NATIONAL HEALTH SERVICE, ENGLAND

The Primary Medical Services (Directed Enhanced Services) Directions 2014

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 2014 and come into force on 1st April 2014.

(2) These Directions are given to the Board.

Interpretation

2.—(1) 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 the National Health Service (General Medical Services Contracts) Regulations 2004(**c**);

"core hours" has the same meaning as in the National Health Service (General Medical Services Contracts) Regulations 2004;

"CRP" means the Contractor Registered Population as defined in the Statement of Financial Entitlements;

"financial year" means the twelve months ending with 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;

"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(**e**) (The Professional Standards Authority for Health and Social Care);

(**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). 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 is established by section 1H of the Act. Section 1H is inserted into the Act by section 9(1) of the Health and Social Care Act 2012.

(**c**) S.I. 2004/291.

(**d**) S.I.2013/335.

(**e**) 2002 c.17; as amended by section 127 of, and paragraph 17 of Schedule 4 to, the Health and Social Care Act 2008 (c.14) and article 68 of, and Part 1 of Schedule 4 to, S.I. 2010/231 and section 222(5) of the Health and Social Care Act 2012.

"out of hours services" has the same meaning as in the National Health Service (General Medical Services Contracts) Regulations 2004;

"PMS agreement" means a section 92 arrangement(**a**) 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 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(**b**) (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 any directions given by the Secretary of State under section 87 of the Act (GMS contracts: payments)(**c**); and

"working day" has the same meaning as in the National Health Service (General Medical Services Contracts) Regulations 2004.

(2) In these Directions, a reference to a contract entered into before 1st April 2013 is a reference to the primary medical services contract entered into before that date and to which the Board became a party to as a consequence of an order made under section 300 of the Health and Social Care Act 2012(**d**).

Establishment etc. of directed enhanced services schemes

3.—(1) The Board must exercise its functions under section 83 of the Act so as to secure the provision of primary medical services throughout England by (as part of its discharge of those functions) establishing, operating and, as appropriate, revising 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) an Alcohol Related Risk Reduction Scheme, the underlying purpose of which is to—

(i) encourage primary medical services contractors to review newly registered patients aged 16 and over, and

(**a**) Section 92 is amended by section 55(1) of, and paragraph 36 of Schedule 4 to, the Health and Social Care Act 2012. See also section 92(8) of the Act.
(**b**) Section 83 is amended by section 55(1) of, and paragraph 30 of Schedule 4 to, the Health and Social Care Act 2012.
(**c**) Section 87 is amended by section 55(1) of, and paragraph 33 of Schedule 4 to, the Health and Social Care Act 2012.
(**d**) 2012 c.7.

(ii) where any such patient is identified as possibly drinking alcohol at increasing risk or higher risk levels, to offer and deliver a brief intervention to such patients aimed at seeking to reduce alcohol related health risks;

(c) 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;

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

(i) who have attained the age of 2 years but not yet 3 years are able to benefit from the recommended immunisation courses (that is those that have been recommended nationally and by the World Health Organisation(**a**)) 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 not yet 6 years are able to benefit from the recommended reinforcing doses (that is those that have been recommended nationally and by the World Health Organisation) for protection against diphtheria, tetanus, pertussis and poliomyelitis;

(e) 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;

(f) 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;

(g) 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;

(h) a Patient Participation Scheme, the underlying purpose of which is to encourage primary medical services contractors—

(i) to develop and maintain a system for the purpose of obtaining the views of patients and enabling the practice to obtain feedback from the practice population through a Patient Participation Group(**b**),

(ii) to review patient feedback received at such intervals as are agreed with the Patient Participation Group, and

(iii) to agree an action plan for improvement to services based on feedback received;

(i) a Dementia Scheme, the underlying purpose of which is to encourage and support primary medical services contractors to proactively offer assessment to patients at risk of dementia and to continually improve the quality and effectiveness of care provided to patients with dementia**;** and

(j) an Avoiding Unplanned Admissions and Proactive Case Management Scheme for the purpose of providing a high quality service to patients that will help avoid their unnecessary or unplanned admission to hospital and keep them living healthily and independently in the community.

(**a**) Information on such recommended immunisation courses can be accessed on the following website: http://www.who.int/en/.

(**b**) See paragraph 11(7)(a) regarding the requirement under the Patient Participation Scheme for a contractor to establish a Patient Participation Group which is representative of its registered patients.

(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 plan agreed under 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 the Board to enter into such arrangements with a contractor if it has not been able to satisfy itself in this way about the contractor.

Extended hours access scheme

4.—(1) As part of its Extended Hours Access Scheme, the Board must before 30th April 2014 offer to—

(a) each GMS contractor who has entered into a GMS contract before 1st April 2013 which subsists on 1st April 2014; and

(b) each PMS contractor for which the Board holds a list of registered patients and who has entered into a PMS agreement before 1st April 2013 which subsists on 1st April 2014,

the opportunity to enter into arrangements under the Scheme in respect of the twelve month period ending on 31st March 2015.

(2) Subject to paragraph (3), the Board must, as far as is reasonably practicable, agree proposals to enter into arrangements under the Scheme referred to in paragraph (1) and enter into such arrangements before 1st July 2014.

(3) The Board is only required to enter into arrangements, as part of its Extended Hours Access Scheme, after 30th June 2014 where—

(a) the contractor—

(i) has not provided the Board with its proposals to enter into arrangements before 1st July 2014, and

(ii) on the 30th June 2014, 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 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,

(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,

in which case the Board is required to enter into new arrangements under the Scheme referred to in paragraph (1) on or before the expiry of the period of 28 days beginning with the date of the merger; or

(c) 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 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(**a**),

in which case the Board is required to enter into new arrangements under the Scheme referred to in paragraph (1) on or before the expiry of the period of 28 days beginning with the date of the split.

(4) 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 (3) 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.

(5) 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.

(6) The arrangements that the Board enters into with a GMS or PMS contractor for extended hours access must be in writing and must include—

(a) a written 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 registered health care professional 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 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,

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(**a**) See sub-paragraph (6)(d)(iii) as to how the minimum number of hours required is to be calculated.

(iii) the additional period of the clinical session or sessions provided must, as a minimum, equate to a period of time calculated as follows—

(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 sub-paragraph (aa) by 30,

(cc) then, convert the figure obtained from the calculation made under sub-paragraph (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 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,

and the Board must, where necessary, vary the GMS or PMS contractor's GMS contract or PMS agreement so that the arrangements comprise part of the contractor's contract or agreement and the requirements of the arrangements are conditions of the contract or agreement.

(7) No variation of the 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 3 of Schedule 6 to the National Health Service (General Medical Services Contracts) Regulations 2004(**a**), or

(ii) paragraph 4 of Schedule 5 to the National Health Service (Personal Medical Services Agreements) Regulations 2004(**b**),

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(**a**) S.I. 2004/291; as amended by S.I. 2004/865, 906 and 2694, S.I. 2005/893 and 3315, S.I. 2006/1501, S.I. 2007/3491, S.I. 2008/528 and 1700, S.I. 2009/309, 2205 and 2230, S.I. 2010/22, 231, 578, 1231, S.I. 2012/970, 1479, 1909, 1916 and 2404, S.I. 2013/363.

(**b**) S.I. 2004/627; as amended by S.I. 2004/1906 and 2694, S.I. 2005/893, 3315, 3491, S.I. 2006/1501, S.I. 2007/3491, S.I. 2008/1700, S.I. 2009/309, 2205 and 2230, S.I. 2010/22, 231, 234, 478, 578,1621, S.I. 2012/970, 1479, 1909, 1916, 1919, 2404 and S.I. 2013/363.

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".

(8) 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.

Alcohol Related Risk Reduction Scheme

5.—(1) As part of its Alcohol Related Risk Reduction Scheme, the Board must before 30th April 2014 offer to—

(a) each GMS contractor who has entered into a GMS contract before 1st April 2013 which subsists on 1st April 2014**;** and

(b) each PMS contractor for which it holds a list of registered patients and who has entered into a PMS agreement before 1st April 2013 which subsists on 1st April 2014,

the opportunity to enter into arrangements under the Scheme in respect of the twelve month period ending on 31st March 2015.

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

(a) each GMS contractor who enters into a GMS contract on or after 1st April 2014; 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 2014,

the opportunity, after that date, to enter into arrangements under the Scheme referred to in paragraph (1) for the remainder of the financial year.

(3) The Board is only required to enter into such arrangements, as part of its Alcohol Related Risk Reduction Scheme after 31st December 2014 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 which is a party to such a new or varied contract or agreement wishes to enter into new arrangements under the Scheme 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 which is a party to such a new or varied contract or agreement wishes to enter into new arrangements under the Scheme referred to in paragraph (1),

in which case the Board is required to enter into the new arrangements under the Scheme referred to in paragraph (1), and such arrangements must commence on or before the expiry of the period of 28 days beginning with the date of the merger or the split as the case may be.

(4) The Board must—

(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.

(5) The Board is not required to consider and reach a decision in respect of entering into any arrangements under the Scheme referred to in paragraph (1) 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.

(6) The arrangements that the Board enters into with a GMS or PMS contractor as part of its Alcohol Related Risk Reduction Scheme must be in writing and must include—

(a) a requirement that the contractor screen newly registered patients aged 16 and over using either one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaire: FAST (which has four questions) or AUDIT-C (which has three questions)(**a**);

(b) a requirement that if a patient is identified as positive using either shortened version of the AUDIT questionnaire, the remaining questions of the full ten-question AUDIT questionnaire are to be used to determine increasing risk, higher risk or likely dependent drinking;

(c) a requirement that if a patient is identified as drinking at increasing risk or higher risk levels, the contractor—

(i) deliver the recommended brief intervention specified in paragraph (7) to such patient,

(ii) respond to any other identified need in such patient that relates to their levels of drinking, including by providing any identified additional support required for people with mental health issues, and

(iii) provide any treatment that relates to the patient's levels of drinking and which may be required under the contractor's primary medical services contract;

(d) a requirement that if a patient is identified as a dependent drinker the contractor must offer to refer that patient to specialist services;

(e) a requirement that any patient who has been identified as drinking at increasing or higher risk levels, or a dependent drinker, is—

(i) assessed for depression and anxiety,

(ii) offered screening for anxiety or depression, and

(iii) where depression or anxiety is diagnosed, provided with any treatment and support which may be required under the contractor's primary medical services contract, including referral for specialist mental health treatment;

(f) a requirement that the contractor make relevant entries in the patient's medical record;

(g) a requirement that before 30th April 2015, the contractor provides the following information (in writing) to the Board in respect of the twelve month period ending on 31st March 2015—

(i) the number of newly registered patients aged 16 and over who have been screened by the contractor using either one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaire (FAST or AUDIT-C) during that period,

(ii) the number of newly registered patients aged 16 and over who have screened positive under either one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaire FAST or AUDIT-C) during that period who then undergo a fuller assessment using the full ten-question AUDIT questionnaire to determine an increasing risk, higher risk or likely dependent drinking,

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(**a**) The World Health Organisation Alcohol Use Disorders Identification Test (AUDIT) questionnaire can be accessed at http://www.who.int/substance_abuse/activities/sbi/en/.

(iii) the number of newly registered patients who have been identified as drinking at increasing risk or higher risk levels who have during that period received a brief intervention to help them reduce their alcohol-related risk,

(iv) the number of newly registered patients scoring 20 or more on the full ten-question AUDIT questionnaire who have been referred by the contractor for specialist advice for dependent drinking during that period; and

(v) the number of newly registered patients scoring between 8 and 19 on the full ten question AUDIT questionnaire who—

(aa) have been identified as drinking at increasing or higher risk levels) who have been assessed for depression or anxiety during that period,

(bb) have been offered screening for anxiety or depression,

(cc) have received screening for anxiety and depression,

(dd) who are receiving ongoing support and treatment, or

(ee) the number of patients who have been referred for specialist mental health services following screening for anxiety or depression;

(h) 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 (g);

(i) details of the arrangements for the monitoring of the arrangements by the Board; and

(j) 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 8 of the Statement of Financial Entitlements,

and the Board must, where necessary, vary the primary medical services contractor's GMS contract or PMS agreement so that the arrangements comprise part of the contractor's contract or agreement and the requirements of the arrangements are conditions of the contract or agreement.

(7) The recommended brief intervention for use in the case of patients identified as drinking at increasing risk or higher risk levels is the basic five minutes of advice used in the WHO clinical trial of brief intervention in primary care, using the programme modified for the UK context by the University of Newcastle – *How Much Is Too Much?*(**a**).

Learning Disabilities Health Check Scheme

6.—(1) As part of its Learning Disabilities Health Check Scheme, the Board must before 30th April 2014 offer to—

(a) each GMS contractor who has entered into a GMS contract before 1st April 2013 which subsists on 1st April 2014; and

(b) each PMS contractor for which it holds a list of registered patients and who has entered into a PMS agreement before 1st April 2013 which subsists on 1st April 2014,

the opportunity to enter into arrangements under the Scheme in respect of the twelve month period ending on 31st March 2015.

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

(a) each GMS contractor who enters into a GMS contract on or after 1st April 2014; and

(b) each PMS contractor in its area for which it holds a list of registered patients and who enters into a PMS agreement on or after 1st April 2014,

the opportunity, after that date, to enter into the arrangements under the Scheme referred to in paragraph (1) for the remainder of the financial year.

(**a**) This programme and associated audit tools can be accessed on the following website: http//www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice.

(3) The Board is only required to enter into an arrangement under the Scheme referred to in paragraph (1) after 31st December 2014 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),

in which case the Board must enter into a new arrangement under the Scheme referred to in paragraph (1), and such an arrangement must commence on or before the expiry of the period of 28 days beginning with the date of the merger or the split as the case may be.

(4) The Board must—

(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.

(5) The Board is not required to consider and reach a decision in respect of entering into any arrangement under the Scheme referred to in paragraph (1) 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.

(6) The arrangement that the Board enters into with a GMS or PMS contractor as part of its Learning Disabilities Health Check Scheme must be in writing and 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 their 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 and ensure

(**a**) See Appendix 2 Guidance and Audit Requirements for the learning disabilities health check scheme in the Clinical Directed Enhanced Services for the GMS Contracts Guidance published jointly by NHS Employers and BMA on http//www.nhsemployers.org/Aboutus/Publications/Documents/Clinical_DES_guidance_140212.pdf.

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 is to 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 is to, 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,

(cc) a physical examination,

(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,

(ii) the production of a health action plan for all patients with a learning disability 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(**a**), or

(ii) a similar protocol agreed with the Board;

(k) a requirement that, before undertaking any health check under the arrangement, 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 whose roles are analogous to those designations,

(ii) the training session must consist of a multi-professional education session approved by the Board, and

(**a**) The website can be found at http//www/regp.org.uk/clinical-and-research/clinical-resources/learning-disabilities.aspx

(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 2015 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 2015;

(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

(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,

and the Board must, where necessary, vary the contractor's GMS contract or PMS agreement so that the arrangements comprise part of the contractor's contract or agreement and the requirements of the arrangements are conditions of the contract or agreement.

Childhood Immunisation Scheme

7.—(1) As part of its Childhood Immunisation Scheme, the Board must, each financial year, offer to enter into arrangements with 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 plan setting out the arrangement that the Board enters into, or has entered into, with any GMS or PMS 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 (who may already have been immunised, by the contractor or otherwise, or to whom the contractor has offered or needs to offer immunisation),

(ii) undertakes to offer the recommended immunisations referred to in direction 3(d) 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) undertakes to record the information that it has in its 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 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,

(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 plan;

(g) arrangements for an annual review of the plan 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 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 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,

and the Board must, where necessary, vary the contractor's GMS contract or PMS agreement so that the plan comprises part of the contractor's contract or agreement and the requirements of the plan are conditions of the contract or agreement.

Influenza and Pneumococcal Immunisation Scheme

8. 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 plan setting

out the arrangements that the 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 they are—

(aa) aged 65 or over at the end of that financial year,

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

(cc) 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—

(i) to offer pneumococcal immunisation to those at risk patients as identified at paragraph (a)(ii) and, in the case of influenza immunisation, offer influenza immunisation to those patients who are at risk as identified at paragraph (a)(i), and in each case—

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

(bb) 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 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

(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,

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.

Violent Patients Scheme

9.—(1) The Board must consult the local medical committee (if any) for the area in which a primary medical services contractor who wishes to enter into arrangements in respect of a Violent Patients Scheme provides primary medical services about any proposals it has to establish or revise a Violent Patients Scheme.

(2) As part of its Violent Patients Scheme, the Board may enter into arrangements with any primary medical services contractor, but where it does so—

(a) 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; and

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

Minor Surgery Scheme

10.—(1) As part of its Minor Surgery Scheme, the Board may enter into arrangements with any primary medical services contractor, but where it does so, the plan setting out the arrangements that the 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 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

(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, 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 plan;

(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 plan; and

(i) the payment arrangements for the contractor,

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

Patient Participation Scheme

11.—(1) As part of its Patient Participation Scheme, the Board must before 31st May 2014 offer to—

(a) each GMS contractor who has entered into a GMS contract before 1st April 2013 which subsists on 1st April 2014; and

(b) each PMS contractor for which it holds a list of registered patients and who has entered into a PMS agreement before 1st April 2013 which subsists on 1st April 2014,

the opportunity to enter into arrangements under the Scheme in respect of the twelve month period ending on 31st March 2015.

(2) The Board must offer to—

(a) each GMS contractor who enters into a GMS contract on or after 1st April 2014; 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 2014,

the opportunity to enter into arrangements under the Scheme in respect of the remainder of the period ending on 31st March 2015.

(3) The Board is required, after 31st December 2014, to enter into any arrangement under the Scheme referred to in paragraph (1) in respect of any part of the twelve month period ending 31st March 2015 only where paragraph (4) applies.

(4) This paragraph applies 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 under the Scheme 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 new arrangements under the Scheme referred to in paragraph (1),

in which case the Board is required to enter into the new arrangements under the Scheme referred to in paragraph (1), and such arrangements must commence on or 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—

(a) consider any proposals put forward by a GMS or PMS contractor which wishes to enter into arrangements under paragraphs (1) and (3) 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 on any proposals in accordance with paragraphs (1) and (2) 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 42 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.

(7) The arrangements that the Board enters into with a GMS or PMS contractor as part of its Patient Participation Scheme must be in writing and must include—

(a) a requirement that the contractor establishes a Patient Participation Group comprising of some of its registered patients if such a Group has not already been established by the contractor pursuant to the provisions of directions previously given by the Secretary of State;

(b) a requirement that the contractor uses its best endeavours to ensure its Patient Participation Group is representative of its registered patients;

(c) a requirement that the contractor, if it has not already done so, establishes a website to include information on the services provided by the contractor under the terms of the primary medical services contract no later than 28th February 2015;

(d) a requirement that the contractor develops and maintains a system to obtain the views of patients and which enables the practice to obtain feedback from the practice population;

(e) a requirement for the Patient Participation Group to review patient feedback received by the practice (such as the National GP Patient Survey(**a**), review of complaints or suggestions and, when available, the results of the Friends and Family Test(**b**)) at such intervals as are agreed with the Patient Participation Group and to reach agreement on any changes to services with the practice;

(f) a requirement that the practice develops an action plan and agrees with the Patient Participation Group any proposed changes and how the practice is to implement those changes including three key priorities for improvement;

(g) a requirement that if, as a consequence of the findings or proposals arising out of the review of patient feedback referred to in sub-paragraph (e), the contractor wishes to implement changes in the manner in which it delivers primary medical services, the contractor must—

(i) seek the agreement of the Patient Participation Group to implement those changes, or

(ii) in the event that such agreement cannot be obtained and—

(aa) the proposed changes are significant (for example, a change in opening hours), or

(bb) the proposed changes relate to or impact on the terms of the contractor's primary medical services contract,

discuss those changes with the Board and obtain the Board's prior agreement to implementing them;

(h) a requirement for the contractor—

(i) to publicise any actions taken to the practice population, including the Patient Participation Group, together with updates on progress and an assessment of subsequent achievement within the timescales agreed, and

(ii) to provide a report to the Board, using the agreed national template, on any actions taken during the year, the involvement of the Patient Participation Group and the outcomes which have been achieved including outcomes for patients with mental health needs;

(i) a requirement that the report referred to in sub-paragraph (h)(ii) also includes details of—

(i) the make up of the Patient Participation Group against the practice population, how often that group meets and how it engages with the practice population to routinely capture feedback,

(ii) feedback received and reviewed by the Patient Participation Group,

(iii) the three key priority areas identified for improvement by the practice and the Patient Participation Group,

(iv) the actions which were taken to address the priority areas referred to in (iii) and the resulting changes made;

(j) a requirement for the contractor to provide the report to the Board and to publish the report on its website by 31st March 2015;

(k) a requirement that the contractor consider whether any amendments are necessary to any of its published information relating to the services provided by the contractor as a consequences of the implementation of any changes;

(**a**) The GP Patient Survey is carried out by Ipsos Mori on behalf of the National Health Service Commissioning Board (known as "NHS England"). The survey assesses patients' experiences of the access to and quality of care they receive from their local GPs, dentists and out-of-hours doctor services. The survey results can be found here: http://www.gp-patient.co.uk/.

(**b**) The NHS Friends and Family Test (FFT) is a simple single question, which asks NHS patients whether they would recommend the service they have used. The responses to the FFT question are used to produce a score for each provider, which is also aggregated up to national level. The data is published on the NHS England website in a way that allows comparisons between providers on a national and regional basis.

(l) details of the arrangements for the monitoring of the arrangements by the Board;

(m) 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 10 of the Statement of Financial Entitlements,

and the Board must, where necessary, vary the contractor's GMS contract or PMS agreement so that the arrangements comprise part of the contractor's contract or agreement and the requirements of the arrangements are conditions of the contract or agreement.

Dementia Scheme

12.—(1) The Board must offer—

(a) to each GMS contractor who has entered into a GMS contract before 1st April 2013 which subsists on 1st April 2014; and

(b) to each PMS contractor for which it holds a list of registered patients and who has entered into a PMS agreement before 1st April 2013 which subsists on 1st April 2014,

the opportunity to enter into arrangements under a Dementia Scheme in respect of the twelve month period ending on 31st March 2015.

(2) The Board must offer to—

(a) each GMS contractor who enters into a GMS contract on or after 1st April 2014; and

(b) each PMS contractor for which it holds a list of registered patients and who enters into a PMS agreement on of after 1st April 2014,

the opportunity to enter into any arrangements under the Scheme in respect of the remainder of the financial year.

(3) As part of its Dementia Scheme, the Board may enter into arrangements in respect of the financial year ending 31st March 2015, the purpose of which is to ensure that the GMS contractor or PMS contractor have systems in place to enable a proactive approach—

(a) in respect of the assessment and diagnosis of those patients who are at risk and may present the early signs of dementia, including allowing a greater degree of professional judgement to be exercised about the circumstances in which patients are to be offered an assessment to detect the possible existence of dementia;

(b) to improving the manner in which dementia is diagnosed including the promptness in diagnosis; and

(c) to the care and support given to patients who are diagnosed as suffering from dementia including the provision of personalised care planning**.**

(4) The arrangements entered into relating to the Scheme referred to in paragraph (2) must provide, in respect of the financial year ending 31st March 2015, for the payment arrangements for the contractor participating in and meeting its obligations under that scheme.

(5) 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 requirements of the scheme are conditions of the contract or agreement.

Avoiding Unplanned Admissions and Proactive Case Management Scheme

13.—(1) As part of its Avoiding Unplanned Admissions and Proactive Case Management Scheme the Board must, each financial year, offer to—

(a) each GMS contractor who has entered into a GMS contract before 1st April 2014 which subsists on 1st April 2014; and

(b) each PMS contractor for which the Board holds a list of registered patients and who has entered into a PMS agreement before 1st April 2014 which subsists on 1st April 2014,

the opportunity to enter into arrangements under the Scheme in respect of that financial year.

(2) The Board must offer to—

(a) each GMS contractor who has entered into a GMS contract on or after 1st April in any financial year; 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 in any financial year,

the opportunity to enter into arrangements under the Scheme referred to in paragraph (1) for the remainder of that financial year.

(3) The Board must consider any proposals put forward by the GMS or PMS contractor which wishes to enter into arrangements under the Scheme referred to in paragraph (1) for the financial year with a view to agreeing them.

(4) The arrangements that the Board enters into with a GMS or PMS contractor as part of its Avoiding Unplanned Admissions and Proactive Case Management Scheme must be in writing and must include—

(a) details of the availability of the contractor's practice for all patients at risk of admission including providing telephone access for—

(i) patients, and

(ii) healthcare professionals and other providers of health and social care relating to hospital admissions and transfers to hospital;

(b) proactive case management for vulnerable older people, high risk patients and end of life care including providing a named accountable GP and a shared personalised care plan for any such patient;

(c) a requirement to review and improve the discharge process by—

(i) regularly reviewing emergency admissions and Accident and Emergency Department attendances of the contractors registered patients from care and nursing homes, and

(ii) sharing information, and any action points relevant to wider commissioning decisions, with the contractor's clinical commissioning group to help inform commissioning decisions;

(d) internal review and monitoring requirements including a requirement to undertake a regular review of all unplanned admissions and re-admissions for vulnerable patients; and

(e) the payments to be made to the contractor for agreeing and meeting its obligations under the plan,

and the Board must, where necessary, vary the terms of the contractor's GMS contract or PMS agreement so that the arrangements comprise part of the contractor's contract or agreement and the requirements of the arrangements are conditions of the contract or agreement.

Revocations and savings

14.—(1) Subject to paragraph (2), the Primary Medical Services (Directed Enhanced Services Directions) 2013 are revoked.

(2) Notwithstanding the revocation provided for in paragraph (1), the Primary Medical Services (Directed Enhanced Services) Directions 2013 as in force immediately before 1st April 2014 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

Name GARETH ARTHUR
Member of the Senior Civil Service
Department of Health

Date 28 March 2014