NHS Circular:
PCA(M)(2006)3

SCOTTISH EXECUTIVE

Health Department
Directorate of Primary Care & Community Care

St Andrew's House
2 Regent Road
EDINBURGH
EH1 3DG

Dear Colleague

PRIMARY MEDICAL SERVICES (DIRECTED ENHANCED SERVICES) (SCOTLAND) DIRECTIONS 2006

Summary

1. This Circular encloses the Directions required to implement nine primary care Directed Enhanced Services (DESs) for 2006.

Background

2. The new General Medical Services contract introduced four DESs which NHS Boards must establish. These are:

(i) Childhood immunisations (target payments)

(ii) Influenza and pneumococcal immunisation for at-risk groups

(iii) Minor surgery

(iv) Services to support staff dealing with violent patients.

3. There are in addition five DESs to be introduced which reflect the agreement negotiated between the Department and the Scottish General Practitioners Committee as part of the 2006-07 UK new General Medical Services Contract review. These are:

(v) Cardio-vascular Disease (CVD) Risk Dataset

(vi) Cancer Referral

(vii) Adults with Learning Disabilities

(viii) Carers

(ix) Access to Contractor-based Primary Care Services.

3 April 2006

Addresses

For action
Chief Executives of NHS Boards
General Medical Practitioners

For information
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4. An electronic copy of this document can be found on the SHOW Website at

http://www.show.scot.nhs.uk/sehd/pca/PCA2006(M)03.pdf

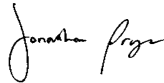
or the Pay Modernisation Website at

http://www.show.scot.nhs.uk/sehd/paymodernisation

Action

5. NHS Boards are requested to bring this Circular to the attention of GP practices in their area and their Area Medical Committee for the attention of the Secretary of the GP sub-committee.

Yours sincerely



DR JONATHAN PRYCE
Head of Primary Care Division

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THE NATIONAL HEALTH SERVICE (SCOTLAND) ACT 1978

THE PRIMARY MEDICAL SERVICES (DIRECTED ENHANCED SERVICES) (SCOTLAND) DIRECTIONS 2006

The Scottish Ministers, in exercise of the powers conferred upon them by sections 2(5) and 105(7) of the National Health Service (Scotland) Act 1978([1]), and of all other powers enabling them in that behalf, hereby give the following Directions:-

Citation, commencement and application

1.—(1) These Directions may be cited as the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2006 and shall come into force on 1st April 2006.

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

Interpretation

2. In these Directions—

"48 hours" means two working days;

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

"carer" means a person who, without payment, provides help and support to a partner, child, relative, friend or neighbour who could not manage without such help due to age, physical or mental illness, addiction or disability; "carer" does not mean a parent with a child under 16 years of age;

"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;

"health care professional" has the same meaning as in section 17L(5) of the Act and

"health care profession" shall be construed accordingly ([3]);

"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;

"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);

"primary medical services contractor" means—

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

([1]) 1978 c.29. Section 2(5) was amended by the National Health Service and Community Care Act 1990 (c.19). Schedule 9, paragraph 19(1). Section 105(7) was amended by the Health Services Act 1980 (c.53). Schedule 6, paragraph 5 and Schedule 7. The Health and Social Services and Social Security Adjudications Act 1983 (c.41), Schedule 9, paragraph 24 and the Health Act 1999 (c.8), Schedule 4 paragraph 60.

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

([3]) Section 17L(5) was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4.

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(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; and

"Statement of Financial Entitlements" means any directions given by Scottish Ministers under section 17M of the Act([4]) (GMS contracts: payments).

Establishment etc. of Directed Enhanced Services Schemes

3.—(1) Each Health Board must exercise its functions under section 2C of the Act (functions of Health Boards: primary medical services) 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 the following schemes for its area—

(a) a Childhood Immunisation Scheme, the underlying purpose of which is to ensure that patients in its area—

(i) who have passed their second birthday but not yet their third 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, 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, acellular pertussis and poliomyelitis;

(b) an Influenza and Pneumococcal Immunisation Scheme, the underlying purposes of which is to ensure that patients in 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 that have been subject to immediate removal from a patient list of a primary medical services contractor because of an act or threat of violence; and

(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 the Health Board's area.

(e) a Cardio-vascular Disease (CVD) Risk Dataset Scheme, the underlying purpose of which is to ensure the completion of information on all patients aged between 45 and 64 years of age on whom there is missing data.

(f) a Cancer Referral Scheme, the underlying purpose of which is to ensure that patients with the suspicion of cancer are referred with appropriate urgency.

(g) an Adults with Learning Difficulties Scheme, the underlying purpose of which is to ensure that patients aged 18 and over with learning difficulties have appropriate access to services so that their health needs are effectively addressed.

(h) a Carers Scheme, the underlying purpose of which is to identify the health needs of carers to ensure that the quality of their life and the patient cared for are maximised.

(i) an Access to Contractor-based Primary Care Services Scheme, the purpose of which is to ensure patients have guaranteed access to a health care professional within 48 hours.

(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 the plan setting out those arrangements; and

(b) in particular, has the necessary facilities, equipment and properly trained and qualified general practitioners, 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 arrangements with a contractor if it has not been able to satisfy itself in this way about the contractor.

([4]) Section 17M was inserted by section 4 of the Primary Medical Services (Scotland) Act 2004.

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Childhood Immunisation Scheme plans

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 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 pre-school 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 the arrangements that a Health Board enters into, or has entered into, with any primary medical services contractor as part of its Childhood Immunisation Scheme 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 national 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 Statement of Financial Entitlements,

and the Health Board must, where necessary, vary the primary medical services 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. As part of its Influenza and Pneumococcal Immunisation Scheme, each Health Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out the 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 or over at the end of that financial year,

(bb) suffering from chronic respiratory disease (including asthma), chronic heart disease, chronic renal disease, immuno-suppression due to disease or treatment, or diabetes mellitus,

(cc) living in long-stay residential or nursing homes or other long-stay health or social care facilities, or

(ii) pneumococcal infection if he is aged 65 or over at the end of the financial year;

(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 concentrate the immunisation programme during the period from 1st September to 31st January in that financial year, and

(ii) to record the information that it has in its Influenza and Pneumococcal Immunisation Register using any applicable national 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 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 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 primary medical services 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 Patient Scheme consultation and plans

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

(2) As part of its Violent Patients Scheme, each Health Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out those arrangements must provide, in respect of each financial year to which the plan relates, for the payment arrangements for the contractor agreeing and meeting its obligations under the plan.

Minor Surgery Scheme plans

7. As part of its Minor Surgery Scheme, each Health Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out the 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;

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(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 Central Sterile Service Departments, disposable sterile instruments (ie 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 primary medical services 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.

Cardio-vascular Disease (CVD) Risk Dataset Scheme plans

8. As part of its Cardio-vascular (CVD) Risk Dataset Scheme, each Health Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out the 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 dataset (its "CVD Dataset") of all patients aged between 45 and 64 years of age on whom there is no entry in the electronic patient record since 1st April 2001 of:-

(i) blood pressure; or

(ii) smoking status; or

(iii) neither of (i) or (ii);

(b) a requirement that the CVD Dataset will comprise the following information:-

(i) age,

(ii) gender,

(iii) body mass index,

(iv) past medical history with special regard to heart disease, stroke, diabetes or hypertension,

(v) family history with special regard to heart disease or diabetes,

(vi) tobacco use (whether smoker, ex-smoker or non-smoker),

(vii) blood pressure;

(c) a requirement for contractors to run a search as at 1 April 2006 to identify the number of patients on their lists with missing data as described in (a) above and to submit the result to Practitioner Services Division of NHS National Services Scotland (PSD) by 17 April;

(d) a requirement for contractors to run a search as at 1st April 2007 of those patients identified in (c) that by then there is completed data for and to submit the result to PSD by 15 April 2007;

(e) a requirement for contractors to demonstrate to the Health Board the initiatives they have undertaken to reach those patients with missing data;

and the Health Board must, where necessary, vary the primary medical services 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.

Cancer Referral Scheme plans

9. As part of its Cancer Referral Scheme, each Health Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out the 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 conducts a review of all new cancer cases diagnosed in the year preceding 1 April 2006 taking account of the whole patient pathway from primary to acute sectors and specifically

(i) record whether new cases were referred urgently, by local protocol (if available), or routinely;

(ii) review and discuss the appropriateness of the mode of referral for each case;

(b) a requirement that the contractor shares the findings of the review with the Health Board and be available to discuss the review with the local cancer lead (if requested), which may include discussion of appropriate and relevant referral protocols and of further initiatives the arrangements for which would be covered by a Local Enhanced Service;

(c) a requirement that the contractor produces a summary of the review to the Health Board.

and the Health Board must, where necessary, vary the primary medical services 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.

Adults with Learning Difficulties Scheme plans

10. As part of its Adults with Learning Difficulties Scheme, each Health Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out the 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 a policy for dealing with patients with learning disabilities;

(b) a requirement for the contractor to hold and update a register of patients with learning disabilities containing (where available) the following information

(i) cause of learning disabilities,

(ii) severity of disability – mild, moderate, severe or profound,

(iii) living and support arrangements, if available from a relavent outside agency

(iv) cervical screening status (where appropriate), and

(v) other major medical problems including epilepsy, visual and auditory impairment or behavioural problems;

(c) a requirement for the contractor to liaise effectively with Acute and Community Learning Disability Health Services, Local Authority and Voluntary Organisations by the identification of one person from the

practice team to act as liaison officer with such organisations and by ensuring appropriate contact with them;

and the Health Board must, where necessary, vary the primary medical services 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.

Carers Scheme plans

11. As part of its Carers Scheme, each Health Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out the 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 produces and maintains a register of those of its patients who are carers;

(b) a requirement that the contractor liaises effectively with relevant outside local carer agencies, where they exist, and social work services by the identification of one person from the practice team to act as liaison officer with such organisations (if they exist) and social work services, and by agreeing a referral process for referring carers to such organisations (if they exist) and social work services to ensure access to appropriate information and support at an early stage in the caring role;

and the Health Board must, where necessary, vary the primary medical services 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.

Access to Contractor-based Primary Care Services Scheme plans

12 (1). As part of its Access to Contractor-based Primary Medical Services Scheme, each Health Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out the 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 requirement that the contractor demonstrates 48 hour access by having in place one, or more, of the following:-

(i) open access whereby patients are seen on the same day without an appointment;

(ii) the contractor has adopted advanced access, or equivalent, wherby patients are provided with "same day" appointments;

(iii) the award of Practice Accreditation, Training Practice Accreditation or QPA and the access criteria have been achieved;

(iv) telephone or e-mail access to a member of the primary care team for professional advice or a consultation within 48 hours such as a booked appointment in a doctor or nurse led "telephone surgery";

(v) formally established arrangements for triage by a doctor or a nurse for either telephone or face to face consultation;

(vi) arrangements for patients to be seen by a doctor, nurse or other healthcare professional within 48 hours or sooner where there is a clinical need.

(2) patients can and should be able to request a consultation or medical advice at a time that does not clinically require them to have contact with a healthcare professional within 48 hours and the following exclusions apply to compliance with 48 hour access:-

(i) situations where the patient does not wish to have contact or be seen within 48 hours;

(ii) situations where the patient specifies a particular professional or individual, where an appropriate, alternative professional is available within 48 hours;

(iii) situations where the patient is offered access within 48 hours but declines stating a preference for an alternative that is not within 48 hours.

(3) Other exclusions are:-

(i) requests for emergency and urgent treatment which should be dealt with immediately;

(ii) pre-planned courses of elective treatment or care programmes where access arrangements are established in advance;

(iii) out-of-hours coverage;

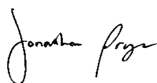
(iv) planned closures such as public holidays and staff training.

(4) The Health Board must, where necessary, vary the primary medical services 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.

Revocations

13. The Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2005 are hereby revoked.

Signed by authority of the Scottish Ministers



Jonathan Pryce

Scottish Executive Health Department : A member of the Senior Civil Service

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