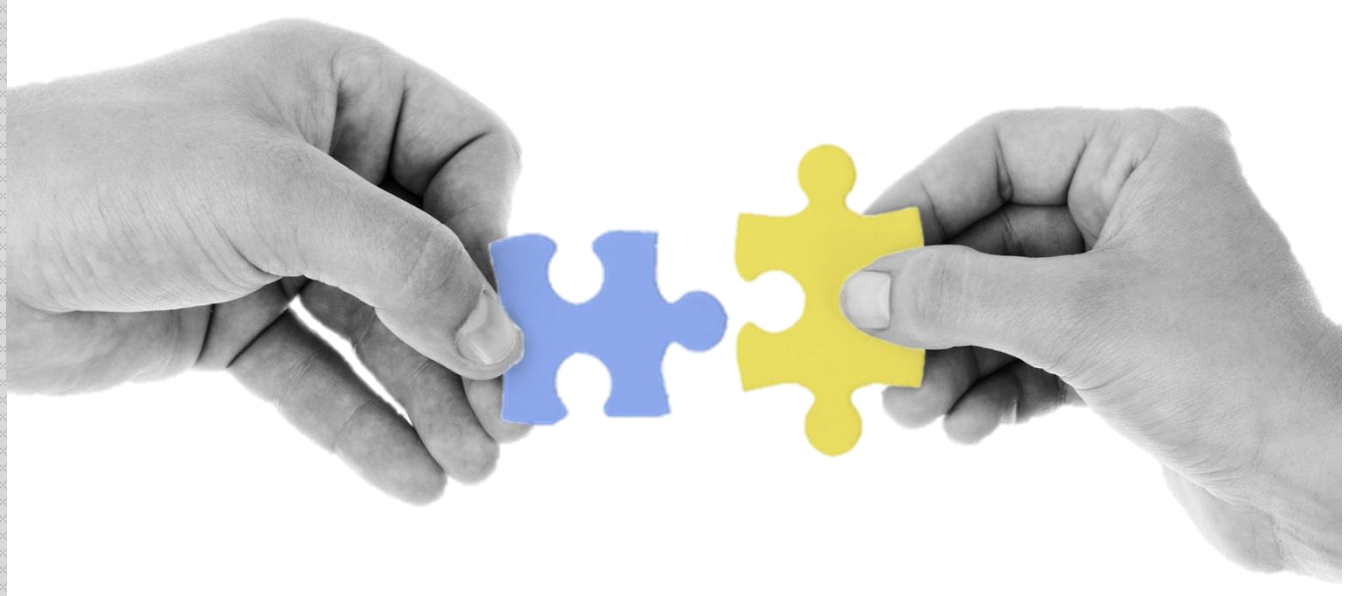
Bedfordshire & Hertfordshire Local Medical Committee Ltd

Working in partnership for excellence in General Practice

LMC GUIDE

TO PRACTICE MERGERS

June 2022



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Bedfordshire & Hertfordshire Local Medical Committee Ltd

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SECTION ONE: A QUICK GUIDE TO PRACTICE MERGERS

1 Introduction

In simple terms a practice merger is when two or more practices join together to form a single practice. Ultimately, each practice wishing to merge will need to weigh up the potential advantages and disadvantages of merging to establish whether it is right for them.

This document is intended to act as a guide for practices that are considering merging and to give an overview of areas that need to be considered through the merger process.

This toolkit has been created with advice sought from organisations that are involved in the merger process as well as input from various practices within Bedfordshire & Hertfordshire that have merged. Please note this guide is not exhaustive but aims to highlight the main areas and concerns to be considered if merging and full support should be taken from relevant, professional advisors throughout the process. The document has been prepared with support from LMC Law, HBLICT, Herts Valleys CCG and BLMK CCG.

2 Why consider Merging?

Embarking on, and completing a successful practice merger, is not an easy process. It is time consuming and expensive, requiring leadership skills and plenty of emotional energy. It is vital that each 'partner' organisation involved in the merger has a clear reason as to why a merger is the way forward for their business.

Regardless of the underlying causes for a merger, it is important for there to be a clear collective vision as to the 'end point' with respect to how the merged business will look and function.

The table[1] below highlights some of the general pros and cons of merging.

Advantages	Disadvantages
Improved sustainability in providing services	A merger could put practices outside of established primary care networks/neighbourhoods geographically
The potential to reduce workload and workforce pressures	Time constraints and costs may pose difficulties during the infancy of a merger
Economies of scale through the ability to increase the volume and type of services offered to patients	There could be a reduction in funding, for example, a reduction in the value of the core contract and impact on QOF
The ability to attract, recruit and retain more clinicians and senior management staff	Some GPs may have less influence in decision making within a large partnership
The ability to share facilities and premises	Each practice will sacrifice an element of their independence
Benefits of economies of scale, for example: • The ability to bulk buy • The ability to reduce business costs/sharing back-office functions • A greater chance of successfully bidding for contracts	Any liabilities belonging to a specific practice may pose an issue unless positive action is taken to mitigate the liabilities or ring-fence them
The ability to offer greater training functions to develop a more skilled workforce	GPs and staff could leave if the merger is not managed sensitively and inclusively
The opportunity to become a transformational, innovative practice.	Poor preparation, communication and planning can lead to a breakdown in relationships pre-merger and post-merger
Attract more patients due to the innovative and forward-thinking culture of the practice	Patients could leave the practices where they are unhappy with the merger
The ability to offer increased/extended patient access	Patients may have difficulty in accessing the services if the practice operates from more than one location

[1] *Table extract from 'NHS Doncaster Clinical Commissioning Group Practice Merger Guidance Manual' 15/03/2021*

3 What is a Merger?

Key merger definitions

There are a number of common terms used when talking about practices mergers, which can often be confused. In the section below we have tried to provide clear definitions of the most important terms you are likely to hear when discussing a merger.

3.1 Partnership vs GMS Contract

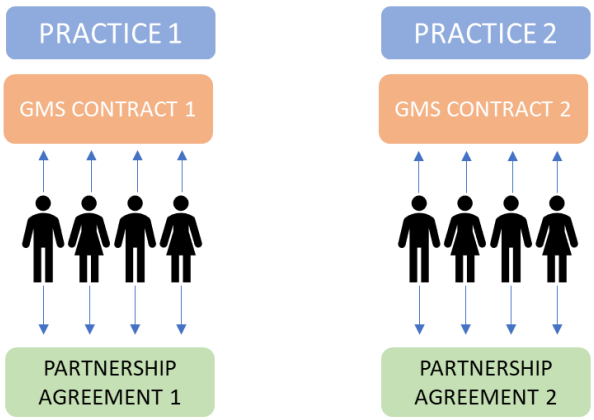
GP practices run by partnerships have two types of formal contractual agreement. The first is the partnership deed which is a contract between the partners that governs how the partnership will operate, the expectations of the partners etc. Those partnerships without a partnership deed are termed as partnerships at will. The second is the contract the partnership has with the commissioner, which will be a General Medical Services (GMS) contract for the vast majority of partnerships.

These two legal agreements often get conflated or confused when talking about mergers. Consideration needs to be given to both when contemplating a merger.

3.2 Soft vs Hard Merger

When people talk about merging practices, you often hear the use of the terms hard and soft merger. These terms refer to the extent to which two (or more) practices become merged and require different levels of change to the partnership deed and GMS contracts mentioned above.

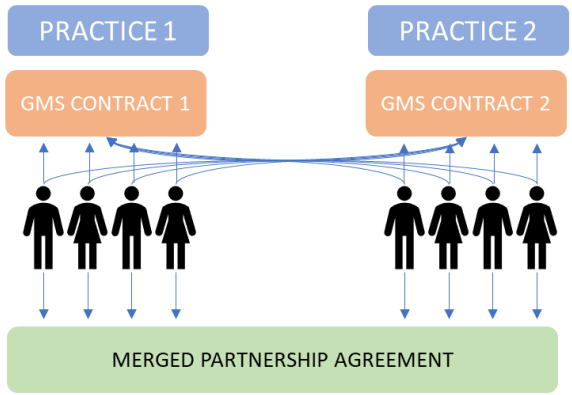
For the purposes of illustrating the difference between a soft and a hard merger, let us consider a situation where two practices each holding a GMS contract with four partners, decide to merge. The diagram below shows the two practices, with their separate partnership deeds and GMS contracts with the commissioners.



3.3 Soft Merger

A soft merger takes place when the individual practices merge their partnerships, forming one large partnership, but where they do not merge their GMS contracts. Each of the individual

partners places their name on both of the GMS contracts, but the two GMS contracts remain separate.



PROS of a Soft Merger

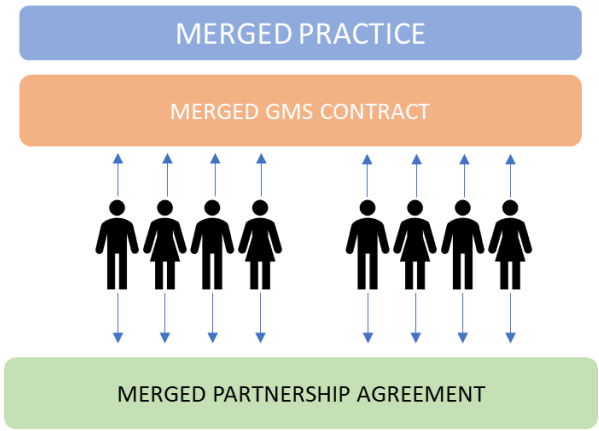
- **Integration of Services**. The merger allows sharing and integration of services that are not contract specific across the two practices.
- **Economies of Scale**. There are a lot of operational activities and expenditures that can be brought together under the merged partnership (e.g. payroll, services contracts, phone systems etc.), saving time and money.
- **Contract Separation**. As the merged partnership holds two separate GMS contracts, the partnership retains the ability to hand any of the contracts back or split back to two partnerships if the merger arrangement is not working.
- **Dilution of Individual Risks**. Working under a single partnership agreement brings all the partners in line with each other, sharing the responsibility over a greater number of partners.
- **Culture and Identity**. As the two practices are still separate entities held under one partnership, it is possible to maintain the culture and identity of the individual practices.
- **CQC Independence**. Holding two GMS contracts means that both practices will be inspected by the Care Quality Commission (CQC) independently. This means that if one practice is judged as requires improvement or inadequate by the CQC, the other practices rating will not be affected.

CONS of a Soft Merger

- **Duplication of Work**. As the partnership holds two GMS contracts, there are many elements that cannot be done once across both practices, as the work is tied to the individual GMS contract. Examples of this include CQC, QOF, CCG & Public Health data reporting.
- **Partial Integration of Clinical System**. Soft merged practice cannot fully merge their clinical systems and patient lists. This acts as a barrier in terms of using staff flexibly across the two practices and the integration of clinical processes.

3.4 Hard Merger

A hard merger mirrors the partnership changes in the soft merger, in that both the partnerships merge into a single partnership. However, a hard merger goes one step further, also merging the two GMS contracts into one single contract. When this happens, one of the practice lists is merged onto the others, creating one list. The merged practice will then have one main site, and the other practice premises will become a branch of the main site.



PROS of a Hard Merger

- **Full Integration of Services**. The merger allows sharing and integration of services as it is no longer limited by tasks that are contract specific.
- **Economies of Scale**. All operational activities and expenditures can be brought together under the merged partnership (e.g. payroll, services contracts, phone systems etc.), the practice can run as one large practice with multiple sites.
- **Flexibility in Operating Model**. Once the GMS contracts become merged, the practice is free to use its premises differently. Where previously services had to be offered at both practices as per the GMS contract, now different services can be offered across the multiple sites (e.g. some merged practices have one site for acute on the day work and another for chronic care).
- **Dilution of Individual Risks**. Working under a single partnership agreement with a single contract means that there are more partners named on the contract. This spreads the risk and responsibility over more partners and reduces the risk of any one partner becoming the “last man standing”.
- **Full Integration of Clinical System**. Holding one merged list means the clinical systems can be merged, allowing flexibility across both sites and staff.
- **Removal of Duplication**. The merged GMS contract means that any work that is tied to the contract only has to be done once. Examples of this include CQC, QOF, CCG & Public Health data reporting.
- **Becoming too Big to Fail**. By the nature of merging two practices into one GMS list, you create a large(r) practice. Where smaller practices who struggle run the risk of their list being dispersed or their contract put out to tender as an APMS contract, commissioners are less willing to do this with larger practice.

CONS of a Hard Merger

- Long-term commitment with no ability to separate contracts.
- Likely to lose individual practices culture and identity.
- Requirement to develop new management structures.

3.5 Merger vs Takeover

When two practices merge (either via a soft or hard merger) there are several different ways the merger can take place, depending on the circumstances that have led to the merger. These are generally viewed as either a merger of equals or a takeover, explained further below.

3.5.1 Merger of Equals

A merger of equals is when two or more practices come together, usually both of a similar size in terms of patient list size and number of partners, to form one unified practice. Generally, both practices will share an equal burden of the merger with the staff from both practices having to develop new ways of working and the partners from both practices forming a new partnership.

3.5.2 Takeover

A takeover is where one practice subsumes another practice, taking on their list. This is often (but not always) a bigger practice taking over a smaller one. The practice doing the taking over will not change the way it works but will impose its processes on the practice being taken over. Staff from the dominant practice will be largely unaffected by the takeover, while staff from the practice being taken over will transfer across to the new employer. Partners from the practice being taken over may be offered a salaried role at the new practice, leave to work elsewhere, or retire.

The reality is that these two scenarios are the two extremes and are rarely seen. Most mergers fall somewhere on the line between a merger of equals and a takeover, depending on circumstances. That said, before entering any sort of merger talks, it is important to be clear on where your practice sits on the line between a merger of equals and a takeover. Mergers where one party believes they are undertaking a merger of equals, while the other views it as a takeover, rarely go well.

3.5.3 NHS England definition of a Merger vs Takeover

While we often use the term takeover, in terms of the GMS contract, takeovers are not allowed, only mergers. Even when all the partners from one practice leave on the day of a merger, it is still termed a merger in the eyes of NHSE, as a merger must take place before those partners can be removed from the contract.

4 How to Merge?

A practice merger is the process by which parties work towards the date at which GMS contracts are merged. In reality, this process can take between 6 months to 2 years to reach that point, with another 1-2 years after that merger date for the 'new' Practice to be operating as a single entity.

The merger process takes a large amount of resource in terms of time, energy and money. It is a large operational piece of work that many try to fit around their day job. The reality is that most people will only experience a merger once in their career, no two mergers are the same and there are very few 'experts' available to project manage the process. It is important to consider the resource implications, have an agreement early on between the parties as to how this will be managed/apportioned and consider the project management skills needed, whether sourced through external project management or internal backfill. Formation of a 'merger' team with authority to set meeting schedules and make financial decisions can be invaluable in keeping the project on track and enable timely decision making.

Some pre-merger advice…

- Be open and honest with each other.
- Maintain open channels of communication - keep talking to each other throughout the process.
- Share information – this is an opportunity to implement best practice wherever possible.
- Be willing to accept and embrace change.
- Be aware that the timescale of a merger can be a lengthy process.
- The merger process does not halt after the contracts and clinical systems are merged – often the challenges/workload increases after the official merger date.
- The merger process will require input of a wide range of resources from staffing to financial input, so all parties involved need to be prepared to participate in the process.
- Some of the biggest risks to be aware of when merging – property issues, core contract, staff, pensions, unresolved disputes, pending or threatened legal actions.
- Get professional accountancy advice early in the process, especially if there is a non-March year end or practices have different year ends.
- Remember that your GMS contract is separate to your Partnership agreement. Think about reviewing existing agreements and discussing what a 'new' agreement might look like. This will help expose possible contentious areas early on and prevent them de-railing a merger process later.

SECTION TWO: PRACTICE MERGER TOOLKIT

Once the decision to merge has been taken, various steps will need to take place that will affect all the practices involved in the merger. To help navigate this checklist, it has been divided into two sections: 'Business Aspects' and 'Operational Aspects', however many aspects will cross over into both sections.

5 BUSINESS ASPECTS

5.1 Due Diligence

This needs to be undertaken with each practice in the merger process, in particular with respect of the liabilities of all parties concerned. This should include:

- Contractual issues – identify all contracts held
- Contact NHS England (NHSE) to inform them of the intended contract variations and ensure they agree to it. More details on the requirements can be found here, in particular chapter 6, sections 4-9. A number of templates for notification of changes to practices can be found in the appendices of this document.
- Staff (see section on HR)
- Finances (see section on Financial management)
- Breach of contract issues
- Premises/lease issues (see section on 1e Property & Estates)
- Any practice issues
- Patient complaints of a significant nature in the past 18 months
- Any partnership issues

- Compliance with CQC
- Insurances in place (see section 1f)
- Check all relevant registrations & fitness to practice for staff and partners are in place
- Clinical service delivery
- Practice lists – will these be merged or remain separate?

Legal advice on due diligence should be taken from a mutually agreed source. It can be noted that Beds and Herts LMC have a retainer arrangement with LMC Law.

Once the due diligence process has been completed, a merger agreement should be signed, which commits the parties to the onward process of merging, including committing the individual parties to bear pre-merger costs.

5.2 Legal aspects

- If any party has a PMS contract, then NHS England must give consent for the partners to be added to the contract. This is not applicable to GMS contracts.
- What format should the newly merged practice take? Partnership Agreement? Who will the partners be?
- Do both parties have different legal teams supporting individual interests or accept joint advice and support to move to a single unit?
- Heads of term agreement. Ensure this includes details of how partners can join and leave the partnership without causing disruption to the newly merged practices.
- What authorities have to be notified?
  - Inform the CQC of the change in entity and ensure the registration is valid
  - CCG
  - NHS England - Rent reimbursement
  - NHS England - Agreement to the merger. Remember timescales on this, 6-9 months as a minimum.
  - PCSE
- Wherever possible, try to have the merge date to be the 1st April, as this will make reporting (to NHSE, CCG etc.) for the new entity much more straight forward. However, the merger of the clinical systems may not be able to take place on the exact same date as the contractual merger (see 'Clinical System' section).
- Changes to PCN membership? Are the merged practices in the same PCN? If hard merging will the PCN schedules need to be changed to reflect the new practice? Will it affect the PCN membership in other ways, such as voting or service provision?

5.3 Financial management

- Are there any loans and/or mortgages to be considered?
- Financial planning
- Forecasting
- View of the current picture
- Be open & honest – share current and past information
- Inform the practice accountant of the proposed merger and the proposed merger date
- Consider impact if change in date for end of year accounts needed
- Chose and appoint an accountant to represent the newly merged practice
- Estimation of funds required to carry out merger - Contacting local CCG to request funds – Transformation funds, Section 96 funds
- Additional staffing costs, HR support, Project Manager
- Sorting joint account early for merger funds – changes to bank details, contact NHS Pensions

Financial advice should be taken from advisers who are experienced dealing with GP Practice matters.

5.4 Tie up the old businesses

- Remember to budget for tying up the old businesses – accounts, leases, bank accounts, loans, other financial obligations
- No debts at takeover and nothing that might come out of the woodwork later
- Stock take, an independent inventory
- Buildings costs, anything outstanding
- Practice bank account
- Accruals and credits
- Locum costs; IR35 issues?
- Align charges across sites e.g., Non-NHS Charges

5.5 Pensions

- Contact NHS Pensions early in the merger process – various forms required to complete such as 'NHS Pensions Estimate of GP and non-GP provider NHS Pensionable Profits/Pay' form.
- Process all the staff as leavers from the pension account that will no longer be in use and inform NHS Pension the account is closed to ensure the practice(s) are not

chased for monthly payments.

- Ensure all staff are processed onto the 'new' pensions account.

5.6 Property and estates

- Are there any terms in the lease (e.g. minimum number of partners to be signatories to the lease) that need to be adapted?
- Are the same buildings still being used post-merger?
- What lease amendments need to be made (if any)?
- What is the remaining term on the lease?
- How much rent is paid? What other charges are there?

5.7 Services and suppliers

- Are there any economies of scale that might be available to the larger practice? Stationery, suppliers, etc.
- Are there any ongoing contracts in place with suppliers that might need to be considered?

See Appendix 1 produced by East & North Herts CCG Premises Team outlining points to consider with understanding the terms of the lease; understanding the land registry title and understanding any loan and ownership arrangements.

Further advice on premises can be given by the LMC preferred suppliers – click here and scroll down to the Legal advisors section.

5.8 Insurance

- Is all the correct indemnity insurance in place?
- Are all the buildings adequately insured?
- What other insurance might be required?

Advice on insurance can be given by the LMC preferred supplier MIAB – click here for more details.

5.9 Care Quality Commission

Ideally contact the CQC as soon as possible to start the process of any changes to registration(s) early. Action will be dependent on the type of merger taking place, including most likely updating the 'Statement of Purpose' and carrying out DBS checks of Partners through CQC.

The following article from DR Solicitors gives an overview of the potential process involved with CQC.

"This is often overlooked as an 'administrative matter', when in reality it can inform both the structure and the timing of the merger. The situation is further complicated because NHS England's processes don't align well with the CQC's.

Merger scenarios
Below, we've run through some of the most common merger scenarios and what you need to do:

1. *If a partner, or partners, join an existing partnership (Practice A) and close their previous practice (Practice B), then Practice A's CQC registration will continue. The CQC will need to be notified of the names of the new partners in Practice A and an application made to terminate Practice B's registration.*
2. *If a partner, or partners, join an existing partnership (Practice A) and their previous practice (Practice B) becomes a branch surgery of Practice A, then Practice A must apply to have their CQC registration varied BEFORE the merger, to include the new branch surgery and any new services which were previously provided by Practice B but not by Practice A. The merger should not take place until a decision notice has been received. Notification will also be required to terminate Practice B's registration.*
3. *GPs from two separate practices may sometimes become partners in each other's practices, but continue to trade as two separate entities. This is more common among smaller practices, where it can help in managing 24-hour retirement and reduce risk. Whilst each practice will keep its own CQC registration, if a practice moves from a single hander to a partnership in this process, they must re-register first. If they are already a partnership, then they just need to notify the CQC of the change in partners.*
4. *If two practices merge to form a new practice, then a new CQC registration will be required BEFORE the merger can take effect. After the merger, notification should then be sent to cancel the two old registrations"*

Taken from DR Solicitors Blog (February 20th, 2017)
https://www.drsolicitors.com/dealing-cqc-during-practice-merger

5.10 Primary Care Networks

PCNs have added a new layer of complexity to practice mergers. Where practices in the same PCN are merging the change may be minimal. If hard merging, then the schedules will need to be updated to reflect the change. Thought also needs to be given to how the merger will affect voting rights amongst the PCN members. Where voting rights are done based on list size this will be simple to calculate but may result in the merged practice dominating any votes in the PCN. Where voting is based on one vote per practice, it will depend on if the practices are hard or soft merging.

Where the practices are in different PCNs, a plan needs to be agreed with the PCNs and CCGs as to if the practices will remain in two PCNs (which is only possible with a soft merger) or move into one PCN. This will then have a knock-on effect on the PCN finances and ARRS staff, and depending on the list size of the remaining practice in the PCN, may mean that PCN is no longer viable.

6 OPERATIONAL ASPECTS

6.1 Project Management of the Merger

- Who is doing what (roles & responsibilities) and when are they doing it?
- Set up a board made of partners to oversee the merger
- Explore option of recruiting a temporary project manager to oversee operational aspects of the project
- Risk register to be put in place and regularly updated during the merger
- Consider appointing a senior member of the operations team (e.g. Practice Manager) to the decision making group
- Set some objectives/milestones to enable the project management team to be able to measure the success of the project
- Be realistic – it will take time to implement the changes

Managing a merger alongside the day to day running of two busy practices would be almost impossible, therefore using a project manager to guide us through was probably the best decision we made. She instigated a timeline for us to follow and made sure we kept on track. She liaised with all the public bodies such as the CCG, PCSE, CQC etc and acted as first port of call for our staff and patients. It wasn't easy but I believe her guidance and assistance throughout the process was invaluable and kept the stress levels to a minimum.

Practice Manager, East and North Herts

6.2 Practice Management and Strategy

- Consider the proposed new practice management structure – the original or inherited structures may not be fit for purpose for your new organization.
- How will the merged practices be run?
- How will decisions be made?

It is important to be clear about who the decision makers are – just because someone was the decision maker at one practice does not automatically mean they will be part of the decision-making group in the merged practice.

- Roles and responsibilities in the merged practice
- Look outside of the merger to see if there are any other opportunities that could be incorporated at the same time. For example, is there another practice that might want to merge as well – bite the bullet and do it all at one time. Or, if they are not ready yet, let them know that the door may be open to them in the future.
- Goals and targets – where does the practice want to be in 12 months, 18 months, 24 months?

6.3 Staffing and Skill Mix

- Calculate the revised 'appointment capacity' for the merged practices and how this may affect the skill mix
- How will staff be utilised for cross site working and which staff may have an appetite for working cross sites
- Will the existing Practice Managers' roles change post-merger, to focus on specialist areas such as HR & Finance or Operational; their roles need to be clarified
- Review all rota templates - if 'soft merger' ideally start to introduce changes early on and encourage cross site bookings
- Start discussions with GP teams to see how rota templates could be amalgamated
- How will the skill mix of the nursing teams and other healthcare professionals change with multisite/merged working
- Will appointment durations alter such as for set nursing appointments?
- Important to consider changes to admin/back-office teams
- Combining specialist admin roles and creating cross site teams
- Changes to admin rotas/shift patterns
- The above points may lead to the need to update job descriptions of staff, particularly for Practice Managers
- Don't underestimate the time and resources needed to bring staff together to create a 'new' team. It is time well spent to ensure the efficient functioning of the Practice going forward.

6.4 Documentation Control

Consider to what extent policies and procedures, protocols will be aligned across sites and the staff access to these documents.

- Agree on key policies/procedures/protocols to start implementing as priority and dates to start
- Where will these documents be stored? Hard copies and electronic versions
- How will staff access these and ensure they are accessing the most up to date version of documents? Sort access to shared drives
- Will practice letters/referrals/templates all be aligned and incorporate any amended practice/merger branding?
- Compile an information risk register of all important documents, who has access to them and how they are secured.

6.5 Clinical Processes / Protocols

An obvious key area of the operational changes required in the merger process at practice level is how the clinical processes/protocols will change on the ground. This is even more important when practices move from single site to cross site working.

Key areas to address first:

- Pathways for managing patients including Long Term Condition pathways
- Requesting and processing of pathology and other results – how is the patient informed of the results and what information are they told
- Medicines managements and prescribing – managing repeat prescription requests. Controlled Drugs procedures
- Further considerations for dispensing practices
- Cross site meetings including MDT and other clinical meetings - how could these practicably work cross site?
- Managing home visits
- Agree on changes of GP and Nurse Leads for various clinical areas
- Managing of QOF
- Amendments to the clinical governance structure
- Clinical supervision of staff – will the reporting structure alter?
- Safeguarding – changes to clinical lead and processes
- Ensuring effective management of safety alerts
- Changes to the management of patient complaints

6.6 Physical aspects of practice move / merger

- Managing multiple sites; potentially moving clinics and staff across sites
- Disruption to practice services during the site move/changes
- Removal services to support any sites moves/changes
- Changes to capacity of clinical rooms
- Changes to capacity of waiting room(s)

6.7 Human Resources

Ensure staff are kept up to date with the whole merger process. They will function as advocates for the merger and are key to achieving a smooth merger process.

- Obtain details of all current employees and those that have left within the past 6 months to include:
    - Full name
    - Length of continuous service

- Copies of all contracts and letters of relating to employment: letter of appointment, amendment to terms, conditions of employment
- Staff performance issues, to include any grievances (raised or threatened), and disciplinary action (threatened or taken)
- Legal action threatened or taken
- Any complaints made against an employee in the past 12 months
- Any other staff liabilities
- Address any outstanding staff training

- TUPE (Transfer of Undertakings (Protection of Employment)) implications – get advice early on as this process needs to be handled with care to ensure staff have sufficient input into the process.
- Regular communication with staff, starting early in the process. Bear in mind there will be plenty of concern about potential changes to the organisation, job roles and potential new positions available– the process of filling these positions needs to be clear and fair.
- Staff consultations regarding new contracts – different practices will have different staff contracts. Best practice would be for all staff to be moved onto a standardised contract at the time of the merge, bearing in mind TUPE implications, however this may not be possible and contract terms will need to be abided by.
- Other laws and regulations to be considered?
- ACAS as a point of contact for queries
- The aim is to not to be sued by following a clear and appropriate path!

6.8 Clinical System

The below information is predominantly based upon mergers for SystmOne, however many themes will be applicable to EMIS practices also and some specific points are noted for EMIS mergers. Early discussions should take place directly with the ICT provider, HBLICT (for Beds & Herts) and Primary Care IT team (for Herts Valleys CCG), regarding the options for types of mergers and possible date options for merging clinical systems.

- Shared Admin/Soft Merger - discuss options with ICT provider team re 'shared admin' approach so the practices can start to share their clinical system together prior to the final merger date. If planning to introduce a shared admin system then practices can establish a 'soft merger' prior to the final merger date.
- SystmOne 'Remaining unit' vs 'Outgoing unit' - All staff across the practices will have to have some input in helping to 'tidy up/clear the units' prior to the clinical system merge date. The workload for the 'outgoing unit(s)' prior, during and after merge is significantly greater than for the 'remaining unit(s)'.
- Merger date - at the time of writing, TPP will not carry out the SystmOne clinical system mergers in the last couple days of March or first couple of days of April (due to end/start of new financial year with other system requirements that take priority); TPP usually arrange mergers on a Monday, Tuesday or Wednesday. Therefore, it may not be possible to for the merger of the clinical system to take place on the same date as

the contractual merge date.

- For EMIS merger requests, these are to be requested in the online site: https://form.egton.net/machform/view.php?id=503721. Once the form is completed, the EMIS system will generate a request for the EMIS Account Director to produce a quote which the CCG needs to approve- once approved and returned back to EMIS, only then will potential merge dates be looked at. EMIS mergers for larger lists will take place over a weekend. Small mergers may happen midweek.
- Types of mergers - discussions of the options around types of mergers, in regards to the clinical system changes, should be discussed before decisions are made with the contractual aspect of merging. The practice(s) that are considering 'handing back' their GMS contract for the merger, to become a branch surgery in this process, need to be aware of the operational changes that this will result in.
- Merger checklist - Nearer to clinical system merge date - thorough documentation / checklists are provided by ICT providers for various actions/changes required around the clinical system, see Appendix 2 'Pre-Merge Action Plan' and 'Outgoing Unit – Pre-Merge Action Plan' provided by HBLICT– contains detailed actions required for the clinical system merger with focus on the outgoing unit(s) for SystmOne. However, the latest version of the document should be obtained from the HBLICT and the equivalent document/guidance from ICT providers for EMIS mergers.
- Day of Merger - Ideal that ICT providers are on site at practices on day of clinical system merge and the day after, again more so for the sites that are the outgoing units. Clinics will need to be limited on the merger day and the day after merge to allow for various clinical system issues.

In SystmOne, there are two main options for how the branch sites link to the main 'remaining unit' practice. The below highlights some of the considerations to be aware of when deciding between these options.

- Merging patients across sites into one pooled list:

  Creating one patient list all registered under one clinical system. This will have knock on effect to the clinical system and most significantly the outgoing unit(s), including not being able to direct patients or communications to different (branch) sites. The sole remaining 'unit' will be the primary physical address and point of contact for the new merged practices. Therefore, communication from external organisations will all be directed to the remaining unit; this can lead to restrictions/adaptations for the outgoing unit.

- Creating branch sites with separate patient lists:

  Branch sites created keeping their existing patient lists but branch site(s) sit under one clinical system. Patient lists are held separately but branch site(s) listed still within one clinical system. Suitable for sites that are not located near one another, gives greater control to branch sites but means practices may operate differently despite merging. External correspondence can be sent directly to branch sites and run reports for individual branches.

In EMIS systems, the patients from the source (outgoing) practice can all be registered to a pooled patient list or remain with several registered GP's. At the end of the merger process, the patients from the new branch(s) can be given a flag of 'notes held at' which allow reporting for the different patients at the different branches.

- Where the branch sites are geographically distant you may wish to have separate online appointments which will require a separate branch ODS code. This will need to be requested in the early planning stages when you Contact NHS England (NHSE) to inform them of the intended contract variations.
- Online Services –the patient links to online services in the EMIS 'source practice' (outgoing) will not carry over to the new practice. Patients will need instruction as to how to reset their online services to connect to the remaining (Target) practice.

6.9 Smartcard / Registrations Authorities (RAs) changes

Changes required to all smartcard access for staff across all practices; needs to link in with changes to clinical systems and particularly the outgoing unit(s).

- Designate an in-house RA sponsor to carry out all RA changes with NHS portal etc prior, during and after merge
- Practice(s) that are the outgoing unit(s) to move over to remaining unit portal
- Staff smartcard roles will need to be aligned across sites – agreeing permissions for roles
- Updating of physical staff smartcards – plan prior to merger
- Users from outgoing unit, that monitor Choose & Book Worklists will need to retain their old smartcard access until the worklists have been cleared.

6.10 Non-Clinical IT / other practice software and systems

- Consider what other systems are used and what for? Is there duplication?
- Link back to best practice and ensure the best options are used in the merged practice
- Bear the pain of learning new systems to ensure standardisation and easier working in the future
- Request onsite IT support on day/day after merger
- Hardware changes - changes to server and PCs – outgoing units to transfer over to remaining unit server. Bulk data transfer – can interfere with practice operating.
- Telephone system – new telephone lines/changes to numbers/accounts. Changes to call volumes? Retain/change call recording? Upgrade or replacements – upgrading cabling, N3 connections. Changing answer phone messages.
- Medical records storage/cloud storage – capacity of sites and additional costs.
- Aligning other system packages cross sites e.g. dictation system and other software packages e.g. IGPR toolkit, ECG machines software, Spirometry software – same both

sites, loading onto new PCs/server.

- NHS Mail - Replacing existing practices' email accounts to reflect merger. Create one sole NHS email account for new partnership or keep multiple accounts. Implications on the clinical system as to what account SMS messages to patients are sent from – can only have one email address entered into the clinical system; requests through HBLICT. Whitelisting of any new email address can take place before merge to ensure new accounts live at point of merger so can switch between 'old' and 'new' email accounts.

6.11 Role of external bodies within primary care

6.11.1 NHS England

See 'Supporting Sustainable General Practice – A Guide to Mergers for General Practice' NHS England South (South West) v1.3 31.03.16 – some useful templates

https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/guide-mergers-gp.pdf

6.11.2 PCSE

Identify Mergers team at PCSE to navigate through various changes required for mergers. The below steps provided by PCSE, give an outline of the internal process carried out from PCSE's perspective.

- PCSE initially require the fully completed 'PCSE GP Practice Mergers and Closures Form' located at

  https://pcse.england.nhs.uk/services/practice-mergers-closures/

  This can only be submitted once there is a confirmed clinical system merge date. Although practices may contractually merge, PCSE can only make changes to the system from the clinical merge date.
- When the form is received it is checked for completion, at this point it is only checked for all parts of the form being completed and not the content of the information.
- The submitter of the form is then emailed to state the form has been received. The form is then sent to every department in PCSE that will be required to action this.
- It is then that the form will be checked for content, particularly by the Performer team who begin the process of the merge. If there are any issues with the Performers that have been entered on the form, a colleague from this team will contact the practice for clarification.
- The practice remaining will receive an email closer to the merge date from the Performer team asking them to contact PCSE as soon as the merge has been successful. At this point on receipt of the confirmation any Performer moving across to the remaining code are issued new local codes etc and are added to the system.

- A memo is generated for NHSBSA to advise of the changes to the performers and a Bulk Transfer request is emailed to the patient data team for the patients to be transferred on the PCSE system and subsequently Personal Demographic Service (PDS). This also updates Open Exeter as this is a web-based mirror image of the system.
- The Performer team emails the practice with the details of the new codes for the Performers advising them to add them to the system and transfer patients across to the agreed codes. Generally moving to pooled codes for patients so this will be promoted at the time of the first email from the Performer team and if this has been agreed the patients moving into the remaining code will need transferring to this code.
- The registration team prepare for the merge by ensuring all registrations have been processed for the losing Organisation Data Service (ODS) code 48 hours prior to the merge and then the link is suspended for that practice.

Creating of branch ODS type codes

PCSE create branch codes only specific to PCSE e.g. if main ODS code (once merged) is E82013, PCSE create branch sites codes e.g. E82013 001, E82013 002 etc for subsequent branches created from the merger.

E82103 001 is the branch site code for PCSE. Branch code is mainly used for the portal to distinguish the physical sites for deliveries etc.

For performer and patients, the basic ODS E82103 is used, PDS and our NHAIS system have no concept of branch sited when it comes to patient care and registrations. Patients and performers are registered to E82103.

6.11.3 NHS Digital

- Ensure NHS Digital are aware of merger and any effects on allocation / request of branch surgery codes
- Link with ODS team - GP Practice and Pharmacy data is managed and supplied to NHS Digital team by the NHS Prescription Service (NHS RxS).

6.11.4 NHS Prescription Services

- A form will need to be completed by the CCG prescribing signatory and sent through to the NHS Prescription services https://www.nhsbsa.nhs.uk/sites/default/files/2017-02/GP_Practice_Merger_3.2.doc. If you are unsure of who your Authorised Signatory is, please contact the NHS Prescription Service via phone or email on 0191 203 5112 or nhsbsa.prescriptioninformation@nhs.net for further advice
- Contact local Prescribing team
- Changes required to GP codes and Prescription Pricing Authority (PPA IDs).

6.11.5 NHS Business Services Authority

- Advice NHS BSA team of merger - including Pensions division

6.12 Communication Strategy

Consider new partnership brand identity for the merged practices or maintaining an element of individual identity of each practice. Consider how patients will receive any changes to new brand identify for 'their' practice.

- New partnership logo
- Signage outside practices to reflect any changes in branding
- Review presentation of information on display in practices and letterheads for external communication
- Website upgrade – update existing site with all merged practice info on one site. Or one new partnership interface directing through to individual practice sites.
- Updates to patient leaflets
- Telephone system changes for patients – centralised telephone system or separate at each site. Communicate any changes to patients
- Potential media interest with merger – work with local patient engagement teams.

6.13 Patient involvement

- Regular updates -through a variety of mediums such as websites/texts/letters, to ensure all cohorts are aware of the merger
- Start early – engage with patients as early as possible to see potential concerns around a merger. Each practice may have different concerns
- Allay fears and answer questions
- Ensure consultation and engagement – at local level and consider involving HealthWatch
- Promote the benefits of the merge and be clear with patients what's in it for them
- Remember the patients need to be informed, but not control the merger.
- Consider soft merging so patients start to see practices working together before the final merge date.

6.13.1 Patient letters

There is potential requirement to send letters to all registered patients dependent on the type of merger. Some costs for patients' letters covered and organised through PCSE, again dependent on type of merger. Consider initial letter outlining intentions to merge and second letter confirming details and exact date. Involve local patient groups and patient engagement teams.

6.13.2 Patient Participation Groups (PPGs)

Work with practices' established patient participation groups or look to increase the PPG membership through the merger engagement process. PPGs can communicate positive aspects merger of the merger process and help to reassure any concerns to the rest of the patient population.

6.13.3 Patient Drop in Events / Open Day

Nearer to merge date, run a patient engagement event through holding onsite patient drop-in events. Involve staff across all sites to meet patients and answer questions around merger.

6.14 Informing other external agencies / stakeholders

Commence informing any relevant external agencies/stakeholders process at least 4/5 months prior to clinical system merge date (and/or contractual merge date). The following list includes some of the companies/agencies/sectors that may need to be informed of the merge by either the merging practice(s) or the CCG:

- Local Hospitals and Trust
- Pathology/Radiology
- District Nurses/Health visitors
- Mental Health
- Midwifery
- Palliative Care
- Pharmacies
- Child Health-public health
- Screening services – Breast, Bowel, diabetic retinopathy, AA
- AccuRx
- Jayex Board
- Lexacom
- Docman
- DXS
- Ambulance service
- NHS 111
- Sexual Health
- Any Suppliers to the practice(s)
- Local practices
- Courier services
- Utilities
- Service contracts e.g. photocopier
- Subscriptions, levies etc. – anything outstanding.

7 Post-Merger Tips

Consider the following areas once you have gone through the formal merger process;

Finance (following a hard merger)

- Payments from PCSE – likely to be errors e.g., only being paid for the original list size of whichever practice's ODS code you have kept
- List size recalculation - your new list size will not be the sum of your previous two list sizes due to weighting
- Drug and prescription payments – take some time to be harmonised
- Payments for Local Enhanced Services (LES) and Direct Enhanced Services (DES) missing
- Pension payments and deductions incorrect
- Rent reimbursement paid for only one premises
- Don't assume that possible QOF attainment will be equal to the sum of previous individual targets
- Agree the way in which day-to-day finance is handled to avoid confusion i.e. petty cash, credit cards, cheques
- Agree on the provision of private services and standardise the charges.

Staff

- Time it takes to embed staff changes and break down silos
- Joint meetings and cross site working
- A merger changes the functioning of the practice – these changes needed to be assessed against staff mix and senior management roles
- Take time to assess training needs across the whole team to ensure consistent standards of delivery.

Patients

- Impact of services moving across multiple sites
- Increased chance of having interaction with clinical and admin staff that they don't know highlights importance of communication and agreed messaging between staff
- Merging PPGs
- Maximise the use of IT for efficient delivery of care cross site – limit the use of paper-based processes.

Processes

- Movement of notes – PCSE will only deliver and collect notes from the Primary site
- Identify areas where you are unable to employ one process immediately and consider short term mitigation i.e., Cloud based notes vs Lloyd George notes

Partners

- Lead by example – make an effort to engage with staff, be visible, practice what you preach
- Build trust and relationships with new acquired partners and salaried GPs
- Recognise that there is a merging of cultures, as well as business. It will take time for the new merged culture to develop.

NOTE 1: *This list is not exhaustive and is guidance only. Please ensure that all relevant and significant disclosures are made by each party that would in the reasonable opinion of the party concerned, affect the business and should reasonably be disclosed to the other party.*

NOTE 2: *That if the intention is to create a true merger rather than a takeover, the debts and liabilities will require disclosure under the financial due diligence as conducted by accountants, but the partners will need to decide on the partnership shares of each partner going forward and these will need adjusting and added as a schedule to the merger terms, or, if not determined by that time, should be added to the final partnership agreement.*

NOTE 3: *The date on which the merger will be affected should be a date 6 – 9 months in the future. This is the date which parties should aim to complete and the date on which any variation notices as issued by NHS England should be signed, as well as the new partnership agreement.*

NOTE 4: *Parties are strongly advised NOT to complete and sign any variation notice until such time as all parties are satisfied that all significant issues, legal and/or financial have been resolved. If there are matters still outstanding at that date then parties should move to extend the time to complete until the longstop date which is a date approximately one month after the actual date of intended completion.*

Useful contacts List:

(Correct at the time of publication)

Scheme Access Team Direct Line: 01253 774546

Employer Helpline: 0300 3301 353

Member Helpline: 0300 3301 346

Pensions Online (POL) Helpline: 0870 011 7108

www.nhsbsa.nhs.uk/nhs-pensions

Pcse.patientletters@nhs.net

Consider the following in regard to the premises - document produced on behalf of East & North Herts CCG (March 2021) **APPENDIX 1**

LEASEHOLDS	**Understand the terms of the lease**	1. Who are the parties to the lease i.e. who is/are the landlord(s) and who is/are the tenant(s)? 2. Are the parties to the lease still current, perhaps over the life of the lease either party may have changed? The lease ought to have been updated as any changes occurred. 3. Are there assignment rights in the lease that permit other named parties to take on the lease? 4. When did the lease start? 5. When does the lease end? 6. Are there any break rights in the lease for landlord or tenant? If there are understand them, they are likely to be date specific and require formal notice to be served. 7. What is the lease provision in regard to ss. 24 – 28 of the 1954 Act, does the practice have any rights to renew, or, are they excluded? 8. Careful attention to the tenants covenants: • Is the rent paid up to date? • What are the rent payment dates, is rent demanded, some are not demanded but payable on set dates? Late payment is subject to interest and potential breach. • Are the rates paid up to date? • If there is a service charge, are all payments up to date and has there been annual reconciliation and audited account? • What is the extent of repair liability? Some leases are Full Repairing and Insuring (FRI), some are Tenant Internal Repair (TIR). • Have all tenant repair covenants been suitably undertaken; if not is there a planned programme and funds allocated? Be aware that a landlord can at any time during the lease and/or at the end of the lease enforce the tenant to attend to and/or pay for repairs; all professional costs are recoverable. Depending on the future plans for the premises after lease end, dilapidations could be diluted. • Does the practice have a sinking fund for the purpose of building repairs and maintenance, if yes, what is the value of the fund? • As partners to the lease have been released from the lease or added to it and as partners come and go, there should have been and should be a building survey having regard to the lease obligations ensuring that all partners have paid a fair proportion of repair obligations. E.G if a lease has a 20 year term and a partner leaves after 5 years, that partner should meet 5 years of repair costs before being released from the lease. Any in-coming partner should only be liable for the remaining 15 years and no inherent liability. 9. Has there been any previous NHSE Grant Funding, if yes, ensure the Grant Agreement is updated, as any NHS funding requires a minimum tenure else pro rata payback and rent abatement terms apply. 10. Get legal and surveyor's advice.
	Understand the land registry title	1. Instruct a lawyer to check the title and perhaps prepare a Report on Title. 2. There may be positive or restrictive covenants that burden or benefit the land. Such as rights of way, easements, etc. 3. There could be legal charges against the title.
FREEHOLDS	**Understand any loan and ownership arrangements**	1. Who owns the practice premises, they may be deceased, retired or still practicing? 2. Is there a loan, or loans on the premises, if so, who are the parties and what are the terms of the loan? 3. If there is equity in the premises, how will this be managed? 4. Get the property valued by a RICS valuer. 5. Status of condition, repair and maintenance, see above management of partners that leave and join, sinking fund etc. 6. Has there been any previous NHSE Grant Funding, if yes, ensure the Grant Agreement is updated, as any NHS funding requires a minimum tenure else pro rata payback and rent abatement terms apply. 7. Get legal and surveyor's advice.

Pre – Merge Action Plan (SystmOne) APPENDIX 2

Work Package No.		**TPP Ref No:**	
Customer Organisation:		**Merge Date(s):**	
Customer Contact Details:			
Business Change Analyst/s:			

Date: *Date Action Plan last updated:* **Version:** **Author:**

		Contact Name	**Contact Number**	**Email**
Outgoing Unit(s):				
Receiving Unit :				
Key Information	i.e. • Sharing: Approved Lists and sharing preferences need to be the same • Electronic Prescribing: If active in Outgoing Unit, needs to be switched on in Receiving Unit prior to merge			

Category	**Task**	**Actions**	**Owner**	**Timeframe**
Org Groups & Memberships	Group Owners & Memberships PN: Anything published to a group "owned" by outgoing unit will be lost in the merge. 1. Groups owned by Outgoing Units to be deleted.	Discussion regarding contents of owned group and decision to delete or transfer ownership 1. End membership with Org Groups	HBLICT	By 3pm on day of merge

	2. If the outgoing unit is a member of any organisation groups then you will need to remove the unit from the groups.	2. To delete/transfer ownership of 1 Org Group (As Owner)		
Staff Lists	SystmOne 1. Archive all staff members' profiles at the outgoing unit that you do not wish to include in the merge prior to the agreed merge date. They will show as archived at the receiving unit after the merge. 2. (Good practice to clean up the Receiving Unit)	Outgoing & Receiving Units to Archive accordingly	Outgoing Unit & Receiving Unit	Asap
	3. Access to be enabled for all staff transferring PN: Staff managing Choose & Book Worklists will need to keep their existing access on their smartcard post merge until the worklist are cleared. Once cleared then the access should be removed asap.	Either Receiving Unit self-sponsor to add Outgoing Unit Staff to Receiving Unit OR forward RA02's to HBL ICT RA Department	Practices Or HBLICT RA dept	Asap
	4. Once access enabled, request Users to log in to Receiving Unit with Smartcard.	Update local access rights and Org Prefs for new users	Receiving Unit	Asap (in time to allocate rota's & visits, add staff leave etc)
	5. Check outgoing units GP's, Local GP codes for Receiving Unit	Contact PCSE for List and ensure correct code in Receiving Unit	Outgoing Unit	Asap
	6. All users must be logged out of SystmOne by 16:00 and cannot login	Recommended that all users out of both Receiving and Outgoing	Outgoing / Receiving Unit	By 16.00 on day of merge

	to either the receiving unit or the outgoing unit during the unit merge. This includes "fake users" (touchscreen set up and gateways etc)	units by 3.30pm apart from 1 or 2 to monitor new activity (Tasks etc) and complete accordingly		
	7. User Groups	7. Need to be agreed and set up in Receiving Unit for Branch if required	7. Receiving Unit	7. 1 week before merge

Unit Clean Up	1. File all **pathology/radiology** reports at the outgoing unit prior to the merge. The merge cannot proceed if there are outstanding pathology/radiology reports at the outgoing unit. *Bowel Screening / Other screening – need to discuss of receive results electronically*	1a.Practices to contact Path Labs asap and agree a date for Labs to stop sending files (2 working days before merge) 1b.Outgoing Unit to clear all existing files 1c. Switch off "Request" (EDI Set UP) 1d. Path lab start to return all results back to receiving unit 2a. Stop sending registrations at least one week prior to merge and inform PCSE not to send anything back to unit 3 working	1a. Receiving / Outgoing 1b. Outgoing Unit 1c. HBLICT 1d. Practices agree with Pathology 2a. Outgoing Unit 2b. Outgoing Unit	1a. Make contact asap 1b. Before 3pm on day of merge 1c. At 3pm on day of merge 1d. day after merge 2a. One week prior to merge 2b.by 3pm on day of merge

	2. Action all **EDI messages** at the outgoing unit prior to the merge. The merge cannot proceed if there are outstanding EDI messages at the outgoing unit. This relates to GP practices only.	days before merge. 2b. All existing messages need to be cleared before 3pm on day of merge. 2c. Remove EDI Links	2c. HBLICT to remove EDI links	2c. day of merge once messages cleared
		3.OOH / Hospital Discharge Letters Tasks need to be cleared	3. Outgoing Unit	3b. by 3pm on day of merge
	3. Action all **OOH and Hospital Discharge Letter tasks** at the outgoing unit prior to the merge. The merge cannot proceed if there are outstanding OOH and Hospital Discharge Letter tasks at the outgoing unit.	4. Delete those not required	4a. Outgoing Unit	Asap
		5. Delete those no longer required	5b. HBLICT & Outgoing Unit	Asap
	4. **Letters and Forms** –Local letters/forms not required are to be deleted. All others will merge. **Using Ardens for referral forms**	6. Delete those no longer required	6a. Outgoing Unit (Users who created reports)	6. Asap
	5. Templates –> Local versions of templates will transfer, therefore	7. All scanned Docs need to be	6bcd. HBLICT & Outgoing Unit 7. Outgoing Unit	

	need to delete all those that you do not want to merge. **Using Ardens – no action required**	cleared from outgoing uni		7. By 3pm on day of merge
	6. Local Reports –> Local reports will transfer. **Using Ardens – no action required**			
	7. Process all documents on the **Acquired Documents** screen and all updates on the Documents Inbox screen. The merge cannot proceed if there are documents/updates on either screen.	8a. Contact DOS Team: to inform merge taking place. 8b. Remove NHS 111 in Org Preference – Primary Message Settings & Copy Message Settings > unticked & code deleted	8a. OutgoingUnit 8b. HBLICT	8a. Asap 8b. By 3pm day of merge
	8. **NHS 111** – Remove links to Outgoing Unit and inform the Dos Team of merge.	9a. Ensure all scripts are signed & printed 9b. Run Prescription Search (Workflow > Prescription Search)	9a. Outgoing Unit 9b. HBLICT	9a. By 3pm day of merge 9b. At 3pm on morning of merge
	9. Ensure that all unsigned and unprinted **prescriptions** at the outgoing unit are signed and printed. If not completed the merge will not	10a. Create two branches in Receiving Unit, 10b. Create Rota's (in a Branch) for Outgoing Units clinics, starting from day after the merge). 10c. Book textual appointments	10a. Both Units 10b. Outgoing Unit 10c. Outgoing Unit 10d. Outgoing Unit	10a. Asap 10b. Asap 10c. Asap

	take place. After the split it will not be possible to view the outgoing unit's past prescriptions from the Prescription Search screen. Of course, the prescriptions will still be present in the patient record.	10d. Match Patients 11.	n/a 12. Outgoing Unit	10e. morning of day after merge n/a
	10. **Appointment** Rota Templates / Slots etc	12 Delete duplicates	13. Outgoing Unit	
	11. **Auto-consultations - Using Ardens – no action required**	13. Outgoing unit – need to complete all tasks from task list No action required	n/a n/a	13. Start to clear asap and continue to complete prior to merge n/a
		No action required	16.Outgoing Unit Start process as soon as start booking appointments for post merge date. (receiving unit will need to allow access to those staff booking visits)	n/a Asap
	12. Recalls –(see TPP notes at end of document)	16. Ensure all staff performing visits have logged into receiving unit. Can book outgoing unit patients as textual for post merge dates into receiving unit. After merge – patients can be matched. No action required	n/a 18. Receiving unit	n/a

	13. Tasks – TASK LIST WILL NOT MERGE Patient related scheduled tasks **will** merge in the patient record **14. Task Rules –** do not merge **15. Questionnaires -** do not merge **16. Visits** – do not merge **17. Protocols -** Do not merge. **18. Address Book** – Will merge	18. The merged address book will create duplicates therefore will require a clean up day after merge 19a. Contact the device Org/dept and advise them of merge. 19b. Remove all Mobile Working devices from the Device Manger screen by going to Setup> Mobile Working & Integration>Device Manager. **This needs to be done on the outgoing unit and the receiving unit** 19c. contact to reinstall Devices 20. Clear SCR messages 21a. Switch off on-line services in Org Pref's for Outgoing Unit 21b. Switch off online services in Receiving Unit	19a. Outgoing/ Receiving Unit 19b. HBLICT 19c. Receiving Unit 20. Outgoing Unit 21a. HBLICT 21b. HBLICT	18. Morning after merge 19a. Asap 19b. Day before the merge 19c. Day after the merge 20. by 3pm day of merge 21a. 1 or 2 days before merge 21b. Morning of the merge 21c. Morning after merge

	19. Mobile Devices - **20. SCR** **21. Online Services –** SystmOnline Registrations merge so users log in details stay the same.	21c. Switch back on the online services in receiving unit	21c. HBLICT	
Considerations	SMS – configuration - agreement re messaging (including locations/rota name or leaving generic) If going to use a new SMS email. Sarah Newton (sarah.newton@nhs.net) to be informed to update the White List Rotas to be created to Branches			

Informing	• Pathology Lab(s) re: – To agree timeframes for required actions • PCSE re: (EDI Messages, Inform them of Name Change for ODS Code and Request list of GP Local Codes) • Hospital re: Discharge Summaries • DoS 111 Team: re informing them of merge • Local Community Services – re: stop sending tasks to outgoing unit on day of merge • Mobile Devices – re; informing that devices will be removed day of merge and need to be reinstalled post merge • Child Health – re: child vaccination programme – scheduling / clinic lists • RA • MJOG

PLEASE READ THE BELOW THREE PAGES FROM TPP

In additon to this action plan - please refer to the merge details produced by TPP - pay particular attention to the items that will stop the merge if actions not completed:

Important information

When two units are merged on SystmOne, only the following information will be transferred to the receiving unit:

- Patients (including deducted patients) – including data directly in the patient record, such as referrals.
- Staff
- Drug formularies
- Recall types
- Forms
- Views
- Vaccination templates
- New templates
- Old templates
- New letter templates

- Word letter templates
- Care plan templates
- Pharmacies
- Caseloads
- Dispensary stock/pending jobs/wholesaler orders
- Outstanding issues on Contact Tracking
- SystmOnline registrations
- Patient-related tasks (including Scheduled Tasks)
- Address book
- Local clinical reports
- Patient Status Alerts
- eDSM sharing preferences
- New Sharing Preferences: If the patient is using the practice default, the patient will inherit the receiving units practice default. If the patient has a different preference to the practice default, the patient will retain their preferences after the merge.

You will need to review as to whether the information that does come across in a merge will be required after the merge, as having too many reports and templates etc. may cause performance issues.

TPP cannot transfer any other information (e.g. appointments & waiting lists) from the outgoing unit. **This information will be lost after the merge has taken place**. By consenting to the merge, you confirm that you understand and are happy to proceed on this basis.

- All users must be logged out of SystmOne by 16:30 and cannot login to either the receiving unit or the outgoing unit during the unit merge.
- TPP recommend that all users who have access to the outgoing unit remove the role profile associated with that unit from their Smartcard and ensure they have access to the receiving unit.
- If a patient record is restricted to a User Group at the outgoing unit and no matching User Group exists at the receiving unit, the restriction will still apply and only System Administrators will be able to retrieve the record. User groups will need to be reconfigured at the receiving unit or the restriction removed prior to the merge; whichever is most appropriate.

- If staff members at the outgoing unit are using the PPA ID of another user, these details will need to be re-entered after the merge. The 'Using PPA ID' field (found in Amend Staff Details > Local Settings) will be populated with a PPA ID which refers to the outgoing unit. It will therefore need to be re-entered.
- You will have to go through the organisation preferences and add all the staff working at the branch to the relevant lists i.e. registered/usual GP's, can block appointments etc.
- The address book, letter templates and other items such as views may be duplicated and will require either renaming or deleting after the merge.
- The way that practices are merged can affect CHS treatment centres if your Child Health Unit uses SystmOne. If a patient is registered at GP Practice A and the Child Health Unit has this practice set as their treatment centre, the following will happen after the merge:

    a. If GP Practice A is merged directly into GP Practice B, the child's treatment centre will change at the Child Health Unit to be GP Practice B.

    b. If GP Practice A is merged into a branch site of GP Practice B, the child's treatment centre will change at the Child Health Unit to be the selected branch site at GP Practice B.

    This means that the Child Health Unit may have to amend their scheduling setup accordingly.
- The merge taking place on the agreed date is subject to the approval of TPP's Technical Operations team. **TPP retain the right to cancel/reschedule any merges without notice.**
- **Please note, reporting will not build on the night of the merge.**

Actions

1. Archive all staff members' profiles at the outgoing unit which you do not wish to include in the merge prior to the agreed merge date. They will show as archived at the receiving unit after the merge.
2. File all pathology/radiology reports at the outgoing unit prior to the merge by navigating to Workflow > Pathology/Radiology Inbox.
3. Action all EDI messages at the outgoing unit prior to the merge (Links > EDI Administration). This relates to GP practices only.
4. Action all GP2GP Transfer in, Electronic referral, OOH and Hospital Discharge Letter tasks at the outgoing unit prior to the merge. These can be seen from the Task List (Workflow > Task List).
5. Inform all third parties such as all relevant pathology labs and Health Authorities that a unit merge is taking place. From the date of the merge, labs and HAs previously linked to the outgoing unit will need to send all reports or EDI messages to the receiving unit.
6. Process all documents on the Acquired Documents screen (you may need to tick 'show unallocated batches' and untick 'Restrict Acquired Documents to Team' in Settings>Organisation Settings>Document Processing) and all updates on the Documents Inbox screen. Both screens can be found by navigating to Workflow > Document Management.
7. Remove the DoS Service ID(s) from Primary Message Settings under Organisation Preferences > NHS 111 and then disable the preference by unticking the enable tick box.
8. Create a branch site at the receiving unit if you want the outgoing unit's patients to be transferred to a branch at the receiving unit. Please also complete the details of the branch you have created, if applicable, below. TPP will not move patients to a branch site after the merge has taken place.
9. After the merge, if the outgoing unit's patients have been transferred into a branch site at the receiving unit, users at this branch will need to specify that they are located here in System > PC Settings > Site Selection.
10. If the outgoing unit already has patients registered at branch sites, these will be transferred over to the receiving unit in their existing branches.
11. Check in all patients from Briefcase, if applicable, at the outgoing unit prior to the merge. Any information added to a patient record in Briefcase will be lost if you do not check that patient back into SystmOne before the merge. TPP cannot retrieve that information after the merge.
12. Go to the Recall Types screen (Setup > Data Entry > Recall Types). Delete any duplicates, ensuring that the remaining one has any required restrictions on which patients they can be given to. (Deleting/amending recall types will not affect the information on patient records or clinical reporting.)
13. Remove all Mobile Working devices from the Device Manager screen by going to Setup > Mobile Working & Integration > Device Manager. This needs to be done on the outgoing unit and the receiving unit, then reinstall Mobile Working the following day once the merge has been completed.
14. Navigate to Setup > Users & Policy > Organisation Groups and ensure that the outgoing unit is not an organisation group owner or a member of any organisation groups. If the outgoing unit is an organisation group owner then you will need to transfer ownership or delete the group. If the outgoing unit is a member of any organisation groups then you will need to remove the unit from the groups.

15. Ensure that all unsigned and unprinted prescriptions at the outgoing unit are signed and printed by going to Workflow > Prescription Search. After the merge it will not be possible to view the outgoing unit's past prescriptions from the Prescription Search screen. Of course, the prescriptions will still be present in the patient record.

CCG:

Date of Merge:

Outgoing Unit (Name & ODS Code) **Receiving Unit (Name & ODS Code)**

MERGE CHECKLIST (All entries in red to be completed by HBLICT) **One week prior to Merge**	
• **Pathology** Lab(s) – need to have been informed of merge date. • Agreement that RESULTS will not be returned to Outgoing Practice as from 2 working days before merge date. Lab will hold on until morning after merge date to then start to return results to the Receiving unit (Confirm ODS Code) • Agreement made that **requests** can be sent via outgoing unit until 3pm on day of merge.	☐
• Email DOS111 Team to inform them of merge	☐
• Local reports, letters and templates that are not currently used are deleted from Outgoing Unit (best practice is to also remove in Receiving unit)	☐
• Contact **PCSE** for list of Outgoing Practice's GP Codes to ensure that the correct local code is entered into the Receiving Unit. (Pcse.practicechanges@nhs.net • Stop registering Patients (EDI) until post merge and continue to clear all EDI lists.	☐
• Local Hospital – contact to inform of merge and request to stop forwarding Hospital Discharge Summaries to Outgoing Practice 1 week prior to merge date. To resume post merge, to Receiving Unit	☐
• Switch off on-line services at Outgoing Practice 1 week prior to merge (Org Pref's) • (can add message to inform patients that on-line services are unavailable day after merge	☐

• Send Communication to local Community Services to inform them of the merge and request that they do not send tasks through on the day of the merge. (If the services continue to send, these tasks will need to be completed prior to 4.30pm on day of merge)	☐
• Ensure that Medical Secretaries (or whoever monitors Choose & Book Worklist) retain their old smartcard access to enable continued access to the portal, post merge (once the worklist in Outgoing unit is clear) the old access can be removed.	☐
• As many outgoing practice staff have logged in to receiving unit using their smartcards and relevant local access rights ticked.	☐
• If a new email address is set up for the purpose of SMS , then ensure that HBLICT GP IT (Shane Scotts team) are informed by email (to update White List)	☐
• Inform Mobile Device Providers of merge date and that we will be removing devices on morning of the merge from **both units**. These will need to be re-installed in receiving unit post merge.	☐
• Ensure that scanned doc's, pathology results, tasks and OOH's/Hospital Discharge Letters, SCR Updates are being filed, completed in a timely manner and no major back logs are in place. (best practice for both units to complete this however these MUST be complete in Outgoing Unit.	☐
• Complete new list of User Groups in Receiving Unit to reflect both sites	☐
• Ensure task rules agreed across the practices and set up in receiving unit	☐
• Ensure Branch(es) are set up accordingly and Rotas set to appropriate branch	☐
Day of Merge (by 3pm)	
All following items have been cleared from Outgoing Unit: 1. Task List completed 2. OOH and Hospital Discharge letter tasks actioned 3. All Pathology results filed 4. EDI links for Pathology – untick in EDI set up	1. ☐ 2. ☐ 3. ☐

5. All EDI Messages cleared 6. EDI links – Delete HA for EDI Set Up 7. All scanned documents filed 8. SCR Updates completed 9. All prescriptions to be signed and printed. Make sure to run a Prescription search in Outgoing unit(***Workflow>Prescription search***)– there should be no Prescriptions and all should be cleared. 10. NHS 111 in Org Preference – Primary Message Settings & Copy Message Settings > unticked & code deleted 11. Switch off On-Line Services for Receiving Unit. 12. Remove Outgoing Memberships to any Org groups	4. ☐ 5. ☐ 6. ☐ 7. ☐ 8. ☐ 9. ☐ 10. ☐ 11. ☐ 12. ☐
• All members of staff (apart from 1 or 2 who are monitoring last minute tasks etc.) are to be logged out of unit	☐
Check the all Mobile integration to 3rd Party Applications has been removed • Remove Mobile Devices (anything with linked patients) in Outgoing Unit AND Receiving unit – to be re-installed post merge (on the Wednesday) *Setup > mobile working & Integration > Device Manager*	☐
Day of Merge (by 4.00pm)	
All staff have logged out of both Outgoing Unit and Receiving Unit and do not log back in until start of work following day.	☐
MERGE SUCCESSFUL	

Inform all relevant parties that merge successful *(PCSE, DOS Team, Labs, CCG staff etc.)*	☐
Outgoing Unit Merged Successfully as Branch (if applicable)	☐
Receiving Unit Renamed (if applicable)	☐
Check all items merged successfully	☐
All merged items added to categories/folders accordingly	☐
All duplicate items deleted accordingly	☐
Organisation Preferences configured as required (including registered/usual GP's. Blocking appointments	☐
EDI setup : Check the receiving unit have the correct Path Labs ticked (inform Labs as well)	☐
Mobile Devices re-installed	☐
Textual Patients matched to Live Patients in Appointments and Visits	☐
MERGE FAILED	
Inform all relevant parties that merge failed	☐
Reason for Failed Merge investigated	☐
New date scheduled	☐