

**Strictly Private and Confidential**

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Your ref:  
Our ref: 17/MJ/D10045.0001  
(Please quote on all correspondence)

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**BY EMAIL**

Dear Jonathan

**Re: PDS+ Agreement Review**

I have now reviewed the PDS+ Agreement documentation you sent to me and have set out the following report.

**General concerns**

Some general concerns/summaries of our main concerns are as follows:

- As previously explained, the PDS+ Agreement derives from the PDS Regulations but whilst the majority of the content derives from the PDS Regulations and is acceptable, there are a substantial number of additional non-mandatory terms which seek to place a substantial and unacceptable burden on contractors. We are also particularly concerned that the arrangements could potentially expose the contractor, who is an individual, to being regarded by HMRC as being an employee of the PCT, despite clause 70 of the Agreement.
- Essentially, many of these new features seem to be imposing onerous obligations on contractors seemingly with a view to discharging PCTs from their obligations.
- In particular, encumbering the contractor with requirement on reviews, appraisals, policies and administrative burdens seems to be entirely counter-productive to the aim of creating greater access to dentistry.
- On a positive note, this version of the PDS+ Agreement has incorporated many of the concerns we previously had with earlier drafts of this type of PDS+ Agreement. This makes many of the clauses more acceptable.

- I have noted that the footnotes provide some assurance that the wording should be adapted to local requirements but these footnotes should be retained on copies provided to contractors (where the proposed wording is retained) so that Contractors can also provide input on the suitability of the provisions.
- A further major point for note is the superannuity of the Access and Performance Payments (see comments Schedule 3 below).
- We are also concerned about the impact on goodwill where the agreement is only for a five year term.
- Any potential contractor who is considering bidding for a PDS+ Agreement should seek advice from a specialist dental accountant regarding the pricing of the bid. It is imperative that contractors budget adequately in terms of pricing their bid to ensure that the venture is financially viable.
- Existing contractors should clarify how the services will sit along side their additional services and how the two will integrate.

#### Clause 4 – Warranties

The content of the warranties is very important since they give the right to the PCT to sue for breach of warranty, rather than having to give notice to terminate the agreement.

It must be noted that save for clauses 4.1(g) and (h) the other warranties continue throughout the term of the Agreement (pursuant to clause 4.2(b)). When you look at warranties such as clause 4.1(b), this means that if the contractor loses the power to own its assets it could be sued by the PCT for breach of warranty. Contractors should think carefully about whether they would want to give such a warranty. In respect of continuous warranties clause 4.1(i), also places an onerous burden on the Contractor since it has little control over the actions of its staff or any third party.

In clause 4.1(i), I would suggest this read "...to the best of their knowledge is not aware that..." rather than, "having made all due enquiries is not aware that..."

Clause 5.4 may cause concern. It suggests that if a new patient who does not have an appointment turns up at the practice they must be provided with general mandatory services during that "surgery period". Contractors can only see patients subject to appointment availability and capacity. Clauses 5.4(a) and (b) do provide some comfort in this regard. However, this is subject to interpretation. Depending upon the size of the contract some practices operating a recall system may be booked up for several months in advance. An appointment several months down the line is likely not to be deemed acceptable.

Clause 5.5(c) - It is completely inappropriate for a contractor to be required to procure that every agreement, lease, licence or other arrangement in place with a third party in relation to the provision or support of the services is assignable and is able to be novated or assigned to the PCT on termination or expiry of the

agreement. Firstly, dentists are independent contractors with business autonomy, and any leases, licences, agreements etc relating to any of the contractor's assets or commercial arrangements are private and not within the control of the PCT. Any agreement to assign or to novate in favour of the PCT or any other person must be at the complete discretion of the Contractor at the time of termination or expiry of the agreement. Secondly, in practical terms it is extremely difficult if not impossible to procure that third parties agree to such terms. Commercial providers and suppliers will operate using standard terms and conditions that will in all likelihood prohibit assignment or novation.

Additionally, the requirement for a Contractor to procure that any assignment or novation is on terms and conditions no less favourable than those enjoyed by the contractor and at no cost to the PCT or a new contractor is absurd and could be impossible to change existing third party arrangements.

The footnote suggests that clause 5.5(c) should reflect local agreement but contractors should bear the above in mind.

Clause 5.5(d) (iii) - How is it envisaged that a contractor will at all times perform the services in co-operation with local and national health service bodies and relevant local government authorities? Again this seems to be an unnecessary catch-all provision.

Clause 8.3(c) - The reference to the Private & Voluntary Healthcare (England) Regulations 2001 should be removed.

Clause 10.1 - Creates unnecessary administration.

Clause 12.1 - The requirement to meet the essential requirements of HTM 01-05 immediately and to achieve best practice within 24 months may be inappropriate.

Clause 13.17 - The obligation for the contractor to notify the PCT in the event that a DCP is referred to their professional body for misconduct or is suspended or removed from the register is inappropriate.

Clause 13.18 - See comments to Schedule 4 below.

Clause 14.1 - Any commitments relating to training should be dealt with in the contracts between the contractor and their staff/performers, rather than in the contract with the PCT.

Clause 17.1 - Should read "whether in the Regulations or otherwise". Opening this up too wide could leave the contractor unnecessarily exposed to technical breach of contract.

Clause 19.1 - The wording "delegate its obligations" is a recent insertion with which I do not agree. The Contractor is ultimately responsible for its obligations under this Agreement but obviously staff will carry out many of these. This wording should be deleted and the position is adequately covered by the remaining wording.

In respect of clause 19.2(a), it may not be possible or practical to identify all sub-contractors in advance/as part of the tender application.

Clause 30.3 - Contractors are required to comply with the principles of the current BDA Good Practice Scheme but may not be BDA Good Practice Scheme members.

Clause 31.5 - See notes to Schedule 7 below.

Clause 34A - The sub-heading is incorrect and misleading. It should read "Evidence of exemption under the Act".

Clause 36 - See notes on Schedule 7 below.

Clause 37 (f) and (g) - It is inappropriate for the contractor to be required to notify the PCT of anything affecting the status of Contractor Staff and any criminal investigations or proceedings in relation to Contractor Staff. Again, this potentially compromises contractors' business autonomy

Check how widely Contractor Staff is defined.

Generally, consideration needs to be given to the extent that the Contractor has knowledge of some of these matters and the clause needs to be re written to provide for this. Many matters e.g. under (i) will not be known to the contractor.

Clause 44 - Should be section 8 and section 109(4).

Clause 46 - There may be a concern that the definitions of Clinical Governance and Integrated Governance are too wide with the potential of putting the contractor at greater risk of technical breaches.

As noted above, contractors should be certain that any local adaptations are suitable.

Clause 47 - This clause is not well drafted and contractors should be certain of what liabilities they would face under this Agreement. The clause purports to limit both parties' liabilities to an agreed multiple of the annual contract value. However, the contractor's liability is then increased by the amount which should have been insured. See comments on Schedule 9.

47.5 - This indemnity provision is inappropriate. The scope of the liability for the contractor is huge. The references to IP, Trade Union and employment claims are not relevant to this type of agreement. In any event the saving provision at the end of 47.4(c) should cover all of 47.4 and 47.5.

The limitations on the PCT's liability are a further illustration of the inequity in this type of agreement.

47.6 - The Contractor cannot be expected to accept liability for the negligence of all staff, other contractor parties, trainers or trainees. All clinical staff will have personal professional indemnity insurance.

Clause 48.1 – See comments below in respect of Schedule 9.

Clause 48.3 - It is inappropriate for the contractor to be required to notify or to seek approval of the PCT for a change in insurer / terms of insurance. This potentially compromises contractors' business autonomy

Clause 48.5 - Any requirements in respect of vocational trainees will be covered by the agreement between the contractor and the deanery. It is not appropriate for it to be dealt with in this agreement.

Clause 48.6 – Clause is too general.

Clause 48.7 - It is inappropriate for the contractor to provide warranties to the PCT in respect of its own insurance policies.

Clause 48.8 - It is inappropriate for the contractor to be subject to a requirement to notify the PCT in respect of matters affecting the contractor's own insurance policies.

Clause 50.1 (a) Presumably this clause should refer to services undertaken by the contractor rather than services undertaken by the PCT. Even though the Regulations use this wording, regulation 20(1) does not require wording which is not applicable to the arrangement:

"An agreement must, unless it is of a type or nature to which a particular provision does not apply, contain other terms which have the same effect as those specified in Schedule 3"

Clause 51 – See comments on Schedule 8 below.

Clause 53B – Contractors should check this Contract User Guide. This clause does not provide the PCT with any right to terminate without cause, rather to provide information that where termination occurs in accordance with clause 54, 55, etc, this will be done by notice. This clause is not in the DH standard model terms for PDS but is acceptable provided the PCT do not see it as a stand alone clause giving a right to terminate.

Clause 61.2(c) – This is not appropriate. Claims can still arise following the Termination Date and the PCT may be liable to make payments which arise out of and in accordance with the Agreement. I do not believe this clause is needed and is not a clause which was required for standard GDS Contracts or PDS Agreements. Does the PCT have any particular concern which has arisen out of those arrangements which it feels needs to be covered?

Clause 61.2(d) - It is inappropriate to impose a requirement on the contractor to take steps to mitigate any costs incurred by the PCT.

Clause 61.2(e) – It is unclear what the intention of this provision is and unless this can be clarified the provision should be removed. There are requirements elsewhere in the Agreement for the Contractor to retain records after termination of the agreement. There are also provisions covering what

information should be provided to the PCT on termination. Check the definition of Confidential Information and its appropriateness for a dental agreement.

Clause 61.2(f) - It is entirely inappropriate for the contractor to be required to make available to the PCT or a new contractor the contractor's staff or self-employed personnel.

Clause 61.3 - It is entirely inappropriate for the contractor to be required to supply to the PCT, within a specified time following termination of the agreement, any information requested by the PCT in a fully indexed and catalogued format with a view to facilitating further commissioning of the services by the PCT. Co-operation is expected but this goes too far.

Clause 61.4 - It is inappropriate for the contractor to be required to provide full cooperation with the PCT in terms of access and the provision of information for the purposes of facilitating the setting up of a new contractor.

Clause 61.5 - It is absurd to require the contractor to provide, at no cost to the PCT, all computerised files, records, documents etc in a fully indexed and catalogued disk format that will operate on a software package identical to that used by the PCT. The caveat at the end does little to assist if the Contractor does not know what software the PCT is using. Perhaps this should be agreed at an early stage.

Clause 61.6 - It is inappropriate for the contractor to be required to meet the costs of a replacement contractor together with any additional expenditure incurred by the PCT. If the contractor fails to meet its obligations during the term of the agreement the appropriate avenues of recourse should be followed.

Clause 61.7(c) - See notes to clause 5.5(c) above. It is not appropriate to expect contractors to agree to remain liable under an agreement that the PCT would like to have assigned or novated to it, in the event that the relevant third party refuses its consent to such assignment or novation.

The clause potentially also diminishes the value of the practice.

Clause 61.7(d) - This provision is inappropriate. Any rights for staff to transfer to the PCT or the new contractor following termination of the agreement would be governed by the TUPE Regulations, as would any associated liabilities. It is also inappropriate for the contractor to agree to release any staff or personnel who choose to take up employment or engagement with the PCT or the new contractor from any liability that they owe to the contractor.

See notes to Schedule 14 below.

Clause 63.1 - See notes to Schedule 18 below.

Clause 67.2 - It must be confirmed that the Access Payment and Performance Payments are regarded as part of the contractor's annual contract value, are superannuable and should be included as part of the contractor's pensionable earnings for the purposes of claiming additional specific payments.

If this is not the case it will be significantly financially detrimental to contractors and performers.

See notes to Schedule 3 below.

Clause 70.1 – As noted above, there are some concerns that despite the intentions of the parties as set out here, the contractor's status is a matter of fact to be resolved, if relevant, by HMRC and/or an Employment Tribunal.

Clause 70.5 – This is new provision to that which I have seen in recent PDS+ Agreements but is a provision which PCTs are increasingly attempting to insert into dental contracts. Usually only drafted to apply to dental bodies corporate, it would prevent a change in shareholding of the company which would mean that the control of the company shifts to a different party. This would effectively put in jeopardy the Contractor's ability to sell the business/affect goodwill. The fact that PCT consent should not be unreasonably withheld provides little comfort.

Clause 76.1 - It is inappropriate for the PCT to transfer to the contractor its own obligations.

Clause 77.5 - This catch all clause is disproportionate and unnecessary. Previous versions of this Agreement have also had a definition of Confidential Information which is far too wide. The contractor cannot be expected to give a blanket authorisation to the release of confidential information, particularly where it is for the purposes of the PCT gathering market information.

Clause 79.2 - Dentists are independent contractors with business autonomy. It is inappropriate for them to be expected to seek PCT approval of changes to their business name. Notification rather than approval is more appropriate.

Clause 83.7 – It may be sensible to include a provision which suspends PCT action pending the outcome of any dispute resolution procedure that the contractor may invoke. Further, if the contractor would incur additional expense by complying with such steps as the PCT may consider reasonable in accordance with clause 83.7, how is this to be borne?

**Schedule 1 (Definitions) – Missing**

**Schedule 2 (Service Requirements)**

Paras 2.1, 3.1, 4.1 and 4.2, 5.1, 6.1, 7.1, 10.1, 12.1, 13.1, 14.1, 15, 17, 18 - Why are these catch all provisions necessary? It seems to open up scope for technical breach of the contract and is a further indication on the micromanagement of the agreement.

Para 7.1(f) - What if contractors are not BDA Good Practice Scheme members?

Para 11.1 – What constitutes involvement for the purposes of satisfying this obligation?

Para 12.1(a) - What in practice does the DH expect to be included in a System of Integrated Governance?

Para 12.1(g) - It is inappropriate for the contractor to be contractually bound to "participate in all quality and clinical governance initiatives agreed between the PCT and its other dental practices." This allows too much scope for the PCT to unilaterally impose quality requirements.

Para 13 - As long as the services are performed there should not be an ability for the PCT to micro manage the contract and to be able to approve skill mix within a practice.

Para 17.2(c) & (d) - The records to be maintained are extensive and it seems that the PCT is attempting to pass on its own responsibility to maintain records to the contractor.

The requirement to prevent any corruption or loss of the records and to provide the PCT assistance to interpret or understand the records is inappropriate and indeed wholly unrealistic. How can contractors contractually commit to prevent corruption or loss of the records?

## **Part 2**

Para 2.5 - There is a risk that a cap on the number of "unique patients" could affect the contractor's ability to fulfil its UDA requirement

Para 3.2 - Does Annex 1 (urgent treatment list) accord with the definition of urgent treatment? Otherwise this may possibly lead to confusion and dispute, as well as unreasonable expectations by patients.

Para 3.2(c) - The requirement for appointment times to be tailored to patients needs might also risk technical breach as the clinician might not know in advance what the patients needs are.

Para 3.2(g) - The contractual requirement to use a range of consultation methods including but not limited to telephone and face to face consultation is inappropriate in a dental context and should be removed.

Para 6.4 - The treatment plan requires a regular follow up plan but this does not accord with the NICE guidelines on recalls. Surely recall patterns should be determined on each visit depending on the patient's oral health needs at that time?

6.4(d) - How does the PCT envisage that the contractor educate patients about their obligations to attend for treatments?

Para 6.5 - Contractors should not be required to give patients a copy of their records unless requested.

## **Part 3**

Para 1.1 - Ensure definition of Opening Hours refers specifically to Schedule 2 Part 2 Table 4 to avoid confusion.

### **Schedule 3 (Payment)**

Generally, I would advise that Contractors seek the advice of a specialist Dental Accountant with regard to the payment schedule, its local adaptation and its suitability to the Contractor and the particular scheme.

Paras 2.3/2.4/3.2 – It should be made clear that the Access Payment and Performance Payment will be superannuable (ie that they form part of the NAAV). If this is not the case it will be significantly financially detrimental to contractors and performers.

Para 2.5 – Contractors should be warned that exercising their right to a GDS Contract would see their NACV only being 61% of the Bid Price.

Para 6.1/6.2 – It must be clear whether these Additional UDAs can be used for Unique Patients and Regular Patients without causing a contract breach under Schedule 2 Part 2.

Para 7.6/7 – Should the first year not be a performance level of 100% to allow time to get up and running. Will the Contractor have budgeted for a reduced payment in the first year?

Para 9 – This appears optional but we would advise that all elements of the contract payment is increased in line with the DDRB Uplift.

Para 11/annex 2 – The Contractor should determine at an early stage what the minimum income guarantee is going to be.

### **Schedule 4 (Staffing)**

Para 1.1(b) The Code of Practice for the International Recruitment of Healthcare Professionals is not relevant to GDPs.

Para 2.1 – Staffing is a commercial decision for a contractor to make and it is inappropriate for constraints to be placed on independent contractors who have business autonomy (i.e. adherence to a staffing plan).

The requirement for a requisite level of skill and experience is already covered by sub-clause 13.14 of the main agreement.

A clause referring to events such as pandemics should be added to cover situations where the ability to provide staff in sufficient numbers is beyond the control of the Contractor.

Para 2.2 - The requirement to allow the PCT access to all staff information and records raises data protection and confidentiality concerns and purports to allow the PCT to micromanage the agreement.

The Contractor should not be required to do anything that might breach data protection law. Generally, the PCT should not have the right to access to private information held by the Contractor.

Para 3.1(a) – It is unclear which person specifications are being referred to. These require definition. In any event, again, the PCT should not be micromanaging the contract.

3.1(b) – Self-employed dentist performers should be responsible for ensuring that they have their own indemnity insurance in place.

Para 5.1 - This clause results in micro-management of the contract by the PCT.

The requirement for staff appraisal and assessment is already covered by clause 18 of the main agreement.

Para 5.2 - This provision is inappropriate and should be removed. The PCT should not be permitted to approve performers or to prevent performers from performing services other than in line with the provisions of the Performers Lists Regulations.

Para 6 – See comments on Schedule 15.

Para 7 - These are inappropriate and unnecessary provisions for the agreement between the contractor and the PCT. The contractor is already bound by law to comply with equal opportunities legislation. This additional contractual obligation to comply with legislation is a further indication of the move towards micromanagement of the contract.

Para 8.1(d) Is this generic catch all provision really necessary?

8.1(e) This provision would be inappropriate for most GDPs.

### **Schedule 5 (IM&T)**

Much of paragraphs 11 to 15 impose completely unnecessary administrative burdens on contractors and are disproportionate.

### **Schedule 6 (Premises and Equipment)**

Para 2 – only applicable where contractors operating from PCT owned premises.

Paras 4(a), (d) and (g) - It is inappropriate for the contractor to be expected to maintain and insure any PCT-owned equipment, to ensure that the equipment integrates properly with interfacing hardware and software or to ensure that the equipment complies with all laws, statutory requirements and European Standards. Such responsibilities should be borne by the PCT.

Para 4.1(e) - It is impossible for a contractor to contractually commit not to “knowingly or not” introduce any computer virus or other contamination.

Para 4.1 (b) and (c) - It is also inappropriate for contractors to contractually commit to ensuring legal compliance with any licences or agreements, and to commit to operating the equipment in accordance with technical specifications or manufacturer’s instructions. In practice it is unlikely that a contractor would be provided with copies of such documents or would be aware of their existence.

Para 4 - The obligations set out in clause 4 seem inappropriate and unnecessary in light of the note in Annex 2 of the Schedule which states that the equipment to be provided by the PCT typically will not include dental equipment.

Annex 3 - It is inappropriate to require contractors to provide an inventory of all equipment, fixtures and fittings owned by the contractor and used at the practice. What purpose does this serve?

## **Schedule 7 (Contract and Performance Management)**

### Weighting

As PCTs are permitted to allow an agreed period of time for contractors to achieve Band A performance for specific KPIs, who determines what constitutes "sufficient reasonable progress" towards achievement of Band A performance? It is worth noting that this flexibility for a leading period provides that only Band B performance payments are made during the relaxation period.

Para 2 - See notes under Schedule 11 regarding the appropriateness of nominating Board Directors and other similar roles.

Para 4 - Please note that the Half Year Reviews and Annual Reconciliation Meetings are said to be in addition to the Mid Year Review and Annual Review meetings required by the Regulations. What is the likelihood of the PCT having sufficient resources and being sufficiently organised to meet with every contractor on a quarterly basis for a Joint Service Review? Feedback that we receive from members strongly indicates that PCTs do not currently have sufficient resources to meet the requirement to carry out mid-term and end of year contract reviews.

Para 5 - A further unnecessary administrative burden on the Contractor and a further cost to the Contractor. How in practice is the contractor expected to "carry out periodic testing of the accuracy and completeness of the Contractor Performance Data". Check clarity of definition of Contractor Performance Data.

Para 6 - In previous drafts we have seen of this Agreement, this paragraph was entitled "sanctions" and not "remedies". Looking at the remedies in the table, it is clear the PCT remedies still have more in common with sanctions than they do remedies.

Box 2 - There are too many sanctions available for the PCT to use at their discretion if a contractor inaccurately self-assesses their performance against any KPI. Self-assessment is subjective and the sanctions are such that contractors are potentially exposed to the possibility of non-payment, clawback, breach or remedial action and termination if their view of performance success does not accord with that of the PCT

- (i) It is inappropriate for a sanction to allow the past 12 months' performance payments to be recalculated. If Half Year Rear Reviews are being carried out and signed off by the PCT then recalculation of performance payments should only be possible for the last 6 months.

(iii) and (iv) Because of the subjective nature of self-assessment breach notices are inappropriate sanctions for inaccurate representation of KPIs.

**Schedule 8 (Change schedule)** – Not provided but previous drafts have raised concerns the PCT wishes to introduce additional services and the Contractor is required to calculate and provide details of the impact of the change within a short time scale (usually two weeks). It is a further burden on the Contractor to carry out such a task and within a short timeframe. Further costs and time are likely to be incurred in carrying out this work.

**Schedule 9 (Insurance Requirements)** – It is inappropriate for the PCT to have control over the insurance cover put in place by the contractor.

It also remains to be seen whether the cover required by this schedule is actually available in the current market. Further specific advice needs to be sought from the main dental defence organisations.

Para 1.1 – £5m insurance for any one public liability or employer's liability claim and £5m-£10m for any one clinical negligence claim is excessive and possibly unachievable.

The Employer's liability threshold has been increased from £5 million to £10 million in this version of the PDS+ Agreement.

Para 1.4.2 – Why should the PCT have the ability to veto a particular insurer? This is unnecessary and potentially affects the contractor's business autonomy.

Para 1.4.3 – It is extremely unlikely that any insurer would agree to include a waiver of all rights of subrogation against the PCT and to agree not to bring a claim against the PCT or any other NHS Body, even where there has been non-disclosure or underinsurance or where the insurance was not effected or has been vitiated. This requirement is setting the contractor up for an immediate breach.

In part the provision does not seem to make sense. Why would the insurer agree not to bring a claim against the PCT where the contractor could recover loss or damage under their insurance policy? The policy will obviously not cover the insurer's losses.

### **Schedule 11 (Administration)**

Para 1 – The PCT is required to nominate Agreement Managers and Board Directors but what happens when personnel change? This will not get updated in practice.

Does the contractor really need all of the following?

- An Agreement Manager;
- A Board Director (this is clearly not appropriate for an individual set up);
- Someone responsible for confidentiality of personal data;
- Someone responsible for clinical governance;

- Someone responsible for the effective operation of a “System of Integrated Governance;”
- An Organisational Dental Director (this is clearly not appropriate for an individual set up);
- A Local Dental Director (this is clearly not appropriate for an individual set up); and
- A Director of Clinical Services (this is clearly not appropriate for an individual set up).

Para 2.1(a) – Does all correspondence really need to be sequentially numbered?

#### **Schedule 14 (Operational Management Plan)**

This plan is inappropriate for general dental practitioners.

The only setting in which we can see this might be appropriate is where a polyclinic or health centre is being established and it is made very clear to contractors upfront that they will have no rights to goodwill, assets, staff etc on expiry or termination of the agreement. They would also need to be fully aware of the requirements to commit significant resources to facilitate a smooth transition of all assets and staff, etc to the PCT or a new contractor. This commitment would need to be reflected in the bid price.

If the PCT is entitled to opt to purchase the contractor’s business assets, presumably the PCT will pay for the goodwill that the contractor has built up?

Para 1.3 – On expiry or termination of the agreement contractors cannot be required to invest significant time and financial resources or to make staff available to facilitate a smooth transfer of services to the PCT or a new contractor.

Para 1.5 – It is absurd for contractors to be expected to ensure that an exit plan includes a requirement for them to take reasonable steps to mitigate any costs that the PCT might incur as a result of expiry of the agreement.

Para 1.7 – Many of these are onerous and inappropriate (where this service is additional to existing service provision); to procure the transfer of all of the contractor’s staff to the PCT to provide the PCT or new provider with all records, to consult with the PCT to ascertain whether the PCT wishes to have leases, licences or other agreements novated in their favour, to consult with the PCT to arrange for IM&T services to be transferred to the PCT, to allow the PCT or a new contractor access to observe the delivery of services or to take steps to avoid costs being incurred by the PCT or a new contractor.

**Schedule 16 (Approved Subcontractors)** – There is currently no requirement for the PCT to perform financial due diligence in respect of sub-contractors and this should not become a requirement.

#### **Schedule 18 (Staff Transfer)**

Para 4.3 – It is inappropriate to require the contractor to indemnify a third party.

Para 6.1.1 - The information to be given should only be what is required under Regulation 11 of the TUPE Regulations.

Para 6.4 – The PCT should not have the power to control decisions that a Contractor makes about its own staff.

Para 6.4.3 – It is inappropriate to prohibit the contractor from transferring staff to another part of their business. GDPs have business autonomy and should be permitted to continue to run their business on a private basis following expiry or termination of their NHS agreement should they so wish.

Para 6.5 - It is inappropriate to require the contractor to indemnify a third party. If 6.1.1 is amended as per comment above then 6.5 should be removed.

Annex 2 - In para 3.1, second line, insert the words "PCT shall procure that" before "GAD shall calculate...".

There should also be the inclusion of an obligation on the PCT to secure an indemnity from any New Contractor in similar terms to those set out in clause 5.1.

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I apologise for the length of this report but I thought it sensible to cover all the areas of concern, particularly, since many contractors who are familiar with GDS or PDS arrangements will need to be aware of the increase in compliance requirements and what their responsibilities are. This will be a particular concern for contractors who are using this contract in addition to an existing NHS contract since it will be difficult to run a two tier system and the contractor may inadvertently burden itself further.

Kind regards

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