Policy Book for Primary Dental Services
Policy Book for Primary Dental Services

Version number: 3

First published: 12\textsuperscript{th} January 2016

Updated: April 2018

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Classification: OFFICIAL

The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes

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The amended book seeks to provide further clarity. A refresh of the policy document was undertaken to add further clarity to remove any ambiguity or processes that are no longer undertaken.
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Executive summary

This policy and guidance manual has been updated to reflect the changing landscape in primary care co-commissioning.

In 2016, the ‘Policy Book’ for Primary Dental Services was published (Gateway Ref 06254), which provided Commissioners of dental services with the context, information and tools to commission and manage dental contracts.

NHS England commissions all primary and secondary care dental services. Recognising the need to strengthen guidance for dental Commissioners, NHS England reviewed its Policy Book and the feedback received since its first publication and has made the following additions and amendments and published herewith in this ‘Policy Book for Primary Dental Services’.

The policy booklet has been divided into three parts (A-C). Reflecting feedback, all templates have been added as appendices at the end of the document.

Part A – Excellent Commissioning and Partnership Working

1. Introduction – An existing chapter with minor amendments
2. Abbreviations and Acronyms – An existing chapter with minor amendments
3. Commissioning Described – An existing chapter with minor amendments
4. General Duties of NHS England (including addressing health inequalities) – An existing chapter which has been redrafted jointly by the Legal and Equalities and Health Inequalities Teams

Part B – General Contract Management

1. Contracts Described – An existing chapter with minor amendments
2. Contract Variations (templates available) - An existing chapter that has been strengthened and refined by the Legal team
3. Managing a PDS Contractor’s Right to a GDS Contract – An existing chapter with minor amendments
4. Financial Recovery and Reconciliation – An existing chapter with minor amendments
5. Practice Closedown (Planned / Scheduled) - An existing chapter with minor amendments
6. Orthodontics – A new chapter including second opinions, second courses of treatment and close down arrangements

Part C – When things go wrong

1. Contract Breaches, Sanctions and Terminations – An existing chapter with minor amendments
2 Unplanned / Unscheduled and Unavoidable Practice Closedown – A new chapter drafted jointly with PCS Services, Information Governance and GPIT teams, to address issues such as Orphan Records
3 Death of a Contractor (excluding single handers – see adverse events) – An existing chapter with minor amendments
4 Managing Disputes – An existing chapter with minor amendments
5 Adverse Events (e.g. flood fire) – An existing chapter with minor amendments

NHS England recognises the pace and scale of change in Primary Dental 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, the Five Year Forward View and with changes in legislation and regulation.
Part A – Excellent Commissioning and Partner Working
1 Excellent Commissioning and Partnership Working

1.1 Introduction

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 85% of Clinical Commissioning Groups (CCGs) taking on delegated authority. This revised policy book will make reference to ‘The Commissioner’ which includes NHS England local teams which commission primary dental care.

This policy has been reviewed and refined in light of:

- increased CCG delegation;
- feedback from users;
- engagement with stakeholders;
- contractual and regulatory changes

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

The policy book 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.

1.2 Structure

A number of new policies have emerged since this policy book was first published and these have been incorporated in to this single policy book. The policy book has been restructured into three main sections that allow the user to more easily navigate to relevant sections. These are:

- Part A – Excellent Commissioning and Partnership Working
- Part B – General Contract Management
- Part C – When things go wrong

NHS England will update and refine policies periodically and following changes in legislation, contracts or policy and guidance. Users of this policy book 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

This policy book replaces all previous versions. In addition, we have incorporated some other related policy and guidance that has been published by NHS England as standalone documents since the original ‘Policy Book’ was published in December 2016.

The processes and procedures set out must be followed where a matter arises after the date of the publication of this updated policy book.

Where a matter arose prior to the publication of this updated 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.

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.
### 1.4 Abbreviations and Acronyms

The following abbreviations and acronyms are used in the dental policies:

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<th>Definition</th>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>FHSAU</td>
<td>Family Health Services Appeal Unit</td>
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<td>GDS</td>
<td>General Dental Services</td>
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<td>GDS Regulators</td>
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<td>HWB</td>
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<td>LDC</td>
<td>Local Dental Committee</td>
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<td>National Health Service Act 2006</td>
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<tr>
<td>NHS BSA</td>
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<td>PACS</td>
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<td>PCSE</td>
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2 Commissioning Described

2.1 Commissioning Arrangements - Introduction

85% of CCGs assumed delegated responsibility from 1 April 2017. 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 delegated responsibilities.

2.2 Background

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.

The scope of primary care co-commissioning for 2015/16 was primary medical services only.

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

From 1 April 2017, 176 CCGs (out of 209) have delegated commissioning arrangements and approximately one third of CCGs have joint commissioning arrangements.

3 Co-commissioning Described

3.1 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.

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.
3.2 Joint commissioning arrangements

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 give CCGs and NHS England an opportunity to more effectively plan and improve the provision of out of hospital services for the benefit of patients and local populations.

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 branch/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;

- 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.

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.

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.

3.3 Delegated commissioning arrangements

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 own statutory duties, for instance, in relation to quality, financial resources and public participation.

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 branch/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).

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.

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.

### 3.4 Co-Commissioning and Primary Care Policies

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:

- Where a CCG has adopted greater involvement in primary care co-commissioning, the Commissioner will usually be NHS England;
- 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
• Where a CCG has adopted delegated commissioning arrangements, the Commissioner will usually be the CCG.

• Although CCGs may assume the role of the Commissioner, 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.

• The primary care policies that cover dental, community eye health and pharmacy services retain the reference to the Commissioner but for 2017/18 this is NHS England.

• 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.

Under delegated commissioning arrangements, a CCG will have agreed 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.

Equality and Health Inequalities:

• Clinical Commissioning Groups (CCGs) and NHS England have legal duties in respect of equality and health inequalities. Supporting guidance has been issued within the 2017 2019 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 dental services due regard should be given to these duties. Further detail is also provided in the next section.

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

4.1 Introduction

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.

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.
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 chapter 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 under delegated authority.

There are many general duties on Commissioners. It is important that decision makers are familiar with all of 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.

This policy 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.

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 dental 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.

In the text box below is a summary of the duties that are covered by this chapter. The chapter (from section two 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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<td>• The “Involvement Duties”</td>
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<td>• Duty to act fairly and reasonably</td>
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<td>• Duty to obtain “appropriate advice”</td>
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<td>• Duty to exercise functions effectively</td>
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<td>• Duty not to prefer one type of provider</td>
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Summary of duties covered by this chapter:

Equality and Health Inequalities duties

a) Equality Act 2010

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".

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

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

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)

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:

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

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:

- 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)
- 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)

- 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"

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)

The "Promote Duties"

The "Promote Duties" 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)

The "Involvement Duty"

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

- the planning of commissioning arrangements by Commissioners;
- 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

- 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 and reasonably*

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*

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*

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*

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

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.

**EQUALITY ACT 2010**

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 2010. 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.

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 the Commissioner
is unable to demonstrate how it had 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**

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.

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

**Unlawful discrimination**

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

- Direct discrimination occurs where services are not available to someone because they are, for example: 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 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 shorter than men. 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 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 policy.)

Public sector equality duty

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.

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 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).

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.

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 dental 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
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 the commissioner takes steps to investigate and take enforcement action if needed.

Carrying out appropriate equality and health inequalities impact assessments (EHIAs) is usually critical to demonstrating compliance with 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.

It is not always easy to assess equality impact. A robust service user involvement exercise will help the Commissioner identify any issues. It is advisable to ask question(s) directly aimed at equality 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/.

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 includes outlining costs concerns. It also makes sense to monitor the situation (e.g. the demographic of service users change as a result of the decision and timetable a formal review in e.g. a year’s time).

There are a few themes arising from the cases we have seen on the application of the PSED (and similar duties in previous legislation).

- A need to explicitly recognise that the PSED applies and equalities issues need to be considered;
- The duty is an ongoing one – to be considered at all stages of decision-making not just at the end;
- A need to be clear about the factors driving a decision, even if these are unpalatable e.g. budgetary pressures;
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.

If a decision is made that will impact negatively on a protected group, that should be acknowledged and the rationale explained.

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.

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 are being considered.

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


THE EQUALITY ACT 2010 SPECIFIC DUTIES

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.

The 2017 Regulations came into force on 31 March 2017. The 2017 Regulations replace the first set of specific duty regulations made in 2011.

Amongst other things, the 2017 Regulations require Commissioners to publish:
- equality objectives that should be achieved to comply with the PSED (Regulation 5). This has to be completed by 30 March 2018 and the objectives need to be updated once every four years. Details of NHS England’s equality objectives have been be 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.

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)

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

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 data on existing health inequalities, and to consider whether its decision can be used to reduce these. A vast amount of data is available e.g. JNSA’s; e.g Right Care packs to help Commissioners identify health inequalities in their area.

The key point is that the Commissioner should be able to demonstrate (through documentation, principally an EHIA) the impact a decision will have on health inequalities, this has been taken into account and is supported by relevant data and evidence. 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 and Assessment Framework indicators and NHS Right Care 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

The "Have regard", "act with a view to" or "promote" duties under the NHS Act are a series of additional legal duties which commissioners must bear in mind:

- 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.
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.)

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. 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, 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.

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**

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

**ACT WITH AUTONOMY**

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 (GDS, PDS or PDS+ should weigh in the balance the desirability of the extra autonomy a PDS or PDS+ contract offers.

**PROMOTE EDUCATION AND TRAINING**

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**

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 NHS England and the CCG discusses the impact that commissioning services on the English side of the border will have on the Scottish border. It takes this impact into account when it makes its decision about the commissioning of services.
4.4 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; and, in respect of CCGs, see section 14P(1)(b) of the NHS Act);

- 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; and, in respect of CCGs, see section 14U of the NHS Act);

- 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);

- 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; and, in respect of CCGs, see section 14Y of the NHS Act);

- 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 patient involvement could easily be promoted. In such cases the safest course of action is to ensure that this is done.

To meet the duty a Commissioner does not have to do everything itself. It can meet the duty by encouraging other people to do things; as examples, by promoting innovation and use of research data.

4.5 The View to Duties

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; and, in respect of CCGs, see section 14P of the NHS Act);

- 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; and, in respect of CCGs, see section 14R of the NHS Act);

- 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; and, in respect of CCGs, see section 14R of the NHS Act);

- 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; and, in respect of CCGs, see section 14Z1 of the NHS Act).

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; and in respect of CCGs, see section 14Z1 of the NHS Act.)

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.

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.

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.

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

Under section 13Q of the NHS Act, 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 of the NHS Act).

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; and
- decisions that would impact on the manner in which services are delivered to individuals or the range of services available to them.

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 section 13Q requirements.

(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

The statutory duty to ‘make arrangements’ under section 13Q of the NHS Act is essentially a requirement to make plans and preparations for public involvement.

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 and Guidance on Patient and Public Participation in Commissioning.
• **The Framework for Patient and Public Participation in Primary Care Commissioning**

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.

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 which 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 the section 13Q applies, put in place appropriate arrangements for public involvement and avoid legal challenge.

• 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.

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.

4.7 Duty to Act Fairly and Reasonably

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.

Acting fairly

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 and 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.

Commissioners also need to be careful about keeping to promises made to contractors or the public; for example, that there will be a public consultation before any final decision is made on closing a particular dental practice. It is sometimes (but not always) possible 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 co-commissioning under delegated authority from NHS England, the NHS England legal team should be contacted for further guidance.

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

Acting reasonably

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.

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

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; and, in respect of CCGs, see section 14W of the NHS Act).

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.

The duty is most relevant to strategic decisions taken at 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

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; and, in respect of CCGs, see section 14Q of the NHS Act).

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 policy – 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

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 of the NHS Act). CCGs must also act in accordance with this duty when they are co-commissioning under delegated authority from NHS England.

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, for example, company, partnership, public sector, private sector, charity or not for profit organisation.

EXAMPLE
In partnership with local authority social services departments, the Commissioner wishes to commission new in-reach support to support people living in care homes. It carries out a patient involvement exercise. Much of the feedback expresses a preference for the services to be delivered by a charity rather than a for profit organisation. However, the feedback does not give any reason for this. The feedback is a relevant consideration but in order to comply with its duty not to discriminate the Commissioner should not prefer non-profit organisations, simply because they are non-profit.
Part B – General Contract Management
5 Which Dental Contract When?

5.1 Comparison of Dental Contract Type

<table>
<thead>
<tr>
<th>Comparison of Dental Contracts</th>
<th>GDS Contract (General Dental Services)</th>
<th>PDS Agreement (Personal Dental Services)</th>
<th>PDS+ (Personal Dental Services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who can hold contract</td>
<td>• Individual dental practitioner</td>
<td>• Dental practitioner</td>
<td>As for PDS</td>
</tr>
<tr>
<td></td>
<td>• Two or more individuals practicing in partnership where:</td>
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<tr>
<td></td>
<td>a) At least one partner is a dentist, and</td>
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</tr>
<tr>
<td></td>
<td>b) Any other partner is either NHS employee; a PDS/PMS employee (UK); a health care professional working in the NHS; or a PMS, GMS, PDS, or GDS provider (UK);</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dental practitioner</td>
<td>• Healthcare professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Healthcare professional</td>
<td>• Individual already providing services under a GMS, PMS or GDS or PDS contract equivalent (UK)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Limited liability partnership</td>
<td>• Limited liability partnership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dental corporation</td>
<td>• Dental corporation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Company limited by shares</td>
<td>• Company limited by shares</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• NHS trust or foundation (The above is a summary only. Please refer to Annex 3 for more detail.)</td>
<td>• NHS trust or foundation (The above is a summary only. Please refer to Annex 3 for more detail.)</td>
<td></td>
</tr>
<tr>
<td>Where two or more individuals are practicing in partnership, is the contract</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>

As for PDS
<table>
<thead>
<tr>
<th>treated as being made with the partnership?</th>
<th>NO</th>
<th>YES</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the contract time limited?</td>
<td>NO Except in certain circumstances when a temporary GDS contract can be used (see Urgent Contracts below)</td>
<td>YES However, this does not mean an end date needs to be specified. Note that a PDS contractor providing mandatory services may apply for a GDS contract any time prior to the end of the PDS agreement</td>
<td>YES As long as mandatory services are provided. Note that a right to a GDS contract also exists for PDS+ contractors</td>
</tr>
<tr>
<td>Can the Commissioner terminate at will?</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Must the contractor provide mandatory services?</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Can the contract contain KPIs?</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Payment arrangements</td>
<td>GDS SFE</td>
<td>PDS SFE</td>
<td>PDS SFE, Access and performance payments</td>
</tr>
<tr>
<td>Standard form contract</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

5.2 Urgent Contracts

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;
- termination of an existing contract due to patient safety; or
- termination of an existing contract due to the contractor giving 3 months’ notice, when there is a need to re-procure the services.
Before a decision to issue an urgent contract is made, Commissioners should undertake an options appraisal to confirm that a new contract is needed in their area. This opportunity should be taken to evaluate whether activity needs to be re-distributed.

The Commissioner will need to follow NHS England’s Standing Financial Instructions in relation to procurement. As this will be a new contract, this would require an application for a Single Tender Action to be submitted prior to any approval.

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 policy on practice closedown). 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.

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

**Procurement**

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 Monitor.

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

- value of the new contract and whether it is best value for money;
- duration of the new contract;
- 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; and
- extent to which the need to procure a new contract was foreseeable.

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.
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.

Premises

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.

Public Involvement

One of the general duties of NHS England 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.

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.

Commissioner SOs and SFIs

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.

Other factors

Further factors may be relevant depending on the circumstances of the matter. Please refer to the policy on practice closedown (chapter 13) for a list of all factors that may be relevant.

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.

Which contract form?

GDS contracts are often considered unsuitable for a temporary solution as they are not time-limited. However, a GDS contract can be used where the Commissioner has terminated a contract of another provider of primary dental 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.
A time limited PDS agreement may not be attractive in this scenario as the PDS contractor, if providing mandatory services, can request a non-time limited GDS contract at any time provided the contractor gives at least three months' notice of such request.

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.
6 Contract Variations

6.1 Introduction
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.

6.2 Types of Contract Variation
Variations to contracts fall broadly within four categories:

- changes due to legislation or regulatory change;
- changes to the contracting party;
- changes to services; or
- changes to the payment arrangements.

Where a GDS contract or PDS agreement is varied and there is a change in the range of services provided, the contractor must display written details of that change in a prominent position in a part of the premises to which patients have access.

The Commissioner must inform those patients of the steps they can take to obtain elsewhere the services in question or seek treatment for the provision of mandatory services (or their equivalent).

6.3 Legislation / Regulatory Changes
Usually both parties to a primary dental contract must agree 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 GDS contracts and PDS agreements.

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.

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.

The process for issuing a variation notice due to legislation and or regulatory changes is:
A regulatory amendment to the existing GDS and PDS Regulations is 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.

Where the GDS Regulations are amended, there may be a centrally issued GDS variation to the Standard GDS Contract and a supporting notice both of which should be used to inform the contractors of the change. This is not possible for PDS agreements as these are locally defined, which vary significantly across the country.

The Commissioner must notify contractors of the variation and its effective date. A template variation letter is provided in Annex 4 for GDS contracts and Annex 5 for PDS agreements. A template variation notice is provided at Annex 6.

For GDS contractors, the notification should include the GDS variation and the relevant pages of the amended contract document for completeness. For PDS 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.

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.

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.

6.4 Changes to the Contracting Party

Changes to the contracting party may be due to:

- partnership changes;
- company changes;
- retirement (including 24-hour retirement);
- novations, mergers and splits; and
- death of a contractor.

There are specific processes to follow on the death of a contractor. Please refer to the policy on the death of a contractor for further information.
The GDS Regulations and PDS Regulations contain provisions relating to the remaining scenarios listed above which are considered in more detail below.

6.5 Sub-contracting

Notification of Sub-Contracting of GDS/PDS Clinical Services

Standard GDS contracts and PDS agreements detail sub-contracting which is allowable, as shown below:

Sub-contracting of clinical matters

The Contractor shall not sub-contract any of its rights or duties under the GDS contract or PDS agreement to any person in relation to clinical matters unless—

a) It has taken reasonable steps to satisfy itself that—
   • it is reasonable in all the circumstances, and
   • that the person is qualified and competent to provide the service; and

b) It is satisfied in accordance with clauses 251 to 254 that the sub-contractor holds adequate insurance.

c) It is satisfied that there is an expectation that contracted activity / access levels are maintained

d) It is satisfied that the relevant superannuation rules have been applied to the sub-contracting party

Where the Contractor sub-contracts any of its rights or duties under the GDS contract or PDS agreement in relation to clinical matters, it shall—

a) inform the Commissioner of the sub-contract as soon as is reasonably practicable; and

b) provide the Commissioner with such information in relation to the sub-contract as it reasonably requests.

Where the Contractor sub-contracts clinical services in accordance with clause 198, the parties to the contract shall be deemed to have agreed a variation to the agreement which has the effect of adding to the list of the Contractor’s premises any premises which are to be used by the sub-contractor for the purpose of the sub-contract and clause 287 shall not apply.

A contract with a sub-contractor must prohibit the sub-contractor from sub-contracting the clinical services it has agreed with the Contractor to provide.
Some local contracts/agreements include additional requirements/restrictions so contract holders should confirm the terms of their contract/agreement before proceeding to notify of sub-contracting.

In order to provide the necessary assurance of appropriate sub-contracting arrangements the form at Annex 7 should be used by contractors to notify the Commissioner.

6.6 Partnership Changes

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.

Procurement law may be relevant as, in some circumstances, adding 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.

The Regulations place restrictions on the organisational structures that are eligible to enter into different types of primary dental contracts.

Please refer to chapter on ‘Which dental contract when?’ for details on the eligibility criteria.

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:

- individual contractors changing to more than one individual (which may be a partnership requiring a different process depending on whether it is a GDS contract or PDS agreement);

- 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); and

- disputes between partners or members.

Individual to partnership – GDS contracts

If a GDS contractor is currently an individual dental 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:

a) the name of the person or persons with whom the contractor proposes to practice in partnership;

b) confirmation that the person or persons is either:
• a dental practitioner; or

• a person who satisfies the conditions specified in section 102(2)(b) of the NHS Act;

c) confirmation that the person or persons satisfies the conditions imposed by regulation 4 of the GDS Regulations;

d) whether or not the partnership is to be a limited partnership and if so, who is a limited partner and who is a general partner; and

e) 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).

f) Commencement of the new contract should be made conditional on the new contractor being CQC registered. The CQC will issue a sales and transfer position statement document but this is no guarantee of registration. A practice cannot commence seeing patients until they have received their registration certificate with the regulated activities included.

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 a contractor contacts the Commissioner about such a change, the Commissioner should send Annex 8A.

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 GDS contract.

Commissioners shall 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. Both partners should sign 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 contract holder in their initial notice, or the nearest date to it. A template acknowledgement letter is provided in Annex 8B.

A variation notice must include the wording of the proposed variation and the date on which the variation will take effect. A template variation notice is included at Annex 8C. 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.

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 – PDS agreement**

The PDS Regulations allow PDS agreements to be agreed with limited liability partnerships but do not allow PDS agreements to be treated as made with general partnerships.

Where individuals are practising in general partnership (not a limited liability partnership), the PDS agreement will be entered into with each individual. The individual signatories to a PDS agreement collectively form the contractor.

The PDS Regulations do not require a PDS agreement to define a specific process for any variation to the signatories. The Commissioner must, therefore, review the relevant PDS agreement to determine whether any provisions have been added relating to this and prior to following any process for variation.

If the contractor is currently an individual dental 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 a contractor contacts the Commissioner about such a change, the Commissioner should send Annex 9A. The Commissioner must have consideration of any procurement implications, along with other influencing factors, when considering such an application.

The Commissioner must ensure the proposed individual(s) meet the eligibility criteria for holding a PDS agreement. Please refer to (Which dental contract when?) for further information.

Commencement of the new PDS agreement should be made conditional on the new contractor being CQC registered. The CQC will issue a sales and transfer position statement document but this is no guarantee of registration. A practice cannot commence seeing patients until they have received their registration certificate with the regulated activities included.

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. A template acknowledgement letter is provided in Annex 9B.

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. A template variation notice is included at Annex 9C. 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.
If the contractor does not return a signed copy of the variation notice, then no amendment to the agreement can take place.

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.

**Changes to contracts with more than one individual – GDS contracts**

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.

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

- the former partner must be nominated by the contractor; and
- the former partner must be a dental practitioner.

The nomination of the former partner by the contractor must:

- be in writing and signed by all of the persons who are practising in partnership. Where a contractor contacts the Commissioner about such a change, the Commissioner should send Annex 10A;
- specify the date on which the contractor proposes to change its status from that of a partnership to that of an individual dental practitioner;
- 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 dental practitioner; and
- specify the name of the dental practitioner with whom the contract will continue, which must be one of the partners.

Where the Commissioner receives the information, 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 dental practitioner. A template notice is provided in Annex 10B. A variation notice will need to be included with this letter. 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.
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 dental practitioner. A template variation notice is included at Annex 10C.

The Commissioner should be satisfied that the arrangements in place for continuity of service provision are robust.

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.

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.

Where the contractor consists of two or more individuals practiseing 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.

The following process should be followed in the above scenario:

- The partnership issues notice to NHS England setting out:
  - the date that the new partner(s) intend to join or have joined the partnership;
  - confirms that the new partner(s) are a dental practitioner, or that he satisfies the conditions specified in Section 102 of the NHS Act;
  - confirms that the new partner meets the conditions imposed by regulation 4 of the GDS Regulations; and state whether the new partner(s) are general or a limited partner(s).
  - confirms that the relevant CQC change has been made or is in the process of being made.

- The Commissioner would then issue a variation notice in writing and signed by all parties to the contract (e.g. signed by all partners).

The Commissioner should be aware that where the contractor is two or more persons practising in partnership, the Commissioner may terminate the contract where one or more persons have left the practice during the existence of the contract. This right of termination only arises where the Commissioner, in its reasonable opinion, considers that the change of membership of the partnership is likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform their obligation under the contract.
If the Commissioner intends to rely on this right of termination, please refer to the policy on contract breaches and termination for further information on this right and on termination generally.

**Changes to contracts with more than one individual – PDS agreements**

The PDS Regulations do not require a PDS agreement to define a specific process for any variation to the signatories. The Commissioner must, therefore, review the relevant PDS agreement to determine whether any provisions have been added relating to this and prior to following any process for variation.

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 a contractor contacts the Commissioner about such a change, the Commissioner should send Annex 11A. The Commissioner must consider any procurement implications, along with other influencing factors, when considering such an application.

The Commissioner must ensure that the proposed individual meet the eligibility criteria for holding a PDS agreement please refer to (Which dental contract when?) for further information.

Commencement of the new agreement should be made conditional on the new contractor being CQC registered. The CQC will issue a sales and transfer position statement document but this is no guarantee of registration. A practice cannot commence seeing patients until they have received their registration certificate with the regulated activities included.

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. A template letter is provided in Annex 11B.

If the decision is to consent to the variation, then the Commissioner must 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.

If the contractor does not return a signed copy of the variation notice, then no amendment to the agreement can take place.

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.

The principles outlined 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. A template variation notice is included at Annex 11C.

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.

The Commissioner should also be satisfied that the arrangements for continuity of service provision to the local 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.

GDS contracts are required to contain a right of termination where one of more persons has left the practice during the existence of the contract. PDS agreements are not required to contain such a right of termination. The Commissioner should therefore review the relevant PDS agreement to determine whether any such provision has been included.

**Partnership splits/members dispute – GDS and PDS**

Where the contractor to a GDS 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. The Commissioner may have little time to make arrangements to ensure service continuity.

It is, therefore, desirable that the partners of a GDS contract are able to resolve disputes internally where possible, with the support of the LDC and/or mediation services.

If the partnership holding a GDS 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 three months unless agreed by the Commissioner. Failure to give three months’ notice of termination is a breach of contract and the appropriate action may be taken in line with the policy on contract breaches and termination.

Under PDS 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).

If a PDS 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 agreement, such notice being a minimum of three months unless agreed with the Commissioner. Please refer to the policy on contract breaches and termination for more information on this.
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.

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.

The Commissioner should not get involved in endeavours to resolve the dispute between the partners, instead insisting that the parties notify the Commissioner of their final decision when it is reached.

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 resolve the dispute.

Throughout the dispute the Commissioners should maintain open dialogue with the LDC and implement contract performance management protocols, if and when necessary.

6.7 Retirement of a Contractor – Single Handed

There is no specific reference to retirement in the GDS and PDS Regulations. The Commissioner should deal with a request to retire as a request to terminate the contract by the contractor on notice.

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. 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.

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.

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.
Although not required by the GDS Regulations, the Standard GDS 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:

- cease performing any work or carrying out any obligations under the contract;
- co-operate with the Commissioner to enable any outstanding matters under the contract to be dealt with or concluded satisfactorily;
- co-operate with the Commissioner to enable the contractor’s patients to be transferred to one or more other contractors or providers of mandatory services (or their equivalent); and
- deliver up to the Commissioner all property belonging to NHS including all documents, forms, computer hardware and software, drugs, appliances or dental equipment which may be in the contractor’s possession or control.

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.

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.

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.

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.

For a list of considerations relating to termination, please refer to the policy on contract breaches and termination.

### 6.8 Retirement of a Contractor – Two or More Partners/Individuals

Where a partner wishes to retire from a GDS 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 as detailed under the sub-heading changes to contracts with more than one individual – GDS contracts.
Where an individual wishes to retire from a PDS 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 contract. The Commissioner should follow the process as detailed under the sub-heading changes to contracts with more than one individual – PDS agreements.

The Commissioner should always keep in mind the possible implications on procurement and competition when applying the guidance in this policy.

Any changes to the partners within a contract may require a new registration with CQC. The Commissioner must ensure that the provider has received CQC registration or where this has not yet been achieved the sale and transfer position statement from the CQC for the new partnership arrangements.

6.9 Twenty-Four Hour Retirement

24-hour retirement is a process that members of the NHS Pension Scheme must satisfy to qualify for their NHS pension benefits at retirement.

If someone is a member of the 1995, 2008, or 2015 pension schemes they must all take 24 hour retirement if they want to claim their NHS pension benefits in full. However, members of the 2008 or 2015 schemes can take ‘partial retirement’. If members take partial retirement, they are not required to take 24 hour retirement but must reduce their commitment to the NHS by 10%. This option is attractive to ‘single-handers’ as they don’t have to give up their GDS contract or PDS agreement.

24-hour retirement requires resigning from all involvement in an NHS contract and not returning to the NHS in any capacity for at least 24 hours. Where a person with 1995 Section membership of the NHS Pension Scheme takes their normal NHS age pension, voluntary early retirement pension, or deferred (including ill health deferred) pension they are also subject to the ‘16 hour a week rule’ in the first calendar month.

If the Commissioner is approached by a contractor wishing to take 24-hour retirement, it must not offer advice relating to pension arrangements. Contractors should be sign posted to NHS Pensions for professional advice.

Further information on Pensions, can be found in the [NHS Pensions Guide for NHS General Dental Practitioners](https://www.nhspensions.nhs.uk/).  

Contractor’s should ideally provide three months’ notice of their retirement to both the local team and NHS Pensions.

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:

- termination on notice in the case of a single handed contractor; or
• termination or variation of the contracting party in the case of a partnership.

The Commissioner may wish to suggest single-handed practitioners take independent legal advice, as 24-hour retirement using the method described above would necessitate the termination of the contract. Please see attached suggested template (Annex 12) to send to single-handed providers who are interested in 24-hour retirement.

The Commissioner must make clear to the contractor that there is no guarantee that the Commissioner would commission services from that individual following termination of their current contractual arrangement.

If the GDS contract or PDS agreement is held by a partnership or a dental body corporate it will not automatically be terminated when an individual named as a partner or director takes 24 hour retirement, as the contracting party (i.e. the remaining partner or dental body corporate) continues to be the provider of the contract during the period for which the individual is retired. However, the make-up of the directors would need to meet the 50/50 requirement of clinical to lay people. If no other directors are clinical, they would need to consider taking on another clinical person as a director for the contract to continue during the 24 hour retirement.

A single-handed practitioner may wish to go into partnership in order to facilitate their 24 hour retirement and the continuation of their contract. A new partner would be subject to the necessary checks as detailed in the GDS Regulations. Individuals may request to form a partnership under a GDS contract at any time using clause 292.

If there are no concerns about the provider entering into partnership, NHS England would request the provider submits a 292 notice (signed by both parties) stating the date the partnership will be formed and the 231 Notice (signed by both parties) which states the date that the contract will revert back to an individual. It may be prudent for Commissioners to ensure that the original provider is eligible to hold the contract at the same time as the new partner, as although they are an existing contract holder, once they are removed, the retiring provider would be subject to the same GDS/PDS performer checks.

On receipt of the above the Commissioner would issue the relevant contract variation including the following clause:

• “This variation is made to enable [name of individual] to apply for 24-hour retirement from the NHS contract, in order to satisfy the NHS pension scheme regulations. The registration of this partnership with the Care Quality Commission (CQC) is unlikely to be required if the partnership will not be delivering any regulated activities during the period for which the NHS contract is held by the partnership. The contract held by [partnership name] will revert to being held by [name of individual] on [date].” Please use attached Annex 13 for ease of reference.
The Commissioner may consider undertaking an options appraisal, to give due consideration to the procurement regulations including:

- “new award” is unlikely to be visible to the market;
- the contract is not ostensibly due for renewal (and so the market will not be looking for the new opportunity to be available);
- the practice of 24 hour retirement has been accepted historically;
- the duration and other terms and conditions of the GDS contract will not change from the original GDS contract and therefore there is in reality no material change; and/or
- This options appraisal should include appropriate legal advice and be signed off via each teams local governance process.

Please refer to the NHS England Legal Team for further information on procurement implications england.legal@nhs.net.
7 Variation - Body Corporates

GDS contracts and PDS agreements may be held by different types of bodies corporate. Please refer to chapter 5 (Which dental contract when?) for a summary of the types of bodies corporate.

There are various eligibility criteria that must be satisfied before any of these types of organisation can hold GDS contract or PDS agreements. For further information, please refer to chapter ‘Which dental contract when?’.

A change to or from an individual or partnership contractor to or from these types of organisations is a complete change of the identity of the contracting party, regardless of whether the organisation is owned and/or run by the original contractors. This will technically require termination of the existing contract and immediate replacement with a new contract on the same terms. This is a contract novation and is explained further in paragraph 8.1.

Where the novation involves a transfer of the contract from an individual or partnership to a corporate body, this is often referred to as "incorporation". Where the novation involves a transfer of the contract to an individual or partnership from a corporate body, this is often referred to as "dis- incorporation". Such changes will not technically be a variation to the original contract as the original contract will be replaced by the new contract.

7.1 Contract Novations and Incorporation/Dis-incorporation

Incorporation of a GDS agreement usually occurs where a contractor that is an individual or a partnership wishes to transfer the agreement to a dental corporation or a limited liability partnership.

Incorporation of a PDS agreement usually occurs where a contractor that is one or more individuals wishes to transfer the agreement to a dental corporation, a company limited by shares or a limited liability partnership.

Dis-incorporation is the same process in reverse.

Where one party to a contract (A) proposes to completely remove itself from the contract to be replaced by a separate party (B), this cannot be a variation to the contract. Instead this is a transfer of the rights and obligations under the contract which is termed a contract novation.

A contract novation is not a variation. A contract novation involves the termination of the existing contract and entering into a new contract on the same terms as the original contract but with the parties’ details changed. Where a new contract is awarded, regardless of the fact that it may be a contract novation or may be on the same terms as the original contract, there may be procurement law implications.
Commissioners must also act in accordance with any procurement protocol issued by NHS England.

Contract novations are often requested where a person or company is selling its business and as part of the sale it is transferring its contracts and its customers to the buyer. The contracts are novated and the buyer agrees to take over the seller’s responsibilities for performing the contracts and takes on any associated debts and obligations.

There is no express right for a contractor to incorporate or dis-incorporate a contract. Contractors should be made aware that incorporation or dis-incorporation could potentially result in the Commissioner deciding to competitively tender the new contract in accordance with procurement law. The contractor to the original contract may not be successful in winning the new contract.

Further to recent legal advice, the new Procurement Regulations, the Public Contracts Regulations 2015 (PCR2015), provide protection from a procurement challenge where there is an incorporation or dis-incorporation. The relevant parts of PCR 2015 provide as follows:

Contracts may be modified without a new procurement procedure in accordance with this part in any of the following case:

a) where the modifications, irrespective of their monetary value, have been provided for in the initial procurement documents in clear, precise and unequivocal review clauses, which may include price revision clauses or options, provided that such clauses—

• state the scope and nature of possible modifications or options as well as the conditions under which they may be used, and

• do not provide for modifications or options that would alter the overall nature of the contract;

b) 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 sub-paragraph (a), 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 this Part.

c) where the modifications, irrespective of their value, are not substantial within the meaning of paragraph (8)...."
- Regulation 72(8) of PCR 2015 provides that a modification to a contract during its term is to be considered substantial for the purposes of Regulation 72(1)(e) where, amongst other things:
  - (e)”a new contractor replaces the one to which the contracting authority had initially awarded the contract in cases other than those provided for in paragraph (1)(d).”

PCR 2015 means that if there is a change in structure, including 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.

Therefore, if the contract is not likely to be substantially modified, the provider complies with the relevant checks, and a contract is needed in the proposed area, there may not be a need for a new procurement procedure.

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 contractor under the new contract. As set out below, there are factors that the Commissioner should consider before providing any such assurance.

**Managing a request for Incorporation or Dis-incorporation**

On receipt of a request from a contractor to incorporate or dis-incorporate, the process below should be followed:

- 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 14 and 15 with a form for internal Commissioner use provided in Annex 16.

- A letter and assessment template for dis-incorporation are provided in Annex 17 and 18 with a form for internal Commissioner use provided in Annex 19.

  - The Commissioner should make the contractor aware of the potential implications of the incorporation or dis-incorporation.
• On receipt of the information, the Commissioner should review the information and decide whether to agree the request.

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 in Annex 20 and in respect of dis-incorporation in Annex 21.

Commissioners should undertake an options appraisal to confirm that a new contract is needed in their area. This opportunity should be taken to evaluate whether activity needs to be re-distributed.

Additionally, Commissioners may wish to seek additional benefits to ensure that services meet the needs of the local population.

Where the proposed contractor is eligible, the Commissioner should consider a number of further matters listed below. In considering these matters, the Commissioner, is required to act reasonably and otherwise in accordance with public law principles:

• the Commissioner’s obligations under procurement law to determine whether there is a risk of challenge in agreeing the request or whether a competitive tender process should be carried out;

• the effect of the proposal on the statutory duties of NHS England, particularly the duty under Section 13K of the NHS Act (duty to promote innovation) and Section 13P (duty as respects variation in provision of health services) - for further information, please refer to chapter 4 (General duties of NHS England);

• the value of the contract;

• the level of market interest;

• the potential for innovation;

• the need to protect services in the core contract;

• continuity of patient care;

• the extent to which the original contractor(s) will be controlling and giving instructions to the proposed contractor to comply with contractual obligations;

• that extent of change to the terms of the existing and new contract (i.e. contract value or activity level);

• payments under the existing contract and value for money;
• benefits to service users of the proposal;

• amendments to the activity level in the contract, e.g. where there has been previous underperformance, the commissioned UDAs or UOAs may be reduced to a realistic and achievable level;

• opening hours (including evening and weekend) and urgent access slots required;

• whether the Commissioner requires that the existing contractor guarantees the performance of the proposed contractor – 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;

whether the proposed contractor is a company:

  • 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);

an unsatisfactory Disclosure and Barring Scheme;

• the potential to review any restricted contracts; for example, the contract is restricted to child/exempt only and whether the restrictions should be removed;

• whether the existing contractor has outstanding NHS debts which may include repayment due to underperformance from previous years and whether novation is made conditional on repayment being made;

• whether the existing contractor has received a breach or Remedial Notice and whether novation is made conditional on the proposed contractor taking on the consequences of the notices (e.g. action the remedial activity);

• whether the circumstances that led to the issue of a Breach Notice or a Remedial Notice has any relevance to the request for incorporation/disincorporation particularly where the contractor has complied with any remedial notice issued; and/or

• 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.
Requests for incorporation or dis-incorporation should be agreed with or without Conditions unless there are concerns as to whether a request would present a benefit to patients or create a significant risk of successful procurement law challenge.

**Agreeing the Request**

Where the Commissioner agrees the request, the original contract will be novated. Legal advice should be sought on whether a deed or a simple novation agreement should be used. Please refer to Annex 22 for a template agreement notice and Annex 23 for a Deed of Novation

- The Commissioner should ensure that the provider has adhered to points 1.1.1 and 1.1.2 in Annex 24 before any approval is given.

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 the termination of the original contract including:

- carrying out a financial reconciliation;
- managing any under performance in terms of financial recovery, service delivery or performance concerns and details of how these will be managed going forward; and
- any other requirements in the contract relating to termination.

The Commissioner will need to agree a new contract with the new contractor which may vary from the original contract in terms of services provided, numbers of UDAs and UOAs and any other changes agreed.

Where the request is for incorporation, the new contractor will be a body corporate and the Commissioner should consider whether it is 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. Legal advice should be sought on the wording of the change of control clause. Where a contract contains such a clause and the Commissioner does not consent to the change but the contractor proceeds anyway, the Commissioner may issue a Remedial Notice.

Commencement of the new contract should be made conditional on the new contractor being CQC registered. The CQC will issue a sales and transfer position statement document but this is no guarantee of registration. A practice cannot commence seeing patients until they have received their registration certificate with the regulated activities included.
Disputes
Where the contractor does not agree with the Commissioner's decision, the contractor may appeal against the decision. Please refer to the policy on managing disputes for further information.

NHS dental services payment system requirements
Following the Commissioner's decision, any changes to the contracts must be made on the relevant payment and contract management systems. Please see Annex 24 for further details.

7.2 Practice Mergers and/or Contractual Mergers
Dental practices may wish 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 contractors will have their own reasons for considering such a union.

An individual or partnership may hold more than one form of primary care contract with the Commissioner and can also be a party to more than one contract. For example, a GDS contractor can also be a party under a PDS agreement and vice versa.

The underlying principles for the Commissioner to consider when any such proposal is made to them are what the benefits are for the patients and what the financial implications are for the Commissioner.

There are two ways in which practices may propose to merge:

a) by informal arrangements such as sharing staff which requires no change to the contracts – it is a private arrangement between the practices; or

b) by "merging" the contracts which may be done by:

   - each contractor becoming a party to the other contractor's contract (through variations of the contracting parties);

   - terminating one of the existing contracts, continuing the other contract but varying it to include the other contractor as a party to the contract; or

   - terminating the two existing contracts and creating a single organisation or partnership which will enter into one new contract.

If one or both contracts are terminated, the relevant contractor must give notice to the Commissioner to terminate (giving at least three months' notice).
Merging contracts is a complex matter which should not be approached lightly by either the contractors or the Commissioner. Adding or removing individuals or partners may be carried out in accordance with this policy but where termination is proposed, the final commissioning decision on whether contracts should be merged lies with the Commissioner. There are a number of important issues that would need to be considered, prior to giving consent.

a) The Commissioner should require the parties to submit a service plan to support their application, which should provide detail on:
   
   - how patients would access a single service;
   
   - assurances that all patients will access a single service with consistency across provision, i.e. booking appointments, mandatory and additional services, opening hours, extended hours, and so on, single IT and phone system;
   
   - premises arrangements and accessibility of those premises to patients; and
   
   - proposed arrangements for consulting with the patients about the proposal, communicating the change to patients and ensuring patient choice throughout;

b) financial arrangements – the impact of directions under the SFE, or any specific terms included in the individual contracts;

c) premises reimbursements;

d) general duties of NHS England; and

e) procurement and competition.

This is not an exhaustive list and the Commissioner should refer to and seek appropriate guidance in each case to ensure that all relevant matters are considered.

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.

**General duties of NHS England / the Commissioner**

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.

As set out in the relevant chapter on NHS England's general duties, section 13Q of the NHS Act 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).

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 and Guidance on Patient and Public Participation in Commissioning" (the "Statement").

The Statement sets out that a change in the dentist 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.

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.

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 a practices' patient participation group.

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:

- Involvement should take place when the proposal is still at a formative stage;
- Sufficient information regarding the proposals should be provided, to allow meaningful involvement;
- Adequate time should be given for consideration of the information provided and for response;
• The product of the involvement should be conscientiously taken into account by the decision-maker.

• 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.

7.3 Changes to Services

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.

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.

The paragraphs below outline the principles and steps required to process the most commonly occurring service changes.

Where the parties have entered into a Capitation and Quality Scheme 2 Agreement, the PDS and GDS Regulations apply to amend the process for varying certain terms of the contract. Where this applies, the parties should consider Regulation 24B of the GDS Regulations or 20B of the PDS Regulations before varying any term of the contract to determine if that term is affected by the Agreement.

7.4 Level of Services

GDS contractors must provide mandatory services. PDS agreements are not required to provide mandatory services but such services can be included in the agreement.

A GDS contract must specify the number of UDAs to be provided by the contractor. Where a PDS agreement includes the provision of mandatory or advanced mandatory services, the agreement must specify the number of UDAs to be provided by the contractor.

Where a contract includes the provision of orthodontic services, the contract must also specify the number of UOAs to be provided by the contractor.

Either party can notify the other if it believes the number of UDAs or UOAs should be varied. The notice must specify the variation that the parties considered necessary and the reasons for the variation.

The Commissioner may, for example, send such a notice after a mid-year review if it believes the contractor will not achieve the number of UDAs or UOAs in the contract.
Following such notice, both parties are required to use their best endeavours to communicate and co-operate with each other with a view to determining what (if any) variation should be made to the number of UDAs or UOAs and any related variations to the agreement which may include payments to the contractor.

Where a variation is agreed, it must be in writing and signed by both parties in order to be effective.

Premises

A contractor may wish to make changes to its contracted premises from which services are provided.

This would likely be a significant change to services for potential service users 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. Failure to seek agreement with the Commissioner before a change of premises could constitute a breach and possible termination of the GDS contract or PDS agreement.

Each application has to be dealt with on a case-by-case basis and the Commissioner should take into consideration such things as the local population’s demography, local oral health needs assessment and existing access to dentistry within the Commissioner local team’s geographical coverage as well as the overall benefit such as improvements to allow for greater use of skill mix, overall improvement in practice premises and benefits to the patient by the proposed relocation.

It is suggested that a letter is sent to the provider asking for further information as follows:

a) Location
b) benefits to patients of the new location
c) patient survey results

A template letter is provided at Annex 25 for ease of reference.

Canvassing patients views on the proposed move is essential to ensure that their views are captured and taken into account as part of the relocation process. It is suggested that practices should develop a patient questionnaire as it is a legal duty to consult with patients when a change to service is proposed. A survey should be carried out by the practice for a minimum period of four to six weeks, and achieve a response rate that is proportionate to the amount of patients that are regularly seen.

It is important to ensure that any new premises are compliant with legislation and meet contractual clinical requirements such as HTM 01-05, infection control policies and the Equalities Act 2010 compliance and the Commissioner should consider a
visit to the proposed premises to ensure they are suitable to meet the relevant requirements. This can be undertaken by the contract manager and clinical adviser.

Any new premises must receive the appropriate CQC registration to provide services before the GDS contract or PDS agreement is varied and services provided from the new premises. The CQC will issue a sales and transfer position statement document but this is no guarantee of registration. A practice cannot commence seeing patients until they have received their registration certificate from the CQC with the regulated activities included.

Once, and if, the final date for closure is confirmed, the Commissioner will issue a variation agreement notice to amend the registered address of the contract, and, as in other variations referred to in this policy, include the wording of the variation and the date on which it will take effect. Please see attached template letter in Annex 26.

The contractor will be fully responsible for cessation or assignment of the lease for any rented premises and any disposal of owner occupied premises.

An agreement to vary the contract to include the new premises should be signed by the director/head of primary care or another officer with delegated authority.

If the relocation is refused, a template letter is provided in Annex 27.

**Public involvement**

As outlined above, it is the Commissioner's responsibility to ensure that an appropriate public involvement exercise takes place and that any feedback from this exercise is considered before a final decision is made. This should be done in accordance with the 'NHS England statement of arrangements and guidance for involving patients and the public in commissioning.'

Where appropriate, the Commissioner must ensure that it engages with the LDC, Healthwatch, the HWB, CCGs and the local council (which is likely to have an Overview and Scrutiny Committee for this purpose), discuss the feedback and ensure that this forms part of the formal application.

### 7.5 Financial Changes – Statement of Financial Entitlements

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.

For GDS contracts, the financial terms must reflect those set out in the SFE. There is no such requirement under PDS agreements which have been locally agreed. Any changes under the 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.
8 Managing a PDS Contractor's Right to a GDS Contract

8.1 Introduction

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 PDS contractor exercises its right to transfer from a PDS agreement to a GDS contract.

Commissioners will need to ensure that its finance department and relevant persons are made aware of the change to the contracting arrangements as there will be long term financial implications. A GDS contract is not time limited and exists until terminated. Anyone with delegated authority can sign off the transfer.

The NHS BSA payment and contract management system must be updated by the officer managing the transfer and the contracts linked for payment and patient free repair and replacement purposes.

A contractor holding a PDS or PDS plus agreement which is providing mandatory services, has the right to a GDS contract in accordance with regulation 21 of the PDS Regulations which states:

"A contractor which is providing mandatory services and which wishes a general dental 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 dental services contract to be entered into."

This policy sets out the decision making process that the Commissioner will follow, together with refusal and appeal processes and discussions regarding any actions that are required.

8.2 Notification from a Contractor

The Commissioner should receive at least three months' notice in writing from the contractor exercising its right to a GDS contract.

The contractor's notice must:

- state that the contractor wishes to terminate the PDS agreement;
- state the date on which the contractor wishes the PDS 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 GDS contract (a person’s name may only be given in a notice if that person is a party to the PDS agreement); and

• confirm that the person(s) so named meet the conditions set out in section 102 of the NHS Act and regulations 4 and 5 (where applicable) of the GDS 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 or persons immediately prior to entering into the GDS contract will meet those conditions.

8.3 Process for PDS Agreements

The Commissioner must acknowledge receipt of the notice within seven days beginning on the day it received the notice.

The Commissioner will check that all necessary information has been provided in the contractors notice, undertake a review of the PDS agreement to establish if the contractor provides mandatory services and if they are eligible to hold a GDS contract (as set out in section 102 of the NHS Act persons eligible to enter into GDS contracts) and regulations 4 and 5 of the GDS Regulations please refer to Which dental contract when? for further information on who is eligible to hold GDS contracts.

If the contractor does not provide mandatory services the Commissioner must notify the contractor that they are not entitled to transfer to a GDS contract. A template letter is provided in Annex 28.

If the contractor is not eligible to hold a GDS contract the Commissioner must refuse to enter into a GDS contract. A template letter is provided in Annex 29.

If the Commissioner confirms that the contractor provides mandatory services and is eligible to hold a GDS contract under section 102 of the NHS Act and regulations 4 and 5 of the GDS 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 30.

The new GDS contract must require provision of the same services as were provided by the contractor immediately prior to the PDS agreement terminating. This includes the same number of courses of treatment involving the provision of sedation services or domiciliary services specified in the PDS agreement, unless the parties otherwise agree.

Unless the parties otherwise agree the same number of units of dental and (where commissioned) units of orthodontic activity must be provided under the new GDS contract.
The contractor will be entitled to a Negotiated Annual Contract Value (NACV) for the GDS contract as set out in the GDS SFE. The Commissioner and the contractor must agree, in respect of the first financial year during which a GDS contract has effect a NACV for the GDS contract, based on the number of units of dental activity and, where applicable, orthodontic activity that the contractor is required to provide under its GDS contract.

The Commissioner has the right to consider and negotiate the average value of the units of dental and orthodontic activity that it commissions from the contractor. This position has been confirmed by the FHSAU case number 15189 (August 2009). The activity and services must remain the same as they were under the PDS agreement unless agreed by both parties but the average UDA (and if applicable UOA) rates may be considered and negotiated.

On receipt of a notice exercising the right to transfer to a GDS contract, the Commissioner shall undertake an internal review of the PDS agreement. The Commissioner can access benchmarked data (including, for example, average UDA values, NICE recall and patient access data) from NHS Dental Services to enable them to determine whether a PDS agreement is providing value for money and performance in terms of activity and compliance. The Commissioner will negotiate the NACV to bring the contractors in line with the average local UDA/UOA rates. Annex 31 contains a contract review template that should be considered. The Commissioner may at its discretion negotiate a decrease or an increase to the average UDA/UOA rate for example, in reasonable and appropriate circumstances such as if the contractor is a financial outlier and such decrease will seek to ensure that the service remains safe and viable.

The Commissioner will offer the contractor, in writing, a meeting to discuss the NACV offer being made to them in view of the contract review. A template letter is provided in Annex 32.

During this period of negotiation the contractor may wish to issue a counter offer for consideration. Once the negotiation period has been completed the Commissioner will provide a final offer confirmed in writing.

If the contractor agrees the new NACV, this will be confirmed in writing, a date for the termination of the PDS agreement will be agreed and a new GDS contract issued with a start date immediately following the termination of the PDS agreement. The termination of the PDS agreement and commencement of the GDS contract should be on the date provided in the notice from the contractor exercising its right to a GDS contract unless a different date is agreed between the parties. A template letter is provided in Annex 33.

If the contractor does not agree the new NACV, the Commissioner cannot agree to transfer the PDS agreement to a GDS contract. The contractor must be informed of their right to dispute the decision under regulation 21(9) of the PDS Regulations. A template letter is provided in Annex 34.

Following the agreement to transfer the PDS agreement to a GDS contract the Commissioner must update the NHS Dental Services payment system. Details
are contained in Annex 35.

The contractor may at any point choose to withdraw their application to transfer to a GDS contract and continue with their current PDS agreement should agreement not be reached on the NACV for the GDS contract.

Where a GDS contract commences on a day other than 1 April the contractor must provide, during the remainder of that financial year, any UDAs or UOAs and any courses of treatment including the provision of sedation or domiciliary services the contractor would have been obliged to provide or contribute to immediately before the GDS contract begins.

### 8.4 PDS Plus Agreements and Non Standard PDS Agreements

PDS plus agreements and other non standard PDS agreements are regulated by the PDS Regulations and contractors have the same right to transfer to a GDS contract. Where a notice to transfer a PDS plus agreement or non standard PDS agreement is received the Commissioner should acknowledge receipt of the request.

The process above should be followed when a notice from a PDS plus contractor is received but should also include compliance with any terms of the PDS plus agreement which govern the transfer to a GDS contract (for example, paragraph 2.5 of Schedule 3 of the DH Standard PDS Plus Agreement states):

"In the event that the contractor exercises its right to a GDS contract the contract value that will be negotiated as the NACV will be based on the payments that are made under the SFE. For the avoidance of doubt the payment made under the SFE is the services payment”. The ”services payment” is considered the total contract payment NOT just that paid for the services element of a PDS plus contract.

The minimum service activity of a PDS plus agreement may have been procured at a higher level than 51% of the total PDS plus agreement value.

Further to a recent litigation case, NHS Resolution indicated that a safe and viable offer needed to be agreed by both parties. Further information from NHS Resolution and a calculator to determine a safe and viable rate is provided in Annexures 36 and 37.

### 8.5 Disputes

Where there is a dispute about whether or not a person satisfies the conditions set out in section 102 of the NHS Act or regulation 4 or 5 of the GDS Regulations, the contractor may appeal to the First-tier Tribunal.

Any other dispute relating to the GDS contract shall be determined by the Secretary of State (the FHSAU) in accordance with regulation 8(3) and (4) of the GDS Regulations (pre-contract disputes).
The Commissioner can identify whether the contract is an NHS contract or not by reviewing the contract. 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.
9 Financial Recovery and Reconciliation

9.1 Introduction

This policy provides guidance on the management of the mid-year and year-end financial reconciliation and recovery process for all dental contracts.

The policy covers all GDS and PDS contractors regardless of their legal entity.

The Commissioner will need to ensure that, where there are any adjustments that are made to dental contracts, reclaimed money will need to be logged and superannuation reclaimed. Any rebasing that takes place will also need to be accounted for, as this may affect the recurrent financial obligations placed upon the Commissioner.

The NHS BSA payment and contract system also needs to be updated by the officer managing the processes as this will affect contractual payments to contractors.

This policy provides Commissioners with the process required for carrying out their mid year and year-end reviews as required by the terms of the GDS contract and PDS agreement. It provides guidance, scenarios, flow charts and standard templates to be used in the reviews and subsequent meetings (if required) with contractors.

This policy refers to the specific clauses in the model GDS contract and model PDS agreement and cross-checks where applicable with the GDS Regulations, the PDS Regulations, the NHS Act and the GDS SFE and the PDS SFE.

This policy removes any deviation from the regulations and provides a fair and equitable process for all contractors. It also provides an element of proportionality when dealing with contractors.

This policy will be used to implement the contractual and regulatory processes required to:

- review activity at both mid-year and year-end;
- make the required financial recovery; and
- issue a Breach Notice, in line with requirements as set out in paragraph 73 of Schedule 3 of the GDS Regulations, and the same provision in the PDS Regulations.
9.2 Mid-Year Review

The obligation for mid-year reviews are set out at paragraph 58 of Schedule 3 of the GDS Regulations and the same provision in the PDS Regulations. A flowchart of the mid-year process is provided in Annex 38.

The Commissioner must, by 31 October in the relevant financial year, determine the number of UDAs and UOAs that the contractor has provided between 1 April and 30 September in that year. This information will be based on the notifications of treatment (FP17s) made by the contractor under paragraph 38 of Schedule 3 of the GDS Regulations and paragraph 39 of Schedule 3 of the PDS Regulations and provided to the Commissioner by NHS DS. Where the notifications of treatment are disputed by the contractor, the contractor should liaise directly with NHS DS for resolution of their issue.

Notifications of courses of treatment must be made within 2 months of a course of completed treatment. Contractors must ensure that notifications are made on time as the Commissioner is not obliged to pay for activity which is not notified in accordance with this 2 month deadline.

Where the Commissioner determines that the contractor has provided more than 30 percent of the activity that it is required to deliver in that financial year (between 1 April and 30 September) the Commissioner should send a letter to the contractor. A template letter is provided in Annex 39. It is also important to identify where the contractor has delivered over forty-five percent of the total number of UDAs or UOAs as the contractor may over provide against the contracted total of UDAs or UOAs in the relevant year.

- Where a contractor has delivered more than 30 percent of the activity, a mid-year review meeting is not required.

- The contractor should be advised that over delivery is at local discretion. The Commissioner may agree to carry forward up to 2 percent of activity in the following financial year or pay for the additional activity.

Where the Commissioner determines that the contractor has provided less than 30 percent of the activity that it is required to deliver in that financial year (between 1 April and 30 September) the Commissioner should:

- notify the contractor that it is concerned about the activity provided under the contract in the first half of the year;

- set out the number of UDAs and UOAs that the contractor has provided together with the percentage total of the total number of UDAs and UOAs that this represents; and

- require the contractor to participate in a mid-year review of its performance in relation to the contract.
• Develop a SMART plan with contractor

9.3 Mid Year Review Meeting

This meeting does not necessarily need to be face to face and can be conducted on the telephone if appropriate. The review should be followed by a SMART action plan to identify how the contracted activity will be delivered by the year end and/or a withholding of monies (as set out at paragraph 59(2) and (3) of Schedule 3 of the GDS Regulations and the same provision in the PDS Regulations).

Where the contractor provides evidence or reasonable explanations and/or remedies at the review meeting, the Commissioner may take no further action following the mid-year review. The Commissioner should be satisfied that the contractor is on target to deliver the contracted activity by the year-end.

At the mid-year review meeting the Commissioner and the contractor shall discuss:

• Any written evidence the contractor put forward to demonstrate that it has provided a higher number of UDAs and UOAs during the first half of the financial year than the Commissioner has indicated; and

• Any reasons the contractor provides for the level of activity in the first half of the financial year.

Where, having taken into account any evidence or reasons put forward by the contractor at the mid-year review (e.g. as a result of a force majeure event) and the Commissioner nevertheless has serious concerns that the contractor is unlikely to provide the number of UDAs or UOAs that are required by the year-end, the Commissioner may:

• require the contractor to comply with a written plan drawn up by the Commissioner to ensure that the level of activity during the remainder of the financial year is such that the contractor will provided the contracted total UDAs and UOAs; or

• withhold monies payable under the contract.

Process for the Commissioner to follow:

• send a letter asking the contractor to arrange a review meeting (a template letter is provided in Annex 40);

• hold mid-year review meeting (a template agenda for the meeting is provided in Annex 41);

• Follow up the mid-year review meeting:
• a final copy of the notes of the meeting should be sent to the contractor;

• if the Commissioner is still concerned about contracted delivery it may request an action plan to be followed (a template action plan is provided in Annex 42);

• the Commissioner may withhold any monies as appropriate and make any adjustments to the payment system in accordance with paragraph 59(2) and (3) of Schedule 3 of the GDS Regulations and the same provision of the PDS Regulations;

• Send a written copy of the review and any feedback from the action plan to the contractor.

9.4 Withholding Payments Following a Mid-Year Review

Any withholding of monies needs to be calculated in line with paragraph 59 (3) of Schedule 3 of the GDS Regulations and the same provision of the PDS Regulations. The maximum amount that may be withheld is:

- the amount that is payable under the contract in respect of the number of UDAs or UOAs required to be provided in a financial year; less

- the amount that would be payable under the contract as a relevant proportion of that amount if the contractor provided in the whole of the financial year only twice the number of units of dental activity or orthodontic activity that he provided between 1 April and 30 September.

Where the Commissioner withholds monies it shall ensure that it pays the withheld monies to the contractor promptly following the end of the relevant financial year where the contractor has:

• provided the contracted UDAs and UOAs; or

• has failed to provide the contracted UDAs or UOAs but that failure amounts to 4 percent or less of the total contracted UDAs or UOAs.

The Commissioner and the contractor may agree at any time to vary the contract to adjust the number of UDAs or UOAs to be provided under the contract and the monies to be paid to the contractor under the contract. Either the Commissioner or the contractor can notify the other party of its need for a variation, specifying why this is considered to be necessary together with reasons. The parties will use their best endeavours to communicate and co-operate with each other to agree what (if any) variation should be made and the related variations to the contract. No amendment or variation to the contract will have effect unless it is in writing and signed on behalf of the Commissioner and the contractor.
9.5 Year-End Review – GDS, PDS and PDS Plus

The Commissioner will carry out a year-end reconciliation on all of its primary care dental contracts to ensure that activity is being delivered against contracted requirements and to ensure dental activity is being commissioned accurately and in line with local oral needs assessments.

In June of each financial year, NHS DS will provide Commissioners with contract level data. This will provide Commissioners with the actual level of dental activity which has been delivered against each contract during the previous financial year. This figure is the total of the notifications sent by the contractor to NHS DS by way of FP17 submissions on completed courses of treatment.

NHS DS provides contractors with a monthly total of the notifications sent by the contractor to NHS DS.

If a contractor disputes the total number of notifications sent by the contractor to NHS DS, they should liaise directly with NHS DS for resolution by 31st May.

The contractor is required to provide notification of a course of treatment, orthodontic treatment, etc within 2 months in accordance with paragraph 38 of Schedule 3 of the GDS Regulations and paragraph 39 of Schedule 3 of the PDS Regulations. Where the contractor fails to provide a notification within the 2 month time limit, the Commissioner does not have to pay for this activity nor take into account its delivery and therefore does not have to have it included within the activity report.

The Commissioner will use data supplied by NHS DS in relation to the total number of notifications received (the total number of UDAs and UOAs). The contractor is responsible for providing written documentation and evidence of any dispute with the NHS DS data and any outcome to the Commissioner’s primary care dental lead to take into consideration.

When carrying out the year-end reconciliation, refer to the flow chart in Annex 43 and the financial template in Annex 44.

While the contract holder should aim to deliver one hundred percent of their total contracted units of activity, there will be deviations from this and they must be dealt with as set out below.

NB: Rounding up or down of year end performance figures is not allowed

It is recognised that sometimes manual adjustments need to be made to the NHS Dental Services data. This can be as a result of:

- Missing claims (Providers are encouraged to submit electronically to support any manual post end year statement publication changes)
- Exceptional circumstances (as defined in this policy booklet);
• Change of ownership which requires contract figures to be combined at year end

Where any amendments are made, they should be highlighted on the year end spreadsheet and signed off by the appropriate signatory e.g. Senior Contract Manager and/or Senior Finance Manager who must be independent from the individual who has calculated the amendment.

From an audit perspective, Commissioners should undertake a quarterly reconciliation of NHS Dental Services data. This will enable Commissioners to identify any anomalies or exceptions in a timely manner and discuss any issues with practices with immediate effect.

9.6 Under Delivery of UDAs or UOAs – Below 96 Percent

Where a contractor has delivered less than 96 percent of their contracted activity, the Commissioner will recover the full amount of money (the overpayment to the contractor in respect of the activity actually delivered under the contract) up to the full contract value. Please see Annex 45

In addition to recovery of the overpayment, the Commissioner may also serve a Breach Notice on the contractor for the failure to deliver the contracted activity (Annex 46). The Commissioner will have regard to the reasons for under-delivery including those covered by the circumstances in Annex 49.

Where a variation to the contract is agreed, adjustments should also be made on the payment system. Any contract variation or 're-basing' must be agreed, in writing and signed on behalf of the Commissioner and the contractor.

Where a contractor chooses to make a one-off payment in respect of the repayment of the overpayment, this must be set up as a debt on the payment system.

Where a repayment plan is agreed, the Commissioner will need to take into account PCR charges, superannuation and levies and so on, to ensure there is enough money in the scheduled payment to cover the debt. This minimises the financial risk to the Commissioner and should ensure that it does not allow the contractor to go into negative payments, therefore creating a further cumulative debt. The repayment plan should be agreed in writing between the Commissioner and the contractor and signed by the parties.

The Commissioner is able to agree a mix of a lump sum payment and a repayment plan for the balance.

The preferred repayment mechanism is through the NHS DS payment and contract management system.
The timing of entering a lump sum or repayment plan on the payment and contract system must fit into NHS DS scheduled cut-off points for NHS England cycle of processing, so it is always advisable to contact the NHS DS finance team in advance on 0300 330 1348.

Except in exceptional circumstances, the maximum length of a repayment plan is the end of March following the review date.

If either of the following circumstances occurs and the time period in the relevant circumstances has elapsed, the Commissioner shall act as if the Breach Notice was not issued. The Commissioner will not look to rely on the Breach Notice when taking any future actions under the GDS contract or PDS agreement:

1. A Breach Notice is issued to a contractor who has achieved between 90 per cent and less than 96 per cent of a contract’s UDA/UOA target in a particular financial year and, in the following two financial years, the contractor achieves 96 per cent or more of the contract’s UDA/UOA target.

2. A Breach Notice is issued to a contractor who has under-delivered against the contract’s UDA/UOA target in a particular financial year and, in a following year, the contractor and Commissioner agree a recurrent rebase of the contract’s UDA/UOA target

**9.7 Under Delivery of UDAs or UOAs - Between 96 Percent and 100 Percent**

Where the contractor fails to deliver the full contracted UDAs or UOAs and that failure amounts to 4 percent or less of the total contracted UDAs or UOAs and the contractor agrees to provide the units it has failed to deliver within a period of no less than 60 days and agrees with the Commissioner, the Commissioner will not take any action for failure to provide the contracted UDAs or UOAs. This is commonly known as the 4 percent tolerance and permits the carrying forward of some contracted activity with the agreement of the Commissioner. This is set out at regulation 18 of the GDS Regulations and regulation 15 of the PDS Regulations.

If a contract under-delivers within the tolerance level then this activity must be delivered within the financial year. Any carry forward of activity must be entered onto the payment system.

Breach Notices in relation to the under delivery of UDAs or UOAs cannot be issued if a contractor delivers activity within this range.

The Commissioner should send the contractor a copy of the standard letter and reconciliation report (Annex 47).

**9.8 Under Delivery of Domiciliary and Sedation Services**
Where the contractor is contracted to provide domiciliary and/or sedation services the contract must specify the number of courses of treatment the contractor is required to provide or contribute to as a referral service.

Where the contractor fails to provide the contracted number of courses of treatment the Commissioner may serve a Breach Notice on the contractor.

Where the contract details the financial sum payable in respect of the domiciliary and sedation services and these are not provided by the contractor in the relevant financial year, the Commissioner may seek recovery of the overpayments in this regard.

9.9 Over Delivery

Unless the contract specifies that the Commissioner will pay for the delivery of UDAs or UOAs over the contracted activity set out at clauses 77 and 78 of the standard GDS contracts and PDS agreements there is no requirement for the Commissioner to make additional payments to the contractor or to take this activity into account during the next financial year. The Commissioner may allow a tolerance of up to two percent of UDAs only, per year (therefore a maximum of 102 percent of the contracted UDA activity). The Commissioner may pay for the additional activity or it may be credited to the following contract year. This flexibility is at the discretion of the Commissioner and will need to be entered on the payment system and would be unlikely to be agreed where the contractor is in breach or has had a remedial or Breach Notice issued in the last 12 months.

A Template letter to the contractor is provided in Annex 48.

The Commissioner has the discretion to commission non-recurrent activity in any financial year which may be funded according to local priorities and circumstances.

9.10 Exceptional Circumstances

In exceptional circumstances, there may be instances in which a contract holder is unable to fulfil its contractual requirement to deliver the contracted activity. These cases need to be considered on an individual basis and could include a decision by the Commissioner to waive its rights to recover overpayments in exceptional circumstances where agreement is reached on how the activity will be delivered or the funding repaid over a longer period than is set out above. Where appropriate the Commissioner should refer to the policy on adverse events.

If a contractor is claiming for dental relief, the Commissioner should postpone consideration of the issue of a remedial or Breach Notice for under-delivery until the outcome of the claim is known. Where the claim is successful, it is inappropriate for the Commissioner to issue a breach or Remedial Notice for under-delivery. For audit purposes the Commissioner will need to ensure local governance processes are followed.
Annex 49 contains a table of some elements which could be considered exceptional circumstances. This list is not exhaustive.

### 9.11 PDS Plus

The Commissioner will follow both the mid-year and year end procedures set out above, in line with the PDS Regulations and SFE for any PDS plus agreements.

Schedule 3 of the PDS plus agreement provides the breakdown of agreement values in to service payment, access payment and performance payment. All payments are paid monthly and paragraph 8 of Schedule 3 of the PDS plus agreement outlines the annual reconciliation for the service, access and performance payments. Commissioners will need to calculate any under performance in line with the details contained within each specific PDS Plus agreement.

Where PDS plus agreements contain KPIs, Commissioners should request evidence from providers to confirm that the KPIs have been met. This information should be sent by providers annually and be managed as part of the year end process. Information should be submitted by providers no later than 30th June each year. A template letter is attached for the information request (Annex 50).

Commissioners should review the KPI evidence and factor their achievement into the overall year end calculations of the provider. A sample template is provided (Annex 51).

The Commissioner should share the findings with the provider in order to agree the year end position.
10 Practice Closedown

This policy outlines the approach to be taken when a time-limited primary dental 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).

Time-limited contracts can be in place for GDS and PDS contract types. GDS contracts, however, do not usually have an end date but it is possible for a temporary GDS contract to 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.

PDS agreements may be in perpetuity or for a time limited period. Commissioners should review the relevant PDS agreement to establish if there is a defined end-date.

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.

The Commissioner must consider whether the expiring contract contains provisions relating to the end of the contract that impact on any practice closedown actions. The standard form GDS Contract contains 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.

Contracts may come to an end by reasons other than by expiry including by:

- being terminated by either the Commissioner or the contractor (in which case please refer to the policy on contract breaches and termination);

- an adverse event (in which case please refer to the policy on adverse events);

- the death of the contractor (in which case please refer to the policy on the death of a contractor); or

- retirement of the contractor (in which case please refer to the policy on contract variations).

10.1 Timetable for Managing Contracts Coming to an End

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.
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 Annexures 52 and 53 are guides to communications with contractors and a proposed checklist for documentation recording.

In each of the stages below there are a range of activities that may need to be undertaken, depending on the Commissioner’s preferred route, and the Commissioner may wish to consult with the appropriate LDC throughout.

10.2 Summary of Key Stages

There are three key stages:

**Stage 1: minimum 9 to 15 months before contract end (all essential):**

- needs assessment;
- value for money;
- impact assessment; and
- engagement proposal.

**Stage 2: 12 months before contract end:**

- notice period – exit plan;
- wind-down of services;
- commence procurement and either:
  - begin negotiations for continuation with contractor; or
  - begin exit arrangements of incumbent provider and mobilisation of any new provider.

**Stage 3: at contract end:**

- arrangements for ongoing treatment of patients under existing course of treatment;
- variation to contract/extension: and
- commencement of new provider.

10.3 Stage 1 – 9 – 15 Months before Contract End
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.

**Needs assessment**

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

Does the contract specification still address current local priorities?

Has the contract delivered on the expected outcomes?

Has the service provided added value to the local population and service provision?

Have you assessed the potential service needs for an forthcoming new developments?

What is the capacity of other local providers and the market for other providers to deliver services?

Have you given consideration to any specialist services needs in the locality?

Are there any needs which are not met by the contract which could be delivered?

**Value for money**

Have you considered all available outcome and delivery data held nationally and locally, regarding the current service and impact on other providers?

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?

Is the current service still affordable within projected future budgets?

Has the contract delivered on the expected financial outcomes?

What other objectives might be set within the existing budget?

**Impact assessment**

Have you considered the potential impact on service users/patients?

Have you considered the potential impact on other service providers, e.g. GPs, pharmacy, local trust, out of hours, community services?
Have you considered the potential impact on the current provider, i.e. continued viability within the locality?

Have you considered patient choice and equality?

Have you considered the potential risks i.e. reputational (adverse publicity, Commissioner/provider relationship), market testing, timescales and financial?

Have you considered how the expiry of the contract affects compliance with the general duties of NHS England? For further information on these duties, please refer to the chapter on General Duties of NHS England.

**Engagement proposal**

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 consultation before taking action, the Commissioner should consider:

- have service users/patients been involved? Refer to chapter 4 (General Duties of NHS England) for more information on this requirement;

- have other local providers and other interested parties been involved i.e. LDC;

- local members of parliament, review and scrutiny committee, etc. been consulted?

- have the local CCGs been consulted?

If the answer is ‘no’ regarding any of the above, the Commissioner should be able to identify the grounds under which they felt consultation was unnecessary and these should be included in the report defined below.

**Completion of Stage 1**

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 5.4) about the investigations undertaken, consultation and outcomes. This report shall demonstrate that the Commissioner has considered all possible options and the rationale behind the decision taken.

**10.4 Stage 2 - 12 Months before Contract End**

Below are the potential next stages following stage1 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

Issue a letter of notice of intentions.

Develop an exit plan (a template is provided in Annex 55) 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.

Wind-down of services

The contractor should use best endeavours to complete patients' treatments prior to close-down because, where a continuation of treatment at the same or lower band within two months is needed, patients will be required to pay the relevant dental charge when this is carried out by another provider.

The Commissioner should discuss with the contractor on a case by case basis how the Commissioner will support the transition to a new provider (if applicable),

Procurement

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.

Once a preferred provider is established, agree an operational management plan (a template is provided in Annex 56 – this template should only be used where the contract does not contain exit arrangements as any such arrangements take precedence over the template).

Begin negotiations for continuation of the contract with the existing contractor, if appropriate

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.

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.
Once the decision to extend has been reached and all correct processes have been followed the Commissioner will need to consider:

- the length of extension;
- any alterations to the existing contract (including the financial arrangements); and
- any agreement of new key performance indicators (KPIs)

**Completion of stage 2**

Completion of stage 2 will provide the Commissioner with the firm foundations and detailed preparations ready to manage the end of the contract.

**10.5 Stage 3 – At Contract End**

Below are the possible outcomes culminating from stages 1 and 2 Arrangements for ongoing treatment of patients under existing course of treatment.

Where courses of treatment have not been completed, the Commissioner should ensure that patients are aware that where a continuation of treatment at the same or lower band within two months is needed, patients will be required to pay the relevant dental charge when this is carried out by another provider. Similarly, patients seeking recourse under free repair and replacement provisions need to be made aware that there will be a fee to pay if a repair and/or replacement treatment is performed by an alternative practice.

Where a patient is undergoing an orthodontic course of treatment, it may not be possible, due to the nature of treatment patterns and their longevity, that treatment can be completed prior to close-down. The Commissioner should work with the contractor’s representatives to:

- obtain copies of any orthodontic health records for patients currently in treatment that could then be provided to an alternative provider; and
- obtain patients’ details so that they can be contacted regarding continuation of their treatment.

The Commissioner will need to secure alternative provision for those patients undergoing a course of orthodontic treatment. This can be with other local orthodontic providers or they may need to consider commissioning these services from secondary care providers where alternative primary orthodontic care provision is not available.

Currently the GDS contract or PDS agreement and the relevant SFE state the level of payment for an orthodontic course of treatment. Due to the payment structure and length of an orthodontic course of treatment, the Commissioner may wish to
raise the cost pressures of paying for these patient transfers within its risk register. Payments should be made in accordance with the policy on orthodontic close down arrangements.

The Commissioner may wish to procure additional activity from orthodontic providers on a non-recurrent basis, on a case by case fee structure while they consider whether or not to procure a contract or agreement. If this is the path that is chosen by the Commissioner it would be advisable to seek independent procurement and legal advice.

**Contract end**

Service ceases.

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.

**Variation to contract – extension**

Contract variation issued and signed off by both parties.

**Commencement of new provider**

Issue of new contract.

Operational management plan implemented.

Relevant communications undertaken, internally and externally.

On completion of stage 3, the Commissioner will have reached an agreed, structured outcome about the management of contract end.
11 Orthodontics

11.1 Introduction

Second Course of Treatment

The commissioning guide, page 12 point 4.4.1 states: 
Patients will only be offered one course of NHS-funded routine Orthodontic treatment, unless there are exceptional circumstances. Such cases include where interceptive or growth dependent treatment has been undertaken and IOTN remains greater than 3.6. Any patient not meeting these circumstances would need to apply via their Commissioner who will seek clinical advice from either their dental LPN or MCN to approve a second course of treatment. There may be occasions when an appliance has to be removed during a course of treatment to allow a patient to undergo other procedures such diagnostic services. Recommencing treatment would not constitute a new course of treatment.

Second Opinions

- Where a patient has been refused orthodontic treatment and has appealed this decision, please refer to the NHS England Orthodontics second assessment appeals policy.

Orthodontic Transfer from Abroad

Where a patient begins treatment abroad (not just EEA) and subsequently becomes a permanent resident in the UK and entitled to NHS care, NHS criteria is applicable and not the criteria from the country where they began treatment.

Patients should arrange for their original patient records including study models, x-rays, photographs and notes to be provided so that an NHS orthodontic specialist who is calibrated in IOTN can confirm whether they would have met NHS criteria on their original assessment date (i.e. that they were under 18, an IOTN of at least 3.6 and have good oral health). Please see attached draft template (Annex 57) that can be amended for use.

If the orthodontist feels that the NHS criteria would have been met, a course of treatment can be provided.

If the orthodontist does not feel that the NHS criteria would have been met or original patient records are not provided, a course of treatment will not be provided.
11.2 Orthodontic Close Down Arrangements

Introduction

This policy has been written to provide Commissioners with an agreed set of principles to manage close down arrangements following the re-procurement of an existing orthodontic contract.

In addition this may also apply in the following circumstances:

- Where a contractor plans to retire or terminate their contract for personal reasons, and there is no current agreement from them to complete patients in treatment
- Where a contractor plans to retire or terminate their contract for personal reasons, and there is no identified commissioning need to re-procure services
- In the event of the sudden death of the contractor (who is an individual contract holder) where the representatives of the contractor are willing and able to ensure completion for patients in treatment

Where contractors are not willing to agree with close down arrangements, all patients, not just those under assessment or on the waiting list will need to transfer to a new contractor and a full course of treatment provided.

The close down arrangements where applicable include:

- A process for validating the patient list from the existing contractor
- Calculation of close down payments to be made to the existing contractor to complete patients in active treatment
- Contract documentation required to accompany close down payments

Background

Orthodontic expenditure amounts to £253 million based on 2014/15 figures which represents 9% of the overall dental budget.

Since 2006 the majority of NHS primary care orthodontic services have been delivered under time-limited PDS agreements, most of which were initially set up for five years.

Many of these initial agreements were extended and in November 2013 NHS England published orthodontic specific transitional guidance for Commissioners. This policy was intended to support Commissioners with contracts in transition and stimulate improvements in quality and efficiency to contract extensions, prior to any orthodontic needs assessment and formal re-procurement plans.

Following publication of the Orthodontic Commissioning Guide in September 2015,
the legal and regulation sub group (of the national implementation group) were tasked with agreeing a set of principles for Commissioners to adopt when re-commissioning orthodontic services covering:

- Managing patients in transition
- Close down arrangements for contracts - covering a number of potential commissioning scenarios

The group were also tasked with developing guidance for Commissioners to cover:

- How to prepare for an orthodontic procurement process
- Patient consultation and patient choice responsibilities
- Service specifications

The objectives of this group were agreed as:

- Continuity of high quality care for patients; with the current contractor where possible to obtain the best possible health outcome
- A viable financial offer for contractors to complete patients in active treatment
- National consistency for contractors entering into close down arrangements
- Giving due consideration to the current climate of austerity within the NHS, and being able to demonstrate value for money internally and for the taxpayer

The work undertaken by the group covered the following key areas:

- Agree the steps in the patient journey, including labour and material costs at appropriate stages. See Annex 58.
- Set out a process for confirming patients under orthodontic care
- Identify possible payment mechanism for patients under care; consisting of two options

As part of their work the group also undertook a scoping exercise to build up a national picture around re-commissioning of orthodontic services. A template was prepared and sent to local offices for completion. The results from this exercise identified that over the next three months to five years approximately 500 contracts will require re-procurement subject to local oral health needs assessments and commissioning intentions.

This position was based on the data collected in March 2016, and this is currently being updated to reflect single tender awards (STA’s) that have been agreed and local commissioning intentions that have been progressed throughout 2016.
Agreed approach for close down arrangements

The proposals developed by the working group were considered by the Primary Care Delivery Oversight Group in February 2017 and the following principles were agreed:

- One approach is to be applied across NHS England to manage patients affected by contracts in transition and to identify patients in active treatment.
- It is in the best interest of the patient to complete their course of orthodontic treatment with their existing provider and the local office should approach the current contractor as early as possible to discuss the close down arrangements.
- A one-off close down payment will be paid to the contractor to complete outstanding courses of treatment.
- The payment to contractors will be based on the number of patients in active treatment, split into two categories:
  - Patients under active treatment – with a fixed appliance only
  - Patients under supervised retention
- The payment for active treatment only covers those patients who are being treated using fixed appliances; it should not be used for patients who are being treated using removable appliances.
- Patients who are deemed on the waiting list, have had case assessment only or have a removable appliance will be managed separately to this process and most likely by a new contractor.
- A one-off fee of £662 per patient will be paid for those patients in active treatment. This value is based on 50% of the cost of a course of treatment at national average UOA value of £63 (21 UOAs * £63). This one-off fee is payable for all patients in active treatment irrespective of the stage of treatment they are at. It is recognised that there will be a combination of patients at different stages of their treatment.
- A one-off fee of £25 per patient will be paid for those patients in retention. This value is based on 50% of £49 which is the cost per patient to conclusion, based on the costs identified in the patient pathway. See Annex 58 for further details.
- Where a patient in active treatment requires a repair of a fixed orthodontic appliance this is accounted for in the close down payment.
- When calculating the close down payments, Commissioners must use these agreed values. It is not appropriate to apply this calculation using local UOA values. A template has been provided in Annex 60 accompanying this policy to calculate the value of close down payments.
- Close down arrangements do not apply to contractors who have been successful.
in the re-procurement process. In these cases the contractor will continue to treat their existing caseload.

**Local office process for implementing orthodontic close down arrangements**

- The local office, on receipt of notice of termination by a contractor or at time of contract notification during procurement, will begin discussions with the outgoing contractor to discuss the continuation of clinical care for patients who are in active treatment (fixed appliance only) or in supervised retention

- If the contractor is willing to continue to provide this clinical care, the local office will provide the contractor with a template form to complete, provided in Annex 59, with details of all the patients under their NHS care. The contractor must complete this form electronically and submit it back to the local office. Instructions to complete the form are provided in the electronic spreadsheet

- Where the contractor does not agree to the close down arrangements, the local office will need to seek alternative arrangements for patient care. The funding should follow the patient.

- The local office will also request a list of the patients held by NHSBSA for this contractor

- The contractor will confirm the premises out of which they will be providing clinical care. Where this is not the existing premises the local office will need to confirm their suitability for provision of clinical care and that its location still meets the needs of the patients and the commissioning intentions of the local office. Where the premises are not deemed suitable, the local office may refuse to allow the contractor to go forward with close down arrangements and will seek alternative arrangements for patient care or the contractor can make alternative arrangements.

- The local office will reconcile the data sets and will query with the contractor where there are missing patients (i.e. on NHSBSA list but not contractor or vice versa) and agree a finalised list with the contractor

- Based on the reconciled data set the local office will calculate how many patients are in active treatment (fixed appliance only) or in supervised retention

- The local office will calculate the longest period of time a patient may remain under the clinical supervision of the contractor

- Contractor agrees to provide close down arrangements on basis of number of patients on list and payment OR contractor does not agree to close down arrangements and the local office need to seek alternative arrangements for patient care

The local office will agree with the contractor the payment arrangements. The payment is a one off payment per patient regardless of length of treatment.
The total payment will be calculated and paid over a minimum period of 12 months, or longer by mutual agreement between the Contract and Commissioner.

- The agreed payment schedule will form part of the PDS variation notice.
• Where the contract is ending due to a procurement process or it is the end of the natural PDS agreement period, the local office will apply for a STA using NHS England agreed processes for an extension to the PDS agreement period for a period of time not exceeding the length of treatment for the last patient to be completed by the contractor

• When the STA has been made, the local office will extend the PDS agreement which will also be varied to remove the contracted UOA levels and associated remuneration and for the new payment arrangements to be implemented. An example PDS variation notice is provided in Annex 61

• Where the contract is terminating due to notice by the contractor but within the timeframe of the current contract, the PDS agreement will be varied to remove the contracted UOA levels and associated remuneration and for the new payment arrangements to be implemented

• Local office to send documentation to practice for signature of contractor
• Contractor to sign and return documents
• Local office to sign documents and send signed copy to contractor
• Local office to amend Compass noting new end dates, removing UOA level and associated contract payments and adding new payment levels
• Contractor provides clinical care to patients in active treatment (fixed appliance only) and in supervised retention
• Contractor does not provide any new case assessments or case starts
• Contractor submits FP170 to NHSBSA on completion of active treatment / supervised retention
• Local office monitors activity of contract during period of orthodontic close down
• Failure by the contractor to complete the courses of treatment within projected time scales other than for reasons of patient choice, the local office can review the payment received and contractor may be liable for repayment of funds received.

• On completion of the PDS extension the agreement is closed and ended on Compass.
If required Local office request STA requested for extension period of PDS agreement for closedown arrangements

Local office provides contractor with extension document including variation to UOA activity levels and new payment arrangements

Contractor signs both copies and returns to local office

Local office provides contractor with extension document including variation to UOA activity levels and new payment arrangements

Local office amends Compass system to reflect new payment arrangements, end date and 0 UOA delivery requirement

Local office signs contract documentation and returns one copy to contractor

Local office amends Compass system to reflect new payment arrangements, end date and 0 UOA delivery requirement

Local office monitors activity at contract to ensure no new assessments or case starts

Where contractor does not complete treatment local office can review payments and contractor may be required to repay funds.

Where contractor does not complete treatment local office can review payments and contractor may be required to repay funds.

When all patients discharged from care Local office closes PDS agreement and ends contract on Compass
Part C – When things wrong
12 Contract Breaches, Sanctions and Termination

12.1 Introduction

This policy outlines the approach to be taken when primary dental services contracts are considered to have been breached. Where processes differ with regards GDS contracts and PDS agreements, these are highlighted.

Given that any decision to issue a Remedial or Breach Notice, apply Contract Sanctions or terminate a contract 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.

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 dental care commissioning arrangements.

It is important to keep a clear record of each step along the way – what happened, when, why, who was involved – so that the Commissioner is in a position to show that they have acted reasonably throughout and in accordance with the relevant regulations.

Commissioners will submit information on the number of remedial and Breach Notices and terminations issued to the national team on a monthly basis. This information should be submitted to england.primarycaredental@nhs.net.

12.2 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 an action with the contractor;
- issue a Remedial Notice;
- Issue a Breach Notice;
- apply a Contract Sanction; or
- terminate the contract.

Doing nothing and agreeing an action with the contractor are options that are Always available to the Commissioner. The remaining options may only be applied in specific situations as envisaged by the contract.
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.

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 approval of the action, compliance with any standing orders and due consideration of all relevant factors in the decision making process.

### 12.3 Remedial Notices and Breach Notices

The GDS and PDS Regulations 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.

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).

**Remedial Notice**

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.

A flowchart highlighting the main steps that the Commissioner should take when issuing a Remedial Notice is set out in Annex 62.

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.

- provision of untrue information;
- on grounds of suitability;
- a serious risk to patient safety or risk of material financial loss to NHS England;
- unlawful sub-contracting; and
- in the case of a GDS contract, issues relating to the contractor's eligibility to hold the contract.

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 patient information leaflet; or
• failure to provide information to the Commissioner.

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.

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 Commissioners 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:

• 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 Remedial Notice.
• The contractor should be afforded the opportunity to provide an explanation as to the circumstances that led to the breach and this discussion should be recorded accurately in writing.
• The Commissioner should review the evidence related to the breach including any information received during the discussion or in representations.
• 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.
• 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.

A Remedial Notice must specify:

• details of the breach, which led to the Remedial Notice being issued and any evidence gathered in respect of the breach;
• the steps the contractor must take in order to remedy the breach to the Commissioner’s satisfaction;
• the period in which the steps must be taken;
• any arrangements for reviewing the matter to ensure that the requirements of the Remedial Notice have been met; and

• the actions that the Commissioner shall take if the contractor fails to satisfactorily remedy the breach.

The Commissioner may wish to include in the Remedial Notice how the contractor may appeal against the decision to issue a Remedial Notice.

A template Remedial Notice is provided in Annex 63. Where NHS England is the Commissioner, the finalised Remedial Notice should be signed off by the Head of Commissioning or their nominated deputy.

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.

The Remedial Notice must be delivered to the contractor in accordance with the notice provisions of the contract. This usually requires postal delivery (signed for 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.

The Commissioner should ensure that arrangements are in place to follow up a Remedial Notice appropriately and in a timely fashion. A declaration of remedy should be sought from the contractor to confirm their compliance.

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 64.

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 issue a Contract Sanction or terminate the contract with effect from such date as the Commissioner may specify in a further notice to the contractor.

Where the Commissioner intends to terminate the contract, please refer to the Termination and Key Considerations on Termination sections below.

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.
The right to terminate 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. Where the Commissioner intends to terminate the contract under this right, please refer to the section entitled *Termination relating to Remedial Notices and Breach Notices* below.

If the contractor is in breach of any obligation and a Remedial Notice in respect of that breach has been given to the contractor, the Commissioner may withhold or deduct monies which would otherwise be payable under the contract in respect of that obligation which is the subject of the breach.

**Breach Notice**

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.

A flowchart highlighting the main steps that the Commissioner should take when issuing a Breach Notice is set out in Annex 65.

Breach Notices cannot be issued where the breach relates to the following rights of termination:

- provision of untrue information;
- on grounds of suitability;
- a serious risk to patient safety or risk of material financial loss to NHS England;
- unlawful sub-contracting; and
- in the case of a GDS contract, issues relating to the contractor’s eligibility to hold the contract.

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.

An example of a breach that is not capable of remedy is a practice closing during its contracted opening times with no access for the contractor’s patients to access mandatory services.

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.

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 Commissioners 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:

- 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 Commissioners right to issue a Breach Notice.

- The contractor should be afforded the opportunity to provide an explanation as to the circumstances that led to the breach and this discussion should be recorded accurately in writing.

- The Commissioner should review the evidence related to the breach including any information received during the discussion or in representations.

- 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.

**The Breach Notice must specify:**

- details of the breach and the requirement that the contractor must not repeat the breach again; and

- the consequences of the contractor further breaching their agreement.

A template Breach Notice is provided in Annex 66. Where the Commissioner is NHS England, the finalised Breach Notice should be signed off by the Head of Commissioning or their nominated deputy.

The Breach Notice must be delivered to the contractor in accordance with the notice provisions of the contract. This usually requires postal delivery (signed for 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.

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.

If either of the following circumstances occurs and the time period in the relevant circumstances has elapsed, the Commissioner shall act as if the Breach Notice was not issued. The Commissioner will not look to rely on the Breach Notice when taking any future actions under the GDS contract or PDS agreement:

1. A Breach Notice is issued to a contractor who has achieved between 90 per cent and less than 96 per cent of a contract’s UDA/UOA target in a particular financial year and, in the following two financial years, the contractor achieves 96 per cent or more of the contract’s UDA/UOA target.
2. A Breach Notice is issued to a contractor who has under-delivered against the contract's UDA/UOA target in a particular financial year and, in a following year, the contractor and Commissioner agree a recurrent rebase of the contract's UDA/UOA target.

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. Where the Commissioner intends to terminate the contract under this right, please refer to the section entitled Termination relating to Remedial Notices and Breach Notices below.

If the contractor is in breach of any obligation and a Breach Notice has been issued the Commissioner may withhold or deduct monies which would otherwise be payable under the contract in respect of that obligation.

12.4 Contract Sanctions

The Commissioner must follow the process set out in this section. PDS agreements refer to "agreement sanctions" rather than Contract Sanctions. Reference to Contract Sanctions in this paragraph should be read as including reference to agreement sanctions.

Contract Sanctions must not be applied to a contract unless the Commissioner is in a position to move to terminate. Where Contract Sanctions are applied, this is as an alternative to terminating the contract. The Commissioner cannot apply Contract Sanctions and later decide to terminate the contract in the same circumstances.

The circumstances in which the Commissioner may apply Contract Sanctions are those set out below where a right of termination arises. Please refer to the relevant right of termination for further information on how these rights of termination arise:

- provision of untrue information;
- on grounds of suitability;
- 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:
o repeats a breach that was the subject of a Remedial Notice or a Breach Notice; or

o otherwise breaches the contract resulting in a further Remedial Notice or Breach Notice;

• where the contractor carries on business detrimental to the contract;

• where the contractor is a dental corporation (and for PDS agreements, a company limited by shares) and there are certain matters relating to the directors of the dental corporation (or the company limited by shares) and Article 39 of the Dentists Act Order comes fully into force;

• for GDS contracts, where changes in the membership of the partnership (or a limited liability partnership) is likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform obligations under the contract;

  o for PDS agreements, where:

    o the contractor is a company limited by shares and the company ceases to be a company limited by shares or fails to satisfy certain conditions;

    o the contractor is a limited liability partnership and the partnership ceases to be a limited liability partnership or fails to satisfy certain conditions; or

Contract Sanctions must not be applied if they terminate or suspend any obligation that relates to mandatory 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.

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.

Where the Commissioner decides that the most appropriate sanction would be to withhold or deduct monies, this must be calculated in accordance with set criteria in order to establish a consistent, fair and measured approach. Annex 6.7 provides further information on calculating a financial Contract Sanction.
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 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.

A template Contract Sanctions notice is provided in Annex 68. Where NHS England is the Commissioner, the finalised Contract Sanction notice should be signed off by the Head of Commissioning or their nominated deputy.

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 to protect the safety of patients or protect NHS England from material financial loss.

Where a Contract Sanction is imposed, the Commissioner can charge the contractor reasonable administration costs of imposing the Contract Sanction.

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.

Where a dispute arises in relation to the imposition of a Contract Sanction, please refer to the policy on managing disputes.

The Commissioner should ensure that arrangements are in place to monitor the contractor's compliance with a Contract Sanction notice.

12.5 Termination

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. It is essential that the
Commissioner maintains thorough and accurate records of all communications and discussions in respect of all notices.

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.

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.

The GDS and PDS Regulations set out certain rights of termination that are required to be in the different types of primary dental contract. These mandatory termination rights are set out below. Where the termination relates to a matter that is contained within an alternative policy, this is highlighted.

The contract may contain additional termination rights. The Commissioner should consider the relevant contract to ensure it is fully aware of all termination rights. The following circumstances relating to rights of termination are required to be in GDS contracts and PDS agreements:

- agreement of the parties;
- death of a contractor;
- contractor serving notice;
- late payment;
- provision of untrue information;
- suitability;
- patient safety;
- material financial loss;
- Remedial Notices and Breach Notices;
- carrying on business detrimental to the contract; and
- certain matters relating to directors of dental corporations.

GDS contracts are required to contain additional rights of termination relating to:

- no longer eligible to enter into and breach of conditions of the contract;
- certain matters relating to the ceasing of a limited liability partnership; and
• certain partnership (including limited liability partnership) matters.

PDS agreements are required to contain additional rights of termination relating to:

• certain matters relating to directors of a company limited by shares;

• certain matters relating to the ceasing of a company limited by shares and/or a limited liability partnership; and

• Contractor’s exercise of the right to a GDS contract.

Contracts may also terminate or expire by:

• reaching their natural end dates (in which case, please refer to the policy on practice closedown for more information);
  
  o contract novation (in which case, please refer to the policy on contract variations); and

  o Retirement of the contractor (in which case, please refer to the policy on contract variations).

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.

A template Termination Notice is provided in Annex 69. The finalised Termination Notice should be signed off by the Director of Commissioning Operations or their nominated deputy.

Where the termination relates to:

• for GDS contracts and PDS agreements:
  
  o provision of untrue information;

  o suitability;

  o patient safety;

  o material financial loss;

  o Remedial Notices and Breach Notices;

  o carrying on business detrimental to the contract; and

  o certain matters relating to directors of dental corporations

• for GDS contracts:
• certain matters relating to the ceasing of a limited liability partnership; and

• certain partnership (including limited liability partnership) matters,

for PDS agreements:

• certain matters relating to directors of a company limited by shares; and

• certain matters relating to the ceasing of a company limited by shares and/or a limited liability partnership,

the notice must specify 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.

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 policy on managing disputes.

Where a Termination Notice is issued, the Commissioner should submit a Notice Return to the NHS England dental inbox (england.primarycaredental@nhs.net) as soon as practicable after issue. A template Notice Return is set out Annex 70.

12.6 Key Considerations on Termination

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.

A flowchart highlighting the main steps that the Commissioner should take when issuing a Termination Notice is set out in Annex 71.

The Commissioner must consider all relevant information available and decide on the appropriate course of action and whether the contract should be terminated.

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.

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 (refer to the policy on the death of a contractor) and in some part the paragraphs on the closure of a branch surgery (refer to the policy on contract variations).
Continuity of service provision

NHS England has a statutory duty to ensure 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.

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.

The Commissioner should ensure that it is able to signpost any patients seeking treatment, to other local dentists accepting NHS patients. This may be through making information available at the practice or via NHS 111 services, whichever is relevant.

Where a Termination Notice has been issued, the contractor should use best endeavours to ensure the completion of all open courses of treatment. This will not be possible where the termination is effective immediately and the Commissioner will need to work with other local dental providers to secure completion of the active courses of treatment.

Patients seeking recourse under free repair and replacement provisions need to be made aware that there will be a fee to pay if a repair and/or replacement treatment is performed by an alternative practice. Similarly, where a continuation of treatment at the same or lower band within two months is needed, patients will be required to pay the relevant dental charge when this is carried out by another provider.

Where a patient is undergoing an orthodontic course of treatment, it is unlikely due to the nature of treatment patterns and their longevity, that treatment can be completed within the Termination Notice period. The Commissioner should work with the contractor’s representatives to:

- obtain copies of any orthodontic health records for patients currently in treatment that could then be provided to an alternative provider; and
- obtain patients' details so they can be contacted regarding continuation of their treatment.

The Commissioner will need to secure alternative provision for those patients undergoing a course of orthodontic treatment. This can be with other local orthodontic providers or they may need to consider commissioning these services from secondary care providers where alternative primary orthodontic care provision is not available.

Currently the GDS contract or PDS agreement and the relevant SFE state the level of payment for an orthodontic course of treatment. Due to the payment structure and length of an orthodontic course of treatment, the Commissioner may wish to
raise the cost pressures of paying for these patient transfers within its risk register. Payments should be made in accordance with the policy on orthodontic close down arrangements.

The Commissioner may wish to procure additional activity from orthodontic providers on a non-recurrent basis, on a case by case fee structure while they consider whether or not to procure a contract or agreement. If this is the path that is chosen by the Commissioner it would be advisable to access specialist procurement and legal advice.

**PDS to GDS**

PDS agreements provide a right for the contractor to request to enter into a GDS contract. Such a request can only be refused where the contractor fails to meet the conditions set out in the PDS Regulations.

For further information on this, please refer to the chapter on Managing a PDS Contractor's Right to a GDS contract.

**General duties of NHS England**

Under section 13 of the NHS Act, NHS England has a number of statutory duties relating to the exercise of its functions including reducing health inequalities and patient involvement. The Commissioner must ensure that its actions in terminating a contract and any consequential actions ensure compliance with the section 13 duties and other applicable statutory duties of NHS England. In an urgent situation, it may be necessary to balance the duty to involve patients with the public interest in maintaining continuity of care and protecting the health, safety and welfare of patients or staff. Please refer to the Chapter on General Duties of NHS England for more information on the scope of the duties.

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 and Guidance on Patient and Public Participation in Commissioning.
- The Framework for Patient and Public Participation in Primary Care Commissioning.

**Premises**

The Commissioner should ascertain who owns the premises and what arrangements apply to the premises. Where the outgoing contractor controls the premises, a future service provider may not be able to use those premises for delivery of services. The Commissioner should consider what arrangements need to be put in place to ensure continued service provision.

**TUPE**
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.

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.

**Equipment**

Some equipment may be owned by the Commissioner. Arrangements may need to be put in place to retrieve this equipment to ensure it is available to a future service provider.

**Patient records**

Where it is not possible to complete patients’ treatments within the termination notice period, arrangements must be made to transfer patient records securely to any other local dental providers that are completing the courses of treatment. Patients should be fairly notified of the transfer.

**Prescriptions**

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.

**Drugs and medicines**

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.

**Financial Reconciliation**

On termination of a GDS contract or PDS agreement, the Commissioner will need to carry out a financial reconciliation (for further information on this, please refer to the policy on financial recovery and reconciliation).
13 Rights of Termination

Death of a contractor

Please refer to the policy on the death of a contractor for further information.

Termination where both parties agree

Where the parties agree to terminate, the parties must agree the date from which termination will take place and any further terms relating to the termination. Before agreeing 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.

The contractor party may be composed of more than one person. The Commissioner must agree the same termination arrangements with all persons that constitute the contractor.

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.

Termination where the contractor serves notice

Contracts can be terminated by the contractor by serving notice in writing at any time.

Where a contractor serves notice to terminate, it shall terminate three months after the date on which the notice is served.

The Commissioner should send a letter to the contractor to confirm the termination and obtain further details on the transfer of the patient records. Please see template letter (Annex 72).

If the date on which the 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.

NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to the chapter on General Duties of NHS England.

Termination where the contractor exercises the right to a GDS contract

Please refer to the chapter on Managing a PDS Contractor's Right to a GDS Contract for further information.
Termination due to late payment

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.

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.

For further information on the NHS dispute resolution process, please refer to the policy on managing disputes.

NHS England's general duties may be triggered by termination in these circumstances. For further information, refer to the chapter on General Duties of NHS England.

Termination for provision of untrue information

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 GDS contracts, pursuant to paragraph 42(2) of Schedule 3 of the GDS Regulations, in relation to regulations 4 and 5 of the GDS or PDS Regulations (whichever is applicable) was, when given, untrue or inaccurate in a material respect.

NHS England's general duties may be triggered by termination in these circumstances. For further information, refer to chapter on General Duties of NHS England.

Termination due to suitability

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 dental practitioner, a partnership, a limited liability partnership, a dental corporation, a company or a director) falls within any circumstances set out in the relevant regulations. 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.

Details of the type of person connected with the contract and a full list of the relevant circumstances is set out in Annex 73 for GDS contracts and Annex 74 for PDS agreements.

NHS England's general duties may be triggered by termination in these circumstances. For further information, refer to chapter on General Duties of NHS England.

**Termination where there is a serious risk of patient safety**

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 are at serious risk if the contract is not terminated.

NHS England's general duties may be triggered by termination in these circumstances. For further information, refer to chapter on General Duties of NHS England.

**Termination where there is a material financial loss**

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.

NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to chapter on General Duties of NHS England.

**Termination relating to Remedial Notices and Breach Notices**

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.

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.

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.

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 should ensure that it is not looking to rely on a previous Breach Notice in the circumstances set out at the end of section 10.6 above.

NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to chapter on General Duties of NHS England.

**Termination due to the contractor carrying on business detrimental to the contract**

Where the contractor is:

· a dental corporation under a GDS contract; or

· a dental corporation, a company limited by shares or a limited liability partnership under a PDS agreement,

that is carrying on business which the Commissioner considers is detrimental to the 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.

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).

NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to chapter on General Duties of NHS England.
Termination due to certain matters relating to directors of dental corporations

If a contractor is a dental corporation under a GDS contract or PDS agreement, there are certain matters which allow the Commissioner to issue a Termination Notice provided that those matters lead to the Commissioner considering that the dental corporation is no longer suitable to be a contractor.

The three matters are:

a. if the majority of the directors of the dental corporation cease to be either dental practitioners or dental care professionals;
b. the dental corporation has been convicted of an offence under section 43(1) of the Dentists Act 1984; or
c. the dental corporation, or a director or former director of that corporation, has had a financial penalty imposed on it or him by the General Dental Council pursuant to section 43B or 44 of the Dentists Act 1984.

NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to chapter on General Duties of NHS England.

Certain matters relating to directors of a company limited by shares

Under a PDS agreement, the section above entitled Termination due to certain matters relating to directors of dental corporations also applies where the contractor is a company limited by shares and references in those paragraphs to the dental corporation should be read as references to the company limited by shares.

NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to chapter on General Duties of NHS England.

Termination due to partnership (including limited liability partnership) matters

The Commissioner has a right to terminate a GDS contract where:

- the contractor is two or more persons practising in partnership;
- one or more partners have left the practice during the contract; and
- if the Commissioner reasonably considers that the changes in 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.

The same right of termination exists where the contractor under a GDS
contract is a limited liability partnership and references to partners should be read as references to members.

Where these circumstances occur, 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 is likely to have a serious adverse impact on the ability of the contractor or the Commissioner to perform its obligations under the contract.

The Commissioners should note that this right of termination does not exist where the contractor is a limited liability partnership under a PDS agreement.

NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to chapter on General Duties of NHS England.

**Termination due to certain matters relating to the ceasing of a limited liability partnership**

The Commissioner must terminate a GDS contract with a limited liability partnership where the contractor ceases to be a limited liability partnership or where the contractor ceases to satisfy the conditions in section 102(2A) of the NHS Act.

Section 102(2A) sets conditions which must be satisfied in order for a contract to be held and continued to be held by a limited liability partnership. Once condition is that at least one member of the limited liability partnership must be a dental practitioner. There is a further condition relating to who has the power to conduct the partnership's affairs - either paragraph 7.29.1 or 7.29.2 must be satisfied:

- A member who is a dental practitioner or in the list set out in paragraph 7.29.3 below must have the power to secure that the partnership's affairs are conducted in accordance with that member's wishes; or

- If, in any combination of partners or members who, acting together, have the power (or who, if they were to act together, would have the power) to secure that the partnership's affairs are conducted in accordance with their wishes, at least one of them must be a dental practitioner or in the list set out below.

This list includes:

- an NHS employee,

- an individual who, in connection with the provision of services in accordance with either:
o Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972; or sections 17C, 50, 64, 92 or 107 of the NHS Act;

o is employed by a person providing or performing those services

o a health care professional who is engaged in the provision of services under the NHS Act or the NHS (Wales) Act 2006, or

o an individual falling within section 108(1)(d) of the NHS Act.

The requirement for the Commissioner to terminate also applies where the contractor is a limited liability partnership and ceases to be so under a PDS agreement. The conditions in section 102(2A) of the NHS Act don't apply to PDS agreements. Instead the Commissioner must terminate if the contractor is a limited liability partnership and either the limited liability partnership ceases or section 108(1B) and (1C) of the NHS Act cease to apply to the limited liability partnership. These sections relate to who has the power to conduct the partnership's affairs.

NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to chapter on General Duties of NHS England.

**Termination due to certain matters relating to where the ceasing of a company limited by shares**

The Commissioner must terminate a PDS agreement with a company limited by shares where the contractor ceases to be a company limited by shares or where the contractor ceases to satisfy the conditions in section 108(1A) of the NHS Act.

Section 108(1A) of the NHS Act relates to conditions for those holding shares in such a company. There are two conditions, both of which must be satisfied:

- every person who owns a share in the company must own it both legally and beneficially, and

- it must not be possible for two or more members of the company who are not persons who fall within Section 108(1)(a) to (e) to hold the majority of the voting rights conferred by shares in the company on any matter on which members have such rights.

NHS England's general duties may be triggered by termination in these circumstances. For further information, please refer to chapter on General Duties of NHS England.

**Termination due to the contractor no longer being eligible to enter into and breach of conditions of the contract**
The Commissioner must terminate a GDS contract immediately where a contract was entered into with a dental practitioner and the contractor is no longer a dental practitioner.

This requirement to terminate will not apply if the contractor has been suspended as set out in Regulation 69(6) of the PDS Regulations unless:

- the contractor cannot satisfy the Commissioner that adequate arrangements for providing services are in place for the suspension period; or
- the Commissioner is satisfied that the contract should be terminated forthwith due to a serious risk to patient safety or due to a risk of material financial loss to NHS England.

The Commissioner must terminate a GDS contract immediately or take the action where the contract is with two or more persons practising in partnership and the requirement that at least one partner is a dental practitioner is no longer satisfied. The requirement to terminate does not apply where this situation occurs due to the death of one of the persons in the partnership. Please refer to the policy on the death of a contractor for further information on the process to follow.

Where the situation in the above paragraph arises, the Commissioner may choose not to terminate the contract and instead confirm to the contractor that the contract may continue for an interim period. The Commissioner may only choose this option where it is satisfied that the contractor has in place adequate arrangements for the provision of dental services for the interim period. The interim period must only be six months or, if the requirement that at least one partner is a dental practitioner is no longer satisfied is because the relevant partner has been suspended as set out in regulation 69(6) of the PDS Regulations, for as long as the suspension lasts.

The Commissioner must terminate a GDS contract immediately where the contract was entered into with a dental corporation and the contractor ceases to be a dental corporation.

NHS England’s general duties may be triggered by termination in these circumstances. For further information, please refer to chapter on General Duties of NHS England.

13.1 Consequences of Termination

Contracts usually contain certain obligations on both parties on termination of the contract. The GDS and PDS Regulations do not set out any requirements for primary dental contracts to contain such provision but the standard GDS 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 for further information on this, please refer to the policy on financial recovery and reconciliation

The Commissioner should consider the relevant contract to determine what obligations relate to termination.
14 Unplanned / Unscheduled and Unavoidable Practice Closedown

14.1 Introduction

When a dental 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.

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.

14.2 Scope

This policy 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 patients must be at the heart of all decisions and actions;
2. In many cases taking preventive action in conjunction with support could be a preferable option to closing a practice.
3. In the 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 to work effectively together to minimise any disruption to patients and services.
4. Communication must be maintained throughout with patients and their families and carers and with other partners (e.g. LDCs / Healthwatch).

14.3 Roles and Responsibilities

Commissioners

The Commissioner will take the lead in the following actions:

- Ensure appropriate interim measures are put in place 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.
- Communicate to patients the details of alternative dental practices which could provide mandatory services
- Maintain ongoing consultative relations with patients, their families, other local dental 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 resettle, including a review of the placement after a reasonable timeframe.
- Identify a lead to coordinate communications.
- Engage with Local Dental Committee (LDC)

In the event that the practice physically closes, the 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.
- Ensure call forwarding arrangements are in place or appropriate answerphone message are established for the closing practice to alert patients and inform 111, OOH services.
- Dental Practice (during any period where the practice is still open):
  - The Commissioner will ask the dental 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 with people accessing services provided at or by the dental practice and their families.
    - Review and act on any guidance provided by the Commissioner in relation to the closure.
    - Record, collate and remove prescription pads. This includes both hand written and computer scripts.
    - Ensure all drugs / medicines in the practice are noted and handed into the local pharmacy and signed for.
Care Quality Commission (CQC)

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]

Local Dental Committee (LDCs)

The LDC 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 LDC section recognises that LDCs will champion the welfare of its members and wider practice staff.

14.4 The Process

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.

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 dentist or dental team) temporarily overseeing the practice at the closing practice’s existing premises and the care of its patients.

Engagement and re-procurement
Where arrangements have been made for another dentist to temporarily manage the dental practice (refer to the chapter on Urgent Contracts), or a practice has terminated a contract with little notice (e.g. 6 month) the Commissioner should refer to the 3 stages and templates listed in this policy and guidance manual under the chapter on Planned Closedown.

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 and any consequential actions ensure compliance with these duties. Please refer to the chapter on General Duties of NHS England for further guidance.

However, 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. If a Commissioner considers acting in a way that may not comply with its statutory duties, it should seek further advice.
15 Death of a Contractor

15.1 Introduction

The aim of this policy is to provide consistency when dealing with the death of a contractor, whether they are a single-handed contractor, in a partnership or a corporate organisation. This policy includes consideration of GDS and PDS contracts.

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 agreed timescales that are laid down in legislation.

15.2 Individual - GDS and PDS Contracts

Where a contract is with an individual dental contractor and that contractor dies, the contract must terminate at the end of the period of 28 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 six months after the end of the period of 28 days; and

- the contractor's personal representatives have confirmed in writing to the Commissioner that they are employing or engaging one or more dental practitioners to assist in the provision of dental services under the contract throughout the period for which it continues.

Where the contractor's personal representatives have confirmed in writing to the Commissioner that they are employing or engaging one or more dental practitioners, the Commissioner should issue a Notification Letter setting out the timescales of the continuation. A template Notification Letter is provided in Annex 75.

Where the Commissioner is of the opinion that another contractor may wish to enter into a contract in respect of the mandatory services which were provided by the deceased dental contractor then the six month period may be extended by a period not exceeding a further six months. A template Notification Letter is provided in Annex 76.

The Dentist Act 1984 states at section 41(4) that on the death of a registered dentist who was carrying on a dentist business, that person's personal representatives, widow, children (or trustees on behalf of his widow or any of his children) may carry on the business for three years after that person's death. It should be noted that this does not confer the right to an NHS dental contract for the same period.
15.3 Partnership – GDS Contract

The GDS 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.

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 deeds to avoid termination of their contract.

The GDS Regulations require GDS contracts to contain specific provisions relating to the dissolution or termination of partnerships.

Where a partner dies, the GDS Regulations distinguish between GDS contracts that are entered into with a contractor that consists of only two individuals practising in partnership and those GDS contracts where the contractor consists of more than two individuals.

Two individuals practising in partnership - GDS Contract

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.

Where the Commissioner receives such a notice, it must acknowledge receipt of the notice in writing.

If the surviving partner is a dental 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 dental 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.

A template Notification Letter is provided in Annex 77. A variation agreement will need to be included with this letter.

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 range of services provided and any potential capacity issues.

If the surviving partner is not a general dental practitioner, the Commissioner will need to terminate the contract. Please refer to the policy on contract breaches and termination for more information.
More than two individuals practising in partnership - GDS contract

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.

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 a GDS contract. Please refer to eligibility requirements in chapter ‘Which dental contract when?’.

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, it is possible for the contract to continue with one of the former partners if the following conditions apply:

- the former partner must be nominated by the contractor; and
- the former partner must be a dental practitioner.

The nomination of the former partner by the contractor must be:

- in writing and signed by all of the persons who are practising in partnership;
- specify the date on which the contractor proposes to change its status from that of a partnership to that of an individual dental practitioner;
- 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 dental practitioner; and
- specify the name of the dental practitioner with whom the contract will continue, which must be one of the partners.

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 dental practitioner. The Commissioner should ascertain on a case by case basis which persons are required to sign the nomination.

The Commissioner may vary the contract but only to the extent that it is satisfied it is necessary to reflect the change the status of the contractor from a partnership to an individual dental 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.
A template Acknowledgement Letter is provided in Annex 78. A variation agreement will need to be included with this letter.

15.4 Two or More Signatories - PDS Agreement

The PDS Regulations do not allow PDS agreements to be treated as made with a partnership. Where individuals are practising in partnership, the PDS agreement will be entered into with each individual (who may or may not be in partnership). The individual signatories to a PDS agreement collectively form the contractor. The PDS Regulations do not require a PDS agreement to define a specific process for any variation to the signatories. The Commissioner must, therefore, review the relevant PDS agreement to determine whether any provisions have been added relating to this and prior to following any process for variation.

A surviving signatory to a PDS agreement will notify the Commissioner in writing as soon as reasonably practicable of the death of their co-signatory.

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.

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.

The process above does not affect any right that the Commissioner may have to terminate the agreement under any terms of the agreement.

15.5 Dental Corporation, Company Limited by Shares and Limited Liability

Partnership - PDS and GDS Contracts

Where a contract is entered into with a dental corporation, a company limited by shares or a Limited Liability Partnerships, it is not possible for the contractor to die. It is possible that such contractors may indicate to the Commissioner where a performer, a member, a director, a chief executive or a company secretary has died.

Following such notification, the Commissioner must identify whether the organisation remains eligible to hold the contract. Where the organisation is no longer eligible to hold a contract and the issue is not rectified in accordance with any provisions allowing rectification in the contract, the Commissioner must terminate the contract. Please refer to the policy on contract breaches and termination for more information.
15.6 Practical Issues Arising from Death of a Contractor

Request to form a partnership

Where a GDS contract is held by an individual (whether as a result of the death of a partner or otherwise), that individual may propose to practice in partnership with one or more persons during the existence of the contract. Please refer to the policy on contract variations for more information on the relevant process and obligations of the Commissioner.

Procuring a new contract

Prior to the completion of the continuation, the Commissioner will need to decide whether to procure primary care dental services to replace the contract. Any procurement process for a new contract should be completed within the continuation period to allow for continued provision of service.

Considering requests to continue the contract

Where the Commissioner receives a request from the deceased contractor’s personal representatives to extend the contract, before the end of the initial 28 day period it must:

- seek assurance that the dental staff employed are on the national performers list and have the appropriate qualifications and training to provide all mandatory and additional services under the contract;

- ensure the deceased contractor’s personal representatives agree that any course of dental treatment started within the agreed continuation period must be completed prior to termination of the contract;

- ensure that the deceased contractor’s personal representatives agree that:

  - where there is an open course of orthodontic treatment, all endeavour is taken to complete the patient’s care during the agreed continuation period; and

  - at an agreed date during the agreed continuation period, they will communicate with patients, as appropriate, and as agreed with the Commissioner, that:

    - the practice will be under new ownership and a new contractor will be delivering services; or

    - that the practice will be closing/ceasing to offer NHS dental services with patients signposted to local dental practices that are accepting NHS patients and/or referred to NHS111;
- Discuss with the contractor on a case by case basis how the Commissioner will support the transition to a new contract (if applicable).

Time frames for communication with patients are largely dependent upon the length of contract/agreement continuation and the circumstances and impact that this would have on service delivery to patients – for example a contract novation or a contract continuing with a partner would not have a financial impact on a patient in terms of additional patient charges but would mean that their dentist may or would change.

Once a contract continuation period has been agreed, the Commissioner will need to mend the existing contract to reflect the continuation period of the contract and work with NHS BSA to make all relevant changes to the payment and contract systems. Changes may vary in individual circumstances to allow the deceased contractor's estate to access any NHS Pension rights and for payments to continue to be made under the contract. Advice will need to be taken from both NHS Pensions and NHS BSA and the processes followed as advised by them.

**If the practice is to be sold/transfered to a new contractor**

The deceased contractor’s personal representatives have the right to sell the practice to any prospective buyer. The Commissioner must make the deceased contractor's personal representatives aware that the NHS contract cannot be sold with the practice.

The Commissioner may consider a contract novation to a new provider if all three parties agree. The three parties would be the Commissioner, the deceased contractor’s personal representatives and the prospective buyer. The Commissioner needs to be aware that novation may lead to challenge. Please refer to the policy on contract variations for more information on contract novation.

**Non-Continuation or Termination of the Contract**

Where the deceased contractor's personal representatives do not agree to continue the contract, patients will need to seek another dentist. The Commissioner will need to work with those patients who are currently undergoing a course of treatment to secure alternative provision. There may be a financial impact on patients who may need to pay for the completion of their course of treatment by an alternative provider.

A plan to communicate with patients will need to be discussed and agreed between the contractor /contractor’s representatives and the Commissioner.

**If the practice is to be closed or the contract is terminated**
Under current contractual arrangements practices do not have registered patient lists and are only responsible for patients in an active course of treatment. The processes for the management of these patients are below.

The Commissioner, should ensure that it is able to signpost any patients seeking treatment, to other local dentists accepting NHS patients. This may be through making information available at the practice or via the NHS 111 services, whichever is relevant.

**For patients who are currently undergoing a banded course of treatment**

The deceased contractor's family or personal representative(s) must make every effort to complete patients' treatments within the 28 day period. Where this is not possible for whatever reason, the Commissioner will need to work with other local dental providers to secure completion of the active courses of treatment.

Patients seeking recourse under free repair and replacement provisions need to be made aware that there will be a fee to pay if a repair and/or replacement treatment is performed by an alternative practice; or a continuation of treatment at the same or lower band within two months is needed they will be required to pay the relevant dental charge when this is carried out by another provider.

**For patients who are part way through an orthodontic course of treatment**

Where a patient is undergoing an orthodontic course of treatment, it is unlikely due to the nature of treatment patterns and their longevity, that treatment can be completed within the 28 day period. The Commissioner should work with the contractor's representatives to:

- obtain copies of any orthodontic health records for patients currently in treatment that could then be provided to an alternative provider; and
- obtain patients' details so that they can be contacted regarding continuation of their treatment.

The Commissioner will need to secure alternative provision for those patients undergoing a course of orthodontic treatment. This can be with other local dental providers or they may need to consider commissioning these services from secondary care providers where alternative primary dental care provision is not available.

Currently the GDS contract or PDS agreement and the relevant Statement of Financial Entitlements state the level of payment for an orthodontic course of treatment. Due to the payment structure and length of an orthodontic course of treatment, the Commissioner may wish to raise the cost pressures of paying for these patient transfers within its risk register. Payments should be made in accordance with the policy on orthodontic close down arrangements.
The Commissioner may wish to procure additional activity from orthodontic providers on a non-recurrent basis, on a case by case fee structure while they consider whether or not to procure a contract or agreement. If this is the path that is chosen by the Commissioner it would be advisable to seek independent procurement and legal advice.

Where the contract is not continued the Commissioner will need to terminate the existing contract and should follow the policy on contract breaches and termination.
16 Managing Disputes

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.

This policy focuses on primary dental care contracts in their various forms.

The Commissioner must identify whether the contract is an NHS contract or a non-NHS contract. The Commissioner can do this by reviewing clause 14 of the standard GDS contract and PDS agreement.

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.

A non-NHS contract is where the contract is legally binding.

Contractors have the right to be regarded as a health service body under regulation 9 of the GDS Regulations or regulation 9 of the PDS Regulations.

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.

GDS contracts and PDS agreements require the parties to make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute before referring the dispute for determination in accordance with the NHS dispute resolution procedure or, where applicable, before commencing court proceedings.

There are two different routes that can be taken for resolving contractual disputes, depending on the contractor’s health service body status:

- 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.

- 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.

The use of the Court system can be an expensive and public route. In normal circumstances, non-health service bodies will elect to follow NHS dispute resolution.
Where the parties have followed this policy and 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.

16.1 Managing Disputes – Informal Process

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.

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 (LDC).

The use of an informal resolution process helps develop and sustain a partnership approach between the contractor and the Commissioner.

The informal process may include (but is limited to):

- regular telephone communications;
- face-to-face meetings at a mutually convenient location; and/or
- written communications.

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 a contractor’s concerns and communications in a timely and reasonable manner.

16.2 Managing Disputes – Stage 1 (Local Dispute Resolution)

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.

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.

The contractor should notify the Commissioner of its intention to dispute one or more decisions made in relation to its contract. This notification should be received
no later than 28 days after the Commissioner advises the contractor of its decision except in exceptional circumstances.

The Commissioner will immediately cease all action in relation to the disputed notice or decision, until:

- there has been a determination of the dispute and that determination permits the Commissioner to impose the planned action; or

- the contractor ceases to pursue the NHS dispute resolution procedure or Court proceedings,

whichever is the sooner.

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:

- protect the safety of the contractor’s patients; or

- protect NHS England from material financial loss,

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 GDS Regulations and PDS Regulations, pending the outcome of that procedure.

The paragraphs below set out a process that may be adopted for stage 1 (Local Dispute Resolution).

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 79.

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 LDC. An example invite letter is provided in Annex 80.

Once the meeting has been held, the Commissioner should notify the contractor in writing of the outcome of the meeting, whether this is that 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 81), or that the dispute has been successfully resolved (refer to the example stage 1 outcome letter in Annex 82).

Where the matter is resolved the issue can now be deemed as closed and the Commissioner should document the outcome accordingly on the contract file.
Where the matter remains unresolved, the process may be escalated to the next stage of the dispute resolution procedure.

At this point the Commissioner should commence preparation of the contract file to ensure that if and when the FHSAU or Court requests submission of evidence in respect of the dispute the documentation is in order.

16.3 Managing Disputes – Stage 2 (NHS Dispute Resolution Procedure)

The informal process and stage 1 (Local Dispute Resolution) must 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 the FHSAU, which carries out the NHS dispute resolution functions of the Secretary of State in the GDS Regulations and the PDS Regulations, which should include:

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

The written request for dispute resolution must be sent within a period of three years from the date on which the matter gives rise to the dispute occurred, or should have reasonably come to the attention of the party wishing to refer the dispute. Please see FHSAU determination reference 17156 for further details on the date that the dispute should have reasonably come to the attention of the relevant party.

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.

The parties should not underestimate the preparation that may be necessary in the event that evidence is required by the FHSAU, as all records pertaining to the contractor in question may be requested, 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.

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 the FHSAU.
Once the FHSAU has reached a conclusion (the determination) the parties will receive a copy and will be required to act upon it. A copy of a Guidance Note for Parties Involved in Dispute Resolution at the NHSLA (FHSAU) is attached in Annex 83 and should be followed by the parties to the dispute.

16.4 Other Dispute Resolution Procedures

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.

Where the Commissioner is of the view that a person seeking to enter into a contract does not meet the eligibility conditions of Regulations 4 or 5 of the GDS Regulations or the PDS Regulations, the Commissioner must notify the person in writing.

This notice must state the Commissioner view of the person’s eligibility, the reasons for that view and guidance on the person's right of appeal.

Where the Commissioner has issued such a notice, the recipient of the notice has a right of appeal to the First-Tier Tribunal.

Where the dispute relates to the parties being unable to agree on a particular proposed term of a GDS contract or PDS agreement, either party may refer the dispute to the Secretary of State to consider and determine the matter in accordance with:

- For GDS contracts, paragraphs 55(4) to 55(13) and 56(1) of Schedule 3 and paragraph 8(5) of the GDS Regulations; or

- For PDS agreements, 55(4) to 55(13) and 56(1) of Schedule 3 and paragraph 8(4) of the PDS Regulations, except where both parties to the prospective agreement are health service bodies (in which case section 9 of the NHS Act applies).
17 Adverse Events

17.1 Background

Adverse incidents are dealt with in the force majeure provisions of the standard GDS contract and PDS agreement. Although these provisions are not required by the GDS Regulations or the PDS Regulations, the majority of GDS contracts and PDS agreements will include them.

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.

The contractor is responsible for informing the Commissioner of any force majeure event promptly and no later than five working days of the occurrence of such circumstances or events as stipulated in Annex 8.4 and for lodging a claim for relief within the timescales specified within this document.

The Commissioner is responsible for advising contractors of the outcome of any claim once processed and applying that relief to the contractor's contract by way of carry forward activity on the payment and contract systems.

The decision-making process and calculation of relief tools are set out in the appendices.

17.2 Contract Wording

Clause 372 to 375 of the GDS contract and clauses 350 to 353 of the PDS agreement provide that:

'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 in the occurrence of such circumstances or events:

- 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
- take all action within its power to comply with the terms of this Contract as fully and promptly as possible.

Unless the affected party takes such steps, [the clause above] 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.

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.

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 (for the purposes of this policy, a close relative is defined as, mother, father, sister, brother, wife, husband, civil partner, daughter, son, grandparent, grandchild, parent-in-law, son-in-law, daughter-in-law, sister-in-law, brother-in-law, step parent, step child, step sister, step brother, foster child, legal guardian, domestic partner or fiancé/fiancée);
- 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; and/or
- explosion.

Throughout this policy the term dental relief is used. This is used as an
outcome measure that will effectively determine the total units of activity that the contractor was delayed or prevented from providing during the force majeure period and which may be 'carried forward' to the following financial year, instead of the Commissioner recovering the overpayment in respect of the UDAs/UOAs not provided. The Commissioners decision whether to grant dental relief will be based on the assessment of a contractor’s claim for relief, where there has been an inability to deliver the contractual activity required. This policy provides the template documents that are relevant to the process of assessing eligibility for and granting dental relief, and also sets out the criteria, processes and examples of what would constitute a force majeure event. There is also a calculator and methodology provided for calculating the amount of dental activity that can be carried forward.

If the Commissioner is satisfied that a force majeure event occurred and all reasonable efforts have been made to mitigate the consequences of the force majeure event, it may allow the contractor to carry forward to the following financial year a number of unfulfilled UDAs or UOAs which, it is estimated, were not delivered as a direct result of the force majeure event. It is expected that any activity carried forward will be delivered within the next financial year.

Neither the standard GDS contract or PDS agreement make provision for financial compensation or dispensation to be awarded to the contractor, so 'carry forward' activity will be permitted where it is felt that the force majeure event impacted on the contractor’s ability to deliver their contractual obligations.

In order to be considered for dental relief a contractor must have followed the correct procedure of notifying the Commissioner, which is detailed below, promptly and no later than five working days of the occurrence of the force majeure event, and must have submitted the claim form that is provided in Annex 86.

If a contractor is claiming for dental relief, the Commissioner should postpone consideration of the issue of a remedial or Breach Notice for under-delivery until the outcome of the claim is known. Where the claim is successful, it is inappropriate for the Commissioner to issue a breach or Remedial Notice for under-delivery. For audit purposes the Commissioner will need to ensure local governance processes are followed

**17.3 Circumstances of Force Majeure Event**

In considering claims for dental relief it is important to take into account the event and the point in the financial year when it took place.

Claims for relief in respect of planned or anticipated events should not be considered because whilst they may affect service delivery in the short term, the contractor is required to deliver the activity during the relevant financial year. The contractor is expected to plan its own delivery (within the requirements of the contract) and should plan for anticipated events that might affect the day to day delivery of units of activity (i.e. additional bank holidays).
It is entirely reasonable to expect a contractor to make arrangements to ensure that activity lost through an unplanned event occurring at the beginning or middle of the financial year is recovered and the contracted activity is delivered in full by 31 March, and in all circumstances can be accommodated within the 4% tolerance of delivery of activity.

**17.4 Possible Events or Circumstances for Dental Relief Claims**

The following is a list of examples of events or circumstances where the claim for relief may be considered, but it is not exhaustive.

**Death of a performer or individual provider**

In these circumstances it is understood that there may be a temporary interruption of services while arrangements are put in place to secure the successor to the business and/or engage the services of a clinician to resume service provision. Please refer to the policy on death of a contractor as this provides clarity around contract continuations, even when held by a single handed contractor.

**Death or sudden serious illness of a close relative or a significant performer**

Death or sudden illness of a close relative or a significant performer which could result in an inability to:

- fill the post; or
- make up shortfall in activity by year-end.

For the purposes of this policy, sudden serious illness or ill health means an illness or accident causing significant disability. Examples of such illnesses include (but are not limited to) myocardial infarction, CVA or cancer. In the case of a significant performer, sudden serious illness or ill health means illness that is such that the performer is unable to work for a period of time which is likely to substantially impact on productivity

**Significant period of absence due to accident or sudden serious ill health of a significant performer**

If a performer responsible for a significant proportion of the contracted activity is suddenly taken ill and is unable to deliver the services for a significant period of time, the Commissioner may consider that this is a circumstance for which relief may be considered.

**Physical damage to premises**
Physical damage to premises from which the dental service is delivered rendering it impossible and/or an unsafe environment from which to deliver care over a period, such as the following:

- fire causing significant damage which prevents the premises from being used over a prolonged period of time; or
- flood causing significant damage which prevents the premises from being used over a prolonged period of time.

**Essential services failure**

For example, in the event of a power failure or the water supply being turned off rendering it impossible for the dental services to be provided.

**Pest infestation**

Where the infestation would render the delivery of the service impossible from the premises, where the premises must be closed for a period to treat the infestation and/or repair damage that has been incurred.

**Significant adverse weather**

Significant adverse weather for which precautions are not ordinarily taken to avoid or mitigate the impact and which result in damage to the premises which prevent their use over a period of time (minimum three week period), such as following a hurricane.

**Prolonged industrial action**

Industrial action over a prolonged period of time which significantly affects the provision of public services or services upon which the contractor is reliant.

17.5 Unacceptable Events or Circumstances for Dental Relief

**Claims:**

The following is a list of examples of events or circumstances where the claim for relief should not be considered. It is not exhaustive.

**Refurbishment of premises**

It is expected that contractors are able to deliver a high standard of quality care from premises which meet the requirements of the CQC and all relevant legislation. Premises should also meet the requirements of infection control and decontamination as detailed in the Health Technical Memorandum 01-05
(Decontamination in primary care dental practices) produced by the Department of Health.

Claims in respect of interruption to service as a result of refurbishment or renovation will not be considered as relevant circumstances in which relief should be given for failure of contractual obligations.

**Adverse weather**

Severe weather in the UK, particularly during the winter months when snow and ice may be prevalent for varying periods of time, is considered normal and therefore does not constitute exceptional circumstances for which contractors may be given relief, regardless of any inconvenience it may cause.

**Planned events**

A performer’s elective surgery, annual leave, weddings and similar events are occurrences for which prior notification is always required. They are by their nature planned events and it is expected that the contractor will make the necessary provision to ensure the service continues to be delivered in the absence of the relevant performer.

**Long term sickness causing some incapacity disability, maternity, paternity or adoption leave of a performer**

Long term sickness causing some incapacity disability, maternity, paternity or adoption leave of a performer

The term long term “sickness is often applied when the course of the disease lasts for more than four weeks. An example of long term sickness includes but is not limited to, cancer, inflammatory arthritis and severe and enduring mental illness.

It is expected that the contractor will make necessary provision for the continuation of the service in the performer’s absence. Contractors are advised to refer to the relevant SFE for information about payments in respect of long term sickness, maternity, paternity and adoption leave.

**17.6 Evidence**

Contractors must provide evidence of the force majeure event and the impact that it has had on service provision when they submit their claim at year end.

Examples are as follows:

- copy of a death certificate;

- letter from the treating medical professional, hospital or treatment centre, confirming the diagnosis or condition of the performer in question and the period for which it considers the individual should be absent from work;
photographs of damage to premises, dated invoices or estimates for repair, photocopy of day book evidencing the premises closure; and/or

written confirmation from a utilities company regarding service being cut off due to the force majeure circumstances.

Following the review of any claim for dental relief, the Commissioner should return any supporting personal information to the contractor or agree to dispose of it appropriately.

17.7 Contract Compliance

Contractors are required under the terms of their contracts to promptly notify the Commissioner (which for the purposes of this policy is considered to be within 5 working days) 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. Submitting at year end claim form

Failure to notify the Commissioner will mean that the contractor is not absolved from its obligations under the contract and will render any claim for dental relief invalid. This may mean that the contractor is in breach of its contract as a result of under delivery of its contracted activity which will not be mitigated against as a result of the force majeure event occurring.

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.

17.8 Clinical Governance and Risk Management/Termination

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 invoking its termination rights.

If the service provision is delayed or prevented for a continuous period of three months then either party may 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.

17.9 Claims for Relief

Claims for relief cannot be considered until the year end data produced by the NHS BSA has been released to both contractors and the Commissioner. It is the responsibility of the contractor to submit a claim for relief and not for the Commissioner to pursue this with the contractor.
On receipt of claims for relief the Commissioner should consider the following:

- Was the Commissioner advised promptly of the event using the template provided?
- Were there satisfactory business continuity plans in place to help mitigate the consequences of the force majeure event?
- Was it demonstrated that all steps that were reasonably practicable were taken to ensure continuity of patient care during the period in relation to which relief is being claimed?

**17.10 Process for Claiming Dental Relief**

On receipt of a notification from a contractor that a force majeure incident has occurred, the Commissioner will send the contractor an electronic copy of the formal preliminary notice of force majeure that is contained within Annex 84.

The Commissioner will also explain the process for making a claim for dental relief.

On receipt of the completed preliminary notice form from the contractor, the Commissioner will send the contractor the acknowledgement of contractor notification letter based on the template contained at Annex 85, and the template claim form at Annex 86, advising the contractor that it must submit its claim for relief using the template claim form by the date specified in the letter, which will be after the year-end data is available from NHS BSA (usually mid-July). It is the responsibility of the contractor to submit a claim and not for the Commissioner to request or chase a claim.

Any claims must be submitted using the template provided at Annex 86. The template must be completed in full providing details of the force majeure event, the impact on service delivery, the period over which service was interrupted and the action taken to mitigate the impact of the event. The claim template must be accompanied with supporting evidence in order for the Commissioner to assess and award any relief.

On receipt of each claim the Commissioner will check for completeness and allow five working days for the contractor to clarify or provide additional information or supporting evidence as requested. The contractor should be advised that if the requested information is not forthcoming by the due date the claim may not be considered.

The Commissioner will record the status of the claim and acknowledge receipt of the claim. It will also notify the contractor of the date by which they may expect to be advised of the decision.
The Commissioner will assess the evidence provided in the claim and make a decision on whether or not to award relief on the basis of this. If a decision is made to award a claim for dental relief, the level of relief to be provided should be determined using the template calculator provided in Annex 87. Any discussions and decisions taken must be formally recorded and signed off by the relevant person within the Commissioning team. The decision should be communicated to the contractor (template letters are provided in Annexures 88 and 89) by the date specified by the Commissioner when it acknowledged receipt of the claim.

If the contractor's claim for dental relief is successful then the issue of Remedial Notice or Breach Notice is to be waived by local teams. For audit purposes Commissioners will need to ensure local governance processes are followed.

17.11 Calculating Dental Relief

Calculation of the appropriate level of relief that a contractor is awarded should be based on the activity that the relevant performer(s) would normally deliver in the course of a day. This should be evidenced based and recorded on the claim form by the contractor.

Reference should therefore be made to the report produced by NHS BSA at year end entitled ‘Year End Statement of Activity’ which identifies activity (including amendments) collected from FP17s in any of the fifteen schedule months from 1 April to 30 June, where the date of completion of a course of treatment is between 1 April and 31 March (inclusive). This report identifies the activity delivered by every performer listed under the contract in the full financial period.

Calculation of dental relief should take account of the number of working days the performer(s) has been engaged in delivering NHS dental care under the contract in the course of the financial period, which will exclude the days that the performer could not work due to the force majeure event. If employed for a full financial year this equates to 240 days. So for example, in the case of a performer who has worked full time from 1 April to 31 March and delivered 3000 UDAs/UOAs, the estimated daily average will be 12.5. If he/she did not work for a period of five days as a consequence of the force majeure event, the lost activity is calculated to be 62.5 UDAs/UOAs. This would be calculated pro rata for a part time performer. There is a template in Annex 87 for calculating lost activity.

Where the contractor’s whole practice is closed then the total UDAs/UOAs delivered divided by the number of days the practice was actually open would provide the daily amount. The Commissioner should remember that some dental practices are only open or provide NHS care for part of the week.

17.12 Appeals

If on consideration of the information and evidence provided, the Commissioner does not approve the claim for dental relief, the contractor has the right to appeal to the NHS Resolution, FHS Appeal Unit, 1 Trevelyan Square, Leeds LS1 6AE.
The parties should refer to the policy on managing disputes for the process in relation to dispute.

**17.13 Payment and Contract System**

The Commissioner will need to record any carry forward activity that was granted on the payment system and contract file.

Where dental relief is not granted, a repayment plan needs to be agreed, in writing, between the Commissioner and the contractor and detailed on the payment system and contracts file.

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.