

Quality and Outcomes Framework

The West Midlands Guide for
2009-10

Context

The West Midlands Quality and Outcomes Framework Guide for 2009/10 is the result of revision of the West Midlands Quality and Outcomes Framework Guide for 2007/08. The revision was undertaken by a Working Group of clinical and managerial QOF assessors from a number of West Midlands PCTs, representatives from NHS Primary Care Commissioning and a representative from NHS West Midlands and with input from the West Midlands General Practitioners Committee (see appendix 1).

It builds on the 2007/08 Guide, reflects the nationally negotiated changes for QOF for 2008/09 and 2009/10, and incorporates the learning and experiences of both PCTs and GP practices over the past few years.

This Guide represents professional and managerial consensus but must be read in the context of the GMS regulatory framework, the Quality and Outcomes Dataset and Business Rules and national guidance as set out in the 'Quality and Outcomes Framework guidance for GMS contract 2009/10 – delivering investment in general practice', March 2009.

PCTs may wish to refer to a QOF management guide; a suite of three documents published by NHS Primary Care Commissioning. Volume 1 is a simple interactive guide to QOF, volume 2 QOF an in depth guide to QOF assessment and volume 3 a detailed run through each individual QOF indicator.

http://www.pcc.nhs.uk/uploads/QOF/2009/qof_management_guide_vol_1.pdf

<http://www.pcc.nhs.uk/uploads/QOF/2009/qofmanagguide2-jan09.pdf>

http://www.pcc.nhs.uk/uploads/QOF/2009/qof_management_guide_vol3.pdf

Purpose

The West Midlands Quality and Outcomes Framework Guide 2009/10 has been developed specifically for the West Midlands region; for PCT QOF Leads, PCT QOF assessors and managers and GP practices. However the Guide may also be useful nationally.

The aim of the Guide is to ensure that across the West Midlands there is shared understanding by PCTs and their practices of the principles underpinning the QOF review process. Namely that there is:-

- clear understanding by GP practices of what is expected of them in delivering QOF indicators consistent with national guidance
- transparency, consistency and fairness in approach to satisfy internal and external audit requirements at PCTs
- appropriate use of, and accountability for, public money
- consistency of approach towards the application of the Statement of Financial Entitlement

- quality improvement and high quality care for all patients
- The Guide provides clarity and guidance:-
- for practices working towards the achievement of QOF indicators throughout the year – with particular reference to the new indicators for 2009/10 and the development of principles or standards for PCTs/practices, following the pattern established for 2007/08
- for PCTs working with practices throughout the year to deliver their aspirations for QOF
- for PCT QOF Leads and QOF assessors in planning and undertaking QOF reviews
- for PCT QOF Leads and QOF assessors in confirming the accuracy of data collection and quality of data collection in the determination of achievement, and
- a focus on disease register construction, prevalence and exception reporting

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Introduction

The Quality and Outcome Framework was introduced in April 2004 as a voluntary part of the new GP Contract. The intention was to drive up the quality of care for patients in primary care and reward general practice for demonstrating the delivery of care.

As a result to the changes to QOF for 2009/10 there is a strengthening of the clinical indicators without compromising any other aspect of care. There should also be greater encouragement for, and significant improvements to, case finding those patients who will benefit from QOF indicators as payment for higher prevalence will be full rewarded.

All the new clinical indicators will be reviewed prior to the 2011/12 contract year. Indicators may be changed or removed if they have not proved effective.

The expectation for the QOF was that it would be developmental for practices over time. As practices enter year 6, NHS West Midlands and NHS Primary Care Commissioning have refreshed the 2007/08 Guide and again seek to provide clarity for practices, PCT QOF assessors and managers, around some of the indicators, where there have previously been queries raised or varying standards accepted. Practices are normally expected to achieve these levels in order to qualify for payment on QOF indicators in 2009/10. This clarification and consistent NHS West Midlands approach supports both protects highly achieving practices and supports less well achieving practices to improve, to the benefit of their patients.

The characteristics of the standards are that they are

- developed by consensus with representatives from, West Midlands GPs and experienced PCT QOF leads, NHS Primary Care Commissioning and NHS West Midlands
- drawn largely from national guidance and consensus statements,
- clarifying good practice
- achievable over time – as was intended in the original QOF.

These standards will be used to ensure fairness and consistency across the West Midlands where there is evidence that national criteria have been met, If a PCT identifies that a practice has not achieved the intention expressed through the QOF indicator and the associated QOF guidance it may reduce the automated award payment. The PCT may also increase an award where there is evidence to support this. There should be a clear audit trail to support such changes.

Summary

The Guide sets out principles on disease register construction, exception reporting, prevalence and confidentiality as general themes and then hones down to certain individual indicators. The paper should be used alongside the latest QOF guidance for 2009/10; the 'Quality and Outcomes Framework guidance for GMS contract 2009/10 – delivering investment in general practice', March 2009 and the current version of the QOF Dataset and Business Rules and the three QOF management guides produced by NHS Primary Care Commissioning.

Disease register construction and prevalence issues

Accurate disease register construction and maintenance is important because it enables patients with long term conditions to access appropriate interventions from primary and secondary care.

Patients with long term conditions require active clinical management, and unless patients are identified, either with high risk or established diseases and registered, they cannot benefit from interventions.

Across the West Midlands, there is considerable variation between reported prevalence (as recorded on QOF disease registers) and estimated prevalence¹

West Midlands – Good Practice Principle

Practices should have standards and procedures for the accurate construction and maintenance of disease registers with reference to current evidence based medicine and acceptable medical practice. Procedures should ensure that patients are added or removed where the register requirement has changed or in instances where the condition has resolved. It is important for practices to adhere to the QOF guidance and to the principles as set out in the original IM & T DES as the quality of the data is critical for the quality care of patients. Many practices will have been accredited for component 2 of the DES, but this accreditation is only for a time limited period. Practices should be subject to ongoing data quality reviews, using available tools, for examples via PRIMIS.

Many practices will have developed disease registers years before QOF was established, and for these registers it may be inappropriate to ask how the register was developed. The focus should be on maintenance and accuracy, for example, practice protocols and validation processes.

There may be significant improvements in case finding from a change in the payments calculation. This was highlighted in Mark Wilson, NHS PCC Specialist Advisor's paper ['Analysis of the QOF Changes Agreed by the GPC and NHS Employers for the 2009/10 GMS contract'](#).

"In the past the incentives have been dampened by the technical device of applying a square root to prevalence in the payment equation. From now on there is greater encouragement to case find those patients who will benefit from the QOF indicators as payment for higher prevalence will be fully rewarded".

¹ Across 17 PCTs in the West Midlands

Up to 50% of the population predicted to have CHD are missing from practice registers

Over 20% of the population predicted to have diabetes missing from practice registers

More than half of the population expected to have CKD are missing from practice registers

The removal of the 5% trim point in 2010/11 is a further encouragement. Conversely there is also a risk that practices will lower their diagnostic thresholds or fail to remove patients from a register when the condition has resolved e.g. asthma register”.

This means that registers are even more important - achieving the expected prevalence means that a practice will have identified all of the population that can benefit from care within the QOF.

As part of the QOF review process for 2009/10 PCTs are advised to review changes to policies and procedures for disease register construction and maintenance, and examine whether these have been implemented.

Register development should be populated from

- coded and confirmed diagnosis
- at records summarisation or review
- drug searches
- case finding exercises

Practices should be able to demonstrate that there is active management of the register – those based on pure Codes² searches may not be sufficient. Where conditions are episodic or have the potential to resolve e.g. asthma, active management of the target population/register will need to incorporate ongoing review of the patient to ensure that resolution is coded. In some cases this may involve a review of historical diagnoses.

There are resolution codes for patients who may need to be removed from the register, for example asthma and diabetes. Although it is rare for a patient to be removed from the diabetic register. For Mental Illness there are no acceptable codes for ‘resolution’, and therefore it is agreed that patients with a resolved SEMI should be excepted on an individual basis. To ensure that this is fairly applied practices will be assessed on the validity of their exceptions.

Practices should be aware that different disease registers will require different coding requirements and where clinical systems support episodic management of patients these requirements should be used.

Standards of the following registers may require the greatest attention

Hypertension

Specific concern has been raised in respect of the hypertension register:

“Elevated blood pressure readings on three separate occasions are generally taken to confirm sustained high blood pressure.”

The separate occasions should be separate attendances over at least two weeks (unless the hypertension is clearly markedly elevated and immediate drug therapy is clinically indicated). Blood pressure should be taken by a trained observer, after five minutes rest, with the arm horizontal.

² Codes may be READ, CTV3, SNOMED CT

Chronic Kidney Disease

Patients are added to the CKD register when a diagnosis of CKD stage 3-5 is added to their medical record. This diagnosis should be made on the basis of at least two separate readings of an eGFR <60 over a three months period. Once a diagnosis of CKD has been made on the basis of a persistent eGFR <60 then the diagnosis should continue to apply even if future management leads to an improvement in eGFR (The Quality and Outcomes Framework guidance for GMS Contract 2009/10 p. 102/ 103).

Depression

The depression indicators are supported by two underlying registers. The register for DEP1 is the sum of the CHD and diabetes registers. Patients who appear on both registers are only counted once.

The underpinning target population for DEP2 and DEP3 is the total number of patients in the practice with an active diagnosis of depression. It is the total number of patients in the underpinning target population that is used to calculate prevalence. It is therefore important that this is maintained accurately. There has been some concern about the wide range of prevalence. One possible cause is that individual system suppliers are interpreting the extraction differently.

An active diagnosis is one which has not been recorded as being resolved. As well as ensuring that patients with new depression diagnoses are recorded as such, practices should review their ongoing depression diagnoses to ensure that patients whose condition has resolved have been coded appropriately.

Palliative Care

PCTs and their practices are reminded that from April 2008, Palliative Care Registers applies to patients of all ages.

Work undertaken in the West Midlands has demonstrated that on average 1% of patients on a practice list die each year. 56% of patients die in hospital and 20% in care homes which are in contradiction to the research that indicates 91% of patients would wish to die at home. The accuracy of this register and engagement with the multidisciplinary team may improve the end of life care for a number of patients.

Exception reporting

Exception reporting is intended to allow a record of where care cannot be delivered for any of the reasons detailed in the QOF guidance. Exception reporting may also affect QOF Achievement Payments. Figures published by the Information Centre demonstrate considerable variation at both PCT and practice levels. The Quality and Outcomes 2007/08 Exception Report can be found at www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework/the-quality-and-outcomes-2007-08-exception-report

West Midlands – Good Practice Principle

The focus in this section of the guide is on clinical decision making in respect of exception reporting for specific patients. The following principles should be taken into account:

- The duty of care remains for all patients, irrespective of exception reporting arrangements
- It is good practice for clinicians to review those patients from time to time who are excepted from treatment i.e. to have continuing knowledge of health status and personal health goals; an understanding of the technical, clinical and patient factors.. Whilst the most appropriate timeframe will depend upon the specific case, when the reason for exception is non-permanent, it would normally be reasonable for this review to be undertaken on a 15 month basis as a minimum.
- The decision to exception report must be based on clinical judgement with clear and auditable underlying reasons coded. To ensure a robust audit trail, practices are advised to include a full explanation of the reason for an exception report in free text, where there is no clear code available. Practices are advised that prior to sign off by the practice of its achievement, it may be sensible for a GP to review all exception codes at the year end, to ensure that inappropriate codes are removed and to ensure that free text supports the exception codes where appropriate
- 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.

PCTs should encourage their practices to develop a policy for exception reporting to ensure consistency within the practice and to support locum clinicians, as described in volume 2 of the NHS PCC QOF management guide.

The **standards** used in this document are drawn from the BMA/NHS Employers' guidance on exception reporting on the BMA website. www.bma.org.uk/employmentandcontracts/independent_contractors/quality_outcomes_framework/exceptreportingoct06.jsp

Assessors and practices should be aware of the difference between exceptions and exclusions.

Exception reporting is a feature of the QOF which allows practices to remove patients who would otherwise be eligible for the care described from the denominator of an indicator. There are nine exception reporting criteria which are detailed here (hyperlink to guidance or exception reporting publication). Some of these criteria are applied automatically by the rule set whilst others require the practice to enter an exception code.

Exclusions are patients who are removed from the denominator of an indicator because they are ineligible for the care described in the indicator. For example, CHD2 only applies to patients with a diagnosis of angina after the 1st April 2003. However the CHD register will include patients diagnosed with angina before this date. It is therefore necessary to remove those patients from the denominator. This is done automatically by the rule set. It is conceptually different from exception reporting.

Exception codes will be reviewed by PCTs as part of pre payment prior to the sign off by the PCT of practice achievement. A GP assessor should be involved in this review. Exception reporting will also be a focus for pan West Midlands post payment verification process - 5 % Random QOF Check.

The QMAS system does not currently differentiate from the two, so it is important for PCTs to carry out this analysis as part of the pre payment verification process.

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

Invitations to attend must be patient specific and could be in writing (letter or email) or by telephone (voice or text). They can take the form of an individual note at the foot of the patient's prescription requesting them to attend for review, all of which should be recorded in the patient's medical record.

Three invitations should be made at significant intervals, generally one month, and the method of contact recorded in the patient notes. The three invitations must have taken place within the year in question. Thus invitations must have been made in the period 1st April 2009 to 31st March 2010 if applying to the year 2009/10. There must be three separate invitations at three unique periods of time.

It is normally good practice that if two letters are ignored to attempt telephone contact, for example where the patient has not been seen for some time. The telephone call invitation may lead to the application of exception criteria G, informed dissent, if the patient then refuses to take up the invitation to attend and had received the previous two invitations.

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 e.g. flu vaccination.
- ii. A notice in the waiting room inviting particular groups of patient to attend (e.g. for flu immunisation)³.

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

The overriding principle is that blanket exception reporting is not acceptable to exclude all patients above a certain age or all those with a particular diagnosis, e.g. dementia or cancer.

Age, diagnosis, co-morbidity, health and functional status are taken into account when deciding whether to exception report patients under this criterion and a clear reason recorded for the exception.

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

The principle is that blanket exception reporting is not acceptable and each case is to be considered on its own merits, making a clinical judgment. 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.

³ NB The DES for flu requires the contractor to develop a proactive approach and a robust call and reminder system for the at risk groups.

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 and the information recorded in the patient notes. Where the secondary care clinician, in agreement with the primary care clinician, has exercised clinical judgement and decided further action or testing is inappropriate, this should be noted in the patient record.

It would not be correct, for example, to exception code a hypertensive patient whose blood pressure remains poorly controlled if they had failed to respond to only one drug, or one step up in the hypertension protocol

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

The contraindication, allergy or adverse drug reaction should be recorded in the patient notes, as well as the exception reporting code. In line with BMA guidance Native system coding alone should not be used where Read or other codes are available as this will not transfer with the record between systems through GP2GP. Again the decision to exception report should be made on the basis of an individual patient review and supported by free text, rather than a blanket exception e.g. exception reporting all patients with asthma from the indicators relating to beta-blocker prescribing, a relative rather than an absolute contraindication.

F. Where a patient has not tolerated medication:

The nature of the intolerance should be recorded in free text in the patient notes, as well as the exception reporting code.

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

A personal contact or discussion should be documented in the patient records for this criterion to apply, stating the grounds for dissent. The informed dissent must have been given in the period 1st January 2009 to 31st March 2010 if applying to the current year (2009/10).

This can include either face-to-face or telephone contacts between a health professional and the patient. A dated letter from the patient can also be used. It is good practice for this to be face-to-face, where possible.

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

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

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

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

In the event a practice indicates an investigative or other specialist service is not available, Agreement to except should be with the office of the PCT, in consultation with the LMC.

Clinical indicators

The purpose of this guide is to help to solve problems in standards and assessment. New indicators have been included where we might expect to see issues to be raised. Extensive advice on individual indicators, including 2009 -10, is available in QOF Management Guide Volume 3 and Amendments to the Guide 3a

Diabetes mellitus

Retinal screening provision and completion continues to be a problem and practices should ensure that patients are appropriately referred and that screening has occurred where ever possible.

DM23

The percentage of patients with diabetes in whom the last HbA1c is 7 or less (or equivalent test/ reference range depending upon local laboratory) in the previous 15 months

DM24

The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/ reference range depending upon local laboratory) in the previous 15 months

DM25

The percentage of patients with diabetes in whom the last HbA1c is 9 or less (or equivalent test/ reference range depending upon local laboratory) in the previous 15 months

During 2009/10 laboratories are moving to reporting the results of AbA1C in mmol/litre. The Business Rules currently support both reporting methods. Practices should ensure that where they manually enter an HbA1c result that the correct code is used for either DCCT or IFCC HbA1c.

Mental Health

MH 5

The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous six months

West Midlands – Good Practice Principle

If the practice has no patients on lithium – there should not be a payment made under this indicator. If the practice can demonstrate that a different therapeutic range is appropriate for that patient which is different to that registered on QMAS local changes may be required.

MH 6

The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate

West Midlands – Good Practice Principle

It should be recognised that the care plan is a separate process from the annual review, but that the annual review may be used to update the care plan. Patients under the care of secondary services should have a documented care plan developed as part of the Care Programme Approach. This is acceptable for the QOF as long as a copy is kept within the general practice record. Practices can produce a 'Patient Care Audit' in line with NICE guidance.

MH9

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status

West Midlands – Good Practice Principle

Whilst the exact composition for each review will vary with the patient they might be expected to include an assessment – and recording in the clinical record - of some of the following:

- Issues relating to drug or alcohol use
- Smoking and BP recording
- Cholesterol checks
- Weight/BMI recording
- Diabetes risk from olanzepine and risperidone
- Cervical screening
- Medication review

It is good practice for this review to be undertaken as a face to face consultation by a healthcare professional. Where elements of the review have not been undertaken then this decision should be supported by free text in the patient record.

MH7

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance

West Midlands – Good Practice Principle

If a practice does not have any patients who DNA their annual review then they will not be eligible for the points associated with this indicator. Non-attendance at follow-up appointments can be an indication of a deterioration in mental health which should be followed up. In this case follow up should be through telephone contact or a visit, or if the patient is in contact with secondary care a discussion with their key worker. It would be good practice for this follow-up to be undertaken by a healthcare professional.

Asthma

Asthma 1

The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months

West Midlands – Good Practice Principle

The practice should demonstrate how in order to fulfil this indicator they have undertaken a review, on at least one occasion during the year. All patients on the register should have a clear diagnosis, recognising that the disease may change.

Asthma 6

The percentage of patients with asthma who have had an asthma review in the previous 15 months

West Midlands – Good Practice Principle

It is expected that there is documentary evidence of the review. Within any review there should be a review of the inhaler technique carried out face to face with an appropriately trained health care professional⁴.

Depression 1

The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions.

⁴ From 2009-10 national guidance; Summary of Asthma Review:

- assess symptoms (using RCP 3 questions)
- measure peak flow
- assess inhaler technique
- consider personalised asthma plan.

West Midlands – Good Practice Principle

The screening questions should be completed by a GP or a registered healthcare professional ideally this would be part of a face to face consultation.

Depression 2

In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care

Depression 3

In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April and 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care.

West Midlands – Good Practice Principle

It is acceptable for the PHQ9 to be filled in by the patient and to bring to the surgery to inform the consultation.

From 2009/10 Depression 3 has been included which looks at a further assessment of severity 5-12 weeks after the first assessment (see page 100). Depression 3 can only be met if the patient has also achieved Depression 2. NICE guidance recommends that Patients with a diagnosis of depression should be proactively managed by practices and ideally given follow up appointments before leaving the surgery. Where patients do not attend these appointments then they should be contacted by a health care professional, usually by telephone. It is poor practice to assume that non-attendance is an indicator of improvement. It may in fact indicate deterioration in mental health.

Chronic Kidney Disease

CKD6

The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) test in the previous 15 months

West Midlands – Good Practice Principle

This test allows for the quantification of proteinuria and the results should be used to make a diagnosis of this, where appropriate. This diagnosis should be used to identify those patients who also have hypertension who should be treated with an ACE/ ARB. Urine dipstick codes are no longer acceptable as a diagnosis of proteinuria.

Smoking indicator

Smoking 3:

The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder and other psychoses whose notes record smoking status in the previous 15 months. Except those who have never smoked where smoking status need only be recorded once since diagnosis.

Smoking status for patients who are lifelong non smokers needs to be recorded every 15 months but only up to and including 25 years of age, in recognising that life long non smokers are very unlikely to start smoking.

Smoking status for ex-smokers can either be recorded as such in the preceding 15 months, or practices may choose to record ex-smoking status on an annual basis for three consecutive years, thereafter smoking status may only need to be recorded if there is a change. In this instance QOF years should be interpreted as a 12 month period.

Smoking 4:

The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months

West Midlands – Good Practice Principle

As the national guidance says “The recording of advice given does not necessarily reflect the quality of the intervention. It is therefore proposed that only smoking advice should be part of the reporting framework. Clinicians may choose to record advice given in relation to other modifiable risk factors.”

Successfully supporting patients to stop smoking depends on the readiness of the patient to change. Where appropriate patients should be offered advice, the options available and the ‘next steps’ for quitting. All of this should relate back to the practice’s Smoking cessation policy- which should be clear, with comprehensive alternatives and updated in line with new services and treatment options at least annually. (see Information indicator 5).

These indicators now require patients to be categorised as either those who have never smoked, current smokers or ex-smokers. Because of this the codes for current non-smokers have been withdrawn as they cannot consistently be classified into one of these three groups.

Repeat Dispensing

Practices using repeat dispensing may have problems with various areas of the QOF, which rely upon treatment given within a certain time.

For example prescription of Beta-Blockers and ACE/A2RB drugs in the CHD area must occur during the penultimate six months of a year. If a Repeat Dispensing prescription has been issued prior to this period then a practice may appear not to qualify. This is a known problem and it is appropriate for a practice to use an appropriate device (e.g. issue a one off prescription or record hand written prescription) until a definitive electronic solution as part of the D&BRs is found.

Similar problems occur in the Asthma and hypothyroidism areas due to the linkage of treatment to the inclusion of a patient in the denominators

Confidentiality

Patient confidentiality should be considered in respect of all QOF developmental, assessment and 5% random check visits.

Guidance produced by the Department of Health can be found at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4107304.pdf

In nearly all circumstances, patient data should be anonymous. Contractors and PCTs should ensure that they comply with the Confidentiality and Disclosure of Information: General Medical Services (GMS), Personal Medical Services (PMS, and Alternative Provider Medical Services (APMS) Code of Practice, which is intended to ensure compliance with current legislation and is referred to in Directions. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4107303

In paragraph 30 (i) the code states that

“where the practice is unable to anonymise data that is needed to support the wider functioning of the NHS, including the management of healthcare services, such as the QOF annual review process. For example, this may be where the practice does not possess an IT system which can ensure complete anonymisation, or where it is not practicable to anonymise paper records - such as where this would require substantial additional work on the part of the practice, or where the practice cannot guarantee to erase all identifying information. The practice should make a judgement in the context of each request for information as to whether or not anonymisation is practicable. Where anonymisation is not practicable, data may be released to the PCT in patient identifiable form (but see paragraph 32).”

And paragraph 32 says that

“Where the patient’s consent is not sought to identifiable information, the reasons why must be documented and there must be a clear audit trail. The NHS Code of Practice on Confidentiality provides further guidance about access to and disclosure of patient-identifiable information. Where a practice is making a disclosure on the basis that it is justified in the public interest (eg to prevent abuse or serious harm to others) and that the public good which would be achieved by disclosure outweighs the obligation of confidentiality to the individual patient concerned, such a disclosure should be proportionate and limited to relevant details. Contractors should be prepared to justify such disclosures to a court or regulatory bodies.”

Every effort should be made to secure an anonymous record. DH procured the [QOF assessor Toolkit](#) software for that purpose and using data extraction software that anonymises the record should be the first step. If that is not possible, then patient consent should be specifically sought for selected records. Patient consent is opt in and time limited, not forever. If that is not possible, patient records should be anonymised by photocopying or manually – but this must be effective. Only if these steps cannot be taken, then paragraph 30 of the Code does allow the selection of non-anonymised records.

Practices should share data and information when it is reasonably requested by the PCT; the Statement of Financial Entitlement (SFE) instructs practices to comply with any request to provide data and information. For example paragraph 6.13 (c) states:

“the contractor must ensure that it is able to provide any information that the PCT may reasonably request of it to demonstrate that it is entitled to each Achievement Point to which it says it is entitled, and the contractor must make that information available to the PCT on request;”

As well as the guide for contractors on patient information, PCTs should refer to Confidentiality; NHS Code of Practice. We all would like our confidentiality protected and in most cases that should be so. Health information is intensely personal.

Non clinical Indicators

Non clinical indicators are as important for good patient care as directly measured clinical indicators. They underpin patient care and organisational indicators are the foundation of accreditation programmes.

Policies – general guidance

The most important principles around any practice policies are that they are:

- Relevant and individualised to the practice
- Current, up to date and regularly reviewed
- Workable within the practice
- Understood by those who should be acting on the policy
- Monitored for compliance
- Accessible to those who may need to refer to them

A detailed format and guide is shown in appendix 1, but the practice style will be individual.

When assessing practices the key test is evidence of implementation of the policy and evidence that all staff are aware of the procedures within the policies, understand their role in the process and can act competently and confidently.

Records and Information

Records indicators, 15, 18, 19 and 20 – Notes summarisation

Records 15: The practice has up-to-date clinical summaries in at least 60% of patient records

Records 18: The practice has up-to-date clinical summaries in at least 80% of patient records

Records 19: 80% of newly registered patients have had their notes summarised within eight weeks of receipt by the practice

Records 20: The practice has up-to-date clinical summaries in at least 70% of patient records

West Midlands – Good Practice Principle

There are two distinct parts to records management, the transfer of records from paper records to computer records and the notes summarisation. Many practices are aiming to become 'paper light' but still will need to ensure compliance with medical legal requirements on retaining paper records. Appendix 2 sets out a process for records transfer.

The QOF payment is for a record to have an accurate, easy to navigate, accessible, well maintained and dynamic summary- whether computer generated or written.

Many practices will be accredited as 'paperlight' as part of working towards component 2 of the former IM&T DES. Depending on the robustness of the IM&T DES assessments, this may be a useful indicator for PCTs when considering practice achievement against these notes summarising indicators.

In terms of being easy-to-navigate, accessible and accurate, a simple test which a GP assessor could apply during a visit would be whether as a locum, he/she could safely and easily consult, diagnose, refer and prescribe on the basis of information in the summary.

The Good Practice Guidelines v3.1 (which are expected to be updated to version 4 in 2010) www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4116707.pdf agreed between the BMA and RCGP set out key principles but the summary might include.

1. Family History where relevant to the future care of the patient⁵
2. Operations with the correct date
3. Admissions to and discharges from hospital, the reason for admission and significant episodes during the admission
4. All diagnoses with the most accurate start date possible
5. Significant investigations – even if results are negative – this may help in the future
6. Repeat medications
7. Drug and other major allergies.

The practice should have a policy that sets out its process and links to the Good Practice Guide.

The **principles** are that the policy should state:-

- who is responsible for the summarising (a clinically trained person)
- how often the summaries are maintained/refreshed, and by whom.
- how a practice would deal with incoming records for a newly registered patient, which appear already to have been summarised. (The policy should be clear as to whether the practice simply accepts the Read code and/or whether they feel it is still important for the practice to check the main clinical record, in case the summary has not include some important information – which could ultimately pose some clinical risks.)

PCTs may wish to discuss with practices how long ago the notes were summarised (which can be seen by searching on the Read code).

⁵ This should obviate the impact of introducing second person personal information in terms of their confidentiality

Whilst, there is no absolute right or wrong in terms of summarising policies, the QOF assessors may wish to make a judgement about achievement against these indicators, by examining whether the summarising policy has been used consistently by the practice.

In a minority of cases, some practices are still not fully computerised or indeed GPs are using computers for consultations on an intermittent basis, with some clinical information being recorded in parallel and/or inconsistently on Lloyd George record cards. This technique poses clinical risks if there is no one central place with all of the information being stored. Notes received through GP2GP are likely to have a 'summarised code' within the record. Practices may wish to accept the previous practice's summarisation as being appropriate.

Records indicator 21

Ethnic origin is recorded for 100% of new registrations

West Midlands – Good Practice Principle

To ensure achieving the indicator, the new patient registration form (including registering the newborn) should include a section allowing the patient to either supply their ethnicity or tick a box indicating their refusal to divulge.

Practice staff should not take it upon themselves to determine the ethnicity of a patient.

The indicator should match records 19 – in that ethnicity should be recorded within 8 weeks.

Practices are advised to use the NHS Data Dictionary codes for recording ethnic origin (as per the Ethnicity Directed Enhanced Service). This can be found at:

www.datadictionary.nhs.uk/data_dictionary/attributes/e/enh/ethnic_category_code_de.asp?shownav=1

Information indicator 5

The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy

The strategy does not need to be written by the practice team. A local or national protocol could be adapted for use specifically by the practice and implemented. There should be evidence of posters, information leaflets, links to the recording of smoking status and opportunist follow up. There could be links to Information prescriptions. The assessor team should view supporting material that is handed out to patients.

West Midlands – Good Practice Principle

The practice should be able to demonstrate a practice protocol which will include:

- Date protocol produced and revision date
- Names of person(s) responsible for updating

- Names of persons who should be using the protocol
- Advice for service deliverers on determining the patient's point on the 'change cycle'
- A summary of the risks of smoking that should be given to the patient – in an appropriate format (different levels for age/sex/health condition/pregnancy/ethnicity)
- Practice facilities for providing support
- Local options for attending 'smoking cessation' clinics/ services
- Advice on therapeutic options – including likely costs for the patient

Education indicator 6

The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team

West Midlands – Good Practice Principle

In order to demonstrate a learning culture, practices should consider complaints in their widest sense. Many complaints are dealt with informally either between the individuals concerned or addressed in discussion with members of the practice e.g. the practice manager. Problems may also be raised with the practice via PALS and are often resolved through this route.

Therefore consider:

- Verbal and written complaints that trigger the practice internal complaints system
- Contacts through PALS
- Problems reported through the corporate complaints processes

The written evidence (grade A evidence) required for this indicator is a copy of reports/minutes of team meetings where learning points have been discussed, with a note of the changes made as a result. The annual review should include a summary of each complaint or suggestion and an identification of any learning points which came out of the review. Practices may find it useful to agree at the time of the review how to communicate the learning points to the practice team and identify a named individual responsible for implementing and monitoring the change.

If a practice has received no complaints during the QOF year, the practice may also wish to consider any compliments and/or suggestions made during the year, in order to quality for achievement. In addition, if they can demonstrate that they have met as a practice to review their system for handling complaints, compliments and suggestions and can identify why they might not have received any complaints (which might include involving a patients group) then the PCT could consider this as meeting the indicator requirements. The PCT may wish to consider this as a potential training issue for practices.

Education indicator 7

The practice has undertaken a minimum of 12 significant event reviews in the past three years which could include:

- any death occurring in the practice premises
- new cancer diagnoses
- deaths where terminal care has taken place at home
- any suicides
- any patient admitted under the Mental Health Act
- child protection cases
- medication errors
- a significant event, occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss)

West Midlands – Good Practice Principle

Practices must be able to demonstrate an understanding of the process and the purpose of significant event reviews. It is important that processing significant events is an on-going review for practices with completion taking place during the year as part of a learning and development process. New guidance from the National Patient Safety Agency (NPSA) 'Seven Steps to Patient Safety for Primary Care' highlights the importance of this continuous reporting happening within general practice.

Models and examples of best practice have been viewed nationally to determine the simplest and most effective way to report incidents. A template that practice can use if they do not have a process in place can be found in appendix 3 The example was highlighted by the NPSA 'In Safer Hands' which was a paper developed jointly by the RCGP and the NPSA.

The significant event is not completed until any incidents identified by the practice have a final review to ensure the changes identified by the significant event have been implemented and that they are working. It is best practice that a practice or practice focus group should formally sign off these cases at some stage within the three years.

Practices should submit evidence to show that cases have been considered by the appropriate members of the practice and/or multi-disciplinary team. It may occasionally be appropriate to link to other providers (ie secondary care and other primary care providers).

Practices may want to link this process to their complaints procedure.

PCTs can use the pro-forma contained in appendix 3 to assess compliance with education 7 and 10, and enable feedback to be provided to practices about significant events submitted.

PCTs may wish to encourage practices to submit significant event analysis (SEA) to them in order that the PCT can identify themes and trends over time. The themes and trends can be shared with practices in an anonymised manner to develop shared understanding and learning.

Education indicator 8

All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal

In review, assessors should plan to hold discussions with practice-employed nursing staff about their personal learning plans and the appraisal system during the QOF assessment visit. This should include a discussion of how their further learning needs were assessed, how they will be achieved, who is responsible for organising them, within what timescale, and how progress will be reviewed. Also, it might be useful to get a view as to whether there are any blocks in this respect. The discussion may also include the person responsible for managing the appraisal system.

West Midlands – Good Practice Principle

PCTs should see evidence that the process has been undertaken – either, in a large practice viewing an anonymised copy of a completed personal learning plans from one of the nurses in the practice, or a signed statement from the nurse confirming they have a personal learning plan.

Medicines indicators 6 and 10

Medicines indicator 6

The practice meets the PCT prescribing adviser at least annually and agrees up to three actions related to prescribing

Medicines indicator 10

The practice meets the PCT prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change.

West Midlands – Good Practice Principle

The best practice is for the PCTs prescribing advisor to visit the practice in the first quarter to agree and set actions and to revisit in quarter 4 to sign off achievements. The visit should be separate to the QOF review and include all members of the practice involved in prescribing where practical.

The three actions should be SMART (specific, measurable, achievable, capable of review and timely) and the actions to be achieved should be clearly defined, in writing, at the first visit and confirmed before the end of the QOF year. Change such as, for example, “an increase in generic prescribing”, without specifying how much, is poor practice.

Prescribing advisers should provide a key focus on priorities and reasonable stretch agreements with the practices. Stretch agreements are targets that can be achieved, and which others have already achieved.

Medicines indicators 11 and 12

Medicines indicator 11

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines

Medicines indicator 12

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines

PCTs and practices should note that the target has been increased to 80%

West Midlands – Good Practice Principle

The medication review should be undertaken by the GP, nurse prescriber or practice pharmacist- recognising that the intention is to review all the medications that the patient has been prescribed and to ensure that, where possible and practical, in addition to points made in section Medicines 11.1 that

- different drugs do not have contra-indications to each other
- the drugs are in line with good practice
- the patients condition has not changed and the drugs are still required
- the drugs have not been duplicated following a hospital episode
- the patient is asked regarding compliance and advised of its importance.

Ideally the review with the patient should take place face to face to enable the patient to ask questions and the health professional to assess the patient's comprehension in respect of the advice/information being given; this may be with different individuals within the practice. An overall assessment of the whole process will then be required. The free text records should indicate the level of questioning and why telephone/email consultations were given if the patient did not have a face to face consultation, if not clear from the patient record. However, it should be noted that only a review of the medical record will be appropriate for some patients. The guidance must recognise that a patient may have been reviewed in 'parts' by various health professionals. Also there must be some proportionality – e.g. how appropriate is it to review a patient face to face who uses 5 anti-histamine tablets a year at the height of the hay fever season only etc

The practice should be able to demonstrate a protocol that sets out their procedure for undertaking the reviews on a systematic basis.

The review must be undertaken by the practice not in secondary care.

The medication review should not be confused with or replaced by the Pharmacists Medicines Use Review, which is undertaken to check patient compliance.

As the surveys will now be undertaken on a quarterly basis, there will be interim results available for QOF assessment visits. QOF assessors may wish to discuss the results and ways of improving patients' experience of access in the future.

Cervical screening indicators 6 and 7

CS indicator 6

The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every two years

CS indicator 7

The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates

West Midlands – Good Practice Principle

All smears should ideally be audited on an ongoing basis. Monitoring of inadequate smears should be no less than annually.

There is likely to be a reduction in the number of inadequate smears in relation to individual smear takers following the introduction of Liquid Based Cytology. Each tester will have their own PIN number, which will indicate specific problems.

Child health surveillance indicator 1

Child development checks are offered at intervals that are consistent with national guidelines and policy

West Midlands – Good Practice Principle

The Practice will have its own policy, rather than simply referring to a standard policy provided by the Health Visiting service. This will include reference to the role of the practice in undertaking the programme of health and development reviews (as outlined in The Child Health Promotion Programme, Department of Health, March 2008). See: www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083645

The policy may also indicate how relevant clinicians maintain their CPD in this area and how they are kept fully aware of emerging national guidance, such as the Newborn and Infant Physical Examination. Standards and competencies (March 2008) <http://newbornphysical.screening.nhs.uk/quality>

West Midlands – Good Practice Principle

Each practice will be required to demonstrate that their child health surveillance programme (including child protection advice) is consistent with national guidelines. To assist with this PCTs should ensure that their requirements are posted on their intranet and forwarded annually to all practices in paper format.

The practice guidelines, following from this should clearly demonstrate:

- the process for children to obtain the required checks i.e. who undertakes, where and at what intervals
- how those patients requiring further investigations/interventions are linked back to the practice
- what searches are undertaken to ensure the necessary interventions have taken place

Conclusion

The Guide supports the expectation that the QOF would be developmental for practices over time and encourages PCTs to continuously improve their review processes, their support to practices and ultimately the quality of care for patients. Applying this to the QOF review process is in line with the final report of the Next Stage Review, 'High Quality Care for All' and 'Our vision for primary and community care the Primary and Community Care Strategy, (DH, July 2008), which set out the strategic direction for driving improvements in the quality of care across the health service including GP services.

In the next period the NHS will be increasingly focussed on the principles of QIPP – Quality, Innovation, Productivity and Prevention. We believe that these objectives can best be achieved for patients by going forward together to implement the quality standards that are increasingly understood by us.

Appendix 1

A guide to the development of policies in general practice

1.0 Introduction

Easily understood policies, procedures, protocols, guidelines are the means by which an organisation provides rules or guidance to enable staff to produce outcomes that are consistent and reliable. They play a crucial role in risk management and quality systems by defining standards and the means of achieving and monitoring them. They form part of a protection mechanism for patients, staff and visitors.

It is important that as well as being consistent, all policies* are current. An organisational approach by the practice will ensure that all policies follow the same development, format, and review processes. It will also ensure all policies are accessible to all staff.

(*For 'policies' read policies, procedures, protocols, and guidelines)

2.0 Aims

2.1 To minimise risk to patients, staff and visitors to the practice.

3.0 Objectives

3.1 To ensure that there is an agreed structure for policies that is used for the development of all policies throughout the practice.

3.2 To ensure there is a clearly identifiable process for the approval of all policies.

3.4 To ensure policies are reviewed on a regular basis.

4.0 Definitions

Policy	An organisational statement of intent. This means what, in general terms; the practice intends to do about something.
Procedure	The mandatory steps taken to fulfil a policy. In other words precisely how the practice is going to do something. A procedure does not have to be attached to a policy. It is a step by step plan of action – who does what, where and when
Guideline	A statement of principles giving practical guidance, allowing for professional initiative.
Protocol	The rules within which you operate, ie the clinical guidance to be followed which is generally governed by professional advisory body

Aim	The purpose of the policy. An aim is the overall target or goal.
Objective	Measurable statement of how you will achieve that aim.

5.0 Policy Content

All policies should:

- a) Be clearly defined so that it is easy to identify.
- b) Include a stated implementation and review date.
- c) Include a statement of where the policy is located within the practice
- d) Include an identified post holder responsible for implementing and reviewing the policy at the appropriate time.
- e) Include an introduction that will include a statement on any related legal, professional or national guidelines.
- f) Have clearly stated aims and objectives.
- g) Include a statement on training requirements.
- h) State how implementation and compliance with the policy will be audited.
- i) Cross reference to other relevant policies and procedures and all relevant legal guidelines and references.

See appendix A for suggested layout and content.

6.0 Development of Policies

- 6.1 All new policies should follow the practice procedure for the Development and Approval of Policies.
- 6.2 The policy developer must ensure in developing the policy that appropriate consultation with other staff members takes place.
- 6.3 There should be a clear statement on how the policy will be audited.
- 6.4 All policies should be concise and easy to follow.
- 7.0 Access and Maintenance of Policies
 - 7.1 All policies should have clear implementation and review dates. The review date will be no more than two years from implementation
 - 7.2 It should be clear to all staff where policies are kept within the practice.
 - 7.3 Practices should make sure systems are in place to ensure all staff are made aware of new or revised policies

7.4 For Good Practice Principle policies should be organised into the following 6 categories

- a) Clinical
- b) Control of Infection
- c) Finance
- d) Health & Safety
- e) Human Resources
- f) Organisational

Appendix 1a

Title of policy:

Subject:

Date of implementation:

Date of review:

Person responsible for policy implementation and review:

Policy location:

1.0 Introduction (why we need the policy/procedure/guideline)

2.0 Aim/s (purpose/reason for having policy/procedure/guideline)

3.0 Objective/s (How you will get there)

(Define the circumstances and situations in which the policy should be used or not. Any restrictions or limitations in the use of the policy should be recorded here)

4.0 Definition/s

(Clarify the language used within the policy to reduce any chance of misinterpretation especially any abbreviations to be used).

5.0 Specific Detail - Procedure

(Including role of manager, employee or "other" as appropriate).

6.0 Training

(Include any anticipated training requirements).

7.0 Monitoring and Review Mechanism (how implementation of the policy will be monitored and the review mechanism for ensuring the policy is being followed.

Appendix 2

Development of electronic from manual records

Good, accurate and up to date patient records are a prerequisite for good patient care. Achievement of the standards will support and encourage practices to enter new data (completeness standards), that is properly coded (accuracy standards).

The PCT has a responsibility to ensure that all IT equipment and systems are properly maintained.

At the heart of these standards is the Good Practice Guidelines agreed between the BMA, RCGP and Department of Health [ref]

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008657

The computerised record should contain all information that may be relevant to the future care of the patient. A summary should be developed from this electronic record using the appropriate flags or other devices included within the clinical system

Unless records have been scanned and saved in an appropriate format (see Good Practice Guidelines for details of formats) and the practice is accredited as paper light by their PCT it is still a requirement to retain a paper record.

Complete

For a paper light practice data on the electronic record must be coded and entered with the correct date of the event or first diagnosis.

1. From birth (or first registration with the NHS) to present day
2. Family History where relevant to the future care of the patient⁶
3. Major operations with the correct date
4. All significant episodes during any hospital admission should be coded separately where possible (e.g. angioplasties +/- stents during admission for myocardial infarction) and not added as free text⁷
5. Major diagnoses with the most accurate start date possible
6. All investigations since a practice has become paper light – even if results are negative – this may help in the future
7. Drug and other allergies.

⁶ This should obviate the impact of introducing second person personal information in terms of their confidentiality

⁷ to avoid loss on transfer, to ensure population of disease registers, and enable audit the best way to achieve this is to read incoming mail, reports etc. in conjunction with the open electronic record

Timely

1. Paper-light practices should have an agreed and implemented process to maintain the completeness and accuracy of the electronic record.
2. There should be in-house protocols on scanning, subsequent coding, and target from arrival of all mail to be incorporated into patient records. Care should be taken not to record single-event duplicate diagnoses 6
3. New material should be coded and scanned within the practice handling system but no later than within 8 weeks of receipt.

Accessible

Practices are responsible for the governance of the network in house. i.e. re implementation of Caldicott rules, Data Protection, confidentiality, regular back-ups, quarterly verification of back-up data (paid for by the PCT) and periodic storage off site etc.

Accurate & Relevant

1. Long term conditions such as asthma which may resolve should be closed using "resolved" codes rather than deleted.
2. Data must be coded and prioritised as "Significant" in a way that a summary overview can be seen. Correct dates should be used.
3. Most operations should be coded as significant
4. Repeat prescription items should be related to the condition being treated.

The relevance test will always be open for debate. However, members of the public usually feel that admissions to hospital and major investigations are significant episodes in their lives and would expect to see them on their records. Doctors doing reviews might ask themselves "Could I work here as a locum and be confident that all information is available to me?"

The commonest GP clinical system suppliers confirm that their systems do allow for prioritisation of coded entries on to the patient summary. They also have methods of linking medication to coded diseases. Practices having problems or doubting this should contact their system suppliers for clarification.

First registration with the NHS or the date records start should be routinely coded where available.

Appendix 3

Suggested possible Significant Event Audit/Adverse Incident Meeting Reporting Form

Practice name:				
Date of meeting:				
Meeting attendees:				
Type of event:	SEA <input type="checkbox"/>	adverse incident <input type="checkbox"/>	near miss <input type="checkbox"/>	Good Practice Principle <input type="checkbox"/>
Date of incident:	Time of incident:			
Which of the following best describes the incident?				
prescribing & dispensing	vacc & imms	home visits, OOH, emergencies	communication within team/ external	pathology results
appointments	medical records	secondary care	violence & aggression	other
Brief description of event				
Key issues arising from discussion				
Positive points				
Areas of concern				
Suggestions to prevent recurrence				
Actions to be taken				
Review date				

Appendix 4

Education 7 and 10 Significant Event Reviews

Practice aspired to Education 7		Yes/No				
Practice aspired to Education 10		Yes/No				
Education 7						
<p>The practice has undertaken a minimum of 12 significant event reviews in the past three years which COULD include:</p> <ul style="list-style-type: none"> any death occurring in the practice premises new cancer diagnoses deaths where terminal care has taken place at home any suicides admissions under the Mental Health Act child protection cases medication errors. <p>A significant event occurring when a patient may have been subjected to harm, had the circumstance/ outcome been different</p>						
Event ref no.	1	2	3	4	5	6
Date of event						
Subject of event						
Evidence of meeting where event was discussed						
Was the evidence presented in a consistent format?						

Were all elements covered? (Description of event, learning outcome, action plan)						
Was there a good understanding of the process & purpose of significant event reviews?						
Decision reached ie <ul style="list-style-type: none"> • celebration of excellent care • no change • audit required • immediate change 						
Has there been a follow-up discussion about the decision						
Event ref no.	1	2	3	4	5	6
Date of event						
Subject of event						
Evidence of meetings where each event was discussed						
Was the evidence presented in an acceptable format?						

Were all elements covered? (Description of event, learning outcome, action plan)						
Was there a good understanding of the process & purpose of significant event reviews?						
Decision reached ie <ul style="list-style-type: none"> • celebration of excellent care • no change • audit required • immediate change required 						
Has there been a follow-up discussion about the decision						
Education 7 achieved			Yes/No			
Education 10 The practice has undertaken a minimum of three significant event reviews within the last year						
Education 10 achieved			Yes/No			

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