Dental Contract Dispute Workshop
18th May 2006

Introduction

This paper summarises the main points that emerged from a recent workshop held by the PCC with PCT representatives to identify common issues and good practice. There is some commonality with the second Disputes Hints & Tips paper\(^1\), and it is hoped that, taken together, the two documents will assist PCTs in reducing the number of disputes that cannot be resolved locally.

In terms of good practice in handling disputes and providing a clear trail to facilitate a determination by the NHSLA if the dispute cannot be resolved locally, PCTs are strongly advised to:

- deal with cases on an individual basis and refer to the circumstances of the practice
- describe their process - keep a careful record of what they did, when and (most important) why, in order to evidence that they have handled the matter in accordance with the relevant Regulations/SFE etc (NB It is not enough simply to state reliance on Regulations/guidance/Factsheets etc - the PCT needs to show how it has applied these in the particular case)
- state clearly the Regulations, guidance or local policy on which they are relying in relation to the dispute in question
- ensure that they answer the specific point(s) at dispute - it is important to counteract each and every one, as a generic or vague response may result in an adverse decision. If the PCT does not respond at all to a particular point, the NHS Litigation Authority is likely to assume that the PCT agrees with the contractor on the issue.
- stick to the timescale

1. Variation and termination of contracts

Can single-handers effectively sell on a contract without reference to the PCT by making a partnership with another dentist and then resigning from the partnership? No. The change in contractor from an individual to a partnership would constitute a variation of the contract that would need to be agreed with the PCT in accordance with Schedule 3, Part 9 of the GDS Regulations. The contractor cannot simply form a partnership without the prior agreement of the PCT.

What are the clinical governance implications for associates with individually-held contracts, as they do not necessarily have control or ownership of the premises from which they practice?

The contractor must comply with the PCT’s clinical governance arrangements (GDS Regulations, Schedule 3 Part 10 Clause 79). The Regulations also specify the contractor’s responsibility for ensuring the practice premises are fit for purpose (Schedule 3 Part 2)

Is Clause 12\(^2\) of the standard contract/agreement mandatory under the GDS and PDS regulations?

\(^1\) www.pcc.nhs.uk/uploads/Dentistry/june_2006/disputes_hints_and_tips_2.pdf

\(^2\) Clause 12. The Contractor shall not give, sell, assign or otherwise dispose of the benefit of any of its rights under this Contract, save in accordance with the Contract. The Contract
This clause is not mandatory under the Regulations; however, the Department of Health’s lawyers have advised that they regard the contract as a personal contract between the parties and, as such, this clause was included in the standard contract. In the event of a dispute, a PCT could argue that retaining this clause is in line with national DH policy and advice. If deciding not to include this clause in the standard contract PCTs might want to take their own legal advice about their position.³

Where a practice is sold, assigned, or otherwise disposed of, the contract will therefore terminate. In these circumstances, as part of the commissioning process, PCTs will wish to satisfy themselves prior to entering in to a contract.

a) that the new owner falls within the categories of person that the PCT is able to enter into a GDS contract or PDS agreement with, and  
b) that entering into a contract with that person is justified in terms of the local health needs assessment and PCT priorities  
c) that the new contract offers value for money – note that where the sale/assignment/disposal is a straight transfer of services, it is not necessary to go out to tender (unless the PCT so wishes).

Where the PCT decides to re-commission services from the new provider, the issue of goodwill then becomes a matter for discussion between the vendor and purchaser. It would therefore be in the vendor’s interests to enter into early discussions with the PCT.

Recommendations  
Given the widespread concern about goodwill, it would be advisable for an SHA-wide policy to be developed regarding the sale of practices.

2. Transfer of patients (when practices leave the NHS)

Disputes over Clause 357/333 (duty to cooperate with PCT)⁴
Mandatory & additional services: A patient is defined in the Regulations as someone actively undergoing treatment, therefore these people must be able to complete their course of treatment on the NHS with another contractor if they so wish. ‘Patients’ in this context does not refer everyone on a practice’s books, therefore this clause is not an attempt to legitimise removal of all patients from the practice.

Orthodontic services: A patient is similarly defined as someone undergoing active treatment (i.e. case start or retention).

Recommendations

A local policy ⁵ should be developed:

does not prohibit the Contractor from sub-contracting its obligations arising under the Contract where such sub-contracting is expressly permitted by the Contract.

² A recent determination by the NHSLA (no12495) upheld the inclusion of clause 12
⁴ 357.3. [on the termination of the contract, for any reason, the contractor shall] co-operate with the PCT to enable the Contractor’s patients to be transferred to one or more other contractors or providers of mandatory services (or their equivalent), which include providing reasonable information about individual patients to such other appropriate person or persons as the PCT specifies;
⁵ see Annex
• The PCT needs to work with outgoing and incoming providers to ensure continuity of treatment, considering:
  o Who are these patients?
  o What do they want to happen?
  o What have they already paid?

• The PCT should make clear to the practice the expectation that it concentrate on closedown of existing cases and not take on new NHS cases during the notice period.

3. Associates leaving

Practice based contracts: Because performers are acting as subcontractors on these contracts, internal changes in the practice (such as an associate leaving) are a matter for the practice to deal with, not the PCT; providing that the UDA levels are still being met.

Individual contracts: In this case, if an associate leaves then an individual contract is terminated and it is for the PCT to recommission (or not). The practice owner/contractor cannot demand to retain funding (although PCTs are free to pursue the option of a like-for-like replacement in the same practice).

4. Orthodontic practices

What happens to orthodontic practices set up during or after the base period, or growing practices (as opposed to steady-state)?

The PCT has an obligation to offer a contract value that relates to the income of the contractor during the reference period. Anything beyond that is at the discretion of the PCT although it will need to ensure that funding is in place to enable all active cases at 31.3.2006 to be completed. The NHS Litigation Authority will look at the PCT’s statutory obligations and will look for evidence that the PCT has acted reasonably and can justify its decisions.

Recommendations

How has the PCT exercised commissioning discretion? It will help the PCT to prove it has acted reasonably if it can evince a documented strategy underpinning its commissioning decisions (e.g. agreed dental action plan derived from a health needs assessment, explicit priorities, etc.).

5. Notice period for variation of contracts

In most cases, the notice period for variation of contracts is specified in the regulations and therefore not disputable within the contract.

6. Standards of premises

It is not acceptable to practice from inadequate premises; therefore this cannot be disputed in the contract (GDS Regulations Schedule 3, Part 2, Clause 12).
requirement to practice from adequate premises is no change from the previous
terms of service.

7. **NICE Guidelines on recall intervals**

These must be implemented by dentists (GDS Regulations Schedule 3Part 2, clause
14). There has been some distortion of the recommendations of the NICE
guidelines. Contrary to some claims, the guidelines do not mean dentists can only
see patients once a year. The clinical recommendations in the guidelines state:

1.1.1  *The recommended interval between oral health reviews should be determined
specifically for each patient and tailored to meet his or her needs, on the basis of an
assessment of disease levels and risk of or from dental disease.*

1.1.2  *This assessment should integrate the evidence presented in this guideline
with the clinical judgement and expertise of the dental team, and should be
discussed with the patient*\(^6\)

Some dentists have argued that they were already implementing the NICE guidelines
during the base period and that this will mean there is no further capacity for patients
gained under the new system.

*Where’s the proof that the guidelines are best practice?*

The NICE guidelines state the following:

The following guidance is based on the best available evidence. There is evidence
relating to risk factors for oral disease and on the effectiveness of dental health
education and oral health promotion, and this was used to inform the guideline
recommendations. However, the research evidence on many aspects of dental recall
intervals was limited, and recommendations were based on the clinical experience of
the Guideline Development Group and advice received during the consultation
process.\(^7\)

8. **Domiciliary/Sedation services**

**Times**

Hours during which non-mandatory services are delivered must be specified in the
contract. This specification can be exact (e.g. Monday to Wednesday, 12.30pm –
3.30pm), or broad (e.g. “within normal practice hours” or “within the normal working
week, by prior agreement with the patient”)

**Funding**

Payments for sedation and domiciliary sessions will be separately identified in the
monthly payments made by the BSA on behalf of the PCT. This is referred to in the
Statement of Financial Entitlements. Although these payments are separately
identified, they still form part of the total CACV. The separate identification does not
mean that these payments are made in addition to the CACV.

*Managing practices that provide only occasional domiciliary / sedation treatment.*

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Health and Clinical Excellence, p7

\(^7\) Ibid, p5
Practices that perform a very low number of domiciliary and sedation sessions per annum should have their times of provision broadly defined. The PCT may wish to consider whether it is appropriate to contract with such practices if they provide a very low number of sessions.

Recommendation

PCTs should develop local domiciliary and sedation guidelines and policy for dentists to ensure all treatments are appropriate.

9. Breach of contract

How can the PCT determine if the practice is in breach if the contract has been signed in dispute?

During a dispute over a contract, it can be unclear for both PCTs and dentists what constitutes a breach of that contract. Pending resolution, the contractor should offer NHS dental services to patients in a way that is compatible with the contract, including the disputed items. If the contractor radically changes the basis on which s/he provides NHS treatment to patients, or if there is evidence that the practice is not seeing NHS patients (if, for example, the practice has written to all patients stating its intention to go private) PCTS should check carefully on the terms of the contract but this is not automatically a breach of contract. It is recommended that, in such circumstances, the PCT should discuss with the practice what its intentions are, and how it intends to deliver the required level of UDAs under the contract.

10. UDA Levels, Price/Contract Value

How are contract values and activity levels calculated?
GDS: The PCT must issue CACVs to contractors. National policy advised the use of DPB prescribing profile information on activity and payments in the base period to calculate these values, and the PCT will have met statutory requirements and national policy by following this process. The CACV calculation includes a 5% reduction in activity.

PDS: The entitlement for contractors who were working under pilot PDS schemes is to their originally negotiated agreement value at 2006 prices, for at least the duration of the previous agreement. Activity levels are more negotiable under PDS as PDS pilots were established before the new patients’ charges system allowed UDAs to be formulated. Devolved budgets for PCTs were based on assumptions of a 15% reduction on historic GDS activity in the locality, to reflect the kind of work being undertaken in PDS Agreements that may not be amenable to measurement by UDAs. PCTs, however, in deciding their UDA expectations of PDS practices should also have regard to any data they hold regarding the care and treatment provided by the contractor since 1 October 2004. In the event of a dispute, failure to be able to demonstrate that they have taken account of the individual circumstances of the practice could lead to an adverse decision by the NHSLA.

What if there is a proven flaw in the DPB’s calculation of activity?
Dentists may not dispute the methodology used to calculate their Units of Dental Activity levels. If a dentist feels there is an error in his/her particular activity calculation, the onus is on him or her to prove this error.
Three item codes were identified by the DPB that had been assigned to incorrect bands. These were:

- incomplete periodontal treatments (gum treatments) (SDR item codes 1011 and 1021) were attributed to Band 3 in the prescribing profiles distributed at the end of November. These incomplete periodontal treatments are identified by internal DPB treatment codes 7303 and 7304 which do not therefore appear in the published SDR. The allocation of these codes has now been changed by moving 7303 to Band 1 and 7304 to Band 2
- Item code 1734 (pin or screw retention for a core fabricated in the mouth) was also attributed to Band 3 and is now being allocated to Band 1.

Adjustments were made to the UDA levels in the CACVs of all dentists affected by this mistranscription of IOS codes.8

“I didn’t submit a claim until after the end of the base period”
It is true that the base period would not capture any activity performed during it but submitted and recorded afterwards; however, it is equally true that the base period includes activity performed before the beginning of the period but submitted and recorded during the period.

What if the PCT makes an offer to the dentist and the dentist still chooses to dispute the contract value and/or activity levels? Can the PCT withdraw that offer and enter into dispute over the original offer?
It is up to the PCT, but if their offer is rejected it is likely that the PCT would wish to revert to disputing the original offer at the NHS LA.

Can a body corporate or group practice aggregate the UDAs of its practices and redistribute them?
Yes, with the agreement of the PCT - but they have no right to do this. It is purely a commissioning decision for the PCT: if the practices are physically proximate, the PCT may be happy for this to happen; however, redistribution among practices that are spread out across the PCT may adversely affect the levels of service in areas of particular need, and may not be in line with the PCT’s strategy.

What does the PCT do about atypical years in the base period?
Dentists may argue that their activity was atypical during the base period (due to sickness, establishing a practice during the base period, extended leave, etc.) and may therefore request that activity is up- or down-scaled and funded accordingly. In deciding what adjustment, if any, to offer, the PCT must consider:

- Whether it met its obligations (i.e. offering the CACV calculated as previously described)
- Whether it was reasonable in exercising commissioning responsibilities

Maternity leave during the base period requires careful consideration by the PCT, as not compensating for this in a contract offer could lead to allegations of discriminatory behaviour.

What if a practice had a VT during the base period?

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Vocational trainees at a practice will perform a certain level of work on NHS patients as part of their training. A contractor cannot argue that a VT was performing activity for him/her and that therefore their activity should be reduced whilst the contract value remains the same. Under the new contract, it is also not acceptable for overperforming VTs to count towards the practice’s monthly UDA activity; UDAs for VTs are separate from the practice contract.

Contractors cannot argue that, although the VT is no longer at the practice, the patients seen previously by that VT are still presenting for treatment and that, therefore, the PCT must fund the practice to replace that capacity. Provision of NHS dental treatment is now the responsibility of the PCT, and it is up to the PCT how and where it commissions that provision.

**Recommendations**

PCTs will be able to defend their contract offers to dentists more robustly if they can demonstrate a reasonable process by which they came to make their decisions. For UDA levels in PDS practices, the PCT should be able to demonstrate that it arrived at its figure via local benchmarking against similar GDS practices (-15% to reflect new ways of working) and other PDS practices. However it will need to show that it has followed the regulations and taken into account the information relating to the contractor. The PCT may wish to quote the range of £perUDA prices in their area in order to demonstrate where an offer sits. It may be less helpful to quote an ‘average’ figure.

In the case of practices who choose to review the prescribing profile from the DPB for errors, it has been found in some cases that any errors that go against the interests of the dentist are balanced out by errors that go in favour of the dentist. Some dentists have therefore found that the process of challenging details in the prescribing profiles resulted in negligible or no gains for a great deal of effort.

**11. Clinical Governance, clinical audit (CA), CPD, peer review**

Payment for clinical audit, CPD, peer review

Old GDS: A set number of sessions were required. As these were deemed to be performed during practice hours, payments were made as compensation for loss of earnings.

New GDS: There is now no set requirement for a specified number of sessions (although there is still a requirement to conduct clinical audit/CPD). The 5% reduction in activity for nGDS compared with the base period is designed to allow time for CG/CA (and other activities) without loss of earning; therefore no compensatory payments are now made.

Under old GDS, CA/CPD payments were made on a triannual cycle for three years’ worth of CG/CA. Therefore, approximately 1/3 of practices received this payment in the base period and have subsequently had it included in their CACV. These payments do not have UDAs attached to them.

Clinical governance arrangements

Dentists must participate in clinical governance (GDS Regulations, Schedule 3, Part 10): this is not optional. This requirement to participate is not new: it was included under the previous terms of service.
Recommendations

It may appear inequitable that some practices have money included in their CACV recurrently for CA while others do not, however, this followed from the income guarantee given to dentists based on the reference period. The PCT may approach this issue by:

- Negotiating more UDAs with practices where the payment is included in their CACV
- Agreeing with the practices that they should re-pay the money in order that it can be redistributed or held locally by the PCT (it is recommended that the LDC is involved in this – see below).

Negotiating UDAs may be difficult, as the PCT has no power to strip this money from the CACV if the dentist refuses. If they do agree, the number of UDAs set against this extra funding should be f/p (where f = CA payment and p = £/UDA value)

Depending on the PCT's relationship with the LDC, it may be possible for the PCT and LDC to agree that dentists with these payments in their CACV should hand the money back. Dentists without this money may see it as unfair and may apply pressure for this to happen. The money might then either be distributed equally among dentists/practices, or held locally for purposes agreed with the LDC (e.g. ringfenced capital growth funding).

However, all dentists are likely to have significant time freed up for activities such as clinical audit and CPD, both through the 5% reduction in UDAs and through the opportunity to carry out simpler courses of treatment with fewer items of service. It is therefore questionable whether the benefits from marginal re-distribution of UDAs or contract values involved in such an exercise – which would have to be by mutual agreement with all the contractors involved – would be proportionate to the effort involved.

12. Performance monitoring

The PCT receives monthly information from the NHS BSA on the performance of performers and of contracts, specifically in terms of UDAs and other activity (eg domiciliary/sedation sessions). The PCT will want to monitor performance to ensure delivery as per contract.

Recommendation

In practice based contracts, the PCT should focus on contract level, not performer level. It is the responsibility of the contractor in a practice-based contract to monitor the performance of performers under that contract to ensure delivery of agreed levels of activity. The PCT is unlikely to have the capacity to monitor all performers.

13. Change in GDC regulations on bodies corporate

Currently, the number of bodies corporate is restricted under Sections 42-44 of the Dentists Act 1984. This restriction is due to be lifted by the GDC on 31st July 2006. Trading entities which have a majority of dentists on their board will then be able to register with the GDC to be providers of primary care dental services under an NHS contract.
Recommendation

PCTs may wish to bear the above in mind when looking at recommissioning and reprovision of services; there may be more body corporate options and increased competition by late 2006. However, recent recommissioning has shown that there is already robust competition so it should not be necessary to delay reprovision.

15. Locally-added clauses

The ‘model’ or ‘standard’ contracts published by the Department of Health were intended to assist PCTs in contracting with providers of primary care dental services by providing contracts reviewed by DH lawyers. These are not national contracts (unlike GMS) and are not mandatory. PCTs are therefore free to produce their own local versions, which must include the mandatory provisions specified by the Regulations. However, most PCTs have used the DH models, and may add or amend clauses provided:

a) there is no conflict with the Regulations or other legislation and
b) both parties agree.

Can PCTs specify a split in the UDA levels between child and adult patients?

Only if both parties agree. PCTs may wish to ensure that a particular mix of patients is seen by a practice; however, any specific split of UDA levels between children and adult (or exempt and non-exempt) could easily amount to discrimination and if disputed, is unlikely to be upheld by the NHS LA.

PCTs can, however, expect practices to see a similar patient profile from that seen previously (assuming no major external factors such as new housing developments in the area, etc.) PCTs will be able to monitor and spot aberrant behaviour through data from the BSA and should approach practices immediately if they believe that the practice may be discriminating against certain groups of patients.

16. Annual spread of UDAs

There has been some concern that the total number of UDAs to be performed by the contractor in one year could be reached early, and that, consequently, the contractor would not treat NHS patients for the remainder of the contracted year.

A contractor may only refuse to provide services under the contract to a person if s/he has reasonable grounds for doing so, that are non-discriminatory and unrelated to the person’s decision to accept private services (Schedule 3, Part 1). Also, normal surgery hours are specified in the contract (GDS Regulations Part 5, para 14) and must be adhered to; therefore, they must remain open to NHS patients during their specified hours. If a contractor looks likely to finish their contracted UDAs early they need to discuss handling with the PCT.

Recommendation

PCTs should use the Mid-Year Review to discuss performance of UDAs with practices that appear to be over- or under-delivering. In the first year of the contracts, PCTs should find that there is sufficient data by this point to gain a realistic picture of activity. PCTs should clarify with practices how they will treat over
performance against the contract (bearing in mind that, at the margin, contractors may have genuine workload management issues to handle).

17. **Out of and In hours specification of times of service**

The practice opening times specified in the contract should be the times at which the practice is able to see NHS patients. If, for example, the practice is open from 9am until 7pm but only sees NHS patients between 9am and 5pm, the practice opening hours for the purposes of the NHS contract are 9am to 5pm.

Out-of-Hours treatment is defined as treatment outside of these contracted hours.

**Recommendation**

Contractors may find it advantageous to be as non-restrictive as possible about their NHS hours. In the above example of practice opening hours, the practice would be unable to see NHS patients if they did not have OOH agreed in their contract; whereas, if they were more flexible, they would be able to see NHS or private patients between 5pm and 7pm.

18. **Breakdown in relations**

The GDS Regulations (Schedule 3, Part 1) specify that it is the reasonable opinion of the contractor that determines when an “irrevocable breakdown” in relationship between contractor and patient has occurred.

**Recommendation**

To ensure a consistently fair and transparent process, PCTs should look at developing a local policy (perhaps on an SHA-wide basis) to define when a breakdown in relationship is deemed to have occurred and how these should be handled.

As well as violent patients or patients who refuse to pay appropriate charges, breakdowns in relationships may occur when the patient repeatedly misses appointments. PCTs may wish to look at a ‘3 strikes and you’re out’ policy, where the relationship may be deemed to have broken down if the patient misses three consecutive appointments within a course of treatment. For further information, please see the guidance on Managing and Minimising Failure to Attends on the PCC website.9

19. **Provision of information by contractors to PCTs**

The timescales within which information must be provided to the PCT by the contractor are statutory requirements and may not be disputed.

*Clause 22*10

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10 22. *The Contractor warrants that:*
Some contractors have asked PCTs to insert exemption for human error into this clause. Changing this clause would be highly inadvisable, as it would effectively mean that contractors were not responsible for the accuracy of information submitted to the PCT.

**Clause 211 – 212.2**

These clauses should be retained as they provide the legal route to insist on access to information by the Dental Reference Service and its officers should a practice attempt to deny such access.

### 20. Further points to consider around the dispute process

The NHSLA will only consider a dispute after it has been through the local resolution process.

If a dispute is resolved locally after submission to NHS LA, the dentist needs formally to withdraw the dispute. The PCT may wish to consider drafting a standard letter for dentists to use to withdraw their disputes.

It is important that the PCT keeps a careful record of how it has arrived at its decisions regarding a particular contract. The NHSLA will be looking for evidence of consistency and reasonableness (in respect of both parties).

22.1. all information in writing provided to the PCT in seeking to become a party to this Contract was, when given, true and accurate in all material respects, and in particular, that the Contractor satisfied the conditions set out in regulations 4 [and 5] of the Regulations;

22.2. no information has been omitted which would make the information that was provided to the PCT materially misleading or inaccurate;

22.3. no circumstances have arisen which materially affect the truth and accuracy of such information;

22.4. it is not aware as at the date of this Contract of anything within its reasonable control which may or will materially adversely affect its ability to fulfil its obligations under this Contract.

211. The Contractor shall, at the request of the PCT—

211.1. produce to the PCT or to a person authorised in writing by the PCT in such format, and at such intervals or within such period, as the PCT specifies; or

211.2. allow the PCT, or a person authorised in writing by it to access,

the information specified in clause 212.

212. The information specified for the purposes of clause 211 is—

212.1. any information which is reasonably required by the PCT for the purposes of or in connection with the Contract; and

212.2. any other information which is reasonably required in connection with the PCT’s functions,

and includes the Contractor’s patient records.
NHSLA’s final decision is binding on the PCT and the dentist (though the dentist can of course refuse the contract)

Disputing a particular clause does not preclude a dentist subsequently disputing another clause.
Arrangements on contract termination – ensuring continuity of care for NHS patients

Clause 357 of the GDS model contract (clause 333 of the model PDS agreement) appears to be causing concern to dentists because it has been misinterpreted to mean loss of the practice’s goodwill, and that all patients will automatically be transferred to another provider.

The Regulations specify that the contract/agreement “shall make suitable provision for arrangements for the termination of a contract including the consequences (whether financial or otherwise) of the contract ending”, but the wording of clause 357/333 is not mandatory. This means that PCTs/contractors may draft their own provisions instead.

In the context of the model contract/agreement, a patient is defined as “a person to whom the contractor is providing services under the contract/agreement”. It follows that the intention behind the clause was to ensure continuity of NHS treatment for patients, rather than to undermine the practice’s goodwill. The patients most affected by contract termination will be those in the middle of a course of treatment at the time; it is not unreasonable to expect the contractor to co-operate with the PCT to ensure that those patients are able to have their treatment completed under the NHS. This is not the same as requiring the contractor to hand over details of all the patients on his/her books to the PCT.

By way of good practice, PCTs may wish to consider agreeing a local policy for arrangements on termination of contracts upfront with contractors/LDC. This might help to clarify the requirements of the model contract/agreement and allay contractors’ concerns.

Suggested wording for inclusion in PCT local policy:

Clause 357.3 of the GDS contract requires contractors “to co-operate with the PCT to enable the Contractors’ patients to be transferred to one or more other contractors or providers of mandatory services which include providing reasonable information about individual patients to such other appropriate person(s) as the PCT specifies”

The purpose of this clause is to ensure continuity of NHS care, so that patients whose course of treatment has not yet been completed when the termination takes effect may have this treatment completed under the NHS, if they so wish.

It would be best practice, for all the parties concerned – patient, contractor and PCT – for the contractor to complete as many courses of treatment in advance of the termination date as possible. Doing this will minimise the number of patients that need to be transferred to a new NHS provider. The 3 month notice period is likely to be paid at full contract value; however, there should be very little (if any) new work started and therefore a lot of time will be freed up for completion of outstanding treatment.

Information to be supplied to the PCT by the contractor
On termination of the contract for any reason, the contractor shall supply the following information to the PCT:
• a list of the names and addresses of those patients whose course of treatment has not yet been completed
• what NHS charges the contractor has collected from those patients
• copies of the individual treatment plans, each annotated to indicate clearly what treatment has been completed

Transfer of patients

The PCT will then write to those patients, informing them of the termination of the contract and advising the options available to them in order to complete their current course of treatment under the NHS, if they so wish. [The options may include:
• a list of practices, together with details of their respective locations, currently offering mandatory NHS services in the PCT’s area
• temporary services available – eg DACs, short term GDS contracts etc – pending permanent alternative services coming on stream.]

The letter will also explain how patient charges will be handled, and may advise the patient that s/he may choose to stay with current contractor as a private patient.

On receipt of the patient’s reply, the PCT will make the appropriate arrangements for the patient to transfer to the new contractor to enable the course of treatment to be completed. These arrangements will include:
• advising the new contractor of the patient’s name and address
• what NHS charge has been already collected (and/or what remains payable on completion of the course of treatment)
• advising the patients to take a copy of their treatment plan (prepared by the original contractor) along when they first attend the new contractor
• sending a copy of the annotated treatment plan

Information to be supplied by the PCT to the contractor

The PCT will undertake a reconciliation of payments it has made to the contractor and the value of the work undertaken by the contractor. Written details of this reconciliation will be supplied to the contractor as soon as possible, and in any event no later than 3 months after the termination of the contract (Clause 359 of GDS contract).

If the contractor disputes the accuracy of the reconciliation, s/he may refer the matter for resolution under the NHS dispute resolution procedure (Clause 360 of GDS contract).

Payments

Either party will pay the other any monies due within 3 months of the date on which the PCT served the contractor with written details of the reconciliation (or conclusion of dispute resolution process, if applicable) (Clause 361 of GDS contract).

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12 The PCT may wish to consider using its PALS to manage the transfer process