NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 26 November 2013

For: PUBLIC session ☒ **PRIVATE Session** ☐

For: Decision ☐ **Discussion** ☐ **Noting** ☒

Agenda Item and title:	**Second Quarter Report on NEW Primary Care Service Level Agreement 2013/14 (previously PBC/Secondary Care LES) July – September 2013**
Author:	Neal Goodwin, Commissioning Manager, North and East Wiltshire (NEW)
Lead Director/GP from CCG:	Ted Wilson – Group Director NEW Dr Simon Burrell, GP Chair NEW Group; Dr Jonathan Rayner, GP Vice Chair, NEW Group
Executive summary:	The purpose of this paper is to report second quarter progress against the actions set out in the 2013-14 NEW Group Service Level Agreement (SLA). The report gives an update on progress and actions against each of the requirements within the following headings for the period July to September 2013: A. Basic commissioning element B. Improve links with secondary and urgent care services C. Practice engagement with development of specific care pathways D. Community transformation and practice engagement E. Medicines Management F. Care home and frail elderly management The total funds available are £1,347,117 based on a total baseline payment of £1,192,087 (£7.21 per patient) for a list population of 165,338 plus an additional £155,030 (£91 per patient) from CCG funds for additional care homes work. A contingency fund of £34,720 will be top sliced from the baseline sum to fund any unforeseen expenditure or primary care based projects. The first payment of approximately half of the available funds (£578,683) was paid to practices in Jul. The contingency fund of £34,720 was also paid into a central NEW account.
Evidence in support of arguments:	N/A
Who has been involved/contributed:	• NEW Executive • Practice Managers • Practices
Cross Reference to Strategic Objectives:	This SLA supports the following priority areas; Planned and Unplanned Care and frail elderly. It also contributes to the delivery of the QIPP targets for the Great Western Hospital Foundation Trust (GWHFT) and Royal United Hospital (RUH) contracts.

Engagement and Involvement:	Discussion and agreement of work priorities with all practices via GP Executive representatives.
Communications Issues:	None
Financial Implications:	No unfunded financial implications. Payments under SLA will not exceed total funds allocated
Review arrangements:	Quarterly and annual reports will be presented to the Governing Body. Project plans and reports will be monitored by the NEW Executive.
Risk Management:	If the SLA is not delivered it will impact on the ability of the CCG to deliver its strategic plan for 2013 – 15. These risks will be mitigated through monitoring and review of progress using standardised audit and reporting templates. A significant increase in the number of care home patients could result in a cost pressure. A top sliced contingency fund (3% of total budget) is available to assist in mitigation with this and other funding shortfalls or urgent requirements.
National Policy/ Legislation:	N/A
Equality & Diversity:	No adverse impact identified
Other External Assessment:	N/A
What specific action re. the paper do you wish the Governing Body to take at the meeting?	This paper is to be noted.

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North & East Wiltshire (NEW) Group
Primary Care Service Level Agreement (SLA) 2013-14
2nd Quarter Report July - September 2013

1. Purpose

The vision of NHS Wiltshire CCG is *"To ensure the provision of a health service which is high quality, effective, clinically led and local."* At the heart of this vision is the focus on developing a model that delivers care to Wiltshire people in or close to their own homes. In order to deliver this, the CCG in its *Clear and Credible Plan 2013 – 2015* identified 7 key strategic priorities:

- Staying healthy and preventing ill health
- Planned Care
- Unplanned Care and frail elderly
- Mental Health
- Long term conditions (including Dementia)
- End of life care
- Community services and integrated care

The Service Level Agreement (SLA) replaces the old Practice based Commissioning PbC LES and the Secondary Care LES. Its purpose is to outline how practices will utilise Primary Care funding to:

- Support the achievement of the CCGs strategic priorities.
- Support the delivery of the NEW and Wiltshire CCG Quality, Innovation, Productivity and Prevention (QIPP) programme.
- Enable practices to be involved more closely in the commissioning process.
- Enable practices to work together to alter clinical pathways for the benefit of the patient.
- Help practices get involved in the development of community care.
- Benefit patient care and support effective use of resources.
- Build on previous years' PbC outcomes.
- Develop innovation from grass roots.

2. Outcomes

This SLA will support the achievement of the following outcomes:

- Reduction in urgent admissions to Acute hospitals from Care Homes
- Reduction in urgent admissions through appropriate Primary Care interventions
- Increased delivery of local services i.e. patients managed by GP or outpatient services provided in the Primary Care environment
- Support the delivery of the QIPP savings target

3. Funding

It was agreed at the Clinical Executive meeting in May 2013 that the previous PbC LES at £3.20 and Secondary Care LES £4.01 would be combined into a single Service Level Agreement (SLA) payment of £7.21 per patient which forms the baseline sum. This equates to a total of £1,192,087 based on the NEW patient list size of 165,338. An additional £155,030 has been made available by the CCG to fund the additional work being planned to support Residential Homes giving a total of £1,347,117.

A contingency fund of £34,720 (£0.21 per patient) has been top sliced from the baseline sum to fund any unforeseen expenditure or primary care based projects.

4. Payment and Reporting

Practice performance against this SLA will be measured by the provision of direct evidence where indicated e.g. audits, and / or summary quarterly reports where required from practices.

In July 2013 an initial payment from the SLA fund was made to practices. Approximately half of the available monies (£578,683) were paid into practice accounts to support the continued efforts towards the range of initiatives outlined in the SLA. The contingency fund of £34,720 was also paid into the central NEW account.

It was further agreed that to support the work by practices to improve the care of the frail elderly in care homes and to support where possible the reduction of inappropriate admissions, that a first payment of half of the available additional funding would be made in October based on the numbers of patients in care homes from the respective practices as at 1st April 2013.

Progress to date against the proposed areas of activity is shown in blue.

5. Areas of Activity

The SLA focuses on six key areas of activity:

A. Basic commissioning element
B. Improve links with secondary and emergency services
C. Practice engagement with development of specific care pathways
D. Involvement in community transformation and practice engagement
E. Medicines Management
F. Care home and frail elderly management

A. Basic Commissioning Element

- Each practice has a named GP Commissioning Lead as per the table below:

	Named Practice Commissioning Leads			
	Box	Dr A Girdher	**Porch**	Dr S Burrell
	Hathaway	Dr J Hogg	**Rowden**	Dr N Brown
	Lodge	Dr D O'Driscoll	**Patford House**	Dr P Harris
	Northlands	Dr N Ware	**Beversbrook**	Dr C Mowat
	Tolsey	Dr L Harris	**Malmesbury**	Dr J Petit
	New Court	Dr S Nelson	**Tinkers Lane**	Dr P Fudge
	Purton	Dr G Barron	**Cricklade**	Dr L DeSilva
	Ramsbury	Dr J Rayner	**Marlborough**	Dr R Hook
	Great Bedwyn	Dr T Ballard	**Pewsey**	Dr A Collings
	Burbage	Dr T King		

- GP attendance at 70% of regular locality meetings. Provide clinical input as requested and appropriate for the NEW Group work programme – This is a continuous process with excellent attendance and input to date at the group's locality meetings. These meetings are proving to be an excellent forum for addressing priority commissioning issues within NEW and give practices the opportunity to shape the delivery of the NEW work programme.

- Carrying out 100% of audits as agreed at locality meetings, and where appropriate using Perception+ – measured by annual return – All requested audits have been completed. Perception+ is a new tool for practices and whilst containing a plethora of useful data, as with any new database initiative, takes time to bed in and for practices to become familiar with it. The executive team are undertaking practice visits with all NEW practices and conducted eight in the period covered by this report. At all of these visits the use of perception+ was discussed.

- Create a register of between 0.5 and 1.0% of patients in each practice most at risk of hospital admission – where appropriate using Perception+ - Work has commenced across the practices with the creation and development of their own internal risk registers. Practices are comparing their own internal 'at risk' patients with those identified by the risk stratification tool and those identified by social care and raised at practice and multi disciplinary team meetings. East Kennet practices review their at risk patient lists on a fortnightly basis with the GP, Practice Manager, Practice Nurse and Care Coordinator. Some practices are reporting that the 'at risk' patients reported by the risk stratification tool are not necessarily the ones that are already known to the GP. This could be a benefit of the tool in that it is highlighting patients that are in need of particular focus or it may be an issue with the selection criteria in that the tool is merely identifying high users of secondary care, many of whom do so appropriately. The issue is how we create a list that best alerts primary and community care to where it can make most difference so that primary care and secondary care can complement rather than duplicate each other. Practices are monitoring and reviewing this.

- A representative from each practice to attend their appropriate local area board meeting (or health equivalent) annually – Area board meetings have been attended by the NEW Group Director and one of the Executive GPs. GPs are also attending their local health and social care forums and stakeholder workshops.

- Continue to use 'Grumpy/Pleased Docs' initiative – The NEW team decided to strengthen the Grumpy & Pleased processes in August 2013 to ensure that any issues raised to the group were reviewed on a daily basis and managed accordingly by the Service Redesign Leads. For the 6 month period ending in September 2013, a total of 97 Grumpy and Pleased emails had been received by the NEW team. The issues raised by the practices had identified several key trends for the first 6 months that are a concern for the practices. These were: NHS 111, Discharges and general practices, processes and policy issues, with both acute providers and the CCG. The service redesign leads have collated this information and will be reporting these to the NEW executive on a quarterly basis.

- Attend regular GP clinical forums - The NEW group has organised two GP forums so far this year; the first on the themes of Community Transformation, Care Coordination and Dementia was held on the 25th April 2013. The forum was held off site and attended by close to 80 delegates with the majority of them (70) being GPs or consultants. The second NEW GP forum themed 'The Frail Elderly' was held on the 9th Oct and will be reported upon in the 3rd quarter report. Attendance at this however was also excellent with 65 delegates and 50 GPs or consultants.

B. Improve Links with Secondary Care and Emergency Services

- Have a dedicated phone line for use by ambulance service, A&E departments and ambulatory care. Practices utilise the dedicated/direct phone number for Hospital Practitioners and Ambulance Crews to avoid inappropriate admissions and it is fully integrated into the normal working day, both for GPs and for staff receiving the calls. Ambulance crews regularly utilise the practice direct dial number when with patients to seek advice on the necessity to convey a patient to hospital thereby avoiding unnecessary admission.

- Respond quickly to requests by these providers for help in acute situations where GP input may be helpful. Most practices have systems in place that allow a Duty Doctor to take a call immediately, something which saves time and frustration for everybody working in the NHS in terms of dealing with workflow as efficiently as possible.

- To accept urgent calls from A&E departments from Senior Clinicians who feel discussion with the GP could improve patient care and decision making which may reduce need for admission. Discussions with GWH A&E consultants at an early NEW Exec meeting reinforced the need for both parties to actively communicate with each other at the earliest opportunity where appropriate.

- To monitor and review, at least quarterly, Emergency Department (ED) patients from individual practices and explore opportunities for alternative referral pathways. Share the learning and results with the NEW GP Executive Group. This is reviewed regularly by practices at their local practice meetings. Practice data packs have been created and distributed quarterly which contain data on emergency attendances and admissions.

  The data in these packs is also the subject of in-depth discussion at a programme of executive practice visits conducted in NEW. These visits were scoped and agreed early in the period and are aimed at enhancing communications and reinforcing the relationships between the executive, and its non-clinical officers, and the practices. An executive GP, the NEW Group Director, Commissioning Manager and Service Redesign Lead are in the process of visiting every practice and have completed 12 visits so far. The practice data packs, containing details of performance in a number of areas (Non Elective activity, elective activity, cancer 2 week wait data, RSS usage etc) are sent to practices in advance and are discussed in detail at the visits; the visits however also offer practices the opportunity to raise any concerns or issues they may have related to commissioning. All visits have been welcomed enthusiastically with attendance by large numbers of Doctors and staff keen to give up their time to engage with the group executive. They have also highlighted some specific issues which are being addressed by the executive which otherwise might have gone un-reported for some time. These visits will be continued on a rolling programme given their success and inherent value.

C. Practice engagement with development of specific areas of Pathway Development

This activity is to be carried out in conjunction with other practices and will in the main be organised as part of CCG membership. The input required from practices may be in the form of a general review or consideration of ways of improving effectiveness. In some cases this may be part of a wider CCG initiative and therefore not specific to one or all practices.

Where this is the case and to qualify for the payment, each practice will be required to provide evidence that they have met, discussed and considered options as required. The evidence will be in the form of a separate stand-alone report or as part of the annual practice summary report.

All practices are expected to take part in the development of pathways and adhere to agreed outcomes.

NEW has identified several pathways that we aim to develop in the coming year and there are a number of pathways within the work programme that are yet to be developed; GPs are keen to support the development of new pathways and this is actively promoted at the Exec meetings, locality meetings and particularly practice visits. A list has been compiled of GPs and practice managers with an interest in being involved in any new pathway work. The following initiatives are underway:

Dermatology - These very popular clinics run twice a month from East Kennet practices: Ramsbury and Marlborough Surgeries, seeing approximately 10 patients in each clinic. These clinics also provide popular and vital Educational Clinics as GPs and GP Registrars sit in with the consultant during the sessions. Of particular note is that these clinics have shown proven reductions in overall dermatology referrals and importantly significant cost savings. A separate report is being prepared to support the wider roll out of this initiative. In the North, The 3 Chippenham practices have approached RUH to work with them on leading on a tele-dermatolgy project. An initial business case was produced in September 2013 by the RUH, and reviewed by the 3 practices. Concerns over proposed costs are currently being addressed by the RUH.

Orthopaedics - These clinics are designed for patients for whom the GPs may need additional advice, not for patients who are already known to need hip/knee replacements. They are run more for the "query" patients who need guidance on where to go or what to do next. They will also provide a useful educational opportunity for practices. After a tentative start, access to them has been extended to the Calne based practices. It was agreed that they would be rolled out to North practices after the initial pilot has validated their effectiveness. North practices are also progressing a review with GWH and local GPs to develop a more coordinated approach to Musculo-skeletal care.

Ophthalmology – Originally envisaged as a community clinic running from Ramsbury surgery by Guy Smith Consultant Ophthalmologist, this is now being reviewed given some issues around the availability of suitable equipment. An alternative location of Savernake Hospital is being considered and a conference call involving all relevant stakeholders is planned for 13th Nov. The clinic will have a significant impact by dealing with referrals from opticians (not all of which will need to be seen) and organising glaucoma and cataract management.

Rheumatology - The CCG is working on a joint initiative with BANES CCG and Rheumatology Commissioning Support Alliance (independent organisation) to understand what the current situation is a across Wiltshire. Rheumatology Alliance have organised various stakeholder events to collect patient and organisational views on current Rheumatology services and pathways.

Nick Brown as NEW Exec CCG attended the Rheumatology Stakeholder event on 9th September and is part of the CCG project group. The RCSA have produced an initial draft report following all of the stakeholder events, and a further questionnaire will be sent to GP practices in the next couple of months for further information and views regarding the service. RCSA will be producing a final recommendations report after Christmas.

The CCG project group will be reviewing the recommendations of the report and will be using that to initiate a 6 month project to identify Rheumatology Strategy and Pathways that will be used for 15/16 commissioning intentions. The volunteer names have been given to the CCG Project Manager lead.

D. Involvement in Community Transformation – Practice Engagement

The CCG is undertaking a major review of community services. The agreed approach is to make all health related local services become based on practices with specialist services clearly supporting the practices.

Practices will need to alter their management arrangements and ways of working to work with this change and make it fully effective. The CCG will assist with this and practices will need to use a portion of the funding to enable suitable change to occur.

- Practices to comply with and implement plans as they are agreed by the CCG and localities
- Practices to provide representation and support at appropriate community transformation meetings and workshops
- Practices to work with neighbourhood teams to improve integration.

All practices are engaged in actively supporting the community transformation programme. A key part of this is the Introduction of Care Coordinators which NEW is the lead on across the Wiltshire area. Practices have played a critical and pivotal part in the development of the care coordinator role and function. GPs and practice managers have been actively involved in the recruitment process with one practice manager from the North (Elaine Smith) and one from the East (Sarah Simpkins) taking on considerable additional work and responsibility for and attending all shortlisting and interviews for the posts. In NEW 11 Care coordinators have been appointed with phased starts from September to November 2013. The implementation of the care coordination project has also reinvigorated some relationships and communications with Neighbourhood Teams.

E. Medicines Management

Savings in prescribing are a key component of the QIPP plans and essential to the CCG budget. With this in mind we would like the practices to continue working with the medicines management team to optimise clinically effective prescribing.

Practices to work with medicines management team to discuss practice prescribing scorecard, keep practice medication use under review to include use of pain management medication. Identify and implement improvements in clinical prescribing and cost effectiveness in conjunction with the medicines management team.

- Demonstrate progress towards the CCG and/or national average for prescribing costs concentrating on areas where practices are above average.
- Audit and improve use of opioid patches in conjunction with Medicines Management team. Complete audit in Medicines Management folder

- Work with Prescribing Advisers to continue to optimise prescribing. Continue with 'Scriptswitch' and prescribing related audits.

- Practices to meet with prescribing team on an annual basis to discuss prescribing costs to draw up plans for the year and to agree targets.

Quarter 2 is a notoriously busy month for practices that are focussed on immunisation campaigns for Flu and Pneumovax as well as this year being required to implement clinics and processes to offer immunisations for Shingles and Rotavirus. The audits for Opiate Patches have been completed by the majority of practices; ad hoc audits for Bisphosphonates and Metformin continue. Practices also continue to engage with Scriptswitch and work closely with the Meds Management team to identify changes to prescribing that will reduce costs whilst maintaining or improving standards of patient care.

F. Care Home and Frail Elderly Management

Secondary care clinicians report a significant number of care home residents being admitted to the District General Hospital for whom care would be been more appropriate in the care home. A pilot in the East Kennet area has demonstrated the benefits of improved contact with the care homes and as a result of this NEW plan to extend this across the whole area. See Appendix 2 for details of pilot.

The aim of this part of the SLA is to enable GP practices to commit more time working with care homes to improve the care and care planning for patients in the homes and also to support the enhanced care of frail elderly patients identified as being at risk but still managing to live at home. Practices will work with care homes to ensure that all non-elective admissions to secondary care are appropriate and discharges to homes from hospital are supported

GPs will be required to visit care homes regularly, to make sure residents have a record of their future wishes for medical care and intervention, to work with local elderly care consultants, to review all residents from a medical point of view in a timely way and to help the homes develop their own care and support for medical issues. Practices are required to coordinate care in homes where patients are from more than one practice.

£155,030 is available to be divided quarterly based on the number of registered practice patients in care homes. To qualify for the payment of £91 per patient, practices will be required to submit quarterly reports confirming the number of patients in each care home. The first payment will be payable after the first list is submitted by July 2013. Thereafter payments will be made quarterly with the final payment being subject to a summary report by each practice detailing the practice involvement and input throughout the year and confirmation that the following requirements have been met:

- Annual GP review
- Additional reviews at 3 or 6 months for less stable residents where necessary linking as appropriate with the consultant geriatrician
- Update care co-ordination and advanced care planning documentation

- Ensuring information is updated on ADASTRA
- Medication revue
- Key care home staff to participate in review
- Practice to report on each item quarterly to locality meeting
- Interim visits as needed under GMS to be carried out as usual
- Regular weekly/monthly (determined by the size of the home and the number of patients) visits / ward rounds by GP, at the same time where possible – planned and agreed with the care home. To review residents as requested by staff.
- Named GP lead per practice per home and cover arrangements in place
- New residents seen and reviewed within 7 working days of admission
- Residents returning from hospital seen within 7 days
- Clear contact protocol for homes to contact practice
- Practice process in place to triage non routine requests from the home
- Educational forums at least twice annually for residential homes between key practice and residential home staff
- Practices to report on this regularly

Whilst all practices are focussing on the Frail Elderly and particularly on working with care homes to avoid inappropriate admissions from care homes, below are just a few specific examples of these efforts.

The Chippenham Practices held their second workshop with their local care homes on 10th September, to discuss how the best ways the GP practices and the care homes could work better together. This included a practical based scenario situation to understand differences in care home behaviours in the processes of responding to a frail elderly patient. The practices and care homes have agreed that there is a designated practice responsible for each care home, although they will support patient choice for preferred doctors.

The Calne practices have been working with their local care homes to coordinate a joint meeting with the practices to discuss how the practices can work better together and help management of patients going forward. A date for their meeting has been set for 21st November.

In Corsham & Box and in Royal Wootton Basset, homes are getting regular visits and Malmesbury is working hard to review how they manage their relationships with their care homes, one of which (Athelstan House) is the largest in the region.

In East Kennet, all care homes have a named GP who leads on the care provided in these homes. The GPs perform weekly rounds and they have fortnightly rounds by the community Consultant Geriatrician. The pilot initiative to have the Geriatrician visit the care home has now been rolled out across all East based care homes and it is envisaged that the corresponding reduction in admissions as a result will be evident in the remaining care homes not previously covered. Practices in the East and the North are also introducing the 'Allow a Natural Death' form which is a much better and more appropriate form. In the East, every care home patient has an End of Life Plan in place.

During practice visits, all practices have been explaining how they are working with their local care homes to avoid unnecessary admissions. The NEW executive has supported a 'Headroom Bid' for funding from the GWH community team to extend the cover of the Community Geriatrician service across North Wiltshire.

In September 2013 all practices received a letter from the Executive GPs reinforcing the SLA and the need to work closely with their care homes to manage their frail elderly patients. Practices are required to continuously monitor admissions of their patients from care homes into hospital and to consider whether they could have done anything different to prevent an admission.

Practices have submitted details of the numbers of patients in care homes as at 1st April 2013 in order to qualify for half of the additional funds available from the SLA for this additional work. Practices will be paid £45.50 per patient. The remaining funds will be paid at the end of the financial year and practices will be required to submit a report detailing all progress, actions and performance against the criteria laid down in the SLA. The end of year report by each practice will also contain a list of all patients that have been admitted to hospital over the period with the following information:

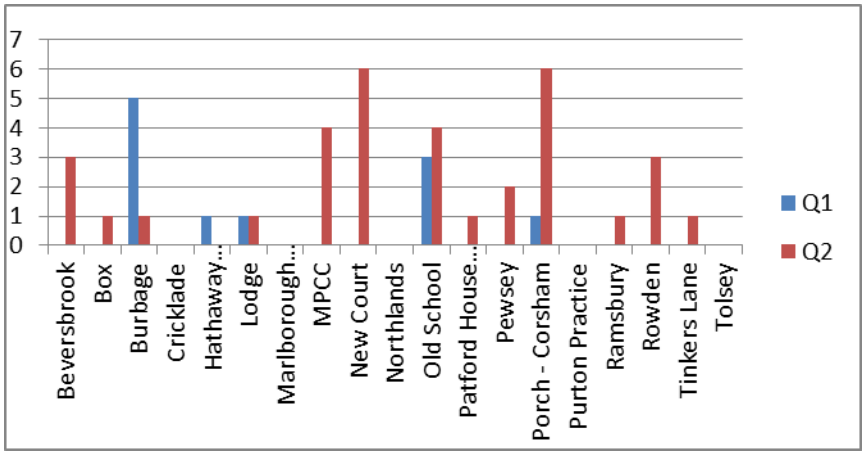
Patient NHS number	Admission date	Time of admission	Person responsible for Admission	Reason for Admission	Outcome

Care home admission data is also reviewed at the monthly Executive FIQ meetings. The SLA has contributed to improving the links between practices and the care homes they support; all practices now visit care homes regularly and practices are proactively looking to build on existing links with care homes to provide more support to assist in reducing avoidable admissions to secondary care whilst improving the quality of care and particularly palliative care.

The overall aim is to reduce unnecessary admissions for patients by ensuring medical care is delivered to them where they are living, rather than in a hospital setting.

Additional Work

Dementia - All the NEW practices have signed up to the dementia LES. GP's have started identifying new 'at risk' patients and undertaking assessments (as part of the DES) followed by diagnosis and prescribing of the acetyl-cholinesterase inhibitor Donepezil where appropriate (as part of the LES). Most practices are reporting single digit diagnoses and prescribing for the period July – September 2013. The number of newly diagnosed patients prescribed Donepezil within NEW over this period is 35.



It's good news to see that referrals from primary care into specialist memory services have been declining, from 12 referrals in July to 9 in August and 3 in September. The training within the practices supported by AWP Memory Nurses appears to be working successfully. The aim is to refer only those unstable or complex cases to specialist memory services. AWP's commitment to maintaining specialist assessments within 4 weeks of referral and treatment within 13 weeks is currently being met.

Patients being repatriated from specialist memory services are spread evenly across NEW, totalling 34 in number over October. We expect to see this number decline over the coming months.

The dementia adviser service commissioned by Wiltshire Council and Wiltshire CCG is provided by Alzheimer's Support (west and east Wiltshire) and Alzheimer's Society (north and south Wiltshire). It provides a personalised information and guidance service to people with dementia and their carers. There are eight advisers in total who work across the county with a particular focus on primary care and the memory service. From 1st May to 31st Sept 2013, 302 county wide referrals were received and 298 people have been provided with information support plans and a third have had these updated since initial development. The majority of referrals have come from individuals themselves contacting the service (36%) and from GPs (27%).

Conclusion

We continue to have good engagement from all Practices with Commissioning but it should be noted that this has been against the background of considerable additional work which has been put onto GPs over the last 12 months adding strain to both the clinical and administrative staff.

Examples of the recent additional work include

1) CQC – all practices have had to submit reports to the CQC and many have been visited by the CQC Officers which has involved both clinical and non-clinical staff.
2) Changes to GP payment. We now receive practice income from CCG, NHS England and Public Health. There have been considerable problems with reconciling payments with this change as well as payments being late or omitted.
3) Care.data – this is a national campaign involving GP practices – all patients are to be made aware that from Spring 2014 automatic data extractions will begin from Clinical systems to hscic for research purposes.
4) EDSM – Enhanced Data Sharing Module – this currently only affects SystmOne practices and requires a member of staff (preferably a Clinician) to have a conversation with each patient to decide whether they would like their medical record shared with other TPP sites such as: hospitals, walk in centres, care homes, stop smoking clinics etc. Details are not yet clarified on how practices will actually implement this due to the time involved in having these discussions with each patient.
5) CQRS/GPES – QMAS has been closed as of April 2013 and "transferred" to CQRS/GPES. This is the new mechanism of extracting data for payments to GP practices for Enhanced Services such as Rotavirus and Learning Disabilities etc.