



Dear Colleague

## PRIMARY MEDICAL SERVICES (DIRECTED ENHANCED SERVICES) (SCOTLAND) DIRECTIONS 2016

### 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 2016 ("DES Directions 2016"), which come into force from 1 August 2016. The Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2015 which were issued on 1 April 2015 under cover of circular [PCA\(M\)\(2015\) 07](#) are revoked by the DES Directions 2016.
3. The DES Directions 2016 are attached to this circular.

### Explanation of changes

4. Changes to the Directed Enhanced Services effective from 1 August 2016 mean that the 2016 Directions will supersede the 2015 Directions. The changes are:
  - Revised Shingles (Herpes Zoster) DES giving details of year 4 of the programme
  - A new Meningitis B DES
  - Meningococcal ACWY vaccination programme is not included as a DES
  - Revised Shingles (Herpes Zoster) DES giving details of year 4 of the programme
  - A new Meningitis B DES

17 January 2017

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#### Addresses

##### For Action

Chief Executives NHS Boards  
Chief Officers  
GP Practices  
NHS National Services Scotland

##### For information

Scottish General Practitioners Committee  
Primary Care Leads NHS Boards

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#### Enquiries to:

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- Meningococcal ACWY vaccination programme is not included as a DES
  - Revised Influenza and Pneumococcal Immunisation DES giving details of year 4 of the programme
  - Revised Pertussis Scheme for Pregnant Women beginning coverage from week 16 of pregnancy
5. These changes have been agreed with the Scottish General Practitioners Committee of the BMA Scotland.

### Board support

6. Practices have historically received a significant degree of support from Boards across many elements of the immunisation programme (child and adult), and at this particular time, in recognition of the fact that;
- practices are under considerable and consistent workload pressures
  - the Scottish Government and SGPC have agreed a period of stability, with as little change in clinical activity as possible, whilst they work on elements of a future GMS contract
  - the vaccination programme, of necessity, has increased significantly this year

Boards are directed to support practices, across the whole of the immunisation programme, to at least the same level as previous years where possible.

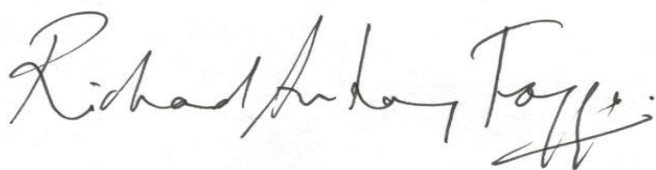
### Action

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 Michael Taylor.

Yours sincerely



**Richard Foggo**  
Deputy Director, Primary Care Division

# DIRECTIONS

## THE NATIONAL HEALTH SERVICE (SCOTLAND) ACT 1978

### The Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2016

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<sup>(1)</sup>, 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 2016 and come into force on 1 August 2016.

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

#### Interpretation

2.<sup>1</sup> In these Directions—

“the Act” means the National Health Service (Scotland) Act 1978;

“core hours” means the period beginning at 8.00am and ending at 6.30pm on any working day; “financial year” means the period from 1 April to 31 March;

“general medical 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<sup>2</sup>;

“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);<sup>3</sup>

“health care professional” has the same meaning as in section 17L(8)<sup>4</sup> 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

(c) contractual arrangements for the provision of primary medical services under section 2C(2) of the Act (functions of Health Boards primary medical services)<sup>5</sup>;

“primary medical services contractor “ means—

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

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

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<sup>1</sup> 1978 c.2 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)

<sup>2</sup> S.S.I. 2004/114

<sup>3</sup> Section 17M was inserted by section 4 of the 2004 Act

<sup>4</sup> Section 17L was amended by the Tobacco and Primary Medical Services (Scotland) Act 2010

<sup>5</sup> Section 2C was inserted by section 1(2) of the 2004 Act

“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; and

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

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 are two years of age but not yet three years of age 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 influenza type B (HiB) and

(bb) Measles/mumps /rubella

(cc) Meningitis C or

(ii) who are five years of age but not yet six years of age 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;

(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;

(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;

(g) a Pertussis Immunisation Scheme, the underlying purpose of which is to extend the temporary programme of pertussis vaccination of pregnant and some post natal women in response to ongoing increase levels of pertussis activity;

(h) a Shingles (Herpes Zoster) Immunisation Scheme, the underlying purpose of which is to provide a one-off vaccination for 70 year olds and a catch up immunisation programme for people aged up to 80 years;; and

(i) a Meningitis B Vaccination Programme.

(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 wide 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),

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 a risk of—

(i) influenza infection if he / she is—

(aa) aged over 6 months to less than 2 years in a clinical “at-risk” group listed in the Schedule to these Directions;

(bb) Aged 2 years : all children born on or after 2 September 2013 and on or before 1 September 2014;

(cc) Aged 3 years: all children born on or after 2 September 2012 and on or before 1 September 2013;

(dd) Aged 4 years : children born on or after 2 September 2011 and on or before 1 September 2012 who are not yet attending primary school;

(ee) Aged 5 years : children born on or after 2 September 2010 and on or before 1 September 2011 who are not yet attending primary school;

(ff) Aged 12 to 17 years and in a clinical “at-risk” group listed in the Schedule. Children born between 1 March 2004 and 28 February 2005 will normally enter secondary one in 2016/17;

(gg) Aged 5-11 years who did not receive the vaccine at school, whether in an “at-risk” group or not

(hh) Aged 18 years to 65 years in a clinical “at-risk” group listed in the Schedule to these directions

(ii) Aged 65 years or over;

- (jj) 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; and
- (kk) unpaid carers,
- (ii) pneumococcal infection is he / she 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 1<sup>st</sup> August to 31<sup>st</sup> March in that financial year, but

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

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

(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 aim 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 side 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.

(3) In this direction—

(i) an "unpaid carer" is 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.

### **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 Patient's 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 for is included in the lifelong medical records held by the patient's general practitioner;

(d) a requirement that the contractor that all tissue removed by surgical procedures is sent for histological examination, unless there are acceptable clinical 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) a requirement that the contractor

(i) includes patients identified with palliative and end of life care needs irrespective of diagnosis on their Palliative Care Register



- (ii) ensures that patients on the 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 patient's 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.

### **Pertussis Immunisation for Pregnant and Post natal Women Scheme**

10.(1) As part of its Pertussis 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 "Pertussis Immunisation for Pregnant and Post natal Women 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 pertussis, and for these purposes a patient is at risk of—

(i) pertussis infection if she is—

(aa) a pregnant woman from 16 weeks onwards, with the optimal time in the period weeks 16 to 32 inclusive, and with a gap of at least one month between any previous immunisation against pertussis, diphtheria, tetanus and/or polio, and this dose;

(bb) 32 weeks until the onset of labour

(cc) New mother who has never previously been vaccinated against pertussis, as soon as possible after birth and until the child receives their first vaccinations.

(b) a requirement that the contractor undertakes, when they are aware that their patient is pregnant—

(i) to offer immunisation against pertussis to those patients,

(aa) record the information that it has in its Pregnant and Post natal Scheme Register using any applicable Read codes

(bb) a requirement that the contractor develops a proactive and preventive approach to offering these immunisations by adopting robust call and reminder systems with the aims of

(aaa) maximising uptake in the interest of at-risk patients; and

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

(c) 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 her 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 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 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
- (g) 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.

### **Shingles (Herpes Zoster) Immunisation Scheme**

11.(1) As part of its Shingles (Herpes Zoster) 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 “Shingles Immunisation Scheme Register”, which may comprise electronically tagged entries in a wider computer database) of patients within relevant age groups to whom the contractor is to offer immunisation against shingles, and for these purposes a patient—

(i) if he/she is born between 2 September 1945 and 1 September 1946 - both dates inclusive)

(ii) those in the relevant catch up age who were born between 2 September 1939 and 1 September 1940 - both dates inclusive)

(b) requirement that the contractor undertakes—

(i) to offer immunisation against shingles to those patients, and—

(aa) to make that offer during the period from 1 September 2016 to 31 August 2017.

(ii) to record the information that it has in its Shingles Scheme Register using any applicable Read codes.

(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/her 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 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.

### **Meningitis B Vaccination Programme**

13. (1) As part of its Meningitis B (MenB) Vaccination Programme, 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 “MenB Vaccination Programme 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 Meningitis, and for these purposes a patient who from 1 September 2016 -

(i) is aged 2 months

(ii) is aged 4 months

(iii) is aged 12 months

(b) a catch up programme for those children born on/after 1 May 2016 who will be aged 3 and 4 months at the beginning of the programme.

(c) infants who are to get the routine vaccinations are to be given three doses of paracetamol

(i) after 2 months vaccination

(ii) after 4 months vaccination

(d) infants who are given the MenB vaccine as part of the one-off catch-up programme will also need three doses of paracetamol following routine vaccinations at

(i) 3 months

(ii) 4 months

The first dose of paracetamol should be given by the GP practice and a prescription written for subsequent two doses.

### **Revocations**

These Directions revoke and supersede the Primary Medical Services (Directed Enhanced Services) Directions 2015, save to the extent necessary to assess any entitlement to payment in respect of services provided under arrangements made in accordance with those Directions.

Richard Foggo  
A Member of the Staff of the Scottish Ministers  
Population Health Directorate, Edinburgh - 17 January 2017

**Clinical at-risk groups for Influenza immunisation**

People with chronic respiratory disease including asthma; People with chronic heart disease;

People with chronic kidney 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

