GUIDANCE ON EXCEPTION REPORTING

October 2006

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1. Purpose of Guidance

1.1 Exception reporting was introduced into the Quality and Outcomes Framework (QOF) in order to allow practices to pursue the quality improvement agenda and not be penalised, where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.

1.2 It has become clear that a variety of interpretations and applications of the nationally defined exception reporting criteria are possible. NHS Employers and the BMA agreed to issue further guidance regarding what constitutes good practice in exception reporting (see Revisions to the GMS Contract 2006/07, paragraph 1.23). This guidance is designed to provide additional clarity in order to help maintain a consistent approach to exception reporting by practices, PCOs and QOF assessors.

1.3 This guidance is supplementary to and does not overtake existing guidance on QOF. Please see section 5 below for where to access current guidance.

1.4 This guidance is applicable to the year from 1st April 2006 until superseded by revised guidance in subsequent years.

2. Principles

2.1 The overriding principles to follow in deciding to except a patient are that:

- The duty of care remains for all patients, irrespective of exception reporting arrangements
- It is good practice for clinicians to review from time to time those who are excepted from treatment ie to have continuing knowledge of health status and personal health goals
- The decision to exception report must be based on clinical judgement with clear and auditable reasons coded or entered in free text on the patient record
- There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

2.2 This guidance lays out general principles and does not attempt to deal with particular cases or indicators, although examples are given.

2.3 In each case where a patient is exception reported, in addition to recording what must be reported for payment purposes (in accordance with QOF Business Rules), the practice should also ensure that the clinical reason for exception is fully recorded in a way that facilitates an audit in the patient record. This is both in order to manage the care of

that particular patient and for the purpose of verification by the practice or PCT.

3. Definitions

3.1 There is an important distinction to be made between “exclusions” and “exceptions”. This guidance is about “exceptions”.

Exclusions are patients on a particular clinical register, but who *for definitional reasons* are not included in a particular indicator denominator. For example, an indicator (and therefore the denominator) may refer only to patients of a specific age group, patients with a specific status (eg those who smoke), or patients with a specific length of diagnosis, within the register for that clinical area.

Exceptions are patients who are on the disease register, and who would ordinarily be included in the indicator denominator. However they are excepted from the indicator denominator because they meet at least one of the exception criteria set out in the Statement of Financial Entitlements. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice.

3.2 The criteria under which a patient may be excepted from a QOF indicator are set out in QOF Guidance and underpinned in the Statement of Financial Entitlements (see references at section 5). The criteria are as follows:

A. Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding twelve months.

B. Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. terminal illness, extreme frailty.

C. Patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels.

D. Patients who are on maximum tolerated doses of medication whose levels remain sub-optimal.

E. Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, another contraindication or have experienced an adverse reaction.

F. Where a patient has not tolerated medication.

G. Where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records

H. Where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease

I. Where an investigative service or secondary care service is unavailable.

3.2 Although the SFE outlines nine reasons why a patient may be excepted, the national QOF achievement analysis systems (such as QMAS) identify exception reporting against a limited number of codes. For example, criterion A and G are both coded as "informed dissent." Any patient is only excepted once by the system for a given indicator, but any patient's clinical record could contain more than one kind of exception reporting Read code entered by the practices. It is therefore not possible to extract accurate or meaningful data on exceptions broken down by each of the criteria defined in the SFE from the national systems. The UK countries will therefore only report the total numbers of patients excepted for each indicator.

3.3 For the purposes of managing the care of the patient and for subsequent audit and verification, it is important that the reason that the patient meets one or more of the criteria for exception reporting set out in the SFE and any underlying clinical reason for this is recorded in the patient's clinical record. For example, where a patient has not tolerated medication, the nature of the contraindication should be recorded in the patient's notes as well as the exception reporting code.

4. Detailed Guidance on Exception Reporting.

Each of the 9 criteria for exception reporting are considered in turn below:

4.1 A. Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding twelve months.

4.1.1 Invitations to attend must be patient specific and can be in writing or by telephone. They can take the form of an individual note at the foot of the patient's prescription requesting them to attend for review.

4.1.2 The three invitations must have taken place within the year in question. Thus invitations must have been made in the period 1st April 2006 to 31st March 2007 if applying to the year 2006/07. There must be three separate invitations at three unique periods of time.

4.1.3 The telephone call invitation may lead to the application of exception criteria G**, informed dissent**, if the patient refuses to take up the invitation to attend.

4.1.4 The following are examples that are **not** acceptable as an invitation:

(i) A generic invitation on the right hand side of the script to attend for eg flu vaccination.
(ii) A notice in the waiting room inviting particular groups of patient to attend (eg for flu immunisation).

4.1.5 Exceptions reporting for flu vaccination has caused some confusion because flu vaccination is also remunerated through a DES. For the DES, payment is based on the number of at risk patients immunised. The DES nevertheless requires the contractor to develop a proactive approach and a robust call and reminder system for the at risk groups.

4.1.6 For the QOF, payment is based on the percentage of patients immunised in each relevant disease area. Exception reporting rules apply and patients need to have been personally invited on at least 3 occasions that year to be excluded from the denominator for achievement under criterion A.

4.2 B. Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances eg terminal illness, extreme frailty.

4.2.1 The overriding principle is that blanket exception reporting is **not** acceptable and that individual decisions based on clinical judgment should be made.

4.2.2 Thus it is not acceptable to exclude all patients above a certain age or all those with a particular diagnosis, eg dementia or cancer. However, age, diagnosis, co-morbidity, health and functional status should be taken into account when deciding whether to exception report patients under this criterion.

4.2.3 In each individual case there is a question of degree which requires clinical judgement to be exercised.

4.3 C. Patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months eg blood pressure or cholesterol measurements within target levels.

4.3.1 Exception reporting is done automatically through the national achievement analysis systems.

4.4 D. Patients who are on maximum tolerated doses of medication whose levels remain sub-optimal:

4.4.1 Again, the over-riding principle is that blanket exception reporting is not acceptable and each case is to be considered on its own merits, making a clinical judgment (see 4.2 above).

4.4.2 Thus it is not acceptable to exclude all patients who are under the care of a consultant. Each case needs to be carefully considered and all reasonable efforts made to provide optimal care.

4.4.3 Even if the patient is under consultant care only, the practice must ensure it has evidence that all the requirements of the contract have been carried out. If this evidence is not available, the practice must assume that the action has not been carried out. The patient should not be exception reported on the basis that they are under consultant care. The practice should either fulfil the requirements or obtain evidence from secondary care that the particular test/check has been carried out. Where the secondary care clinician, in agreement with the primary care clinician, has exercised clinical judgement and decided further action or testing is inappropriate, exception reporting will be allowed. This should be noted in the patient record.

4.5 E. Patients for whom prescribing a medication is not clinically appropriate eg those who have an allergy, another contraindication or have experienced an adverse reaction.

4.5.1 The nature of the contraindication, allergy or adverse drug reaction should be recorded in the patient's notes as well as the exception reporting code.

4.6 F. Where a patient has not tolerated medication:

4.6.1 The nature of the intolerance should be recorded in the patient's notes as well as the exception reporting code.

4.7 G. Where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records.

4.7.1 A personal contact or discussion should be documented in the patient records for this criterion to apply. This can include either face to face or telephone contacts between a health professional and the patient.

4.7.2 Patients not responding to invitations to attend or failing to arrive at appointments cannot be exception reported under G, ie DNA alone does not fulfil the criterion for informed dissent. Patients failing to respond after 3 invitations can be exception reported under criterion A.

4.7.3 The informed dissent must have been given in the period 1st January 2006 to 31st March 2007 if applying to the current year (2006/7).

4.8 H. Where the patient has a supervening condition which makes treatment of their condition inappropriate eg cholesterol reduction where the patient has liver disease.

4.8.1 The nature of the supervening condition should be recorded in the patient's notes as well as the exception reporting code.

4.9 I. Where an investigative or secondary care service is unavailable.

4.9.1 In the event a practice indicates an investigative or other specialist service is not available, agreement should be reached through the office of the PCO Medical Director that exception reporting is appropriate.

5. Guidance on QOF

5.1.1 England

Current guidance on QOF can be accessed through the Primary Care Contracting website at http://www.primarycarecontracting.nhs.uk

The criteria for exception reporting are set out in Annex 1 to Revisions to the GMS Contract 2006/07, available from the Primary Care Contracting website: http://www.primarycarecontracting.nhs.uk). These are legally underpinned in the Statement of Financial Entitlements (see the consolidated SFE Text as at 1 April 2006, available from the Department of Health website www.dh.gov.uk).

5.1.2 Wales

Current guidance on QOF can be accessed through the Howis GMS Contract website:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=6063

The criteria for exception reporting are set out in Annex 1 to Revisions to the GMS Contract 2006/07 Wales, available at:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=12414

These are legally underpinned in the Statement of Financial Entitlements (see the consolidated SFE Text as at 1 April 2006, available at:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=6070

5.1.3 Scotland

Current guidance on QOF can be accessed through 'Scotland's Health on the Web' (SHOW) at http://www.show.scot.nhs.uk

The criteria for exception reporting are set out in Annex 1 to 'Revision to the GMS Contract 2006/07: Delivering Investment in General Practice - Scottish Guidance'. This document along with the 2006 Statement of Financial Entitlements (SFE) (as at 1 April 2006) are also available from the SHOW website, at the following links:

'Revision to the GMS Contract 2006/07: Delivering Investment in General Practice- Scottish Guidance'
http://www.sehd.scot.nhs.uk/pca/PCA2006(M)13.pdf

Statement of Financial Entitlements (SFE) 2006
http://www.sehd.scot.nhs.uk/pca/PCA2006(M)11.pdf

5.1.4 Northern Ireland

Current guidance on QOF can be accessed through the Department of Health, Social Services and Public Safety at http://www.dhsspsni.gov.uk/gp_contract_qof

6. Contact for further information

6.1.1 England

If you are from a practice, you may wish to contact your QOF or Primary Care Lead at your PCT,

If you are from a PCT, you may wish to contact your Primary Care Contracting advisor. For contact details of Primary Care Contracting Advisors please visit the PCC website:

http://www.primarycarecontracting.nhs.uk

6.1.2 Wales

If you are from a practice, you may wish to contact your QOF or Primary Care Lead at your LHB. LHB contact details can be found on the Howis website at: http://www.wales.nhs.uk/catorgs.cfm#5

If you are from a LHB, you may wish to contact the Welsh Assembly Government - General Medical Services branch, you can do so by emailing gmscontract@wales.gsi.gov.uk

6.1.3 Scotland

If you are from a GP practice and have any queries about this exception reporting guidance you should contact your primary care contracting lead in your NHS Health Board in the first instance.

If you work for a NHS Health Board and have any queries about this guidance you should contact Dr Nadine Harrison, Medical Adviser, Scottish Executive Health Department at Nadine.Harrison@scotland.gsi.gov.uk

6.1.4 Northern Ireland

If you are from a GP practice and have any queries about this exception reporting guidance you should contact your QOF Lead in your Health and Social Services Board.