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D I R E C T I O N S

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## NATIONAL HEALTH SERVICE, ENGLAND

### The Primary Medical Services (Directed Enhanced Services) Directions 2017

The Secretary of State for Health, in exercise of the powers conferred by sections 98A, 272(7) and (8) and 273(1) of the National Health Service Act 2006(a), gives the following Directions.

#### Citation, commencement and application

1.—(1) These Directions may be cited as the Primary Medical Services (Directed Enhanced Services) Directions 2017 and come into force on 1st April 2017.

(2) These Directions are given to the Board.

#### Interpretation

2. In these Directions—

“the Act” means the National Health Service Act 2006;

“the Board” means the National Health Service Commissioning Board(b);

“child” has the same meaning as in regulation 3 of the National Health Service (General Medical Services Contracts) Regulations 2015(c);

“core hours” has the same meaning as in regulation 3 of the National Health Service (General Medical Services Contracts) Regulations 2015;

“CRP” means the Contractor Registered Population as defined in Annex A of the Statement of Financial Entitlements;

“financial year” means the twelve months ending on 31st March;

“general practitioner” means a medical practitioner whose name is included in the medical performers list prepared and maintained by the Board in accordance with regulation 3(1)(a) of the National Health Service (Performers Lists) (England) Regulations 2013(d) (performers lists);

“GMS contract” means a general medical services contract;

“GMS contractor” means a person with whom the Board is entering, or has entered into, a GMS contract;

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- (a) 2006 c.41. Section 98A of the National Health Service Act 2006 (“the Act”) was inserted by section 49(1) of the Health and Social Care Act 2012 (c.7) (“the 2012 Act”). Section 273 was amended by sections 21(6), 47(7) and 55(1) of, and paragraph 137 of Schedule 4 to, the 2012 Act. By virtue of section 271(1) of the Act, the powers conferred by these sections are exercisable by the Secretary of State only in relation to England.
- (b) The National Health Service Commissioning Board (known as “NHS England”) is established by section 1H of the Act. Section 1H is inserted into the Act by section 9(1) of the 2012 Act.
- (c) S.I. 2015/1862.
- (d) S.I. 2013/335 and S.I. 2014/465.

“health care professional” means a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002<sup>(a)</sup> (The Professional Standards Authority for Health and Social Care);

“out of hours services” has the same meaning as in regulation 3 of the National Health Service (General Medical Services Contracts) Regulations 2015;

“PMS agreement” means a section 92 arrangement<sup>(b)</sup> with a person which requires the provision by that person of primary medical services;

“PMS contractor” means a person with whom the Board is entering, or has entered into, a PMS agreement;

“practice” means the business operated by a primary medical services contractor for the purpose of delivering services under the primary medical services contract;

“primary medical services” means medical services to which the provisions of Part 4 of the Act apply;

“primary medical services contract” means—

- (a) a GMS contract;
- (b) a PMS agreement; or
- (c) contractual arrangements for the provision of primary medical services under section 83(2) of the Act<sup>(c)</sup> (primary medical services);

“primary medical services contractor” means—

- (a) a GMS or PMS contractor; or
- (b) a person with whom the Board is making, or has made, contractual arrangements for the provision of primary medical services under section 83(2) of the Act;

“registered patient” means—

- (a) a person recorded by the Board as being on a primary medical services contractor’s list of patients; or
- (b) a person whom a primary medical services contractor has accepted for inclusion on its list of patients whether or not notification of that acceptance has been received by the Board;

“Statement of Financial Entitlements” means the General Medical Services Statement of Financial Entitlements Directions 2013<sup>(d)</sup>; and

“working day” has the same meaning as in regulation 3 of the National Health Service (General Medical Services Contracts) Regulations 2015.

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(a) 2002 c.17; section 25 was amended by section 222 of the 2012 Act. Subsection (3) was amended by section 127 of, and paragraph 17 of Schedule 10 to, the Health and Social Care Act 2008 (c.14) and article 68 of, and paragraph 10(1) and (2) of Schedule 4 to, S.I. 2010/231.

(b) Section 92 is amended by section 55(1) of, and paragraph 36 of Schedule 4 to, the 2012 Act. *See* also section 92(8) of the Act.

(c) Section 83 is amended by section 55(1) of, and paragraph 30 of Schedule 4 to, the 2012 Act.

(d) Those Directions were signed on 27th March 2013 and were amended by the General Medical Services Statement of Financial Entitlements (Amendment) Directions 2013 which were signed on 18th September 2013; the General Medical Services Statement of Financial Entitlements (Amendment) Directions 2014 which were signed on 28th March 2014; the General Medical Services Statement of Financial Entitlements (Amendment No.2) Directions 2014 which were signed on 30th September 2014; the General Medical Services Statement of Financial Entitlements (Amendment) Directions 2015 which were signed on 23rd March 2015; the General Medical Services Statement of Financial Entitlements (Amendment No.2) Directions 2015 which were signed on 28th September 2015; the General Medical Services Statement of Financial Entitlements (Amendment No.3) Directions 2015 which were signed on 6th October 2015; the General Medical Services Statement of Financial Entitlements (Amendment No.4) Directions 2015 which were signed on 4th December 2015; the General Medical Services Statement of Financial Entitlements (Amendment) Directions 2016 which were signed on 31st March 2016; the General Medical Services Statement of Financial Entitlements (Amendment No.2) Directions which were signed on 9th May 2016; and the General Medical Services Statement of Financial Entitlement (Amendment No.3) Directions 2016 which were signed on 24th November 2016.

### Establishment etc. of directed enhanced services schemes

3.—(1) The Board must, in exercising its functions under section 83 of the Act so as to secure the provision of primary medical services throughout England, establish, operate and, as appropriate, revise the following schemes—

- (a) an Extended Hours Access Scheme, the underlying purpose of which is to enable patients to consult a health care professional, face to face, by telephone or by other means at times other than during the core hours specified in the contractor's primary medical services contract, as agreed with the Board;
- (b) a Learning Disabilities Health Check Scheme, the underlying purpose of which is to encourage primary medical services contractors to identify registered patients aged 14 and over and who are known to the local authority social services department primarily because of their learning disabilities and to offer and provide such patients with an annual health check;
- (c) a Childhood Immunisation Scheme, the underlying purpose of which is to ensure that patients—
  - (i) who have attained the age of 2 years but who are not yet 3 years are able to benefit from the recommended immunisation courses (that is those that have been recommended in England and by the World Health Organisation<sup>(a)</sup>) for protection against—
    - (aa) diphtheria, tetanus, poliomyelitis, pertussis and Haemophilus influenzae type B (HiB),
    - (bb) measles/mumps/rubella, and
    - (cc) Meningitis C, or
  - (ii) who have attained the age of 5 years but who are not yet 6 years are able to benefit from the recommended reinforcing doses (that is those that have been recommended in England and by the World Health Organisation) for protection against diphtheria, tetanus, pertussis and poliomyelitis;
- (d) an Influenza and Pneumococcal Immunisation Scheme, the underlying purpose 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;
- (e) 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; and
- (f) 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 throughout England.

(2) Before entering into any arrangements with a primary medical services contractor as part of one of the schemes mentioned in paragraph (1), the 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 agreed plan); and
- (b) in particular, has the necessary facilities, equipment and properly trained and qualified general practitioners, health care professionals and staff to perform those obligations,

and the Board is not required by these Directions to enter into such arrangements with a contractor if it has not been able to satisfy itself in this way about the contractor.

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(a) Information on such recommended immunisation courses is available from NHS England, PO Box 16738, Redditch, B97 7PT or can be accessed on the following website: [http://www.who.int/immunization/policy/immunization\\_tables/en/](http://www.who.int/immunization/policy/immunization_tables/en/).

### **Extended hours access scheme**

4.—(1) As part of its Extended Hours Access Scheme (referred to in this Direction as “the Scheme”), the Board must before 30th April 2017 offer to—

- (a) each GMS contractor which has entered into a GMS contract before 1st April 2016 which subsists on 1st April 2017; and
- (b) each PMS contractor for which the Board holds a list of registered patients and which has entered into a PMS agreement before 1st April 2016 which subsists on 1st April 2017,

the opportunity to enter into arrangements under the Scheme in respect of the twelve month period ending on 31st March 2018.

(2) The Board must offer to—

- (a) each GMS contractor which enters into a GMS contract on or after 1st April 2017; and
- (b) each PMS contractor for which it holds a list of registered patients and who enters into a PMS agreement on or after 1st April 2017,

the opportunity, after that date, to enter into arrangements under the Scheme for the remainder of the financial year.

(3) Subject to paragraphs (4) and (6), the Board may, as far as is reasonably practicable, agree proposals to enter into arrangements under the Scheme and enter into such arrangements before 1st July 2017.

(4) The Board must only enter into arrangements under the Scheme after 30th June 2017 in circumstances where—

- (a) the contractor—
  - (i) has not provided the Board with its proposals to enter into arrangements before 1st July 2017, and
  - (ii) on the 30th June 2017, 28 days have not lapsed since the offer to enter into arrangements was made by the Board;
- (b) two or more GMS contracts or PMS agreements (under at least one of which arrangements under the Scheme had previously been entered into) merge and—
  - (i) as a result, two or more patient lists are combined, resulting in either a new or varied GMS contract or PMS agreement,
  - (ii) a contractor who is a party to such a new or varied contract or agreement wishes to enter into new arrangements under paragraph (1), and
  - (iii) pending such new arrangements, the contractor provides extended hours access arrangements which are, in the opinion of the Board, broadly comparable to what is necessary in order to provide the minimum hours of extended access required under these Directions; or
- (c) a GMS contract or PMS agreement under which arrangements under the Scheme had previously been entered into splits and—
  - (i) as a result, the contractor’s patient list is divided between two or more GMS or PMS contractors, resulting in either a new or varied GMS contract or PMS agreement, or a combination of both,
  - (ii) a contractor which is a party to such a new or varied contract or agreement wishes to enter into new arrangements under paragraph (1), and
  - (iii) pending such new arrangements, the contractor provides extended hours access arrangements which are, in the opinion of the Board, broadly comparable to what is

necessary in order to provide the minimum hours of extended access required under these Directions<sup>(a)</sup>.

(5) Where the Board enters into new arrangements under the Scheme under paragraph (4)(b) or (c), it must do so on or before the expiry of the period of 28 days beginning with the date of the merger or, as the case may be, the split.

(6) The Board must—

- (a) consider any proposals put forward by a GMS or PMS contractor which wishes to enter into arrangements under paragraph (1) or (4) with a view to agreeing them;
- (b) not delay any such consideration unreasonably;
- (c) not withhold its agreement unreasonably; and
- (d) in making a decision as to whether to agree to any proposals, have regard to any relevant local circumstances, any known patient preferences and any relevant guidance issued by the Secretary of State.

(7) The Board is not required to consider and reach a decision on any proposals in accordance with paragraph (4) if the GMS or PMS contractor has failed to provide—

- (a) written proposals in response to the Board's offer to enter into arrangements within 28 days of the Board's offer; or
- (b) any information requested by the Board that it reasonably requires in order to ascertain whether the proposals meet its requirements.

(8) The arrangements that the Board enters into with a GMS or PMS contractor for extended hours access must include—

- (a) an obligation on the contractor to implement the agreed arrangements in so far as they place obligations upon it;
- (b) details of the number of patients for whom services are to be provided under the agreed arrangements;
- (c) details of whether the contractor proposes to deliver the services under the agreed arrangements solely for benefit of patients registered with the contractor's own practice or whether the services are also to be offered by the contractor to patients registered with other practices or with a group of practices;
- (d) details of the arrangements the contractor proposes to make in order to enable patients to consult a health care professional, face to face, by telephone or other means, at times other than during the core hours specified in the contractor's primary medical services contract, and those arrangements must comply with the following provisions—
  - (i) the arrangements must include the provision of a specified number of clinical sessions, provided by a health care professional or by another person employed or engaged by the contractor to assist that health care professional in the provision of primary medical services under the contract or agreement, on a regular basis each week which are held at times other than during the core hours specified in the contractor's primary medical services contract and which are provided, in so far as practicable, in a manner which is in line with the patient's expressed preferences (whether face to face or by telephone or otherwise),
  - (ii) any clinical session or sessions provided must be in addition to the contractor's normal provision of clinical sessions during core hours and must, in so far as is practicable, be provided at times which are in line with the preferences of patients expressed either through the GP Patient Survey, Patient Participation Groups, the Friends and Family Test or any other appropriate method of recording patient feedback,
  - (iii) the additional period of the clinical session or sessions provided must, as a minimum, equate to a period of time calculated as follows—

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(a) See sub-paragraph (8)(d)(iii) as to how the minimum number of hours required is to be calculated.

- (aa) first, divide the contractor's CRP at the time the arrangements are agreed by 1000,
  - (bb) then, multiply the figure obtained from the calculation made under subparagraph (aa) by 30,
  - (cc) then, convert the figure obtained from the calculation made under subparagraph (bb) into hours and minutes, rounded to the nearest quarter hour,
  - (iv) the agreed period of time of any additional clinical session or sessions must be provided in full and may be met by a clinical session or sessions consisting of concurrent appointments which, when added together, provide the equivalent of the agreed period of time, and
  - (v) any clinical session or sessions provided must be provided in continuous periods of at least 30 minutes;
  - (e) a requirement that the contractor co-operate with the Board in any review of the arrangements designed to establish whether the pattern of additional hours provided under the arrangements is meeting the requirements of the contractor's registered patients;
  - (f) where the contractor provides out of hours services to its patients, a requirement that the contractor will not limit access to any additional clinical session or sessions it provides under the contract or agreement to those patients that it would in any event have been obliged to see in accordance with its obligations in providing that out of hours service;
  - (g) the arrangements for the provision of information by the Board and by the contractor;
  - (h) the arrangements for the monitoring of the arrangements by the Board;
  - (i) the arrangements for changing the pattern of, or for cessation of, agreed extended opening times, including an agreed notice period for any such changes or cessation;
  - (j) the arrangements to be made by the contractor and the Board for informing the contractor's patients about the additional clinical session or sessions being made available under these arrangements; and
  - (k) in the case of PMS contractors, the amount of the payments to be made to the contractor for meeting its obligations under the arrangements, and in determining the appropriate level of those payments the Board must have regard to the amounts of payments under section 7 of the Statement of Financial Entitlements.
- (9) The arrangements that the Board enters into with a GMS or PMS contractor for extended hours access must, from 1st October 2017, also include—
- (a) a requirement that the contractor's practice is not closed for half a day on a weekly basis unless by written prior agreement with the Board;
  - (b) a requirement that patients must be able to access essential services which meet the reasonable needs of patients during core hours from the contractor's practice or from any person who is sub-contracted to provide such services to the contractor's patients during core hours.
- (10) The Board must, where necessary, vary the GMS or PMS contractor's GMS contract or PMS agreement so that the Scheme comprises part of the contractor's contract or agreement and the arrangements under the Scheme are conditions of the contract or agreement.
- (11) No variation of a primary medical services contract to incorporate an Extended Hours Access arrangement may provide—
- (a) in the case of a contractor that does not provide out of hours services, that any obligation under the contract to attend on a patient outside practice premises in accordance with terms of the contract which have same effect as those specified in—
    - (i) paragraph 5 of Schedule 3 to the National Health Service (General Medical Services Contracts) Regulations 2015(a), or

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(a) S.I.2015/1862 as amended by S.I. 2016/875.

- (ii) paragraph 6 of Schedule 2 to the National Health Service (Personal Medical Services Agreements) Regulations 2015(a),

applies in respect of any additional period during which the contractor is providing services in accordance with the Extended Hours Access arrangements; or

- (b) that Saturday is to be considered a “working day” for the purposes of any calculation of a period of time required under the contract where such calculation is defined by reference to a “working day”.

(12) Where, pursuant to a review by the Board of the arrangements provided by the contractor as part of the service, the Board is of the view that appointments at a contractor’s practice are consistently being under-utilised, the Board may decide to decommission the service at that practice.

### **Learning Disabilities Health Check Scheme**

5.—(1) As part of its Learning Disabilities Health Check Scheme (referred to in this direction as “the Scheme”), the Board must before 30th April 2017 offer to—

- (a) each GMS contractor which has entered into a GMS contract before 1st April 2016 which subsists on 1st April 2017; and
- (b) each PMS contractor for which it holds a list of registered patients and which has entered into a PMS agreement before 1st April 2016 which subsists on 1st April 2017,

the opportunity to enter into arrangements under the Scheme in respect of the twelve month period ending on 31st March 2018.

(2) Subject to paragraph (3), the Board must offer to—

- (a) each GMS contractor which enters into a GMS contract on or after 1st April 2017; and
- (b) each PMS contractor for which it holds a list of registered patients and which enters into a PMS agreement on or after 1st April 2017,

the opportunity, after that date, to enter into the arrangements under the Scheme for the remainder of the financial year.

(3) The Board must only enter into an arrangement under the Scheme after 31st December 2017 where—

- (a) two or more GMS contracts or PMS agreements (under at least one of which arrangements under the Scheme referred to in paragraph (1) had previously been entered into) merge and—
  - (i) as a result two or more patient lists are combined, resulting in either a new or varied GMS contract or PMS agreement, and
  - (ii) the contractor who is a party to such a new or varied contract or agreement wishes to enter into new arrangements referred to in paragraph (1); or
- (b) a GMS contract or PMS agreement (under which arrangements under the Scheme referred to in paragraph (1) had previously been entered into) splits and—
  - (i) as a result the contractor’s patient list is divided between two or more GMS or PMS contractors, resulting in either new or varied GMS contracts or PMS agreements, or a combination of both, and
  - (ii) a contractor who is a party to such a new or varied contract or agreement wishes to enter into a new arrangement referred to in paragraph (1)

(4) Where the Board enters into a new arrangement under the Scheme, it must do so before the expiry of the period of 28 days beginning with the date of the merger or the split as the case may be.

(5) The Board must—

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(a) S.I. 2015/1879 as amended by S.I. 2016/875.

- (a) consider any proposals put forward by a GMS or PMS contractor which wishes to enter into arrangements under the Scheme referred to in paragraphs (1) and (2) with a view to agreeing them;
- (b) not delay any such consideration unreasonably; and
- (c) not withhold its agreement unreasonably.

(6) The Board is not required to consider and reach a decision in respect of entering into any arrangements under the Scheme where a GMS or PMS contractor has failed to provide written proposals in response to the Board's offer to enter into such arrangements within 42 days beginning with the date of the offer.

(7) The arrangements that the Board enters into with a GMS or PMS contractor as part of the Scheme must include—

- (a) a requirement that the contractor set up and agree with the Board a “health check learning disabilities register” for the purpose of identifying those of its registered patients aged 14 years or over with learning disabilities who are to be invited for an annual health check under the arrangement;
- (b) a requirement that in order to establish which of their registered patients should be included on the health check learning disabilities register, the contractor is to liaise with the local authority social services department or departments for the area or areas from which its registered patients are drawn and establish which of their registered patients are known to the local authority social services primarily because of their learning disabilities(a);
- (c) a requirement that the contractor includes those of its registered patients identified by such liaison with the local authority or authorities in its health check learning disabilities register;
- (d) a requirement that the contractor review any learning disabilities register it has already set up under Quality and Outcomes Framework arrangements under its contract or agreement and ensure that such learning disabilities register includes all those registered patients that have been identified for inclusion in the health check learning disabilities register;
- (e) a requirement that the contractor takes reasonable steps to keep the health check learning disabilities register up to date throughout the period of the arrangement by removing and adding registered patients as appropriate;
- (f) a requirement that the contractor provides the Board with such information as the Board may reasonably require to demonstrate that it has robust systems in place to maintain such register accurately;
- (g) a requirement that the contractor must offer an annual health check to each patient on its health check learning disabilities register;
- (h) a requirement that, where the patient consents, the health check provided under the arrangement is to involve any carer, support worker or other person considered appropriate by either the patient or the contractor;
- (i) a requirement that any health check provided under the arrangement must, as a minimum, include—
  - (i) a review of the patient's physical and mental health that includes—
    - (aa) the provision of relevant health promotion advice,
    - (bb) a chronic illness and system enquiry(b),
    - (cc) a physical examination,

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(a) Details of the learning disabilities health check scheme can be found in the 2015/16 General Medical Services (GMS) contract guidance at: <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/enhanced-services>. Hard copies of this guidance are available from NHS England, PO Box 16738, Redditch, B97 7PT.

(b) A systems enquiry is a check of respiratory, cardiovascular and other functions in the body which may not currently present as being subject to chronic illness or disease.



- (dd) a consideration of whether the patient suffers from epilepsy,
- (ee) a consideration of the patient's behaviour and mental health, and
- (ff) a specific syndrome check<sup>(a)</sup>,
- (ii) the production of a health action plan for all patients with a learning disability who are aged 14 years and over,
- (iii) a check on the appropriateness of any prescribed medicines,
- (iv) a review of coordination arrangements with secondary care, and
- (v) where appropriate, a review of any transitional arrangements which took place on the patient attaining the age of 18;
- (j) a requirement that in carrying out any health check provided under the arrangements the contractor must use—
  - (i) the “Cardiff” health check protocol which is available through the Royal College of General Practitioners’ website<sup>(b)</sup> or a similar protocol agreed with the Board, or
  - (ii) the National Electronic Health Check (Learning Disabilities) Template<sup>(c)</sup>;
- (k) a requirement that, before undertaking any health check under the arrangements, the contractor must arrange a training session, if it has not already done so, for its staff which meets the following requirements—
  - (i) the training session must be attended by such members of the contractor’s staff as are agreed between the contractor and the Board, which must include as a minimum—
    - (aa) the lead general practitioner and the lead practice nurse, and
    - (bb) either the practice manager or the senior receptionist, if the contractor’s staff include staff with those designations, or where the contractor’s staff does not include staff with those designations, either of the members of the contractor’s staff who have analogous roles,
  - (ii) the training session must consist of a multi-professional education session approved by the Board, and
  - (iii) the training session must include instruction on overcoming any attitudinal barriers of the staff with a view to improving their communication with patients with learning disabilities;
- (l) a requirement that the contractor makes relevant entries in the patient’s medical record, including any refusal to take up the offer of a health check;
- (m) a requirement that, before 30th April 2018, the contractor informs the Board (in writing) of the number of registered patients on the health check learning disabilities register who have received a health check undertaken by the contractor under the arrangement referred to in paragraph (1) in respect of the twelve month period ending on 31st March 2018;
- (n) details of the arrangements for the provision of information by the Board and by the contractor in addition to any information the contractor is required to provide in accordance with sub-paragraph (m);
- (o) details of the arrangements for the monitoring of the arrangements by the Board; and

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(a) A syndrome check is a bodily check for certain syndromes known to cause learning disabilities which are associated with increased morbidity.

(b) The website can be found at <http://www.rcgp.org.uk/learningdisabilities/>. Hard copies of the protocol are available from the Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS.

(c) The National Electronic Health Check (Learning Disabilities) Template is an interactive code based tool which will be available on GP IT systems from 1st April 2017. The purpose of the tool is to help GPs assess the health needs of those with learning disabilities in a systematic way and to generate a Health Check Action Plan which is tailored towards the needs of individual patients. Further information about the template can be obtained from NHS England, PO Box 16738, Redditch, B97 7PT.

- (p) in the case of PMS contractors, the amount of the payments to be made to the contractor for meeting its obligations under the arrangements, and in determining the appropriate level of those payments the Board must have regard to the amounts of payments under section 9 of the Statement of Financial Entitlements.

(8) The Board must, where necessary, vary the contractor's GMS contract or PMS agreement so that the Scheme comprises part of the contractor's contract or agreement and the arrangements under the Scheme are conditions of the contract or agreement.

### **Childhood Immunisation Scheme**

**6.—**(1) As part of its Childhood Immunisation Scheme (referred to in this Direction as “the Scheme”), the Board must, each financial year, offer the opportunity to enter into arrangements under the Scheme to each GMS or PMS contractor, unless—

- (a) it already has such arrangements with the contractor in respect of that financial year; or
- (b) in the case of a GMS contractor, the contractor is not providing the childhood immunisation and pre-school boosters additional service under its general medical services contract.

(2) The arrangements under paragraph (1) must, in respect of each financial year to which those arrangements relate, 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, or offer to provide, childhood immunisation and pre-school booster services (irrespective of whether or not those children may have already have been immunised, or offered immunisation, by the contractor or otherwise),
  - (ii) offers the recommended immunisations referred to in direction 3(c) in respect of 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) records the information that it has in its Childhood Immunisation Scheme Register using any applicable national Read codes(a);
- (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 immunisation,
  - (ii) where an offer of immunisation was accepted—
    - (aa) details of the consent to the vaccine or immunisation where a person has consented on a child's behalf (and that person's relationship to the child must also be recorded),
    - (bb) the batch number, expiry date and title of the vaccine,

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(a) The “Read codes”, which are the Business Rules that support the relevant enhanced service and vaccination programmes, are available on the Health and Social Care Information Centre website at: <https://www.hscic.gov.uk/qofesextractspecs> or in hard copy form from The Health and Social Care Information Centre, 1 Trevelyan Square, Boar Lane, Leeds, LS1 6AE. See the Business Rules for a full and up to date list of all available codes.

- (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 vaccine, and
  - (ff) any adverse reactions to the vaccine;
- (d) a requirement that the contractor ensures that any health care professional who is involved in administration of the vaccine has—
- (i) the 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 the Board with such information as it may reasonably request for the purposes of monitoring the contractor’s performance of its obligations under the arrangements;
- (g) arrangements for an annual review of the arrangements which must 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 PMS contractors, the payment arrangements for the contractor, which must comprise target payments to the contractor where the contractor—
- (i) meets its obligations under the Scheme, 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 Board must take no account of exception reporting in its calculation of target payments),

and in determining the appropriate level of those target payments, the Board must have regard to the target payments and the targets rewarded under Section 11 of the Statement of Financial Entitlements.

(3) The Board must, where necessary, vary the contractor’s GMS contract or PMS agreement so that the Scheme comprises part of the contractor’s contract or agreement and the arrangements under the Scheme are conditions of the contract or agreement.

### **Influenza and Pneumococcal Immunisation Scheme**

7. As part of its Influenza and Pneumococcal Immunisation Scheme, the Board may enter into arrangements with any primary medical services contractor, and where it does so, the arrangements must, in respect of each financial year to which those arrangements relate, 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 they are—
    - (aa) aged 65 or over at the end of that financial year,
    - (bb) morbidly obese,

- (cc) suffering from chronic respiratory disease (including asthma), chronic heart disease, chronic kidney disease, immuno-suppression due to disease or treatment, or diabetes mellitus, or
  - (dd) living in long-stay residential or nursing homes or other long-stay health or social care facilities, or
- (ii) pneumococcal infection if they are—
  - (aa) aged 65 or over at the end of that financial year,
  - (bb) suffering from Asplenia or dysfunction of the spleen, chronic respiratory disease, chronic heart disease, chronic kidney disease, chronic liver disease, diabetes mellitus, immuno-suppression due to disease or treatment, or
  - (cc) if they have a cochlear implant or a cerebrospinal fluid leak;
- (b) a requirement that the contractor undertakes to offer immunisation against those infections to those patients who are at risk and—
  - (i) in the case of immunisation against influenza infection—
    - (aa) makes that offer before the end of the financial year, and
    - (bb) concentrates the immunisation programme during the period from 1st September to 31st December in that financial year,
  - (ii) in the case of immunisation against pneumococcal infection, offers and delivers such immunisations throughout the financial year, and
  - (iii) in each case, records the information that it has in its influenza and Pneumococcal Immunisation Register using any applicable national Read codes(a);
- (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 their immunisation status, and in particular include—
  - (i) any refusal of an offer of immunisation,
  - (ii) where an offer of immunisation was accepted—
    - (aa) details of the consent to the vaccine 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 vaccine, and
    - (ff) any adverse reactions to the vaccine;
- (e) a requirement that the contractor ensures that any health care professional who is involved in the administration of the vaccine has—
  - (i) the necessary experience, skills and training with regard to the administration of the vaccine, and

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(a) The “Read codes”, which are the Business Rules that support the relevant enhanced service and vaccination programmes, are available on the Health and Social Care Information Centre website at: <http://www.hscic.gov.uk/qofesextractsspecs> or in hard copy form from The Health and Social Care Information Centre, 1 Trevelyan Square, Boar Lane, Leeds, LS1 6AE. See the Business Rules for a full and up to date list of all available codes.

- (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 the 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.

(2) The Board must, where necessary, vary the primary medical services contractor’s primary medical services contract so that the Scheme comprises part of the contractor’s contract or agreement and the arrangements under the Scheme are conditions of the contract or agreement.

### **Violent Patients Scheme**

**8.**—(1) The Board must consult the local medical committee<sup>(a)</sup> (if any) for the area in which a primary medical services contractor which wishes to enter into arrangements in respect of a Violent Patients Scheme (referred to in this Direction as “the Scheme”) provides primary medical services about any proposals it has to establish or revise the Scheme.

- (2) Where the Board enters into arrangements under the Scheme, the Board must—
- (a) as part of those arrangements, make provision for the payment arrangements for the contractor agreeing and meeting its obligations under the Scheme in respect of each financial year to which those arrangements relate; and
  - (b) where necessary, vary the primary medical services contractor’s contract or agreement so that the Scheme comprises part of the contractor’s contract or agreement and the arrangements under the Scheme are conditions of the contract or agreement.

### **Minor Surgery Scheme**

**9.**—(1) As part of its Minor Surgery Scheme (referred to in this Direction as “the Scheme”), the Board may enter into arrangements with any primary medical services contractor.

- (2) Where the Board enters into arrangements under the Scheme, those arrangements must, in respect of each financial year to which those arrangements relate, include—
- (a) which minor surgical procedures are to be undertaken by the contractor and for which category of patients, and for these purposes, the minor surgical procedures that may be undertaken are any minor surgical procedures that the 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 for 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

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(a) A Local Medical Committee is a committee recognised by the Board under section 97 of the 2006 Act.

- (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 Board may stipulate—
  - (i) the use of sterile packs from the local Central Sterile Service Department<sup>(a)</sup>, disposable sterile instruments, or approved sterilisation procedures, and
  - (ii) the use of particular infection control policies in relation to, for example, the handling of used instruments and 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 Scheme;
- (h) a requirement that the contractor supplies the Board with such information as it may reasonably request for the purposes of monitoring the contractor's performance of its obligations under the Scheme; and
  - (i) the payment arrangements for the contractor.

(3) The Board must, where necessary, vary the contractor's primary medical services contract or agreement so that the Scheme comprises part of the contractor's contract or agreement and the arrangements under the Scheme are conditions of the contract or agreement.

### **Revocations and savings**

**10.—**(1) Subject to paragraph (2), the Primary Medical Services (Directed Enhanced Services Directions) 2016 are revoked.

(2) Notwithstanding the revocation provided for in paragraph (1), the Primary Medical Services (Directed Enhanced Services) Directions 2016 as in force immediately before 1st April 2017 are to continue to apply to the extent necessary to assess any entitlement to payment in respect of services provided under arrangements made in accordance with those Directions.

Signed by authority of the Secretary of State for Health



Date 31<sup>st</sup> March 2017

Louise Everett  
Member of the Senior Civil Service  
Department of Health

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(a) The local Central Sterile Services Department is the provider of equipment sterilisation facilities in the local health economy.