suspending registration or cancelling registration completely. Whenever the Commissioner becomes aware of issues identified and/or action taken by the CQC, it needs to consider those issues to see if any contractual action should be taken too.

1.9.2 Where evidence from the CQC's findings and/or any further investigation by the Commissioner identifies any breach(es) of contract, the Commissioner should work through this chapter in the usual way to determine what steps to take. Often, CQC action will highlight a number of breaches and this may result in several breach or remedial notices being served.

- 1.9.3 In some cases, the issues identified may be so significant that it is appropriate to consider termination of the contract. In very serious cases, it may be possible to move straight to termination, if an appropriate termination right arises. The position can be complex, particularly where for example a suspension has removed any immediate risk to patient safety and the contractor has been given a period of time by the CQC to address the issues. In those cases, it may be appropriate to wait and see whether the contractor complies with the CQC's requirements, rather than moving straight to termination. Commissioners should seek legal advice if they are unsure how to proceed.
- 1.9.4 Issues identified by the CQC will sometimes form part of a wider pattern of problems under the contract, in which case the Commissioner should consider the full range of problems in deciding appropriate next steps.
- 1.9.5 During any period of suspension by the CQC, the Commissioner will need to ensure that the patients of that practice are able to access primary medical services elsewhere. It may be that the cost of any caretaking arrangement can be partly offset by appropriate deductions under any breach or remedial notice being served in relation to the issues leading to suspension (see paragraphs 1.3.21 and 1.3.35 of this policy).
- 1.9.6 If a contractor's CQC registration is cancelled, they will not be able to provide any services and the Commissioner will need to terminate the contract. The Commissioner should, however, be aware that the cancellation process can take time and that there is an appeal period following cancellation. Cancellation should not be relied on as final until that appeal period has expired or any appeal has been determined. See the chapter on unplanned/unscheduled closedown for further information.

1.10 Annex 1 Remedial Notice Flowchart

- [Remedial Notice Flowchart](#)

1.11 Annex 2 Template Remedial Notice

[This Annex is provided as a template only and appropriate advice and support should be sought prior to issuing such a notice]

- [Template Remedial Notice](#)

1.12 Annex 3 Template Notice Receipt

- [Template Notice Receipt](#)

1.13 Annex 4 Template Remedial Notice Satisfaction Letter

[This letter is provided as a template only and the Commissioner should ensure that appropriate advice and support has been sought prior to issuing such a letter]

- [Template Remedial Notice Satisfaction Letter](#)

1.14 Annex 5 Breach Notice Flowchart

- [Breach Notice Flowchart](#)

1.15 Annex 6 Template Breach Notice

- [Template Breach Notice](#)

1.16 Annex 7 Calculating a Financial Contract Sanction

- [Calculating a Financial Contract Sanction](#)

1.17 Annex 8 Template Contract Sanction Notice

[This Annex is provided as a template only and appropriate advice and support should be sought prior to issuing such a notice]

- [Template Contract Sanction Notice](#)

1.18 Annex 9 Template Termination Notice

- [Template Termination Notice](#)

1.19 Annex 10 Termination Flowchart

- [Termination Flowchart](#)

1.20 Annex 11 Fitness to Practice Matters (Part A GMS Contracts)

- [Fitness to Practice Matters \(Part A GMS Contracts\)](#)

1.21 Annex 11 Fitness to Practice Matters (Part B PMS Agreement)

- [Fitness to Practice Matters \(Part B PMS Agreement\)](#)

1.22 Annex 11 Fitness to Practice Matters (Part C APMS Contracts)

- [Fitness to Practice Matters \(Part C APMS Contracts\)](#)

1.23 Annex 12 Termination due to breach of Regulation 4

- [Termination dues to breach of Regulation 4](#)

1.24 Annex 13 Template Notice Return

- [Template Notice Return](#)

2 Unplanned / Unscheduled and Unavoidable Practice Closedown

2.1 Introduction

- 2.1.1 When a GP Practice closes at short notice, it is important that commissioners respond and act in a timely way. Such closures may be as result of actions by the CQC, for example voluntary closure in response to an adverse inspection or cancellation of the practice's registration, or due to the sudden inability of a provider to continue providing a service for some other reason such as bankruptcy.
- 2.1.2 Furthermore, it is critical that the management and transfer of patient records (both paper and digital) are undertaken in a secure and robust manner. It is important that adherence to all applicable information governance, records management and both EU general data protection regulations and data protection principals are maintained throughout this process.
- 2.1.3 On 01 September 2015, Capita took on the responsibility for the delivery of NHS England's Primary Care Support (PCS). The new name for the service is Primary Care Support England (PCSE). This is the operating name for Capita whilst delivering this service, but this Policy and Guidance recognises that if PCS Services (PCSS) were to be re-procured then this chapter is still valid using the acronym PCSS interchangeably with PCSE.

2.2 Scope

- 2.2.1 This guidance clarifies the role of the commissioner and the engagement required with patients and any partner organisations (e.g. NHS England or CQC). This chapter is intended as guidance with which commissioners can work, with four fundamental principles at the core:
1. The needs of the registered patients must be at the heart of all decision and actions;
 2. In many cases taking preventive action in conjunction with support could be a preferable option to closing a practice.
 3. In circumstances where this chapter applies (e.g. a closure is unavoidable or in the best interests of patients), all partners and

stakeholders should know what to do, when and how, and work effectively together to minimise any disruption to patients and services.

4. Effective communication must be maintained throughout with patients and their families and carers and with other partners (e.g. PPGs / LMCs / Healthwatch).

2.3 Roles and Responsibilities

2.3.1 Commissioners

2.3.1.1 The Commissioner will take the lead in the following actions:

- Ensure appropriate interim measures are put in place (e.g. a caretaker GP) to keep people safe after the identification of concerns or issues or at the very latest, the point it is informed of the closure.
- Establish a team with specialist skills to oversee the closure, including contracting and communications staff, and lead on arranging meetings / consultations with any partners.
- Establish a task and finish group to oversee the process.
- Co-ordinate assessments of the practices' registered list to ascertain patient needs and preferences. This should be completed by individuals with the relevant skills and governance to access patient records (where this is required) or by those brought in for their specialist skills (risk-stratified e.g. vulnerable patients, children in care, end of life patients, etc).
- Communicate to patients the details of alternative GP Practices which could provide essential and additional services, including any details on the current quality of the service (i.e. links to MyNHS, NHS Choices Practice Website).
- Maintain ongoing consultative relations with patients, their families, other local GP practices and any other system partners to ensure they are kept informed at each step of the process.
- Commission new services and arrange people to move and resettlement, including a review of the placement after a reasonable timeframe.

- Identify a lead to coordinate communications.
- Engage with Local Medical Committee (LMC)

2.3.2 In the event that the practice physically closes, the commissioner / lead Commissioner will:

- Put in place arrangements for practice post to be redirected to the commissioner and where appropriate make a personal visit to the premises.
- Forward clinical correspondence to PCSE for 28 days, who will manage onward forwarding to any new provider(s). GP clinical records are delivered by City Sprint on behalf of PCSE so as part of the closedown process, the closed practice is removed from the delivery locations. PCSE address for returning correspondence can be found here <https://pcse.england.nhs.uk/news/2018/october/important-update-from-nhs-england-redirecting-confidential-patient-information/>
- After 28 days, mails are redirected to the Commissioner, but it is not forwarded to the new provider(s). The Commissioner will return clinical correspondence to the sender (hospitals etc) and should inform the sender of the new provider(s). The sender should update their records accordingly to prevent reoccurrence.
- Ensure call forwarding arrangements are in place or appropriate answerphone messages are established for the closing practice to alert patients and inform 111, OOH services.
- As part of the practice closedown, the Commissioner will ensure that legacy IT Hardware is removed from the practice, *HSCN connections are terminated and clinical system call-off agreements ended* as part of the GPIT System de-commissioning activities.
- Provide guidance to review, remove or copy files/folders that may be required by the outgoing owners

2.3.3 **GP Practice (during any period where the practice is still open):**

2.3.3.1 The Commissioner will ask the GP Practice to:

- Assist with ensuring appropriate interim measures are put in place to keep people safe after the identification of concerns.
- Assist the Commissioner with the assessment of, and communication, with residents and their families to ascertain their needs and preferences.
- Assist the Commissioner in any patient engagement, in particular those people accessing services provided at or by the GP practice and their families.
- As part of the practice closedown, work with the Commissioner to ensure legacy IT Hardware is removed from the practice as part of the GPIT System de-commissioning activities
- Review and act on any guidance provided by the Commissioner in relation to the closure.
- Record, collate and remove prescription pads. This includes both handwritten and computer scripts.
- Ensure all drugs/medicines in the practice are noted and handed in to the local pharmacy and signed for.

2.3.4 Primary Care Support England (PCSE)

2.3.4.1 PCSE will: (see also <https://pcse.england.nhs.uk/services/practice-mergers-and-closures-notifications/>)

As part of any practice close down, make a site visit to remove, store and forward patient records to a new provider(s). Records are held in archive until the patient re-registers or the retention period expires and they are securely destroyed.

2.3.5 Care Quality Commission (CQC)

3.4. CQC will lead in the following actions:

- Share with the Commissioner any information held about the quality of the current service.

- Share with the Commissioner any information held about the quality of alternative services being considered, including the model of care used.
- Share with the Commissioner any information on other providers likely to be involved in the provision of care to people at the new service.
- Consider bringing forward inspection or other evaluative activities for alternative providers where only limited quality information is available (lead role)

[Note 'share with the Commissioner' does not have to be in writing and could be verbal or as part of any scheduled or regular meetings]

2.3.6 Local Medical Committee LMCs:

2.3.6.1 The LMC for the area will be engaged in the following processes:

- Made aware of the engagement occurring with patients.
- Made aware of any interim proposals and immediate next steps.
- Made aware of any long terms plans.

This LMC section recognises that LMCs will champion the welfare of its members and wider practice staff.

2.4 The Process

- 2.4.1 The process for a planned practice closedown commences between 9 and 15 months prior to the scheduled end date of the contract. For unplanned closure(s), it will be necessary to undertake a rapid assessment and determine the most appropriate course of action.
- 2.4.2 In the large majority of cases where closure is rapid (i.e. immediate removal of CQC registration), the most appropriate course of action will likely involve an initial 'caretaker' arrangement (another GP or GP Practice team) temporarily overseeing the practice at the closing practice's existing premises and the care of its registered list. Please refer to the section on Urgent Contracts in Part B, chapter 1 [<Urgent Contracts>](#).
- 2.4.3 In the very unusual circumstance that this is not possible, it may be necessary to rapidly disperse the list. Whilst the NHS Constitution is clear that patients have a right to choose their GP practice, to mitigate against the risk of patients being

without care, the Commissioner may temporarily assign a patient to an alternative provider. However, the patient must be advised of the rights under the NHS Constitution, to change at any time.

- 2.4.4 Patient assignment is also possible during any list dispersal (i.e. at the end of a 'caretaker period') for the same reason. This should be as a last resort, such that the commissioner has been unable to make contact with the patient.

2.5 Key Steps (in the case of a list dispersal)

- 1 Patients are contacted in the first instance advising them of the list dispersal and available options (i.e. neighbouring practices accepting patients)
- 2 In the event of no response or no registration at another practice, patients are re-contacted advising them again of the list dispersal and available options (i.e. neighbouring practices accepting patients). Patients should also be advised at this point that, in order to prevent risk to on-going patient care, particularly in vulnerable patient groups, patients that do not re-register or contact the commissioner to advise them that they do not wish to be registered with a GP, will be allocated to another practice.
- 3 In the event of no response or no registration at another practice following the second reminder, patients **must** be allocated to a GP practice (except where they have not been seen or received treatment for 5 years or more – as confirmed by the GP practice). Commissioners should adopt the same approach as that set out in paragraphs 39 and 40 of Schedule 3, Part 4 'Assignment of patients to lists' of the GMS Contract Regulations (2015) or paragraphs 38 and 39 of Schedule 2, Part 4 of the PMS Agreements Regulations (2015).
- 4 The patient must then be notified in writing of the allocation, the reason for the allocation and of their rights under the NHS Constitution to de-register, or re-register at an alternative GP practice should they wish.
- 5 It is **imperative** that at the end of the process, all patient records and any associated data pertaining to patients (**including digital records**) and any clinical correspondence are transferred to the provider with whom the patient has registered. This process will generally be routine and in any case, is triggered for digital records when the patient registers at an alternative practice.

- 6 For the avoidance of doubt, at the point of closure, all patients that have not self-registered at an alternative GP practice should be allocated to another GP practice (except where they have not been seen or received treatment for 5 years or more). It is recognised that this **may** temporarily result in the allocation of ghost patients or patients that have gone away, however, this will be corrected through the rolling list maintenance programme.
- 7 The GP Clinical system should be monitored by the Commissioner or nominated IT Delivery Partner for a diminishing patient list. The GP Clinical system should not be decommissioned until all patients dispersed/re-registered either with their practice of choice, allocation or in the case of Orphaned Records (where neither allocation nor re-registration occurs) the records transfer to NHSE as the data controller.
- 8 Allocations should however have regard to paragraphs 23 to 31 of Schedule 3, Part 2 of the 2015 GMS Regulations, and paragraphs 22 to 30 of Schedule 2, Part 2 of the 2015 PMS Regulations, in relation to the removal of patients (see below)

- Removal from the list at the request of the patient
- Removal from the list at the request of the contractor
- Removal from the list of patients who are violent
- Removal from the list of patients registered elsewhere
- Removal from the list of patients who have moved
- Removal from list of patients whose address is unknown
- Removal from the list of patients absent from the United Kingdom etc.
- Removal from the list of patients accepted elsewhere as temporary residents
- Removal from a list of pupils etc. of a school
- Termination of responsibility for patients not registered with the contractor

- 2.5.1 They should also have regard to paragraph 40 (GMS) and 39 (PMS) ‘factors relevant to assignments’

When assigning a person as a new patient to a contractor’s list of patients under paragraph 38(1)(a) or (b), the Board must have regard to—

- (a) the preferences and circumstances of the person;

- (b) the distance between the person's place of residence and the contractor's practice premises;
- (c) any request made by a contractor to remove the person from its list of patients within the preceding period of six months beginning with the date on which the application for assignment is received by the Board;
- (d) whether, during the preceding period of six months beginning with the date on which the application for assignment is received by the Board, the person has been removed from a list of patients on the grounds referred to in—
 - (i) paragraph 23 (relating to circumstances in which a patient may be removed from a contractor's list of patients at the request of the contractor),
 - (ii) paragraph 24 (relating to circumstances in which a patient who is violent may be removed from a contractor's list of patients), or
 - (iii) the equivalent provisions to those paragraphs in relation to arrangements made under section 83(2) of the Act⁽¹⁾ (which relates to the provision of primary medical services) or under a contract made in accordance with the General Medical Services Contracts Regulations;
- (e) in a case to which sub-paragraph (d)(ii) applies (or to which the equivalent provisions as mentioned in sub-paragraph (d)(iii) apply), whether the contractor has appropriate facilities to deal with such patients; and
- (f) such other matters as the Board considers relevant.

2.6 Engagement and re-procurement

- 2.6.1 Where arrangements have been made for a caretaker to temporarily manage the GP practice (refer to the Urgent Contract section within the contract described chapter), or a practice has terminated a contract with little notice, (e.g. 6 months) the Commissioner should refer to the 3 stages and templates listed in this policy and guidance manual under the chapter on Planned Closedown.

- 2.6.2 It is recognised that it may not be possible to undertake each of these stages as vigorously or at the same length as if there was a 12-15 months period available as is often the case with a planned closure.
- 2.6.3 NHS England has a number of statutory duties relating to the exercise of its functions including reducing health inequalities and public involvement. The Commissioner must ensure that its actions in re-procuring a contract or dispersing a list and any consequential actions ensure compliance with these duties. Please refer to the chapter on General Duties for further guidance.
- 2.6.4 However, in an urgent situation, it may be necessary to balance the duty to involve with public interest in maintaining continuity of care and protecting the health, safety and welfare of patients or staff. If a Commissioner considers acting in a way that may not comply with its statutory duties, it should seek further advice.

2.7 Links to relevant PCSS information and documentation

- Performer list <https://pcse.england.nhs.uk/services/performers-lists/>
- Practice Mergers and Closure <https://pcse.england.nhs.uk/services/practice-mergers-and-closures-notifications/>

3 Death of a Contractor

3.1 Introduction

- 3.1.1 The aim of this policy is to provide consistency when dealing with the death of a contractor, whether they are a single-handed contractor or in a partnership and includes consideration of GMS, PMS, APMS and where appropriate MCP/PACS contracts.
- 3.1.2 This policy outlines the procedure to follow when the death of a contractor occurs. This is a rare occurrence, but there are certain steps to follow within fixed timescales that are laid down in legislation.

3.2 Individual - GMS Contract

- 3.2.1 Where a GMS contract is with an individual medical practitioner and that practitioner dies, the contract must terminate at the end of the period of 7 days after the date of the contractor's death unless, before the end of that period:
 - 3.2.1.1 the commissioner and the contractor's personal representatives agree in writing that the contract will continue for a further period of up to 28 days after the initial 7 day period (i.e. the longest possible extension is 35 days from the date of death); and
 - 3.2.1.2 the contractor's personal representatives have confirmed in writing to the Commissioner that they wish to employ or engage one or more general medical practitioners to assist in continuing to provide clinical services under the contract during that period; and
 - 3.2.1.3 the Commissioner agrees to provide reasonable support which would enable the provision of clinical services under the contract to continue during that period; and
 - 3.2.1.4 the Commissioner and the personal representatives agree the terms upon which clinical services under the contract can continue to be provided during that period.
- 3.2.2 The Commissioner should issue a confirmation letter setting out the timescales of the continuation. A template letter is provided in Annex 1.
- 3.2.3 Note that it is not possible to extend the existing GMS contract for any longer period. Termination is mandatory and automatically takes place. Commissioners should refer to section 2 (Unplanned / Unscheduled and Unavoidable Practice

Closedown) in relation to planning for caretaking, reprocurement or list dispersal on termination.

3.3 Individual - PMS or APMS Contract

- 3.3.1 Where the PMS or APMS contract is with a single individual and that individual dies, the contract shall terminate at the end of the period of seven days after the date of the contractor's death unless, before the end of that period, the Commissioner has agreed in writing with the contractor's personal representatives that the contract should continue for a further period, not exceeding 28 days after the end of the period of seven days (i.e. the longest possible extension is 35 days from the date of death).
- 3.3.2 The Commissioner should issue a confirmation letter setting out the timescales of the continuation. The template letter in Annex 1 can be used.
- 3.3.3 Note that it is not possible to extend the existing PMS or APMS contract for any longer period. Termination is mandatory and automatically takes place. Commissioners should refer to section 2 (Unplanned / Unscheduled and Unavoidable Practice Closedown) in relation to planning for caretaking, reprocurement or list dispersal on termination.

3.4 Partnership - GMS Contract

- 3.4.1 The GMS Regulations state that where the contract is with two or more individuals practising in partnership, the contract shall be treated as made with the partnership as it is from time to time constituted.
- 3.4.2 The default position in partnership law is that every partnership is dissolved as regards all the partners by the death of any partner. The partners can, however, change this position and agree between themselves that the partnership will not dissolve on the death of any partner. It is likely that most partnerships will have dealt with this issue in their partnership deed to avoid termination of their contract.
- 3.4.3 The GMS Regulations require GMS contracts to contain specific provisions relating to the dissolution of partnerships.
- 3.4.4 Where a partner dies, the GMS Regulations distinguish between GMS contracts that are entered into with a contractor that consists of only two individuals practising

in partnership and those GMS contracts where the contractor consists of more than two individuals.

Two individuals practising in partnership - GMS Contract

- 3.4.5 Where the contractor consists of two individuals practising in partnership and the partnership is dissolved or terminated due to the death of one of the partners, the surviving partner must notify the Commissioner in writing as soon as is reasonably practicable of the death of their partner.
- 3.4.6 Where the Commissioner receives such a notice, it must acknowledge receipt of the notice in writing.
- 3.4.7 If the surviving partner is a general medical practitioner, the contract will continue with that individual. The Commissioner may vary the contract but only to the extent that it is satisfied it is necessary to reflect the change in status of the contractor from a partnership to an individual medical practitioner. The Commissioner must notify the contractor in writing of the wording of the proposed variation and the date upon which that variation is to take effect.
- 3.4.8 A template Notification Letter is provided in Annex 2. A variation notice will need to be included with this letter.
- 3.4.9 To provide assurance that the individual is able to meet the contractual obligations, the Commissioner should discuss with the individual continued service delivery options bearing in mind the size of the practice, the range of services provided and any potential capacity issues.
- 3.4.10 If the surviving partner is not a general medical practitioner, the Commissioner must enter into discussions with the surviving partner and use reasonable endeavours to reach an agreement to enable the provision of clinical services to continue under the contract. The Commissioner may, if it considers it appropriate to enable clinical services under the contract to continue, offer the surviving partner reasonable support.
- 3.4.11 The Commissioner may choose to consult the relevant LMC, if it considers it appropriate or any other person that the Commissioner considers necessary.
- 3.4.12 Where the Commissioner reaches an agreement with a surviving partner who is not a general medical practitioner, the Commissioner must notify that individual confirming:

- 3.4.12.1 the terms upon which the Board agrees to the contract continuing with that individual;
- 3.4.12.2 the interim period during which the contract is to continue which must not exceed six months;
- 3.4.12.3 that the individual will employ or engage a general medical practitioner for the interim period to assist in the provision of clinical services under the contract; and
- 3.4.12.4 the support, if any, which the Commissioner is to provide to enable clinical services under the contract to continue during the interim period.
- 3.4.13 A Template Notification Letter is provided in Annex 3. A variation notice will need to be included with this letter.
- 3.4.14 Where the Commissioner cannot reach an agreement with the surviving partner or if the surviving partner does not wish to employ or engage a medical practitioner, the Commissioner must terminate the contract immediately by serving notice in writing on the surviving partner.
- 3.4.15 The Commissioner must also terminate the contract in writing to the surviving partner if:
 - 3.4.15.1 the surviving partner wishes to withdraw from the agreed arrangements at any stage during the interim period; or
 - 3.4.15.2 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.
- 3.4.16 Where the Commissioner intends to terminate the contract, please refer to the chapter on contract breaches, sanctions and termination for further information on considerations relating to terminating a contract.
- 3.4.17 A template Termination Letter is set out in Annex 4.

More than two individuals practising in partnership - GMS contract

- 3.4.18 Where there are more than two individuals practising in partnership, the death of one of the partners may result in the partnership being dissolved. This may not always be the case as the partnership arrangements between the partners may state that the partnership will continue or make other provision on the death of a partner that does not result in the dissolution of the partnership.

3.4.19 Where the partnership is not dissolved or terminated, the contract will continue and the provisions below will not apply provided that the partnership remains eligible to hold the GMS contract. Please refer to the 'Contracts Described' chapter for further information on eligibility requirements.

3.4.20 It is possible for the contract to continue where the partnership is dissolved or terminated for whatever reason (which may be due to the death of a partner) and the contractor consists of more than two individuals practising in partnership. The contract may continue with one of the former partners if the following conditions apply:

3.4.20.1 The former partner must be nominated by the contractor; and

3.4.20.2 The former partner must be a medical practitioner that meets the condition in regulation 4(2)(a) of the GMS Regulations.

3.4.21 The nomination of the former partner by the contractor must be:

3.4.21.1 in writing and signed by all of the persons who are practising in partnership; and

3.4.21.2 specify the date on which the contractor proposes to change its status from that of a partnership to that of an individual medical practitioner; and

3.4.21.3 be provided to the Commissioner at least 28 days in advance of the date on which the contractor proposes to change its status from that of a partnership to that of an individual medical practitioner; and

3.4.21.4 specify the name of the medical practitioner with whom the contract will continue, which must be one of the partners.

3.4.22 Where the Commissioner receives such a nomination, it must acknowledge receipt of the notice in writing before the date specified in the nomination as the date on which the contractor proposes to change its status from that of a partnership to that of an individual medical practitioner.

3.4.23 The Commissioner may vary the contract but only to the extent that it is satisfied it is necessary to reflect the change in status of the contractor from a partnership to an individual medical practitioner. The Commissioner must notify the contractor in writing of the wording of the proposed variation and the date upon which that variation is to take effect.

3.4.24 A template Notification Letter is provided in Annex 5. A variation notice will need to be included with this letter.

3.5 Two or More Signatories - PMS Agreement

- 3.5.1 The PMS Regulations do not allow PMS agreements to be treated as made with a partnership. Where individuals are practising in partnership, the PMS agreement will be entered into with each individual (who may or may not be in partnership). The individual signatories to a PMS agreement collectively form the contractor. The PMS Regulations do not require a PMS agreement to define a specific process for any variation to the signatories. The Commissioner must, therefore, review the relevant PMS agreement to determine whether any provisions have been added relating to this and prior to following any process for variation.
- 3.5.2 Ideally, a surviving signatory to a PMS agreement will notify the Commissioner in writing as soon as reasonably practicable of the death of their co-signatory.
- 3.5.3 Upon receipt of the notification from the surviving co-signatory(ies), the Commissioner will need to consider the implications that the death of the co-signatory will have on the ongoing provision of services under the agreement.
- 3.5.4 Where the Commissioner is satisfied that the remaining signatory(ies) is eligible to hold the agreement and agrees that the agreement is to continue, the agreement will need to be varied to remove the deceased as a signatory.
- 3.5.5 The process above does not affect any right that the Commissioner may have to terminate the agreement under any terms of the agreement.

3.6 Two or More Signatories - APMS Contract

- 3.6.1 The Commissioner must review the relevant APMS contract to determine whether any provisions relate to the death of a contractor prior to following any process for variation.
- 3.6.2 Where no provisions cover this scenario, paragraphs **Error! Reference source not found.** to **Error! Reference source not found.** are likely to be relevant.

3.7 Practical Issues Arising from Death of a Contractor

Request to form a partnership

- 3.7.1 Where a GMS contract is held by an individual as a result of the death of a partner, that individual (like any individual GMS contractor) may propose to practice in

partnership with one or more persons during the existence of the contract. Please refer to the chapter on contracts variations for more information on the relevant process and obligations of the Commissioner.

Procuring a new contract

- 3.7.2 Where death of a contractor results in termination of the contract in any of the ways described above, the Commissioner will need to decide whether to procure primary care medical services to replace the contract.

3.8 Links to relevant PCSS information and documentation

- Performer list <https://pcse.england.nhs.uk/services/performers-lists/>
- Practice Mergers and Closure <https://pcse.england.nhs.uk/services/practice-mergers-and-closures-notifications/>
- GP Payments <https://pcse.england.nhs.uk/services/gp-payments/>
- GP Pensions <https://pcse.england.nhs.uk/services/gp-pensions/>

Annex 1 Template Acknowledgement Letter (Individual – GMS, PMS or APMS contract)

- [Template Acknowledgement Letter \(Individual – GMS, PMS or APMS contract\)](#)

Annex 2 Template Notification Letter (Medical Remaining)

- [Template Notification Letter \(Medical Remaining, automatic continuation\)](#)

Annex 3 Template Notification Letter (Non-Medical Remaining)

- [Template Notification Letter \(Non-Medical Remaining\)](#)

Annex 4 Template Termination Letter (Non-Medical Remaining)

- [Template Termination Letter \(Non - Medical Remaining\)](#)

Annex 5 Template Notification Letter (Medical Remaining)

- [Template Notification Letter \(Medical Remaining by nomination\)](#)

4 Managing Disputes

4.1 Introduction

- 4.1.1 This policy describes the process to determine the action required when a contractor has requested to follow the NHS dispute resolution process or where the Commissioner elects to follow the NHS dispute resolution procedure.
- 4.1.2 The policy focuses on primary medical care contracts in their various forms.

4.2 Background

- 4.2.1 The Commissioner must identify whether the contract is an NHS contract or a non-NHS contract. In GMS contracts, the Commissioner can do this by reviewing clause 14 of the standard GMS contract. A similar clause will also be set out within PMS and APMS contracts.
- 4.2.2 An NHS contract (as set out at section 9 of the NHS Act) is an arrangement under which one health service body arranges for the provision of goods or services to another health service body. It must not be regarded as giving rise to contractual rights or liabilities.
- 4.2.3 A non-NHS contract is where the contract is legally binding.
- 4.2.4 Contractors have the right to be regarded as a health service body under regulation 10 of the GMS Regulations or regulation 9 of the PMS Regulations or where the APMS contractor is a health service body by virtue of section 9 of the NHS Act.
- 4.2.5 Where a contractor is regarded as being a health service body, its contract will be an NHS contract. Where a contractor is not regarded as a health service body, its contract will not be an NHS contract. Health service body status affects the eligibility and application process for NHS dispute resolution.
- 4.2.6 GMS and PMS contracts require the parties to make every reasonable effort to communicate and co-operate with each other to resolve the dispute before referring the dispute for determination in accordance with the NHS dispute resolution procedure or, where applicable, before commencing Court proceedings.
- 4.2.7 There are two different routes that can be taken for resolving contractual disputes, depending on the contractor's health service body status:

- 4.2.7.1 where the contractor is a health service body and the contract is an NHS contract the steps laid out in this policy will be used to resolve all matters of dispute. The parties should not make a claim at Court in relation to the contracts; or
- 4.2.7.2 where the contractor is not a health service body and the contract is a non-NHS contract, the dispute can either be resolved using the process described within this policy or using the Court system.
- 4.2.8 The dispute resolution process for APMS contracts is specific to the parties' agreement as set out in the APMS contract. The APMS contract must be reviewed in the event of a dispute and that process followed. The APMS Directions do not require the NHS dispute resolution to be included in the APMS contract and more commercial terms are usually set out.
- 4.2.9 The use of the Court system can be an expensive and public route. In normal circumstances, non-health service bodies will elect to follow the NHS dispute resolution.
- 4.2.10 Where the parties have followed this policy and the NHS dispute resolution to the end determination, the result is binding. A second referral to the Court system for a further ruling on the same issue cannot be made other than to enforce the decision as having the status of a County Court Judgement or to seek Judicial Review of the process.

4.3 Managing Disputes – Informal Process

- 4.3.1 The parties must make every reasonable effort to communicate their issues in relation to decision-making and rationale and must co-operate with each other to resolve any disputes that emerge informally before considering referring the matter for determination through formal dispute resolution procedures.
- 4.3.2 The formal process should not 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 (e.g. LMC).
- 4.3.3 The use of an informal resolution process helps develop and sustain a partnership approach between contractor and Commissioner.
- 4.3.4 The informal process may include (but is limited to):

4.3.4.1 regular telephone communications;

4.3.4.2 face-to-face meetings at a mutually convenient location; and/or

4.3.4.3 written communications.

4.3.5 It is essential that the Commissioner maintains accurate and complete written records of all discussions and correspondence on the contract file in relation to the dispute at all levels of dispute resolution. The Commissioner should ensure that it responds to contractor concerns and communications in a timely and reasonable manner.

4.4 Managing Disputes – Stage 1 (Local Dispute Resolution)

4.4.1 The timescales set out in this stage 1 are indicative only. The Commissioner should ensure any timescales used are appropriate to the circumstances. Regardless of timescales, the parties must ensure that every reasonable effort to communicate and co-operate with each other is made prior to invoking stage 2 of the NHS dispute resolution procedure.

4.4.2 Where a dispute arises, the Commissioner should refer to the relevant policy that covers the issue that caused the dispute to determine whether due process has been followed.

4.4.3 The contractor should notify the Commissioner of its intention to dispute one or more decisions made in relation to its contract. This notification should usually be received no later than 28 days after the Commissioner advises the contractor of its decision except in exceptional circumstances.

4.4.4 The Commissioner will immediately cease all actions in relation to the disputed notice or decision, until:

- 4.4.4.1 there has been a determination of the dispute and that determination permits the Commissioner to impose the planned action; or
- 4.4.4.2 the contractor ceases to pursue the NHS dispute resolution procedure or Court proceedings,
- 4.4.4.3 whichever is the sooner.
- 4.4.5 Where the Commissioner is satisfied that it is necessary to terminate the contract or impose a Contract Sanction before the NHS dispute resolution procedure is concluded in order to:
 - 4.4.5.1 protect the safety of the contractor's patients; or
 - 4.4.5.2 protect NHS England from material financial loss;
 - 4.4.5.3 then the Commissioner shall be entitled to terminate the contract or impose the contract sanction at the end of the period of notice it served. This should only be followed with close reference to the GMS Regulations and PMS Regulations, pending the outcome of that procedure.
- 4.4.6 The paragraphs below set out a process that may be adopted for stage 1 (Local Dispute Resolution).
- 4.4.7 The Commissioner may acknowledge the notification of dispute within seven days of receipt and request the submission of supporting evidence from the contractor within a further 28 days from the date they receive the letter. An example acknowledgement letter is provided in Annex 1.
- 4.4.8 Upon receipt of the evidence the Commissioner should review the evidence within 28 days 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 LMC. An example invite letter is provided in Annex 2.
- 4.4.9 Once the meeting has been held, the Commissioner should notify the contractor in writing of the outcome of the meeting, whether the dispute will now need to be moved to stage 2 of the NHS dispute resolution procedure (refer to the example stage 1 outcome letter in Annex 3) or that the dispute has been successfully resolved (refer to the example stage 1 outcome letter in Annex 4).
- 4.4.10 Where the matter is resolved, the issue can be deemed closed and the Commissioner should document the outcome accordingly on the contract file.

- 4.4.11 Where the matter remains unresolved, the process may be escalated to the next stage of the dispute resolution procedure.
- 4.4.12 At this point the Commissioner should commence preparation of the contract file to ensure that if and when NHSR or Court requests submission of evidence in respect of the dispute the documentation is in order.

4.5 Managing Disputes – Stage 2 (NHS Dispute Resolution Procedure)

- 4.5.1 The informal process and stage 1 (Local Dispute Resolution) should be exhausted before proceeding to this stage of the process. The Commissioner or a contractor wishing to follow this route must submit a written request for dispute resolution to Primary Care Appeals (PCA) at NHSR, which carries out the NHS dispute resolution functions of the Secretary of State in the GMS Regulations and the PMS Regulations, which should include:
- 4.5.1.1 the names and addresses of the parties to the dispute;
 - 4.5.1.2 a copy of the contract; and
 - 4.5.1.3 a brief statement describing the nature and circumstances of the dispute.
- 4.5.2 The written request for dispute resolution must be sent within 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. Please see NHSR PCA (formerly FHSAU) determination reference 17156 for further details on the date that the dispute should have reasonably come to the attention of the relevant party.
- 4.5.3 The Commissioner will be required to prepare documentation evidence and potentially an oral presentation in response to evidence presented in support of the dispute. Each party will be asked to prepare representations on the dispute, which will be circulated to the other party and an opportunity to provide observations on the other party's representations will be given. Again, the observations of each party will be circulated to the other party.
- 4.5.4 The Commissioner should not underestimate the preparation that will be required in the event that evidence is required by NHSR PCA, 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 the Commissioner and the contractor) and any electronic correspondence that may have passed between the parties, in relation to the dispute. This process will benefit from a clearly recorded contract file.

- 4.5.5 The Commissioner 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 NHSR PCA
- 4.5.6 Once NHSR PCA has reached a conclusion (the determination) the Commissioner will receive a copy and will be required to act upon it. A copy of the Guidance Note for parties involved in Dispute Resolution at the NHSR PCA is attached in Annex 5 and should be followed by the parties to the dispute.

Co-commissioning - delegated commissioning arrangements

A CCG that has delegated commissioning arrangements will have entered into a Delegation Agreement with NHS England setting out the scope of those arrangements.

The Delegation Agreement includes a section on Claims and Litigation which is likely to include a dispute with a GMS, PMS or APMS contractor that has been referred to Stage 2 of the NHS dispute resolution procedure. In such cases, the CCG is required to act in accordance with the Delegation Agreement which includes but is not limited to:

- notifying NHS England of any documents concerning the dispute and providing copies of these documents;
- co-operating fully with NHS England in relation to such dispute and the conduct of such dispute;
- providing, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such dispute; and/or
- at the request of NHS England, taking such action or step or providing such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the dispute and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such dispute or to comply with the requirements of NHSR PCA (formerly the FHSAU) in relation to such dispute.

4.6 Other Dispute Resolution Procedures

- 4.6.1 The GMS and PMS Regulations allow the NHS dispute resolution procedure to be used by the contractor as a means of resolving every dispute except where an assessment panel makes a determination that the Commissioner may assign new patients to contractors that have closed their practice list of patients. The procedure to follow in such circumstances is set out in paragraph 4.7 below.
- 4.6.2 Disputes may also arise prior to a contract being entered into. Such disputes will relate to the eligibility of the person seeking to enter into the contract or contract terms.
- 4.6.3 Where the Commissioner is of the view that a person seeking to enter into a contract does not meet the eligibility conditions (please refer to the 'Contracts

Described' chapter for further information), the Commissioner must notify the person in writing.

- 4.6.4 This notice must state the Commissioner's view of the person's eligibility, reasons for that view and guidance on the person's right of appeal.
- 4.6.5 Where the Commissioner has issued such a notice, the recipient of the notice has a right of appeal to the First-Tier Tribunal.
- 4.6.6 Where the dispute relates to the parties being unable to agree on a particular proposed term of a GMS or PMS contract, either party may refer the dispute to the Secretary of State to consider and determine the matter in accordance with:
 - 4.6.6.1 for GMS contracts, paragraphs 101(3) to (14) and 102(1) of Schedule 6 and regulation 9(3) of the GMS Regulations; or
 - 4.6.6.2 for PMS agreements, paragraphs 95(3) to (14) and 96(1) of Schedule 5 and regulation 8(3) of the PMS Regulations,
 - 4.6.6.3 except where both parties to the prospective agreement are health service bodies (in which case section 9 of the NHS Act applies).

4.7 Assignment of Patients to Lists: Procedure Relating to Determinations of the Assessment Panel

- 4.7.1 Where an assessment panel makes a determination that the Commissioner may assign new patients to contractors which have closed their practice list 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.
- 4.7.2 If a referral is made to the Secretary of State, it shall be reviewed in accordance with the following procedure:

- 4.7.2.1 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
- 4.7.2.2 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 a dispute resolution which shall include or be accompanied by:
 - 4.7.2.2.1 the names and addresses of the parties to the dispute;
 - 4.7.2.2.2 a copy of the contract (or contracts); and
 - 4.7.2.2.3 a brief statement describing the nature and circumstances of the dispute.
- 4.7.3 Each party will be asked to make representations and observations on the representations of the other party both of which will be allocated between the parties.
- 4.7.4 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 Commissioner may assign patients to contractors that have closed their lists of patients. If the Secretary of State determines that the Commissioner may make such assignments, the Secretary of State shall also determine those contractors to which patients may be assigned.
- 4.7.5 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.
- 4.7.6 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.
- 4.7.7 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:

4.7.7.1 the Secretary of State;

4.7.7.2 the Commissioner; and

4.7.7.3 the contractor(s) that referred the matter to dispute resolution.

4.7.8 The Secretary of State shall record the determination and the reasons for it in writing and shall give notice of the determination (including the record of the reasons) to the parties.

4.8 Annexes

Annex 1 Example Acknowledgement Letter

- [Example Acknowledgement Letter](#)

Annex 2 Example Invitation Letter

- [Example Invitation Letter](#)

Annex 3 Example Stage 1 Outcome Letter (NHSR PCA Referral)

- [Example Stage 1 Outcome Letter \(NHSR PCA Referral\)](#)

Annex 4 Example Stage 1 Outcome Letter (Matter(s) Resolved)

- [Example Stage 1 Outcome Letter \(Matter\(s\) Resolved\)](#)

Annex 5 Guidance Note for Parties Involved in Dispute Resolution

- [Guidance Note for Parties Involved Dispute Resolution](#)

5 Adverse Events (e.g. flood fire)

5.1 Background

- 5.1.1 Adverse incidents are dealt with in the force majeure provisions of the standard GMS, PMS, APMS and where appropriate MCP/PACS contracts. Although these provisions are not required by the GMS Regulations, the PMS Regulations or the APMS Directions, the majority of GMS, PMS, APMS and where appropriate MCP/PACS contracts will include them.
- 5.1.2 The Commissioner is advised to check that the force majeure provisions are included in each contract and if they are to follow the guidance in this policy. This policy is only applicable where the contract in question has retained the recommended force majeure provisions.
- 5.1.3 The contractor is responsible for informing the Commissioner of any force majeure event.

5.2 Contract Wording

- 5.2.1 Clause 27.5 of the standard GMS contract states that:

"27.5.1 *Neither party shall be responsible to the other for any failure or delay in performance of its obligations and duties under this Contract which is caused by circumstances or events beyond the reasonable control of a party. However, the affected party must promptly on the occurrence of such circumstances or events:*

- (a) inform the other party in writing of such circumstances or events and of what obligation or duty they have delayed or prevented being performed; and*
- (b) take all action within its power to comply with the terms of this Contract as fully and promptly as possible.*

27.5.2 *Unless the affected party takes such steps, clause 27.5.1 shall not have the effect of absolving it from its obligations under this Contract. For the avoidance of doubt, any actions or omissions of either party's personnel or any failures of either party's systems, procedures, premises or equipment shall not be deemed to be*

circumstances or events beyond the reasonable control of the relevant party for the purposes of this clause, unless the cause of failure was beyond reasonable control.

27.5.3. If the affected party is delayed or prevented from performing its obligations and duties under the Contract for a continuous period of 3 months, then either party may terminate this Contract by notice in writing within such period as is reasonable in the circumstances (which shall be no shorter than 28 days).

27.5.4. The termination shall not take effect at the end of the notice period if the affected party is able to resume performance of its obligations and duties under the Contract within the period of notice specified in accordance with clause 27.5.3 above, or if the other party otherwise consents."

5.2.2 The provision of individual PMS and APMS contracts should be reviewed and advice sought.

5.2.3 A force majeure event is one which is caused by circumstances beyond the reasonable control of either the Commissioner or the contractor that could not have been avoided or mitigated with reasonable care and where the event has had a material effect on the fulfilment of the contract.

5.2.4 Examples of events that may invoke the force majeure provisions are as follows:

- Fire;
- Flood;
- Severe weather conditions and for which precautions are not ordinarily taken to avoid or mitigate the impact (for example a severe hurricane);
- Industrial action which significantly affects the provision of public services or services upon which the party is reliant;
- Death of a significant performer or close relative;
- Pandemic disease or circumstances that might otherwise be considered "an act of God";
- War;
- Civil war (whether declared or undeclared);
- Riot or armed conflict;
- Radioactive, chemical or biological contamination;

- Pressure waves caused by aircraft or other aerial devices travelling at sonic or supersonic speed;
- Acts of terrorism;
- Explosion.

5.2.5 Examples of events that would not be considered force majeure events are as follows:

- Refurbishment of practice premises;
- Adverse weather in the winter months (including snow and ice);
- Planned events (including elective surgery, leave, weddings and similar events);
- Long term sickness, maternity/paternity or adoption leave.

5.3 Contract Compliance

- 5.3.1 All contractors will likely be obliged under the terms of their contracts to promptly notify the Commissioner of a force majeure event, detailing the cause or event, what service provision is being delayed or prevented and what action(s) within their power they are taking in order to comply with the terms of the contract as fully and promptly as possible.
- 5.3.2 Failure to notify the Commissioner will mean that the contractor is not absolved from its obligations under the contract.
- 5.3.3 Neither party will be responsible to the other for any failure to delay in performing its obligations and duties under the contract which is caused by an event of force majeure
- 5.3.4 A template notification is provided in Annex 1 which the Commissioner can send to the contractor for completion.

5.4 Clinical Governance & Risk Management/Termination

- 5.4.1 If the consequence of the contractor's failure to deliver services is significant and poses a risk to patient safety or the efficiency of wider primary care services, the Commissioner may wish to consider recording the incident on the risk register or consider whether it may invoke its termination rights.
- 5.4.2 If the service provision is delayed or prevented for a continuous period of three months then either party will likely be able to terminate the agreement by notice in

writing within a period which is reasonable (and no less than 28 days). This termination will not take effect where the service is resumed within the period of notice or if the contractor consents to this.

5.5 Appeals

- 5.5.1 The parties should refer to the chapter on managing disputes for the process in relation to a dispute.

5.6 Payment and Contract System

- 5.6.1 The parties should discuss the effect of force majeure on payments by the Commissioner to the contractor. The Commissioner should use its reasonable discretion in determining payments with regard to the need for the contractor to continue to provide services once it is no longer affected by the force majeure event provided the contract has not been terminated.

Annex 1 Contractor's Preliminary Notice of Force Majeure Event

- [Contractor's Preliminary Notice of Force Majeure Event](#)

Annex 2 Acknowledgement of Contractor Notification

- [Acknowledgement of Contractor Notification](#)

Part D – General

1 GP IT Operating Model: Data and Cyber Security Arrangements

1.1 Introduction:

- 1.1.1 This chapter provides an overview of GP IT Operating Arrangements, as outlined in the GP IT Operating Model, [Securing Excellence in Primary Care \(GP\) Digital Services: The Primary Care GP Digital Services Operating Model 2019-21](#), published by NHS England. Particular reference is made to data and cyber security arrangements, following the publication of the National Data Guardian Review in July 2016 which included key recommendations and proposed ten data security standards.

1.2 Background:

- 1.2.1 NHS England is accountable for the delivery of GP IT services, with responsibility for the commissioning of GP IT services delegated to CCGs under the NHS Act 2006 (as amended).
- 1.2.2 The [GP IT Operating Model](#) outlines accountabilities and commissioning responsibilities for the provision of high quality GP IT support services.
- 1.2.3 CCGs are encouraged to work in partnership with primary care stakeholders to develop a local digital strategy and delivery plans, set priorities and local direction for digital support services and technology, that can be used to optimal effect for the benefit of patient care.
- 1.2.4 The [GP IT operating model](#), provides a detailed schedule of 'core and mandated' capabilities and enabling requirements, which includes standards to ensure that procured services are compliant with data protection and cyber security regulations and controls. In addition, 'enhanced' requirements to facilitate local service improvement and transformation should be developed and agreed locally to support local strategic priorities and commissioning strategies to improve service delivery. CCGs are responsible for ensuring all these requirements are provided to the standards described in the GP IT Operating Model.
- 1.2.5 A CCG may choose to commission services from one or more GP IT delivery partners. The [GP IT Commissioning Specification Support Pack](#) is available to support CCGs in the effective procurement and ongoing review of GP IT services. This includes a [GP IT data capture service schedule](#) which can be used by CCGs to

review current service provision arrangements or to support re-procurement activities, including the development of local service specifications.

- 1.2.6 The details of the provision of these services must be recorded in the [CCG Practice Agreement](#), signed by both the CCG and each constituent General Practice, as a core contractual requirement. This nationally developed agreement sets out the terms governing the provision and receipt of digital services in General Practice and will include as an appendix, details of local service provision arrangements. The revised version of the CCG Practice Agreement has been published and local agreements should be signed to align with the contractual end date of GP Systems of Choice and migration to the new GP IT Futures Framework from January 2020.
- 1.2.7 Each practice needs to work with the CCG and its locally commissioned GP IT delivery partner(s), as outlined in the CCG Practice Agreement, to enable them to effectively support the IT infrastructure, respond to service incidents and maintain compliance with security standards, in line with national standards and locally agreed service level agreements.
- 1.2.8 As end users of technology, GPs and their staff need to be familiar with the GP IT services being provided and delivered locally, the support arrangements particularly in cases of cyber security incidents and what local contingency and recovery processes are in place when technology fails.

1.3 GP IT Operating Model: Cyber and Data Security Updates:

- 1.3.1 The [GP IT operating model](#) revised in 2019, provides a detailed schedule of services outlining 'core and mandated' capabilities and enabling requirements, which includes standards to ensure that procured services are compliant with data protection and cyber security regulations and controls.
- 1.3.2 A CCG may choose to commission 'core and mandated' services from one or more GP IT delivery partners. The [GP IT Commissioning Specification Support Pack](#) is available to support CCGs in the effective procurement and ongoing review of GP IT services. This includes a [GPIT data capture service schedule](#) which can be used by CCGs to review current service provision arrangements or to support re-procurement activities, including the development of local service specifications.
- 1.3.3 Each practice needs to work with locally commissioned GP IT delivery partner(s) as outlined in the CCG Practice Agreement, to enable them to effectively support the

IT infrastructure, respond to service incidents and maintain compliance with security standards, in line with national standards and locally agreed service level agreements.

- 1.3.4 As end users of technology, GPs and their staff need to be familiar with the GP IT services being provided and delivered locally, the support arrangements particularly in cases of cyber security incidents and what local contingency and recovery processes are in place when technology fails.

1.4 Review of Data Security, Consent and Opt-Outs (National Data Guardian, July 2016):

- 1.4.1 In July 2016, recommendations and ten proposed standards for Data Security were published for consultation in the [National Data Guardian \(NDG\) for Health and Care Review of Data Security, Consent and Opt-Outs](#). These are aimed at strengthening the safeguards for keeping health and care information secure and ensuring the public can make informed choices about how their data is used.
- 1.4.2 A parallel review was also conducted by the Care and Quality Commission on (CQC) "[Safe Data, Safe Care](#)" which focused on the availability, integrity and confidentiality of patient data.
- 1.4.3 Following national consultation, the plan outlined within '[Your Data: Better Security, Better Choice, Better Care \(DH Data Sharing and Cyber Security Team, July 2017\)](#)' supports the recommendations within the NDG and CQC reviews respectively and centres on ensuring local organisations are implementing the ten data security standards. These have been further strengthened in some areas, including Data Security Standard 6, which now requires significant cyber-attacks to be reported by health and care organisations to the Data Security Centre as soon as possible following detection. These are supported by national support services and backed by clear contractual obligations and by assurance and regulatory action.
- 1.4.4 National services and security advice are offered by NHS Digital's Data Security Centre to ensure patient data and information is used safely and securely and to enable health and care organisations prepare their own resilience to cyber security threats, and to respond effectively and safely when they occur.

- 1.4.5 As part of the GP contract for 2017/18 non-contractual changes to joint guidance have been agreed which include general practice compliance with the ten new data security standards in the NDG Review, as outlined below:

1.5 Ten Data Security Standards:

Category People:

Ensure staff are equipped to handle information respectfully & safely, according to the Caldicott Principles

Data Security Standard 1

All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is shared for only lawful and appropriate purposes.

Data Security Standard 2

All staff understand their responsibilities under the National Data Guardian's data security standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.

Data Security Standard 3

All staff complete appropriate annual data security training and pass a mandatory test, provided through the redesigned Information Governance Toolkit.

Category: Process:

Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses.

Data Security Standard 4

Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All instances of access to personal confidential data on IT systems can be attributed to individuals.

Data Security Standard 5

Processes are reviewed at least annually to identify and improve any which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.

Data Security Standard 6

Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken as soon as possible following a data breach or near miss, with a report made to senior management within 12 hours of detection. Significant cyber-attacks are to be reported to CareCERT immediately following detection.

Data Security Standard 7

A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.

Category: Technology:

Ensure technology is secure and up-to-date.

Data Security Standard 8

No unsupported operating systems, software or internet browsers are used within the IT estate.

Data Security Standard 9

A strategy is in place for protecting IT systems from cyber threats, based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.

Data Security Standard 10

IT suppliers are held accountable via contracts for protecting the personal confidential data they process and for meeting the National Data Guardian's data security standards.

- 1.5.1 In April 2018, NHS Digital released the Data Security and Protection Toolkit (DSPT) which replaced the Information Governance Toolkit. The Data Security and Protection Toolkit is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards. The CCG-Practice Agreement requires General Practices to complete the DSPT annually. Local (CCG) commissioned GP IT Delivery Partners (providers) must also be contractually required to complete the DSPT.
- 1.5.2 The [DSP Toolkit](#) will provide individual organisations with the necessary tools to assess adherence to the standards and level of cyber capability, as well as providing a national picture of data security across the health and social care system, and intelligence for independent assurance processes. A new incident

reporting tool for data security and protection incidents has been launched within the Data Security and Protection Toolkit. Through the Data Security Centre and the Cyber Security Programme, NHS Digital will enable organisations to put those standards into practice.

- 1.5.3 Information from the DSPT will support CQC inspections, which from September 2017 will include the importance of meeting the data security standards. In addition, a new incident reporting tool for data security and protection incidents has been launched within the Data Security and Protection Toolkit. *The DHSC has published the [2017/18 Data Security and Protection Requirements](#)* clarified action required by General Practices.
- 1.5.4 The Network and Information Systems Regulations 2018 which came into force in May 2018 gave further legal backing to the 10 data security standards, by requiring those organisations identified as 'operators of essential services' to comply with defined security requirements. GP IT Operating Model arrangements will continue to be reviewed and will be updated to reflect these requirements.

1.6 Locally Procured 3rd Party Digital Systems, Services and Architecture:

- 1.6.1 Consideration needs to be given to security arrangements for locally procured digital systems, services and architecture which are provided by suppliers outside the GP IT Futures Framework, the local CCG commissioned GP IT services and National Digital Services.
- 1.6.2 The commissioner or General Practice needs to ensure that any digital services and infrastructure procured locally are provided by organisations compliant with the applicable standards in the operating model.
- 1.6.3 Clear support arrangements are essential and should describe how these align with local GP IT delivery arrangements. This is critical in effective incident management

1.7 Disaster Recovery and Business Continuity (DR/BC)

- 1.7.1 Each practice will have a Business Continuity (BC) plan as part of their ~~IG~~ DSP Toolkit compliance and this should include responses to data security and cyber security threats/incidents, significant breaches or near misses and response to a loss of access to patient records.
- 1.7.2 All practices must register with the MHRA Central Alerting System which will be utilised as required, to support any national cyber security incident
- 1.7.3 The CCG will ensure advice/guidance to support the development of the digital element of the practice BC plan, is available. CCGs should approve practice BC plans. As more systems become securely hosted externally and fewer are located within individual practice premises and control the role of a practice Disaster Recovery (DR) Plan becomes less relevant. In the event of a practice ~~local~~ BC plan being invoked, the CCG will ensure specialist technical support is available as necessary.
- 1.7.4 It is important for all staff in the practice to understand their roles when the plans are activated. The practice team will need to work together to do the right thing at the right time and to ensure that the right people are in place with the right support. All practice staff must complete the annual NHS Data Security Awareness Level 1 training.
- 1.7.5 The recovery process after an incident is equally important to ensure that electronic patient records are kept up to date and lessons are learned on how the response to the incident was managed.
- 1.7.6 BC plans should be reviewed as required under the terms of the CCG Practice Agreement.
- 1.7.7 The review of BC plans will need to take into account those circumstances where the practice may be unaffected but providers are. For example, the shutdown of a secondary care provider that supplies pathology services may delay the availability of test results or the availability of discharge advice notes. Whilst these may be beyond the scope of the practice, planning and agreement with the CCG on how to handle these circumstances will be of benefit to the practice and their patients.
- 1.7.8 Local (CCG) commissioned GP IT Delivery Partners (providers) must also be contractually required to prepare and maintain BC and DR plans for those services relevant to the delivery of GP IT.

1.8 Further Information:

- 1.8.1 CCGs seeking further information on the GP IT Operating Model and associated support materials and guidance, can visit <https://www.england.nhs.uk/digitaltechnology/digital-primary-care/> or contact the NHSx Digital Primary Care (GP IT) team at pcdt@nhsx.nhs.uk
- 1.8.2 For further information about the DSP Toolkit please visit [DSP Toolkit help](#) contact cybersecurity@nhs.net

2 Protocol in respect of locum cover or GP performer payments for parental and sickness leave

2.1 Background

- 2.1.1 The General Medical Services Contracts Statement of Financial Entitlement Directions 2013¹⁴ (SFE) as amended in the SFE (amendment) Directions 2017-20 set out the provisions, conditions and payments relating to reimbursement to GP practices for GP performers covering parental leave and sickness leave.
- 2.1.2 This protocol applies only to GMS practices but commissioners should ensure they treat Primary Medical Services (PMS) practices equitably.
- 2.1.3 For the purposes of this protocol:
- “parental leave” means ordinary or additional maternity leave, paternity leave, ordinary or additional adoption leave, or shared parental leave
 - “full-time” means nine sessions of clinical work per working week;
 - “working week” is defined as the core hours set out in the National Health Service (GMS Contracts) Regulations¹⁵: “the period beginning at 8:00 am and ending at 6.30 pm on any day from Monday to Friday except Good Friday, Christmas Day or bank holidays”.
- 2.1.4 The commissioner will not make payments in respect of locum or GP performer cover outside of core hours.

2.2 Parental and sickness leave payments

- 2.2.1 GP practices are entitled to claim reimbursement of the cost for providing GP performer cover when a GP performer is on parental leave or on sickness leave¹⁶.
- 2.2.2 The reimbursement of costs can be claimed where the cover is provided by:
- a locum
 - a salaried GP on a fixed term contract

¹⁴ <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

¹⁵ <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

¹⁶ Providing the provisions of paragraphs 15.3, 15.4, 16.3 and 16.4 of the SFE are met

- a GP already working in the practice but who is not full-time (either employed or a partner)

2.2.3 Payments will not be made on a pro-rata basis having regard to the absent performer's working pattern, and will be the lower of actual invoiced costs or maximum amount.

2.2.4 The SFE sets out the maximum amount of reimbursement for a GP performer providing cover as follows¹⁷.

2.3 Parental leave

2.3.1 In respect of maternity leave or adoption leave where the GP performer going on leave is the main care provider, or shared parental leave, the maximum amount payable is £1,143.06 per week for each of the first two weeks and then £1,751.52 per week for each of weeks 3 to 26¹⁸.

2.3.2 Commissioners should reimburse shared parental leave²¹ in the same way as maternity leave. It will be for the practice to demonstrate that a GP performer is eligible for shared parental leave¹⁹ and ²¹ either under statute (for salaried GPs) or under the terms of a partnership agreement. A sample declaration of eligibility is at Annex B.

2.3.3 In respect of paternity leave or special leave (which is equivalent to the terms and duration of paternity leave) where the GP performer going on leave is not the main care provider, the maximum amount payable is £1,143.06 per week for each of the first two weeks.

2.4 Sickness leave

¹⁷ These are the agreed maximum figures from April 2018 and in force as of October 2020. Any further uplifts will be detailed in amendments to the SFE.

¹⁸ The SFE sets out at 15.5 payment will be the lower of the weekly maximum or actual, invoiced costs

¹⁹ Information on eligibility for shared parental leave: <https://www.gov.uk/shared-parental-leave-and-pay>

- 2.4.1 In respect of sickness leave, for each period of sickness leave, there is a qualifying period of two weeks during which time no payments are made.
- 2.4.2 After two weeks, payments start and the maximum amount payable is £1,751.52 per week for each of weeks 3 to 28. Thereafter, the maximum amount payable is £875.76 per week for each of weeks 29 to 54²⁰.
- 2.4.3 As set out in the SFE, for weeks 29 to 54 the commissioner will pay half of whatever it determined was payable for weeks 3 to 28. The SFE also sets out a methodology for calculating these periods with respect to any payments made in the previous 52 weeks and that methodology continues to apply.

2.5 Sickness leave and phased return to work

- 2.5.1 Commissioners support the safe return to work of GP performers and recognise that GP practices exercise flexibility in managing sickness absence (where GP performers under a Fit Note are declared they may be fit to work, subject to advice and agreement on phased return or adjusted hours). The Fit Note in such cases is continuing to declare sickness absence for the period, subject to and excluding any agreed working arrangements. For example, if a GP performer is advised they may be fit to work 2 days out of 5 for two weeks – then the other 3 days in each week for that period remain as sickness absence.
- 2.5.2 Payment in respect of necessary cover for this sickness absence under a Fit Note advising phased return or adjusted hours may however be mandatory or discretionary, subject to the requirements of the SFE being met.
- 2.5.3 In respect of GP performer who is a partner, the SFE makes no distinction on sickness leave, meaning paragraph 16.3 of the SFE applies whether a GP partner is under a Fit Note declaring they are unfit to work, or may be fit to work subject to advice given on phased return or adjusted hours. Mandatory provision for payment therefore applies and commissioners should continue to reimburse locum cover covers costs as per paragraph 11 above.

²⁰ The SFE sets out at 16.5 payment will be the lower of the weekly maximum or actual, invoiced costs

- 2.5.4 In respect of GP performer who is an employee, the SFE applies further requirements at paragraph 16.3 to qualify for payment – which is that the contractor is required to pay the GP performer Statutory Sick Pay (SSP) or their full salary during sickness leave under their contract of employment.
- 2.5.5 A phased return or adjusted hours arrangement may interfere with a contractor meeting these requirements – SSP is subject to forming a period of incapacity to work of 4 consecutive days. Where these requirements are not met, payment to reimburse any locum cover costs would be discretionary (see section 2.8).
- 2.5.6 Where these requirements continue to be met under a phased or adjusted hours arrangement commissioners should continue to reimburse locum cover costs as per paragraph 2.4.1 above.

2.6 Further discretionary payments

- 2.6.1 This protocol details (as required under paragraph 25.16 of the SFE) a number of policies the commissioner is obliged to set out:
- how the commissioner is likely to exercise its discretionary powers to make payments (including top-up payments) in respect of locum cover for parental or sickness leave, where it is not obliged to make such payments;
 - where the commissioner is obliged to make payments in respect of cover for parental or sickness leave pursuant to Part 4 of the SFE, the circumstances in which it is likely to make payments of less than the maximum amount payable;
 - how the commissioner is likely to exercise its discretionary powers to make payments in respect of cover for absent GP performers, which is provided by nurses or other health care professionals;
 - how the commissioner is likely to exercise its discretionary powers to make payments to a partner or employee who is providing locum cover
 - how the commissioner is likely to use its discretionary powers to make payments in respect of long term sickness leave exceeding 52 weeks.

2.7 Discretionary powers in respect of cover for parental and sickness leave

2.7.1 The commissioner has the discretion to make payments in circumstances where it is not obliged to under the terms of the SFE, including top-up payments above the level of the agreed weekly maximum.

2.7.2 The commissioner may exercise these discretionary powers to make payments **only** in exceptional circumstances, for example (but not limited to) consideration of:

- demonstrable financial hardship
- areas of significant deprivation
- GP recruitment difficulties
- applications from single-handed GPs
- applications from nurse-led PMS practices

2.7.3 Where practices plan to apply for reimbursement in such circumstances they should always ensure they have written agreement from the commissioner prior to arranging cover.

2.8 Discretionary payments in respect of cover for employed GP performers on phased return or adjusted hours arrangement following sickness absence

2.8.1 The commissioner has the discretion to make payments where employed GP performers are returning to work under a phased return or adjusted hour's arrangement following sickness absence.

2.8.2 The commissioner will make payments in the following circumstances:

- the employed GP performer's phased return or adjusted hours arrangement follows directly sickness absence leave which attracted a locum payment under Section 16 of the SFE
- where the phased return or adjusted hours arrangement has been advised under a Fit Note (and for the period only that Fit Note covers or advises).
- where the contractor is paying the employed GP performer their full salary in respect of their phased return or adjusted hours arrangement i.e. taking account of both working and sickness absence days/sessions.

2.8.3 In these circumstances the commissioner will pay the lower of actual invoiced costs or maximum amounts payable calculated in line with paragraph 2.4.1.

2.9 Circumstances where it is likely payments will be less than the maximum amount payable

2.9.1 The commissioner will pay the maximum amount payable except in the following circumstances:

- Where actual invoiced costs are less than the maximum amount payable, then the commissioner will pay the actual invoiced costs subject to the provisions of this protocol including the bullet points below
- With respect to parental leave, where the commissioner agrees to make payments for any week between weeks 27 to 52 for cover for additional maternity leave or adoption leave, the commissioner will pay the lower of either 50 per cent of the weekly rate it paid for weeks 3 to 26 or 50 per cent of the actual invoiced costs.

2.10 Payments for locum cover provided by nurses or other healthcare professionals

2.10.1 The commissioner will not pay for cover provided by nurses or other healthcare professionals.

2.11 Payments to a partner or employee who is providing cover

2.11.1 Where a contractor wishes to engage the services of a partner or shareholder in, or an employee of, that contractor, payments will be made to the GP practice in accordance with the normal provisions set out above. However, the GP performer providing cover would only be permitted to work up to the full-time limit of nine clinical sessions per working week. The maximum of nine clinical sessions per working week is to include any existing/normal commitments by the GP performer providing the cover.

2.12 Discretionary payments in respect of long term sickness leave exceeding 52 weeks

2.12.1 Where a GP performer is on long term sickness leave, and locum payments are no longer payable under Section 16 of the SFE, it will be at the commissioner's discretion whether to continue to make payments.

2.12.2 In any case, those payments will not exceed the half rate payable in the second period of 26 weeks under paragraph 16.6(b) of the SFE, or the amount that would be payable under the NHS Pension Scheme Regulations if the performer retired on ground of permanent incapacity, whichever is the lower

2.13 Claims and payments

2.13.1 For parental leave, payments start from the day the GP performer goes on parental leave for the periods set out above and payment weeks are five working days.

2.13.2 For sickness leave, payments start two weeks from the day the GP performer goes on sick leave for the periods set out above and payment weeks are also five working days.

2.13.3 A sample claim form is at Annex A.

2.14 Annexes

Annex A

Sample claim form**Claim for additional payments during parental or sickness leave**

Please complete this form and send it to [NAME OF COMMISSIONER].

If circumstances should change after your application has been submitted, please complete a new form and forward it to [NAME] as soon as possible, before submitting a claim for payment.

Practice's Details

Practice name:

Practice address:

.....

..... Post code:

Telephone number:

Description of why additional payment is being sought

.....

Details of GP performer taking leave

Surname: First Name:

Claim period: Number of weeks²¹:

Number of clinical sessions worked.....

Reason for claim (*delete as appropriate*): MATERNITY / PATERNITY / ADOPTION /
SICKNESS

²¹ Weeks are defined as five working days

Declaration of GP performer taking leave

I certify that:
(Full name in capitals)

The information shown on the reverse side of this form provides an explanation of how the practice intends to cover my period of absence.

Where necessary, I have already submitted (*please tick the box that applies*):

- a. a certificate of confinement, a confirmation letter of prospective fatherhood or a letter confirming adoption leave from the appropriate adoption agency, in support of this claim ☐
- b. a sick note from my GP stating the reason and expected length of absence ☐

I declare that the information provided in this claim is correct and complete. I agree to provide NHS England with written records demonstrating the actual cost of the cover and will inform NHS England if there is any change to the cover arrangements. I claim the appropriate payment for the practice.

Signature: Date:
(An authorised signatory who is prepared to take responsibility for this declaration may sign here on behalf of the GP performer taking leave if he/she is not available to do so.)

Arrangements to cover GP performer absence

Please provide a brief explanation of how cover will be provided.
(i.e. will this be via a locum, GPs already working in the practice, fixed-term salaried GP or a combination)

.....
.....

.....
.....
.....

Details of external GPs covering absence

If employing an external locum GP to cover the GP performer's absence, then please complete the information below (add more lines if required).

1. Name and surname:

Period of cover: (No. of weeks:)

Number of clinical sessions worked.....

Amount paid to individual: £.....

2. Name and surname:

Period of cover: (No. of weeks:)

Number of clinical sessions worked.....

Amount paid to individual: £.....

3. Name and surname:

Period of cover: (No. of weeks:)

Number of clinical sessions worked.....

Amount paid to individual: £.....

Details of internal GPs covering absence

If employing an external locum GP or a fixed-term salaried GP to cover the GP performer's absence, then please complete the information below (add more lines if required).

4. Name and surname:

Period of cover: (No. of weeks:)

Number of clinical sessions worked.....

Amount paid to individual: £.....

Please provide invoices in support of this claim.

Notification of intention to take SPL– sample form

SECTION A: General (must be completed)	
Please accept this as notification that I (the main carer's partner) am entitled to and intend to take SPL ²⁶ (and ShPP if section C is completed).	
Partner's Surname	
Partner's First name(s)	
Main carer's surname	
Main carer's first name(s)	
Main carer's Address	
Main carer's National Insurance number (State 'none' if no number is held)	
Child's expected date of birth	
Actual date of child's birth (if child not yet born I will provide this information as soon as reasonably practicable following birth and before I take any SPL ²⁶)	
SECTION B: Main carer entitlement details (all answers that apply must be completed)	
Date main carer started (or intends to start) leave (if applicable)	
Date main carer's leave ended (or will end) (if applicable)	
Total number of weeks of leave taken (or that will be taken) when main carer's leave ends	
Date main carer started (or intends to start) SMP or MA (if applicable)	
Date main carer's SMP or MA ended (or will end) (if applicable)	
Total number of weeks SMP or MA has been paid or will have been paid at date of curtailment	
Total number of weeks by which SMP or MA will be reduced (i.e. 39 weeks minus total number of weeks SMP or MA has been paid or will have been paid at date of curtailment)	

SECTION C: Amount of SPL²⁶ available (must be completed)
--

<p>The total number of weeks of SPL²⁶ created depends on the main carer's leave and pay entitlements:</p> <ul style="list-style-type: none"> • If the main carer was/is entitled to maternity leave and SMP/MA, the total created will be 52 weeks less any weeks leave taken • If the main carer was/is entitled to maternity leave but not to SMP or MA, the total created will be 52 weeks less any weeks maternity leave taken • If the main carer was/is not entitled to maternity leave but was entitled to SMP/MA, the total created will be 52 weeks less any weeks of SMP/MA that was paid • If the main carer previously revoked curtailment notice any SPL²⁶ that was taken by the partner must be deducted 	
Total number of weeks of SPL ²⁶ created (50 max)	
Total number of weeks of SPL ²⁶ I (the partner) intend to take	
Total number of weeks of SPL ²⁶ the main carer intends to take (if applicable)	
SECTION D: Indication of Partner's leave intentions (must be completed but is not binding)	
<p>I (the partner) currently expect to take SPL²⁶ as follows:</p> <p>Note: It will usually be helpful to answer this in a "From... To..." format</p>	
SECTION E: Amount of ShPP available (only complete if claiming ShPP)	
Total number of weeks of ShPP created (39 weeks less total number of SMP/MA taken and any ShPP paid from a previous notice and revocation)	
Total number of weeks of ShPP I (the partner) intend to take:	
Total number of weeks of ShPP main carer intends to take:	
<p>I (the partner) currently expect to take ShPP as follows:</p> <p>Note: It will usually be helpful to answer this in a "From... To..." format</p>	

²⁶ Shared Parental Leave only applicable within this protocol 01st APRIL 2019

SECTION F: Partner's declaration (must be completed)**The following points apply in all circumstances:**

- I am giving notice that I am entitled to and intend to take SPL²⁶
- I am the father of the child, or at the time of the birth I was/will be the main carer's spouse, the main carer's civil partner and/or the main carer's partner living with her/him and the child in an enduring relationship
- I have been (or will be) continuously employed for 26 weeks at the end of the 15th week before the week in which the child is due
- I will remain employed with this employer until any period of SPL²⁶ that I intend to take
- I had (or will have) the main responsibility for the care of our child at the time of the child's birth (along with the main carer who has made the declaration below)
- I will give my employer a copy of my child's birth certificate or a declaration of the date and place of the birth where no certificate is available if my employer asks for this within 14 days of the date of this notice
- I will give my employer the name and address of the main carer's employer or a declaration that (s)he does not have an employer if my employer asks for this within 14 days of the date of this notice
- I will inform my employer immediately if I am no longer caring for our child or if my partner revokes her notice to curtail her maternity leave or SMP/maternity allowance period
- I (or my partner) have given a period of SPL²⁶ notice
- The information provided in this declaration is accurate and meets the notification requirements for SPL²⁶

The following points only apply if Section E has been completed:

- I am giving notice that I am entitled to and intend to take ShPP
- I have been (or will be) paid at least the Lower Earnings Limit in the 8 weeks leading up to the end of the 15th week before the expected week of childbirth
- I intend to care for my child in the weeks I receive ShPP
- I will be absent from work in each week in which I will be paid ShPP and I will be on SPL²⁶ in those weeks (if entitled to SPL²⁶)
- I will remain employed with this employer until before the date of my first period of ShPP
- The information provided in this declaration is correct

Signature of partner

Date partner signed

²⁶ Shared Parental Leave only applicable within this protocol 01st APRIL 2019

SECTION G: Main carer's declaration (must be completed)**The following points apply in all circumstances:**

- I had (or will have) the main responsibility for the care of the child at the time of the birth (along with my partner who has made the declaration above)
- I am entitled to maternity leave and/or SMP or MA in respect of the child and I have curtailed (or will curtail) my entitlement to maternity leave (or I have returned to work) and/or my entitlement to SMP or MA.
- I have, or will have, been employed or self-employed in England, Scotland or Wales in 26 weeks of the 66 weeks before the expected week of childbirth
- I have (or will have) earned in total at least £390 in 13 weeks of the 66 weeks before the expected week of birth
- I will immediately inform my partner if I revoke my notice to curtail my leave or, if I am not entitled to leave, my SMP or MA entitlement
- I consent to my partner's intended SPL²⁶ as set out in Section D above
- I consent to my partner's employer processing the information I have provided
- The information provided in this declaration is accurate and meets the notification requirements for SPL²⁶

The following points only apply if Section E has been completed:

- I am entitled to SMP or MA, and I have reduced (or will reduce) the SMP or MA period and the remainder will be available as ShPP
- I consent to my partner's intended ShPP as set out in Section E above
- I will immediately inform my partner if I revoke the reduction of my SMP or MA
- I consent to the person who will pay ShPP to my partner or the child's father processing the information I have provided
- The information provided in this declaration is correct

Signature of main carer

Date main carer signed

Main carer declaration (if applicable)

If main carer is also a GP provider – name of GP practice

Period of locum reimbursement claimed by main carer

²⁶ Shared Parental Leave only applicable within this protocol 01st APRIL 2019

Frequently asked questions

General

1. Who can provide cover – and can practices claim reimbursement?

Practices can choose to organise cover through the use of a locum, a salaried GP on a fixed-term contract, or from a GP already working in the practice. Commissioners will make payments on the same basis, for both sickness leave and parental leave reimbursement.

2. Are all locum costs reimbursable?

Commissioners will reimburse practices for clinical sessions provided by GPs but not for expenses such as car parking fees, or lunch. Clinical sessions may include face to face appointments, telephone consultations, on call and home visits.

3. Are there any restrictions where a GP already working in the practice provides the cover?

Yes. The GP(s) providing the cover must not be already working full time and can only provide cover to bring their weekly commitment up to full time.

4. Can practices claim reimbursement when salaried GPs are taking parental leave or sickness leave?

Yes. As long as the salaried GP is entitled to that leave of absence (either by law, as part of a partnership agreement or under their contract, as set out in the SFE), the commissioner will reimburse practices on the same basis as it would do for absent contractor GPs.

5. Does GDPR prevent practices sharing information about GPs with commissioners?

The only information required for the validation of practice claims is requested, in accordance with Paragraph 15.7 and 16.10 of the SFE. Practices should be assured that sharing this information will not breach GDPR. Data will be stored in accordance with information governance protocols.

Sickness leave

6. Does the two-week qualifying period count to each instance of sickness leave before reimbursement payments can be made?

Yes. For each instance of sickness leave, the payments will only start once the period of sickness is two or more weeks. It is important to note that during the first two weeks

of each instance of sickness leave, no payment is made and as such payments start from week three of the absence.

7. For how long will reimbursement payments be made?

Reimbursement payments will only apply from week three of each instance of absence. From week three, the payments will then be the lower of actual invoiced costs or weekly maximum amount for 26 weeks, followed by half of that amount for the next 26 weeks.

The rolling aggregate period for counting leaves previously taken in order to determine what payment is due remains at 52 weeks.

8. What are the implications for practices – can they now cancel their sickness insurance?

These changes are intended to support practices in better managing the financial and workload implications of long-term sickness leave. NHS England cannot offer specific advice on managing insurance cover as this is a business decision for the individual practice.

However, practices should note that the following conditions apply:

- there are no payments at all for the first two weeks on each occasion that a GP is absent;
- the continuous two-week qualification period applies to every absence and does not 'carry over';
- these reimbursement payments only cover GPs, not other practice staff;
- they only cover core hours;

9. Is the practice entitled to locum reimbursement if the GP on sickness leave has private health insurance?

Yes. The commissioner will not take into account GP's private health insurance payments in respect of the amount they pay to practices.

10. Is the practice entitled to locum reimbursement if the practice has insurance cover?

Yes. The commissioner will not take into account GP Practice insurance payments in respect of the reimbursable amount for locum claims.

11. Are there any long-term medical conditions that would prevent the practice from receiving reimbursement?

There are no changes to the Statement of Financial Entitlements (SFE) with regard to what constitutes sickness leave.

12. What is a phased return to work?

A phased return to work is an arrangement whereby an individual who has been away from work on sick leave returns to their full duties and working pattern gradually, over a defined period of time.. Specific details will depend on medical circumstances and agreement between the individual and their employer/place of work.

13.Does NHS England support practices to allow GPs this opportunity?

Yes. Individuals do not always need to be fully recovered to go back to work, and in fact, it can often help recovery to return to work. This is why the Fit Note allows doctors to make such recommendations and why this protocol outlines how commissioners should facilitate a safe return to work in these circumstances.

Below are some worked examples of how the changes will apply

- GP B is absent **3 April 2018 – 13 April 2018** – less than two weeks so no payment.
- GP C is absent **3 April 2018 – 26 April 2018** – two-week qualification period, then practice is eligible to apply for lower of actual invoiced costs or weekly maximum for the period 17-26 April.
- GP D is absent **10 July 2018 – 19 July 2018**, then **25 July 2018 – 25 August 2018** – the first instance of absence is less than two continuous weeks so does not count towards payments. The second instance of absence is longer than two continuous weeks and therefore, the practice is eligible to apply for the lower of actual invoiced costs or weekly maximum for the period 8-25 August, after the two-week qualifying period for that instance of absence.
- GP E is absent **1 May 2018 – 1 January 2019** – two-week qualification period so practice is eligible to apply for the lower of actual invoiced costs or weekly maximum for 25 weeks, from 15 May – 6 November. From then until 1 January the practice will be eligible for half of whatever was paid in the first period.

Worked examples relating to phased return or adjusted hours arrangements

- GP partner F is absent **3 April–26 April** – two-week qualification period, then practice is entitled to reimbursement for the lower of actual invoiced costs or weekly maximum for the period 17-26 April.

After 26 April the GP partner returns to work but with a Fit Note stating that he/she can work three of his/her regular six weekly sessions for the first four weeks. So, the practice is entitled to reimbursement for three sessions per week for those four weeks.

- Salaried GP G is absent **1 October–30 November** – two-week qualification period, so the practice is entitled to reimbursement for the lower of actual invoiced costs or weekly maximum for the period 15 October – 30 November.

After 30 November, the salaried GP returns to work but with a Fit Note stating that he/she can work four of his/her regular seven sessions for the first two weeks, but must work Monday, Wednesday and Friday so that he/she is not working consecutive days.

He/She will not qualify for statutory sick pay during this time (because he/she is not off work for four consecutive days), and will not be paid his/her full salary, so the practice is not *automatically* entitled to reimbursement for the cost of cover.

However, the practice may claim reimbursement and, if the salaried GP is being fully paid for the sessions he/she does work, the commissioner should use its discretion to reimburse the practice. So, the practice should be reimbursed for three sessions per week for two weeks.

- GP performer H (salaried or partner) C is absent **9 January- 6 February** – two-week qualification period, so the practice is entitled to reimbursement for the lower of actual invoiced costs or weekly maximum for the period 23 January – 6 February.

After 6 February, the GP performer returns to work and suggests working four of their regular seven sessions for the first week.

The practice may not claim reimbursement as the phased return is not subject to a Fit Note recommendation and has been agreed at the employers/place of work's discretion.

3 Guidance Note: GP Practices serving Atypical Populations

3.1 Introduction

3.1.1 Purpose of this document

- 3.1.2 The General Medical Services (GMS) funding formula (Carr-Hill formula) is an attempt to fund practice workload, regardless of the population they serve. It applies to the vast majority of the UK, but there are some practice populations that are so significantly atypical that using the GMS funding formula would not ensure the delivery of an adequate general practice service. This working group has looked at three such atypical populations: unavoidably small and isolated; university practices and; those with a high ratio of patients who do not speak English.
- 3.1.3 Support for practices should directly impact on patient care as well as the long term viability of practices, and therefore commissioners are encouraged to undertake a review of identified practices in their area. By reviewing the practices in your area, commissioners and providers can identify practices that require such support. Without this support, many practices will be unable to maintain the service and as a result, health outcomes may suffer.

3.1.4 Background to this work

- 3.1.5 Whilst the vast majority of GP practices serve communities that have common characteristics and work to contracts that have similar terms, conditions and funding arrangements, a small cohort of practices provide services to a patient population which is sufficiently demographically different to result in particular workload challenges that are not always recognised in the practice's existing contract/s or its funding allocation. A population that triggers 'uncommon' workload challenges that are not experienced by the majority of GP practices is referred to here as 'atypical'.
- 3.1.6 This document was produced to assist NHS England and delegated Clinical Commissioning Group (CCG) commissioners of 3 such atypical 'populations' by detailing the particular challenges faced by providers and offering examples of either provider or commissioner reports that may help either articulate or address these pressures. How members of the public relate to and use GP services is

influenced by the accessibility of other services including, for example, pharmacy, A & E, Walk-In Centres and voluntary agency support infrastructure.

3.1.7 The populations are:

- Unavoidably small and isolated
- University populations and
- Practices with a significantly high ratio of patients who do not speak English including those services designed to address the needs of migrants.²²

3.1.8 This document guides commissioners to the types of issues and data sources they could consider in coming to a judgement about the support that is relevant to their particular circumstance, where commissioners and individual practices have a shared concern about meeting the health needs of their patients.

3.1.9 This document outlines the additional needs of these patient groups, the pressures that providers face and the duty on commissioners to secure quality services which may legitimately require consideration of additional funding support.

3.1.10 In reading this document, commissioners and providers should be aware that services should be equitable for all population groups in line with the Public Sector Equality Duty (PSED) under the Equality Act 2010 and have regard to reduce health inequalities under the Health and Social Care Act 2012.

3.1.11 Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

²² For the central Primary Care Commissioning Team, the project files include further [background to developing this guidance](#)'.

3.1.12 In addition, this guidance is designed to complement but not duplicate or replace other related support initiatives. As such it does not advocate any one service model over another, specify or advocate specific funding arrangements, specify financial arrangements for managing the workload associated with Temporary Residents or describe how to distribute the national programme funds²³ supporting struggling practices to improve their sustainability and resilience over the short/medium term.

3.1.13 Call for evidence

3.1.14 Where available, this document also describes some examples of innovative practice to overcome challenges associated with serving the atypical populations. Hyperlinks to further information are included in this document where available.

3.1.14.1 If commissioners have further examples of local initiatives to address issues associated with 'atypical practices' please submit them to england.primarycareops@nhs.net with the heading 'Atypical Populations: Call for evidence'. Suitable case studies will be published on The Learning Environment website as a resource for commissioners and providers.

3.1.15 To complement these case studies NHS England will consider the viability of commissioning a more detailed investigation into these cohorts of patients to properly understand the difference in workload and related pressures not recognised in the funding formula.

3.2 Context: General Medical Services (GMS) Funding Formula Review

3.2.1 Commitments to reviewing primary care funding

²³ General Practice Resilience Programme £8m per annum)

NHS England has committed to reviewing the GMS funding formula which underpins the capitation payments made to GP practices under the General Medical Services (GMS) contract. This commitment was confirmed in the General Practice Forward View. We are working with the BMA's General Practitioners Committee, NHS Employers, the Department of Health and Social Care and academic partners on the review to develop a formula that better reflects factors that drive workload, such as age or deprivation.

3.2.2 Existing GMS funding formula (introduced in 2004)

3.2.3 The intention of the formula was to weight remuneration to reflect the comparative practice workload, complexity and the relative costs of service delivery based on the demographics of the patient list. As such the formula has two parts:

- a. A workload part that provides an estimate of the workload for each GP practice based on its list size and various patient and practice characteristics; and
- b. A cost part that adjusts the payment for workload for variation in costs experienced by practices in different places.

3.2.4 The workload part is also used to inform the primary medical services component of the primary care allocation formula. It is recognised that due to the wide diversity of populations serviced by GP practices, a national formula will never be able to accommodate the workload needs of all practices, hence the need for guidance on atypical practices.

3.2.5 What does the GMS funding formula not achieve?

3.2.6 It has been suggested that the GMS funding formula could be improved upon in a number of ways:

- The data that make up the formula requires updating (some of the data are more than ten years out-of-date)
- Factors currently included do not adequately reflect the workload associated with older people who may not be living in nursing or residential care and have a range of complex co-morbidities
- The impact of deprivation has been questioned and all the weightings will need to be reviewed.

3.2.7 It is acknowledged that no formula will address the particular characteristics of 'atypical' populations hence this guidance.

3.3 Background to developing this document

- 3.3.1 A joint workshop between NHS England, the British Medical Association's (BMA) GPs' committee, Local Medical Committee (LMC) representatives and NHS Employers was convened in September 2015 to:
- Provide a list of propositions on atypical practices and views on whether these could or could not be reflected in a formula
 - Identify those characteristics that will never be fully met by a formula, and
 - Aid a description about the characteristics of a practice where it is likely that some additional support is required due to the practice characteristics not being fully recognised by any formula approach.
- 3.3.2 The information used at that workshop has been used as the basis for this paper focusing on 3 specific cohorts, agreed with the BMA's GPs' committee:
- Unavoidably small and isolated (from other practices and other NHS services) with static populations
 - University practices
 - Practices with a significantly high ratio of patients who do not speak English including those designed to address the needs of migrants (asylum seekers are excluded from the scope of this work as it is recognised this group requires a more specialised service).
- 3.3.3 These populations were chosen as priority areas because:
- Small and isolated practices have particular challenges when meeting demand from dispersed rural communities. Opportunities to develop primary care working 'at scale' are more limited and population growth is slower, impacting on the available primary care budget
 - Anecdotal evidence tells us that university practices (in particular campus-based services) have a population that consults general practice more than expected for their age and health (e.g. in terms of mental health and sexual health issues)
 - Practices supporting a significant number of patients that do not speak English have operational complications associated with communication problems (this also links to a separate NHS England work stream on translation and interpretation).
- 3.3.4 A working group was convened in Spring 2016, comprising NHS England and Clinical Commissioning Group (CCG) commissioners, LMC representatives, a BMA representative and a Royal College of General Practitioners (RCGP) representative.
- 3.3.5 The working group was chaired and administered by NHS England.

3.4 Identifying 'Atypical' populations locally

3.4.1 Because of the degree of variation nationally in terms of health and social care economies and patient expectation, demand and behaviour, there is no one method of identifying which populations could be considered as atypical. There are however a number of examples of how commissioners have scoped the issues and what data sources they have used (an example from Devon can be found on The Learning Environment's case studies pin board).

3.5 Unavoidably small and isolated

3.5.1 Description of the Issues

- Practices serving small but dispersed populations have limited ways in which to influence their income or costs yet provide a vital primary care service
- Their funding is governed by their registered list (global sum / QOF payments) which, by the nature of their geography, cannot be expanded and may compromise the ability to deliver quality care and exacerbate workload pressures
- Because of their location they are often serviced by small B class roads, potentially making travel difficult and time consuming for patients and service providers
- Many such communities do not have easy access to a pharmacy or an A&E Department, ambulance access and response times can be longer than in an urban environment and community services are diluted
- Public transport makes it difficult for patients to attend outpatient departments and other health facilities. As a result, some patients tend to rely on practices to provide a wider range of services than is normally regarded as 'core' general practice and staff require regular training to maintain their skills for providing first response in the absence of A&E. It may be hard to measure this effect but it can be summarised as a greater independence by patients from hospital care and a higher level of intervention and support from the practice

- Engagement of GP locums or recruitment of successors to a contract can be problematic because of geographic isolation, income and potential workload pressures. It is recognised that country or island life is not everyone's preference
- Housing costs associated with 'desirable' or expensive country or island locations can also negatively impact on recruitment of practice administrative staff
- Some rural locations attract itinerant workers who may not speak English, have no accessible medical record and consultations take longer.

3.5.2 Information / data considerations

3.5.3 Here are some data sources or information that you may wish to consider when trying to define if a population is atypical:

- The average population density and the average distance from patient residences are both available for individual practices and, when considered in conjunction, may produce some useful insights. It should be noted that population density is measured in persons per hectare (calculated from the population density of the relevant electoral ward) and distance to main surgery is measured in 100 metre units (as the average distance from patient's home to main surgery location). It may be useful to consider practices that rank in the top percentiles for both indicators, to help in reaching a judgement about relative rurality and isolation. These data are available as an extract from the Exeter system
- Ambulance response times (available from the local Ambulance Trust on request by the lead commissioning CCG in your area)
- Current Service profile: does the practice provide additional or extra services that are not commonly available in other practices and not additionally funded. Could these be captured in a bespoke enhanced service, set of KPIs or added formally into a PMS agreement? Examples may relate to the absence of locally accessible health and social care services.
- Data sources that you could use to compare practices in your area include:
 - [General Practice Expenses, GMS and PMS Contracts in England 2013/14](#) (NHS Digital, published July 2016)³
 - [Adjusting the General Medical Services Allocation Formula for the unavoidable effects of geographically-dispersed populations on practice sizes and locations](#) (Deloitte, published 2006) ⁴

- [NHS Payments to General Practice, England, 2017/18 \(NHS Digital, published Dec 2018\).](#)

3.5.4 Case studies

3.5.5 The case studies listed below are not an exhaustive list. Commissioners and providers can review these case studies, tailor them to their local area as required, and/or decide on other support arrangements that might be appropriate:

- Contract for primary care support to secondary care (e.g. pre-operative assessments, post-operative wound checks and suture removal)
- The '[My Life A Full Life](#)' programme is a collaboration between NHS Isle of Wight Clinical Commissioning Group, Isle of Wight NHS Trust, Isle of Wight Council, Community Action Isle of Wight and other local voluntary sector organisations. It aims to change the face of social and health care on the Island, helping people live life to the full. Objectives are to achieve a more co-ordinated approach to the delivery of health and social care services for older people and people with long term conditions
- First Responders such as [Rural Responders in Suffolk](#), supporting East of England Ambulance NHS Trust and Community First Responders supporting [South Western Ambulance Service](#)
- [Dorset Community Action's Navigator Pilot](#) was a collaboration with Dorset CCG as part of the [Better Together](#) programme. The pilot aimed to improve the integration of care to provide more efficient use of resources and improve patients' experience by supporting practitioners to refer patients to support services. Its key aims were to:
 - Manage long term conditions, especially those amongst the increasingly large cohort of older people living in, and migrating to, Dorset

- Reducing the demand (need) for high cost care (acute hospital interventions, and long term residential and nursing care)
- Enabling much more care to be delivered locally and enabling people to live independently for as long as possible

Village Agent schemes or Link schemes:

- [Somerset](#): [Work](#) with all ages. A number of clients are elderly and involve social care issues. Village Agents also have the role of helping to shape services by feeding back to the appropriate body information about gaps in service e.g. transport provision. They can also motivate and support a community to respond to a local need by working together to address issues e.g. by helping them to set up a coffee morning for a group of lonely people or start a volunteer car scheme. A Village Agents pilot project is using the social prescribing model, taking referrals from GPs and assisting with care planning for patients. A second pilot is taking referrals from social workers at the area's Adult Social Care Hubs
- [Bedfordshire](#): [Supported](#) 950 clients over the financial year (with an average of three visits per client) delivering a range of outcomes that included accessing health and housing services, getting home adaptations, obtaining mobility aids, take-up of benefits and tackling isolation through transport
- [Gloucestershire](#): [The](#) Village Agents support older people living in the area. Reports on their projects are [here](#) and case studies can be found [here](#). Polish speaking agents are employed to support the local Polish community
- [Wiltshire](#): [The](#) Link Schemes are community-based initiatives that aim to improve the quality of life for disadvantaged, elderly or infirm people by providing a structured good neighbour service delivered by volunteers from

within the local community. The range of Link Scheme services varies from providing volunteer drivers to take someone to a medical appointment, taking them shopping or to visit an old friend, or

- simply providing good neighbour care. They aim to complement the provision of other services, whether statutory or voluntary.

³ The report finds that there is no reduction in expenses per patient as practices grow. The data are basic and commissioners may want to consider the point below which a list size is too small for a WTE GP.

⁴ This document's value might be limited as it is 10 years old and the data cannot be refreshed as the datasets are not available.

3.5.6 Patient Group Observations

3.5.7 Support services provided by volunteers and community groups act as a link between statutory services and the local community (some examples are listed in the [Case Studies](#) section above). They are well-placed to work across various isolated groups and share good practice as needed. Services such as those in Dorset (Dorset Community Action's Navigator pilot as part of the [Better Together](#) programme) and the Isle of Wight ([My Life A Full Life](#)) operate at a strategic level to bring providers and commissioners together to address issues and find solutions. The key challenge is that all these services need support from commissioners and funding in some way so that there is a whole system approach. This support is not free but can be tailored to meet the needs of statutory providers and help to fill gaps and is cost effective, flexible and resourceful in its approach.

Provided by Paul Dixon, Action with Communities in Rural England

3.5.8 [All Our Health](#) is a resource that helps front-line health and care staff use their trusted relationships with individuals, families and communities to take action on inclusion health.

3.6 University populations

3.6.1 6.1 Description of the Issues

3.6.2 Some practices serving university populations are not able to earn as much QOF funding due to the low prevalence of diseases. There is an assumption by some that service provision is less onerous due to low disease prevalence.

- Anecdotally, it is believed that:

Since many students are living independently for the first time, this can be a time when they experiment by engaging in behaviours that affect their health and need for service interventions e.g. around alcohol and drug use and sexual activity, leading to a higher than average demand for services related to these. In addition, for students who do not have access to immediate family support, there can consequently be a greater need for primary care services especially in respect of mental health support

- Students can present with minor ailments or with seemingly unfounded worries about their wellbeing. For those who have moved away from home and are living independently for the first time, it is important that they are provided with information about the range of primary care services available including pharmacy as well as online sources of support (i.e. supported to develop “health literacy”)

- A significant number of students with long term and complex health needs attend university (e.g. CF, transplants, MS, asthma, diabetes)

and transition to new primary care and secondary care arrangements, if they are leaving home, is important as is support for the transition to adult services which can take place during the university years.

- For foreign students, a lack of familiarity with the country and how health services work can create additional demand for GP practices to signpost

patients to more appropriate services or lead foreign students to go directly to A&E which leads to additional demand on CCG resources

- In addition, some foreign students may have greater health risks/needs (e.g. TB, hepatitis)
- Additional administrative effort required to register large numbers of new patients in September / October and de-register in the summer.

3.6.3 Information/Data considerations

3.6.4 Here are some data sources or information that you may wish to consider when trying to define if a population is atypical:

- Comparative consultation rates (if local data available)
- Prevalence of disease not covered by QOF, particularly mental health
- Per-patient weighted funding level provided by global sum
- Registration data in September – October to identify student registrations and de-registrations over the summer.

3.6.5 6.3 Support Initiatives

3.6.6 The case studies listed below are not an exhaustive list. Commissioners and providers can review these case studies, tailor them to their local area as required, and/or decided on other support arrangements that might be appropriate.

- [GP Champions for youth health project](#) - funded by the Department of Health and Social Care
- Promotion of online support tools for young people e.g. [NHS Go app](#)
- Using technology to reduce administration e.g. text message results service, online administration e.g. updating address)

[\(University Health Centre, Sheffield\)](#)

- Local QOF or Local Enhanced Service for specific needs of the population
- Skype consultations e.g. [Newham's young people with diabetes project](#)

- Shared care between 'home' and university-based health care services can help support adherence of and management of long term conditions for young people.

3.6.7 6.4 Patient Group Observations

- There is a risk that primary care practitioners expect young people to behave in a particular way. It is important that assumptions are not made about young people based on their age or that all university students behave the same way
- The issue that a young person may present with may not be the real reason they have attended. Young people need to feel confident to trust a clinician. Clinicians need to be skilled in recognising where there may be an underlying issue and give the young person the confidence to reveal it during a consultation
- Young people are undergoing a significant transition when they start university and having a trusted primary care practitioner to talk to can be extremely significant. They need to have information about the range of health services that exist so that they can be confident to seek help from primary care, pharmacy, A&E etc.
- Young people may wish to attend services with their peers. Practice staff should not be surprised if students attend in a group to support each other using health services, in the same way that younger children attend with a parent or carer. If a peer wishes to sit in on a consultation, clinicians should ensure that part of the consultation is with the patient alone – this would also be recommended for young people attending consultations with parents or carers
- There is a unique opportunity to increase university students' awareness of how to use health services appropriately which has long term benefits for the health service

- Young people with long term conditions need to access repeat prescriptions quickly when they move to university to avoid gaps in medication. Foreign students don't always recognise drug brand names and often do not understand how to access medication.

Provided by Emma Rigby, Association for Young People's Health

3.7 Practices with a high number of patients who do not speak English

Some practices have a high ratio of patients who do not speak English, including practices designed to address the needs of migrants.

Asylum Seekers: The working group had initially intended to include asylum seekers as part of the non-English speaking atypical group. However, it became clear that the needs of asylum seekers may go beyond primary "ordinary" care. There are often significant levels of Post-Traumatic Stress Disorder (a result of trafficking, torture, violence, rape (for women, children and men) and illness (e.g. HIV, Hepatitis B / C, TB)).

Note: A separate work stream to this Atypical Population work stream is ongoing in NHS England's Primary Care Commissioning Team on translation and interpreting services. Further information can be found [here](#). Another separate work stream to the Primary Care Team's translation and interpreting project is ongoing between the Race Equality Foundation and NHS England's Equalities Team to scope the viability of a community languages information standard.

3.7.1 7.1 Description of the Issues

- The need for an interpreter means that all conversations take longer and increases the cost of each patient contact (in relation to the time taken and the cost of interpreting)

- If interpreting is not available, miscommunication increases the risk of patients not attending follow up appointments and delayed access to care
- Surrounding support services (e.g. IAPT, obesity management) and literature are usually in English, thus necessitating the development of additional in-house support
- Lack of literacy, both in English and for some groups their native language removes the value of written material normally used to reinforce appropriate access (e.g. appointments) and health advice
- In addition, the lack of cultural understanding of the NHS requires extra support, signposting and often the recalibration of patient expectations
- Some patients have a basic lack of health education - for instance, no knowledge of terms that describes cholesterol or calories, or the importance of taking medication correctly.

3.7.2 7.2 Information/Data considerations

Here are some data sources or information that you may wish to consider when trying to define if a population is atypical:

- Evidence of languages spoken and percentage of list
- Percentage of patients requiring an interpreter (recognising that the level of support may decrease over time for some patients as they learn English)
- Consultation rates compared to the average and whether different language groups consult more, and what the reasons may be for this

- Reported average length of consultation
- Demand for interpreting (spoken word) and translation (written word) support services and growth in demand over time.

3.7.3 7.3 Examples of support

The examples cited below are not an exhaustive list. Commissioners and providers can consider these, tailor them to their local area as required and/or decide on other support arrangements that might be appropriate.

- Funding that recognises increased consultation times/access
- Education materials available in community languages
- Acknowledgement of costs associated with interpreting, either in contractual payments or a provided service (Local Enhanced Service)
- Public Health support for staff to help manage different needs of patients (e.g. hepatitis B vaccinations)
- Additional training for staff in public health messaging / realistic health interventions e.g. patient issues surrounding diet, behaviours and expectations of services
- Screening for patients new to the UK for communicable diseases
- Staff training on the use of interpreters particularly recognising where a patient is uncomfortable with the interpreter and knowing what action to take if staff question the quality of the interpreting service
- Bilingual receptionist or in-house interpreting.

3.7.4 7.4 Patient Group Observations

Professional interpreters are the preferred means of communication and may also have knowledge of medical language. In addition, family interpreting may not be appropriate where the procedures or consultations are of a sensitive or intimate subject. Family interpreters may have no, or limited, medical knowledge.

Provided by Samir Jeraj, Race Equality Foundation

3.8 Conclusion

We hope that this document will enable local commissioners to identify and support the practices that serve these populations in order that patients will continue to receive effective primary care. Further examples of case studies can be submitted to the Primary Care Commissioning Team by [e-mail](#).

3.9 Notes for NHS England commissioners

When discussing this topic locally, please be aware that you may need to review equalities and health inequalities and the 13Q duty to consult. Copies of supporting documents completed for this project are available in the project files. Please contact the Primary Care Commissioning Team for more details by e-mailing england.primarycareops@nhs.net ..

3.10 Scheduled update

This **chapter** is not scheduled to be updated. Further examples of local initiatives or case studies will be added to The Learning Environment website as they become available.