NHS Circular:
PCA(M)(2012)4

Directorate for Health & Social Care Integration
Primary Care Division

The Scottish Government

Dear Colleague

PRIMARY MEDICAL SERVICES (DIRECTED ENHANCED SERVICES) (SCOTLAND) DIRECTIONS 2012

Summary

1. This Circular advises Health Boards that the Directions which provide the legal framework for Directed Enhanced Services in Scotland have been revised.

2. The new Directions are the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2012 ("DES Directions 2012"), which come into force on 1 April 2012. The Primary Medical Services (Directed Enhanced Services) (Scotland) (No 2) Directions 2011 which were issued under cover of circular PCA(M)(2011) 13 and came into force on 24 September 2011 are revoked by the DES Directions 2012.

3. The DES Directions 2012 are attached to this circular.

Explanation of changes

4. The main reason for the introduction of the DES Directions 2012 is the ending of the Osteoporosis DES after 31 March 2012, a revised Palliative Care DES, PCA (M) (2012) 6, the introduction of a revised Extended Hours Access DES, PCA(M)(2012) 5 from 1 April, replacing both the previous DES that covered Extended Hours access for GP practices and the Nursing Extended Hours DES

5. Transitional arrangements are included in the Directions for the Osteoporosis DES, to allow contractors to continue with an arrangement entered into under the 2011 (No 2) Directions, for a transitional period.

5 April 2012

Addresses

For Action

Chief Executives NHS Boards

GP Practices

NHS National Services Scotland

For information

Scottish General Practitioners Committee

Primary Care Leads NHS Boards

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6. These changes have been agreed with the Scottish General Practitioners Committee of the BMA Scotland.

Action

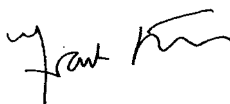
7. The attached Directions place a legal duty on Health Boards to establish the Directed Enhanced Services as specified for their area, and to offer these to primary medical services contractors.

8. NHS Boards are requested to action these Directions and ensure that their primary medical services contractors are aware of them.

Enquiries

9. For any enquiries on this circular please contact Frank McGregor.

Yours sincerely



Frank Strang
Deputy Director, Primary Care Division

DIRECTIONS

THE NATIONAL HEALTH SERVICE (SCOTLAND) ACT 1978

The Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2012

The Scottish Ministers give the following Directions, in exercise of the powers conferred by sections 2(5) and 105(7) of the National Health Service (Scotland) Act 1978([1]), and all other powers enabling them to do so—

Citation, commencement and application

1. These Directions may be cited as the Primary Medical Services (Directed Enhanced Services)(Scotland) Directions 2012 and come into force on 1 April 2012.

(1) These Directions are given to Health Boards in Scotland and apply in relation to Scotland only.

Interpretation

2. (1) In these Directions—

"the Act" means the National Health Service (Scotland) Act 1978;

"the 2011 (No 2) Directions" means the Primary Medical Services (Directed Enhanced Services) (Scotland) (No 2) Directions 2011;

"core hours" means the period beginning at 8.00am and ending at 6.30 pm on any working day;

"financial year" means the period from 1 April to 31 March;

"general practitioner" means a medical practitioner whose name is included in a primary medical services performers list prepared by a Health Board under regulation 4 of the National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004[2];

"GMS contractor" means a person with whom a Health Board is entering or has entered into a general medical services contract;

"GMS Statement of Financial Entitlements" means any directions given by Scottish Ministers under section 17M of the Act (payments by Health Boards under general medical services contracts);[3]

"health care professional" has the same meaning as in section 17L(8)[4] of the Act;

"primary medical services contract" means—

(a) a general medical services contract;

(b) section 17C arrangements which require the provision of primary medical services; or

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([1]) 1978 c.29. Section 2(5) was amended by the National Health Service and Community Care Act 1990, c.19, section 66(1), Schedule 9, paragraph 19(1); Section 105(7) was amended by the Health Services Act 1980 (c.53), Schedule 6, paragraph 5(1) and Schedule 7, the Health and Social Services and Social Security Adjudications Act 1983 (c.41), section 29(1), Schedule 9, Part I, paragraph 24 and the Health Act 1999 (c.8), Schedule 4, paragraph 60. The functions of the Secretary of State were transferred to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998 (c.46).

[2] S.S.I. 2004/114.

[3] Section 17M was inserted by section 4 of the 2004 Act.

[4] Section 17L was amended by the Tobacco and Primary Medical Services (Scotland) Act 2010

(c) contractual arrangements for the provision of primary medical services under section 2C(2) of the Act (functions of Health Boards: primary medical services)[5];

but does not include an arrangement which a Health Board enters into for the provision of primary medical services to prisoners in prison;

"primary medical services contractor" means—

(a) a GMS contractor or Section 17C provider; or

(b) a person with whom a Health Board is making or has made contractual arrangements for the provision of primary medical services under section 2C(2) of the Act;

but does not include a person with whom a Health Board is making or has made contractual arrangements for the provision of primary medical services to prisoners in prison;

"practice premises" means an address specified in the general medical services contract as one at which services are to be provided under that contract;

"QOF" means the Quality and Outcomes Framework which is part of the general medical services contract and which is set out in detail in the GMS Statement of Financial Entitlements;

"Section 17C provider" means a person with whom a Health Board is entering or has entered into section 17C arrangements which require the provision by that person of primary medical services;

"unpaid carer" means someone who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability. A young carer is a child or young person under the age of 18 carrying out significant caring tasks and assuming a level of responsibility for another person, which would normally be taken by an adult; and

"working day" means any day apart from Saturday, Sunday, Christmas Day, New Year's Day and any other public or local holiday.

(2) Unless the context otherwise requires, other words and phrases used in these Directions have the same meaning as they do in the Act.

Establishment etc. of Directed Enhanced Services (DES) Schemes

3. (1) Each Health Board must exercise its functions under section 2C of the Act of providing primary medical services within its area, or securing their provision within its area, by (as part of its discharge of those functions) establishing (if it has not already done so), operating and, as appropriate, revising for its area the following schemes—

(a) A Childhood Immunisation scheme, the underlying purpose of which is to ensure that patients within its area—

(i) who have passed their second birthday but not yet their third birthday are able to benefit from the recommended immunisation courses (i.e. those that have been recommended nationally and by the World Health Organisation) for protection against—

(aa) Diphtheria, tetanus, poliomyelitis, pertussis and Haemophilus influenzae type B (HiB), and

(bb) Measles/mumps/rubella, and

(cc) Meningitis C, or

(ii) who have passed their fifth birthday but not yet their sixth birthday are able to benefit from the recommended reinforcing doses (i.e. those that have been recommended nationally and by the World Health Organisation) for protection against diphtheria, tetanus, poliomyelitis and pertussis;

[5] Section 2C was inserted by section 1(2) of the 2004 Act.

(b) an Influenza and Pneumococcal Immunisation Scheme, the underlying purpose of which is to ensure that patients within its area who are at risk of influenza or pneumococcal infection are offered immunisation against these infections;

(c) a Violent Patients Scheme, the underlying purpose of which is to ensure that there are sufficient arrangements in place to provide primary medical services to patients who have been subject to immediate removal from a patient list of a primary medical services contractor because of an act or threat of violence;

(d) a Minor Surgery Scheme, the underlying purpose of which is to ensure that a wide range of minor surgical procedures are made available as part of the primary medical services provided within a Health Board's area;

(e) an Extended Hours Access Scheme, the underlying purpose of which is to ensure that patients within its area are provided with additional general practitioner, or other health-care professional, consultation time over and above core hours provision; and

(f) a Palliative Care Scheme, the underlying purpose of which is to assess when patients within its area who reach the last days of their life receive appropriate high quality care.

(2) Before entering into any arrangements with a primary medical services contractor as part of one of the Schemes mentioned in this direction, a Health Board must satisfy itself that the contractor with which it is proposing to enter into those arrangements—

(a) is capable of meeting its obligations under those arrangements including under any plan agreed under those arrangements; and

(b) in particular, has the necessary facilities, equipment and properly trained and qualified general practitioners, other health care professionals and staff to carry out those obligations,

and nothing in these directions shall be taken as requiring a Health Board to enter into such arrangement with a contractor if it has not been able to satisfy itself in this way about the contractor.

Childhood Immunisation Scheme

4.(1) As part of its Childhood Immunisation Scheme, each Health Board must, each financial year, offer to enter into arrangements with each primary medical services contractor in its area, unless—

(a) it already has such arrangements in place with the contractor or provider in respect of that financial year; or

(b) in the case of a GMS contractor, the contractor is not providing the childhood immunisations and preschool boosters additional service under its general medical services contract,

thereby affording the contractor a reasonable opportunity to participate in the Scheme during that financial year.

(2) The plan setting out those arrangements that a Health Board enters into, or has entered into, with any primary medical services contractor must, in respect of each financial year to which the plan relates, include—

(a) a requirement that the contractor—

(i) develops and maintains a register (its "Childhood Immunisation Scheme Register", which may comprise electronically tagged entries in a wider computer database) of all the children for whom the contractor has a contractual duty to provide childhood immunisation and pre-school booster services (contractors may use the data held on the Scottish Immunisation and Recall System (SIRS) or any equivalent system, when providing the information relevant to this requirement),

(ii) undertakes to offer the recommended immunisations referred to in direction 3(a) to the children on its Childhood Immunisation Scheme Register (with the aim of maximising uptake in the interests of patients, both individually and collectively), and

(iii) undertakes to record the information that it has in Childhood Immunisation Scheme Register using any applicable Read codes;

(b) a requirement that the contractor—

(i) develops a strategy for liaising with and informing parents or guardians of children on its Childhood Immunisation Scheme Register about its immunisation programme with the aim of improving uptake, and

(ii) provides information on request to those parents or guardians about immunisation;

(c) a requirement that the contractor takes all reasonable steps to ensure that the lifelong medical records held by a child's general practitioner are kept up-to-date with regard to the child's immunisation status, and in particular include—

(i) any refusal of an offer of vaccination,

(ii) where an offer of vaccination was accepted—

(aa) details of the consent to the vaccination or immunisation (where a person has consented on a child's behalf, that person's relationship to the child must also be recorded),
(bb) the batch number, expiry date and title of the vaccine,
(cc) the date of administration of the vaccine,
(dd) where two vaccines are administered in close succession, the route of administration and any injection site of each vaccine,
(ee) any contraindications to the vaccination or immunisation,
(ff) any adverse reactions to the vaccination or immunisation;

(d) a requirement that the contractor ensures that any health care professional who is involved in administering a vaccine has—
(i) any necessary experience, skills and training with regard to the administration of the vaccine, and
(ii) training with regard to the recognition and initial treatment of anaphylaxis;

(e) a requirement that the contractor ensures that—

(i) all vaccines are stored in accordance with the manufacturer's instructions, and

(ii) all refrigerators in which vaccines are stored have a maximum/minimum thermometer and that readings are taken from that thermometer on all working days;

(f) a requirement that the contractor supply its Health Board with such information as it may reasonably request for the purposes of monitoring the contractor's performance of its obligations under the plan;

(g) arrangements for an annual review of the plan which shall include—

(i) an audit of the rates of immunisation, which must also cover any changes to the rates of immunisation, and

(ii) an analysis of the possible reasons for any changes to the rates of immunisation; and

(h) in the case of contractors that are not GMS contractors, the payment arrangements for the contractor, which must comprise target payments to the contractor where the contractor—

(i) meets its obligations under the plan, and

(ii) meets, in respect of the children on the contractor's Childhood Immunisation Scheme Register, immunisation levels designed to ensure adequate protection, both for individual patients and for the public, against the infectious diseases against which immunisation is being offered (and the Health Board must take no account of exception reporting in its calculations of target payments),

and in determining the appropriate level of those target payments, the Health Board must have regard to the target payments and the targets rewarded under Section 8 of the GMS Statement of Financial Entitlements, and the Health Board must, where necessary, vary the contractor's primary medical services contract so that the plan comprises part of the contractor's contract and the requirements of the plan are conditions of the contract.

Influenza and Pneumococcal Immunisation Scheme plans

5.(1)As part of its Influenza and Pneumococcal Immunisation Scheme, each Health Board must,each financial year, offer to enter into arrangements with each primary medical services contractor in its area,

unless it already has such arrangements in place with the contractor or provider in respect of that financial year.

(2) The plan setting out those arrangements that a Health Board enters into, or has entered into, with the primary medical services contractor must, in respect of each financial year to which the plan relates, include—

(a) a requirement that the contractor develops and maintains a register (its "Influenza and Pneumococcal Scheme Register", which may comprise electronically tagged entries in a wider computer database) of all the at-risk patients to whom the contractor is to offer immunisation against influenza or pneumococcal infection, and for these purposes a patient is at risk of—

(i) influenza infection if he is—

(aa) aged 65 years and over;

(bb) aged over 6 months in a clinical at-risk group listed in the Schedule to these Directions;

(cc) living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality (this does not include prisons, young offender institutions, university halls of residence etc);

(dd) an unpaid carer;

or

(ii) pneumococcal infection if he is aged 65 or over ;

(b) a requirement that the contractor undertakes—

(i) to offer immunisations against those infections to those at risk patients, and with immunisations against influenza infection—

(aa) to make that offer during the period from 1st August to 31st March in that financial year, but

(bb) to aim to concentrate that offer during the period up to 30th November in that financial year; and

(ii) to record the information that it has in its Influenza and Pneumococcal Immunisation Register using any applicable Read codes; and

(c) a requirement that the contractor develops a proactive and preventative approach to offering these immunisations by adopting robust call and reminder systems to contact at-risk patients, with the aims of—

(i) maximising uptake in the interests of at-risk patients, and

(ii) meeting any public health targets in respect of such immunisations;

(d) a requirement that the contractor takes all reasonable steps to ensure that the lifelong medical records held by an at-risk patient's general practitioner are kept up-to-date with regard to his immunisation status, and in particular include—

(i) any refusal of an offer of vaccination,

(ii) where an offer of vaccination was accepted—

(aa) details of the consent to the vaccination or immunisation (where a person has consented on an at-risk patient's behalf, that person's relationship to the at-risk patient must also be recorded),

(bb) the batch number, expiry date and title of the vaccine,

(cc) the date of administration of the vaccine,

(dd) where two vaccines are administered in close succession, the route of administration and the injection site of each vaccine,

(ee) any contraindications to the vaccination or immunisation,

(ff) any adverse reactions to the vaccination or immunisation;

(e) a requirement that the contractor ensures that any health care professional who is involved in administering a vaccine has—

(i) any necessary experience, skills and training with regard to the administration of the vaccine, and

(ii) training with regard to the recognition and initial treatment of anaphylaxis;

(f) a requirement that the contractor ensures that—

(i) all vaccines are stored in accordance with the manufacturer's instructions, and

(ii) all refrigerators in which vaccines are stored have a maximum/minimum thermometer and that readings are taken from that thermometer on all working days;

(g) a requirement that the contractor supply its Health Board with such information and at such frequencies as it may reasonably request for the purposes of monitoring the contractor's performance of its obligations under the plan; and

(h) the payment arrangements for the contractor, and the Health Board must, where necessary, vary the contractor's primary medical services contract so that the plan comprises part of the contractor's contract and the requirements of the plan are conditions of the contract.

Violent Patients Scheme consultation and plans

6.(1)— Each Health Board must consult the GP sub committee of the Health Board's area medical committee about any proposals it has to establish or revise a Violent Patients Scheme.

(2)As part of its Violent Patients Scheme, each Health Board must, each financial year, offer to enter into arrangements with each primary medical services contractor in its area, unless it already has such arrangements in place with the contractor or provider in respect of that financial year.

(3) The plan setting out those arrangements that a Health Board enters into, or has entered into, with any primary medical services contractor must provide, in respect of each financial year to which the plan relates, the payment arrangements for the contractor agreeing and meeting its obligations under the plan.

Minor Surgery Scheme plans

7. (1)As part of its Minor Surgery Scheme, each Health Board must, each financial year, offer to enter into arrangements with each primary medical services contractor in its area, unless it already has such arrangements in place with the contractor or provider in respect of that financial year.

(2) The plan setting out those arrangements that a Health Board enters into, or has entered into, with the primary medical services contractor must, in respect of each financial year to which the plan relates, include—

(a) which minor surgical procedures are to be undertaken by the contractor and for which patients, and for these purposes, the minor surgical procedures that may be undertaken are any minor surgical procedures that the Health Board considers the contractor competent to provide, which may include—

(i) injections for muscles, tendons and joints,

(ii) invasive procedures, including incisions and excisions, and

(iii) injections of varicose veins and piles;

(b) a requirement that the contractor takes all reasonable steps to provide suitable information to patients in respect of whom they are contracted to provide minor surgical procedures about those procedures;

(c) a requirement that the contractor—

(i) obtains written consent to the surgical procedure before it is carried out (where a person consents on a patient's behalf, that person's relationship to the patient must be recorded on the consent form), and

(ii) takes all reasonable steps to ensure that the consent form is included in the lifelong medical records held by the patient's general practitioner;

(d) a requirement that the contractor ensures that all tissue removed by surgical procedures is sent for histological examination, unless there are acceptable reasons for not doing so;

(e) a requirement that the contractor ensures that any health care professional who is involved in performing or assisting in any surgical procedure has—

(i) any necessary experience, skills and training with regard to that procedure; and

(ii) resuscitation skills;

(f) a requirement that the contractor ensures that it has appropriate arrangements for infection control and decontamination in premises where surgical procedures are undertaken, and for these purposes, the Health Board may stipulate—

(i) the use of sterile packs from Health Board Central Decontamination Units, disposable sterile instruments (i.e. sterile single-use items), or other approved decontamination procedures,

(ii) the use of particular infection control policies in relation to, for example, hand hygiene, decontamination of instruments, the handling of excised specimens, and the disposal of clinical waste;

(g) a requirement that the contractor ensures that all records relating to all surgical procedures are maintained in such a way—

(i) that aggregated data and details of individual patients are readily accessible for lawful purposes, and

(ii) as to facilitate regular audit and peer review by the contractor of the performance of surgical procedures under the plan;

(h) a requirement that the contractor supplies its Health Board with such information as it may reasonably request for the purposes of monitoring the contractor's performance of its obligations under the plan; and

(i) the payment arrangements for the contractor, and the Health Board must, where necessary, vary the contractor's primary medical services contract so that the plan comprises part of the contractor's contract and the requirements of the plan are conditions of the contract.

Extended Hours Access Scheme

8.(1) As part of its Extended Hours Access Scheme, each Health Board must, each financial year, offer to enter into arrangements with each primary medical services contractor in its area, unless it already has such arrangements in place with the contractor or provider in respect of that financial year .

(2).The plan setting out those arrangements that a Health Board enters into, or has entered into must, in respect of each financial year to which the plan relates, include—

(a) a requirement that the contractor with a practice with a list size of more than 3,000 patients—

(i) provides, subject to (4) below, a minimum of an additional 30 minutes of general practitioner or other healthcare professional consultation time per 1000 patients per week (over and above core hours provision);

(ii) provides no diminution in the current core hours level of service as a result of the contractor providing the additional time under (i) above;

(b) a requirement that the contractor provides the additional consultation time for pre-booked appointments, as well as urgent and routine cases;

(c) a requirement that the contractor supplies its Health Board with such information as it may reasonably request for the purposes of monitoring the contractor's performance of its obligations under the plan; and

(d) the payment arrangements for the contractor, and the Health Board must, where necessary, vary the contractor's primary medical services contract so that the plan comprises part of the contractor's contract and the requirements of the plan are conditions of the contract.

(3) For the purposes of (2)(a)(i) above and (6) below—

(a) the additional sessions are to be held on a consistent basis, for example , at the same time each week, if appropriate and reasonably practicable; and

(b) in deciding the times of the additional sessions, the contractor must take into consideration any appropriate information received on patient preference, as to when such additional consultation time should be provided.

(4) In circumstances where the contractor offers appointments to patients in the first or last 30 minutes of core hours, this time may count towards the additional time required by virtue of (2)(a)(i) above and (6) below, provided that the contractor also provides 30 minutes additional consultation time directly prior to or after (as the case may be) the appointments offered within core hours.

(5) Health Boards are required to discuss the specific local arrangements with each participating contractor and the GP sub committee of the Health Board's area medical committee as appropriate.

(6) Arrangements for smaller practices are as follows—

(a) for practices with a list size of between 1000 and 3000 patients, contractors are required to provide, subject to (4) above, a minimum of an additional 30 minutes of general practitioner or other healthcare professional consultation time per 1000 patients, every two weeks;

(b) for practices with a list size of 1000 patients, or less , contractors are required to provide a minimum of an additional 30 minutes of general practitioner or other healthcare professional consultation time per 1000 patients per every four weeks.

(7) For the purposes of (2)(a) and (6) above, the additional time to be provided is to be calculated on a pro rata basis and rounded up to the nearest 15 minutes.

(8) In calculating the additional time required, contractors operating from multiple practice premises may, where appropriate and reasonable, count minutes from each of those premises towards the extended hours requirements.

(9)Contractors must publicise their extended hours arrangements to patients

Palliative Care Scheme

9.(1) As part of its Palliative Care Scheme, each Health Board must, each financial year, offer to enter into arrangements with each primary medical services contractor in its area, unless it already has such arrangements in place with the contractor or provider in respect of that financial year .

(2) a requirement that the contractor

(i) includes patients identified with palliative and end of life care needs irrespective of diagnosis on their QOF palliative care register;

(ii) ensures that patients on the QOF palliative care register have been assessed and a care plan compiled within 4 weeks of inclusion on the register;

(iii) assesses when a patient on the palliative care register reaches the last days of his or her life and ensures he or she receives appropriate high quality care.

(b) a requirement that the contractor provides a report to their Health Board each year on the above criteria in paragraph (2) and on the contractor's approach to end of life care;

(c) a requirement that the contractor makes relevant entries in the patients' medical records;

(d) a requirement that the contractor supplies its Health Board with such information as it may reasonably request for the purposes of monitoring the contractor's performance of its obligations under the plan; and

(e) the payment arrangements for the contractor,

and the Health Board must, where necessary, vary the contractor's primary medical services contract so that the plan comprises part of the contractor's contract and the requirements of the plan are conditions of the contract.

Transitional Arrangements

10.(1)Where, before the coming into force of these Directions, a Health Board has entered into arrangements with any primary medical services contractor as part of its Osteoporosis Scheme under the 2011 (No2) Directions, such an arrangement may continue for a period of 1 month after the coming into force of these Directions, and in such circumstances the requirements in the plan setting out those arrangements, including specifically—

(a) a requirement that the contractor

(i) ensures that those women on the Register have had or have been offered a referral for a DEXA scan for osteoporosis assessment and those who have received a DEXA scan more than five years previously are considered for reassessment and further scanning if appropriate; and

(ii) offers all those women on the Register with a confirmed diagnosis of osteoporosis preventative treatment with bone sparing drugs;

(b) a requirement that the contractor provides the Health Board with such information as it may reasonably require to demonstrate that it has robust systems in place to maintain such a Register accurately;

(c) a requirement that the contractor co-operates with the Health Board in any reasonable review of such Register that relates to its accuracy;

(d) a requirement that the contractor makes relevant entries in the womens' medical records;

(e) a requirement that the contractor supplies its Health Board with such information as it may reasonably request for the purposes of monitoring the contractor's performance of its obligations under the plan; and

(f) the payment arrangements for the contractor,

shall continue to apply for that period, and the Health Board must, where necessary, vary the contractor's primary medical services contract so that the plan comprises part of the contractor's contract and the requirements of the plan are conditions of the contract.

(2) In this Direction, a reference to the "Register" means a prospective register of women aged 60 years and over who have suffered a fragility fracture on or after 1 April 2011, which the contractor has compiled in accordance with arrangements entered into under the 2011 (No 2) Directions.

Revocations

11. Subject to Direction 10, these Directions revoke and supersede the 2011 (No 2) Directions, save to the extent necessary to assess any entitlement to payment in respect of services provided under arrangements made in accordance with those Directions.

Frank Strang
A Member of the Staff of the Scottish Ministers

Health and Social Care Integration Directorate
Edinburgh

1 April 2012

SCHEDULE Direction 5

Clinical at-risk groups

People with chronic respiratory disease including asthma;

People with chronic heart disease;

People with chronic renal disease;

People with chronic liver disease;

People with chronic neurological disease;

People with diabetes mellitus;

People who are immunosuppressed.

Pregnant women at any stage of pregnancy