

# THE HEALTH AND PERSONAL SOCIAL SERVICES (NORTHERN IRELAND) ORDER 1972

## THE PRIMARY MEDICAL SERVICES (DIRECTED ENHANCED SERVICES) DIRECTIONS (NORTHERN IRELAND) 2006

The Department of Health, Social Services and Public Safety<sup>(a)</sup>, in exercise of the powers conferred on it by Article 17 of the Health and Personal Social Services (Northern Ireland) Order 1972<sup>(b)</sup>, and of all other powers enabling it in that behalf, hereby gives the following Directions:

### Citation and commencement

1.—(1) These Directions may be cited as the Primary Medical Services (Directed Enhanced Services) Directions (Northern Ireland) 2006.

(2) These Directions shall have effect as from 1 April 2006.

### Interpretation

2. In these Directions—

“the Order” means the Health and Personal Social Services (Northern Ireland) Order 1972;

“general practitioner” means a medical practitioner whose name is included in a primary medical services performers list prepared by a Board under regulation 4 of the Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004<sup>(c)</sup>;

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

“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 Services Reform and Health Care Professions Act 2002<sup>(d)</sup>;

“PMS contractor” means a person with whom a Board is entering or has entered into Article 15B arrangements which require the provision by that person of primary medical services;

“primary 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 Services reform and Health Care Professions Act 2002 or by the Northern Ireland Social Care Council, established under Section 1 of the Health and Personal Social Services Act (Northern Ireland) 2001<sup>(e)</sup>;

“primary medical services contract” means—

- (a) a general medical services contract;
- (b) Article 15B arrangements which require the provision of primary medical services; or
- (c) contractual arrangements for the provision of primary medical services under Article 56 of the Order (primary medical services);

“primary medical services contractor” means—

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(a) See S.I. 1999/283 (N.I. 1) Article 3(6)  
(b) S.I. 1972/1265 (N.I. 14)  
(c) S.R. 2004 No. 149  
(d) 2002 c.17  
(e) 2001 C.3 (N.I.)

- (a) a GMS or PMS contractor; or
- (b) a person with whom a Board is making or has made contractual arrangements for the provision of primary medical services under Article 56 of the Order (primary medical services);

“Statement of Financial Entitlements” means any directions given by the Department of Health, Social Services and Public Safety, under section 57C of the Order<sup>(a)</sup> (GMS contracts:payments);

“working day” means any day apart from Saturday, Sunday, a public holiday or a local holiday agreed with the Board.

### **Establishment etc. of directed enhanced services schemes**

**3.—(1)** Each Board must exercise its functions under Article 56 of the Order (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) an Access to Primary Care Scheme, the underlying purpose of which is to improve patient access to primary medical services, and will include—
  - (i) arrangements for ensuring that patients requiring clinical advice or treatment will, on request, have the opportunity for a consultation with a general medical practitioner or appropriate health care professional, by the end of—
    - (aa) the first working day after the day on which the request was made, for a patient with an acute condition, including exacerbation of an existing chronic condition; and
    - (bb) the second working day after the day on which the request was made, for all other patients; and
  - (ii) arrangements for ensuring patients have the opportunity to book appointments in advance of 24 hours;
  - (iii) arrangements for ensuring patients have ease of telephone access to the contractor during core hours;
  - (iv) arrangements for ensuring that, without the imposition of a specified target timeframe, patients have the opportunity to be seen by their preferred general practitioner;
- (b) a Childhood Immunisation Scheme, the underlying purpose of which is to ensure 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 the 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 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, pertussis and poliomyelitis;
- (c) 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;

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<sup>(a)</sup> Article 57C was inserted by the Primary Medical Services (Northern Ireland) Order 2004 No. 311 (N.I. 2)

- (d) a Long-Term Condition Management Scheme, the underlying purpose of which is to improve the long-term health and well-being of patients in its area—
  - (i) who have chronic obstructive pulmonary disease (COPD);
  - (ii) who have asthma; or
  - (iii) who have a Body Mass Index (BMI) greater than 30 who are likely to develop morbidity such as diabetes mellitus;
- (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 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
- (f) a Minor Surgery Scheme, the underlying purpose of which is to ensure that a wide range of minor surgical procedures is made available as part of the primary medical services provided within the Board's area.

(2) Before entering into any arrangements with a primary medical services contractor as part of one of the Schemes mentioned in this direction, a Board must satisfy itself that the contractor with whom 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 Board to enter into such arrangements with a contractor if it has not been able to satisfy itself in this way about the contractor.

#### **Access to Primary Care Scheme**

**4.**—(1) As part of its Access to Primary Care Scheme, each Board must invite each GMS or PMS contractor in its area, thereby affording the contractor a reasonable opportunity to participate in the Scheme during that financial year.

(2) The arrangements that the Board enters into with a GMS or PMS contractor as part of its Access to Primary Care Scheme must, include—

- (a) any agreed arrangements for meeting and maintaining the access targets in directions 3(a)(i) to (iv); and
- (b) any agreed arrangements for the provision of feedback to the contractor arising from the monitoring of achievement of those access targets;
- (c) a requirement that the contractor undertakes to participate in the promotion of the Access to Primary Care Scheme to patients, through the provision of appropriate promotional material supplied by the Board;

(3) and the Board must, where necessary, vary the primary medical services contractor's primary medical services contract so that the arrangements comprise part of the contractor's contract and the requirements are conditions of the contract.

#### **Childhood Immunisation Scheme plans**

**5.**—(1) As part of its Childhood Immunisation Scheme, each Board must, each financial year offer to enter into arrangements with each GMS or PMS contractor in its area, 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 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 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 (his “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 (who may already have been immunised, by the contractor or otherwise, or to whom the contractor has offered or needs to offer immunisations),
  - (ii) undertakes to offer the recommended immunisations referred to in direction 3(1)(b) to the children on his 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 he has in his 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 his Childhood Immunisation Scheme Register about his 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 supplies his Board with such information as it may reasonably request for the purposes of monitoring the contractor’s performance of his 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 his 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 Board must take no account of exception reporting in its calculations of target payments),

and in determining the appropriate level of payments, the Board must have regard to the target payments and the targets rewarded under Section 8 of the Statement of Financial Entitlements,

(3) and the 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**

**6.—**(1) As part of its Influenza and Pneumococcal Immunisation Scheme, each Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out the arrangements that a 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 (his “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, chronic liver disease, immuno-suppression due to disease or treatment, including asplenia or splenic dysfunction, or diabetes mellitus,
    - (cc) living in long-stay residential care homes or nursing homes or other long-stay health or social care facilities,
    - (dd) Carers who are the main carer for an elderly or disabled person or
  - (ii) pneumococcal infection if he is—
    - (aa) aged 65 or over at the end of that financial year,
    - (bb) aged 2 months or over at the end of that financial year, and suffering from asplenia or severe dysfunction of the spleen, including homozygous sickle cell disease and coeliac syndrome, immunodeficiency or immuno-suppression due to disease or treatment including HIV at all stages, chronic renal disease or nephrotic syndrome, chronic heart disease, chronic respiratory disease, chronic liver disease including cirrhosis or diabetes mellitus, or having a cochlear implant or CSF shunt;
    - (cc) aged under 5 years and has previously suffered from invasive pneumococcal disease;
- (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 1<sup>st</sup> August to 31<sup>st</sup> 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 he has in his 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 supplies his Board with such information as it may reasonably request for the purposes of monitoring the contractor's performance of his obligations under the plan; and
  - (h) the payment arrangements for the contractor,
- (2) and the 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.

### **Long-Term Condition Management Scheme plans**

7.—(1) As part of its Long-Term Condition Management Scheme, each Board may enter into arrangements with any primary medical services contractor, but where it does so, the arrangements that a Board enters into, or has entered into, with the primary medical services contractor must, in respect of each financial year, include—

### ***For patients with COPD***

- (a) a requirement that for each patient with chronic obstructive pulmonary disease (COPD), the contractor—
  - (i) undertakes to assess and record the severity of airflow obstruction annually;
  - (ii) undertakes to offer, for those patients who smoke, referral to local specialist smoking cessation services and provide all relevant information to motivated patients;
  - (iii) undertakes to conduct medication review to ensure the patient is receiving the appropriate pharmacological treatment;
  - (iv) undertakes to provide a self-management training and written action plan, a copy of which should be held by the patient, that takes account of the patient's specific needs and includes—
    - (aa) the patient's Body Mass Index (BMI), measured annually;
    - (bb) the patient's MRC dyspnoea score, measured annually; and
    - (cc) for patient's with severe COPD, the S<sub>a</sub>O<sub>2</sub> measurement, measured bi-annually;
  - (v) undertakes to record hospital admissions, readmissions within 28 days and Accident & Emergency attendances due to an exacerbation of the patient's COPD, or where COPD was a major contributory factor, in the previous 12 months;
  - (vi) develops a strategy for liaison with and referral of appropriate patients to community services, e.g. community based pulmonary rehabilitation;
- (b) a requirement that for each patient with moderate or severe COPD, the contractor undertakes to conduct an assessment including pulse oximetry and refer the patient for long-term oxygen therapy in line with guidance issued by the National Institute for Clinical Excellence;
- (c) a requirement that for each patient using a home nebuliser, the contractor undertakes to review the continued use of such a nebuliser to determine if it is clinically appropriate and the patient is using the equipment correctly, in accordance with guidance issued by the National Institute for Clinical Excellence;

### ***For patients with Asthma***

- (d) a requirement that, for each patient with asthma, the contractor—
  - (i) undertakes to review and record patient inhaler technique;
  - (ii) undertakes to offer, for those patients who smoke, referral to local specialist smoking cessation services and provide all relevant information to motivated patients;
  - (iii) undertakes to conduct a medication review to ensure the patient is receiving the appropriate pharmacological treatment, to achieve minimal symptoms during day and night, minimal need for reliever medication, absence of exacerbations, no limitation of physical activity and normal lung function, where possible;
  - (iv) undertakes to provide, for patients over 15 years of age, a self-management training and written action plan, a copy of which should be held by the patient, that takes account of the patient's specific needs. For patients under 15 years of age the self-management and written action plan should be provided to the child or parent, as appropriate;
  - (v) undertakes to record hospital admissions and Accident & Emergency attendances due to the patient's asthma in the previous 12 months;
- (e) a requirement that the contractor will identify patients at risk of developing near fatal or fatal asthma, record this information in patient records and develop a strategy to assist these high risk patients minimise identified risks;

***For patients with a BMI greater than 30 and are likely to develop morbidity such as diabetes mellitus***

- (f) a requirement that for each patient with a BMI greater than 30 who are likely to develop morbidity such as diabetes mellitus, the contractor—
  - (i) develops a written protocol for such patients, that includes—
    - (aa) the frequency of repeat weight measurement, testing for blood lipids and glucose;
    - (bb) if the service is available, the physical activity referral process;
    - (cc) criteria for anti-obesity drug treatment;
    - (dd) description of the contents of the practice resource kit available to such patients; and
    - (ee) description of the follow-up protocols for such patients, including routine blood pressure monitoring and thyroid function tests;
  - (ii) undertakes to offer, for those patients who smoke, referral to local specialist smoking cessation services and provide all relevant information to motivated patients;
  - (iii) undertakes to offer and record an annual follow-up treatment plan for those patients identified with lipid or glucose abnormalities, e.g. impaired glucose tolerance (IGT);
- (g) a requirement that the contractor develop a practice resource kit for, and provides such a kit to motivated patients with a BMI greater than 30 who are likely to develop morbidity such as diabetes mellitus;

***General requirements under the Long-Term Conditions Management Scheme***

- (h) a requirement that the contractor ensures that any health care professional who is involved in the management and treatment of patients under the Long-Term Condition Management Scheme has—
  - (i) any necessary experience, skills and training with regard to—
    - (aa) the correct use of spirometers and oximeters;
    - (bb) the assessment of acute asthma;
    - (cc) the effective immediate treatment of asthma, that may be provided in the practice;
    - (dd) the identification and treatment of patients with a BMI greater than 30 who are likely to develop morbidity such as diabetes mellitus; and
  - (ii) training needs in relation to those areas outlined at head (i) are regularly reviewed;
- (i) a requirement that the contractor supplies his Board with such information as it may request and in the standardised format provided, for the purposes of monitoring the contractor's performance of his obligations under the plan;

(2) and the Board must, where necessary, vary the primary medical services contractor's primary medical services contract so that the arrangements comprise part of the contractor's contract and the requirements are conditions of the contract.

**Violent Patient Scheme consultation and plans**

**8.—**(1) Each Board must consult the Local 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 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

9. As part of its Minor Surgery Scheme, each Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out the arrangements that a 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 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 he is contracted to provide minor surgical procedures about those procedures;
- (c) a requirement that the contractor—
  - (i) obtains written consent to the surgical procedure before it is carried out (where a person consents on a patient's behalf, that person's relationship to the patient must be recorded on the consent form), and
  - (ii) takes all reasonable steps to ensure that the consent form is included in the lifelong medical records held by the patient's general practitioner;
- (d) a requirement that the contractor ensures that all tissue removed by surgical procedures is sent for histological examination, unless there are acceptable reasons for not doing so;
- (e) a requirement that the contractor ensures that any health care professional who is involved in performing or assisting in any surgical procedure has—
  - (i) any necessary experience, skills and training with regard to that procedure; and
  - (ii) resuscitation skills;
- (f) a requirement that the contractor ensures that he 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 Departments, disposable sterile instruments, or approved sterilisation procedures,
  - (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 plan;
- (h) a requirement that the contractor supplies his Board with such information as it may reasonably request for the purposes of monitoring the contractor's performance of his obligations under the plan; and
  - (i) the payment arrangements for the contractor,

(2) and the 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**

**10.** The Primary Medical Services (Directed Enhanced Services) Directions (Northern Ireland) 2005 are hereby revoked.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 28 April 2006.



*Christine Jendoubi*

A senior officer of the Department of Health, Social Services and Public Safety