Exception reporting

Exception reporting is intended to allow practices to “achieve” quality improvement indicators without being penalised for patient specific clinical circumstances or other reasons beyond the contractor’s control. For example, where a medication cannot be prescribed due to a contra-indication or side-effect, where patients do not attend for review or where secondary care services are not available.

A variety of interpretations and applications of the nationally defined exception reporting criteria are possible. This exception reporting summary is valid from April 2017 and should be read in conjunction with the Statement of Financial Entitlements (SFE)\(^1\) which sets out the legal requirements.

This document is intended to help commissioners and practices understand what constitutes good practice in exception reporting and to provide clarity in order to help maintain a consistent approach to exception reporting.

Principles

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 patients who are excepted from treatment eg to have continuing knowledge of health status and personal health goals
- the decision to exception report should be based on clinical judgement, relevant to the patient, 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.

In each case where a patient is exception reported, in addition to recording what should be reported for payment purposes (in accordance with the Business Rules\(^2\)), the contractor should also ensure that the clinical reason for the exception is fully recorded in a way that will facilitate an audit of the patient record. This is to manage the care of that particular patient and for the purpose of verification.

Definitions

There is an important distinction to be made between ‘exclusions’ and ‘exceptions’.

Exclusions are patients on a 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 SFE. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice.

Although Annex D of the SFE sets out nine reasons why a patient may be exception reported, the Calculating Quality Reporting Service (CQRS) identifies exception reporting against a limited number of codes. For example, criteria A and G are both coded as 'informed dissent' or 'patient refused'. Any patient is only excepted once by the system for a given indicator, but any patient’s clinical record could contain more than one type of exception reporting Read code entered by the contractor. It is therefore not possible to collect completely accurate or meaningful data on exceptions broken down by each of the criteria defined in the SFE from the national systems. Therefore NHS Digital only reports the total numbers of patients excepted for each indicator.

For the purposes of managing patient care and for subsequent audit and verification, it is important that the reason the patient meets one or more of the exception reporting criteria and any underlying clinical reason for this is recorded in the patient’s record. For example, where a patient has not tolerated medication, the nature of the contra-indication should be recorded in the patient’s record as well as the exception reporting code applied.

**Exception reporting criteria**

Patients may be excepted if they fall within the strict criteria detailed below:

- patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the financial year to which the achievement payments relate (except in the case of indicator CS002, where the patient should have been invited on at least three occasions during the period of time specified in the indicator during which achievement is to be measured (eg the preceding five years ending on 31 March in the financial year to which achievement payments relate)
- patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, eg a patient who has a terminal illness or is extremely frail
- patients newly diagnosed or who have recently registered with the contractor 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
- patients who are on maximum tolerated doses of medication whose levels remain sub-optimal
- patients for whom prescribing a medication is not clinically appropriate eg those who have an allergy, contra-indication or have experienced an adverse reaction
- where a patient has not tolerated medication
where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient
- where the patient has a supervening condition which makes treatment of their condition inappropriate eg cholesterol reduction where the patient has liver disease
- where an investigative service or secondary care service is unavailable.

When exception reporting on criteria A and B, these patients are removed from the denominator for all indicators in that disease area where the care had not been delivered.

Example

A contractor with 100 patients on the coronary heart disease (CHD) disease register, of which four patients have been recalled for follow-up on three occasions but have not attended and one patient has become terminally ill with metastatic breast carcinoma during the year, the denominator for reporting would be 95. However, all 100 patients with CHD would be included in the calculation of APDF (practice prevalence). This would apply to all relevant indicators in the CHD set.

Contractors may exception report patients from single indicators if they meet criteria C to I, eg a patient who has HF due to LVSD but who is intolerant of ACE-inhibitors (ACE-I) and ARB could be exception reported from HF003. This would result in the patient being removed from the denominator for that indicator only.

Contractors should report the number of exceptions for each indicator set and individual indicator. Contractors will not be expected to report why individual patients were ‘excepted’ patients from an indicator and this can be identifiable in the patient record.

When an appropriate exception code has been added to the patient record, it applies only to the QOF year in which it was added. If the timeframe defined to deliver the care described in the indicator wording spans more than one QOF year, the exception would need to be added for each relevant QOF year.

**Examples of exception reporting**

Examples of each of the nine criteria for exception reporting are detailed below:

**Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding 12 months**

Invitations to attend a review should be made to the individual patient and can be in writing or by telephone. This can include a note at the foot of the patient's prescription requesting that they attend for review.

The three invitations need to have taken place within the financial year in question (eg 1 April 2017 to 31 March 2018 if applying to the year 2016/17). There should be three separate invitations at three unique periods of time. The only exception to this rule is indicator CS002, where the period in which the three invitations are sent reflects the timeframe of the indicator eg five years.
Practices may make use of methods other than written letters to offer patient appointments. However, this must be with the explicit consent of the patient concerned and their acceptance to be contacted via another media. The invitation must also be specific to individual patient. For example:

‘appointment for patient x, at 00.00, on DD/MM/YYYY, at practice Y’

A 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.

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

- a generic invitation on the right hand side of the script to attend a clinic or an appointment eg influenza immunisation
- a notice in the waiting room inviting particular groups of patient to attend clinics or make appointments (eg influenza immunisation).

**Influenza immunisation indicators**

Exception reporting for influenza immunisation can cause confusion as it is also remunerated through a Directed Enhanced Service (DES). For the DES, payment is based on the number of at-risk patients immunised and the DES requires the contractor develop a proactive approach and a robust call and recall system for the at-risk groups.

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

**Cervical screening indicators**

Exception reporting (as detailed in the clinical domain) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

The exception reporting rules regarding criteria A require that three separate invitations are offered to the patient before that patient can be recorded as 'did not attend'. Therefore:

- in those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation before exception reporting patients as DNA, or
- where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitations before exception reporting patients as DNA.

The exception reporting criteria is not applicable to contractors that have opted to run their own call/recall system. These contractors will still be required to offer all three invitations directly in order to meet the DNA criteria. Copies of the letters sent by the contractor may be required for assessment purposes.

Women can choose to withdraw from the national screening programme. As the indicator requires that screening is delivered every five years, in order for a woman to be
exception reported for this period, criteria G which requires that a discussion has taken place between the patient and the practitioner before 'informed dissent' can be recorded.

Women who withdraw from cervical screening call/recall will receive no further offers of screening from the central screening service.

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

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

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 individual patients under this criteria.

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

**Patients newly diagnosed or who have recently registered with the contractor, 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**

Exception reporting is done automatically through CQRS. Where the contractor has delivered the appropriate clinical standard within the timeframe for the indicator, the achievement would automatically override the exception.

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

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 criteria B).

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.

Even when a patient is under the care of a consultant only, the contractor should ensure it has evidence that all the requirements of the contract have been carried out. If this evidence is not available, the contractor should assume that the action has not been carried out. The patient should not be exception reported on the basis that they are under the care of a consultant. The contractor should either fulfil the requirements of the relevant indicator(s) 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.

**Patients for whom prescribing a medication is not clinically appropriate eg those who have an allergy, another contra-indication or have experienced an adverse reaction**
The nature of the contra-indication, allergy or adverse drug reaction should be recorded in the patient record as well as the exception reporting code applied.

**Where a patient has not tolerated medication**

The nature of the intolerance should be recorded in the patient record as well as the exception reporting code applied.

**Where a patient does not agree to investigation or treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient**

A personal contact or discussion should be documented in the patient's record for this criteria to apply. This can include face-to-face, video conferencing or telephone contact between a health professional and the patient. These methods of communication relate to the informed dissent discussion only, they do not apply to consultations.

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

The informed dissent should have been given in the period 1 April 2017 to 31 March 2018 if applying to the year 2017/18) (except cervical screening where a patient has withdrawn from the call and recall system).

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

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

**Where an investigative or secondary care service is unavailable**

The contractor would be expected to explore fully with their CCG, whether or not a suitable investigative or secondary service could be commissioned for the patient prior to deciding to except them on the basis that the service was unavailable.