The new GMS contract explained

Focus on…

Exception Reporting

This is a guidance note produced by the General Practitioners Committee to help GPs and Local Medical Committees understand exception reporting under the new GMS contract, and is part of a series of guidance notes on the new contract. The guidance will be updated as progress is made throughout the implementation discussions and negotiations. We would advise all GPs to read the contract document and supporting documentation, available on the BMA website at www.bma.org.uk. The GPC has produced a list of frequently asked questions and answers which can also be found at the website address.

What is exception reporting?

Exception reporting prevents a practice being penalised under the quality and outcomes framework of the new GMS contract for factors outwith its control or for a range of other patient-related issues. In these circumstances, an exception code is used so that this does not affect the practice's quality point score.

What can be reported as an exception?

Exception reporting can be applied for the following:

A patients who have been recorded as refusing to attend a 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 specific 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 level of outcome 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 (and after a reasonable discussion or written advice they have given their informed dissent), and this dissent 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.

How do I exception report?

Exception codes have been added to systems by suppliers. There are two kinds of codes:

1. A high level code that excepts a patient from the whole clinical domain. For example if a diabetic patient refuses to attend for a diabetic review they can be legitimately excepted from

all the diabetes indicators. Example: 9h42 excepted from Diabetes quality indicators: informed dissent

2. Exception codes for individual indicators within the clinical domain such as 63NE flu injection refused.

It is important to understand that if, despite the presence of a high level exception code, an individual indicator is met, then exception conditions for that indicator are ignored. An example might be a diabetic patient such as a frail elderly lady in a nursing home who is unsuitable for some of the markers and who has been excepted from the diabetic domain. Even though a high level exception code is used to except her, the quality work that is complete lower down the domain (i.e. individual indicators) will still count towards quality points.

In such a case the nurse can go to the nursing home, administer a flu injection and take her blood pressure. The clinical indicators have been achieved by doing this particular work and the payment for this work will follow. So even though the elderly lady has been excepted from the diabetes clinical domain, she will contribute to the prevalence and her flu injection will count towards any other relevant aspects of the contract for example enhanced service, the specific diabetes indicator.

So, in summary, if data is entered for individual indicators it will override the high level exception code for the clinical domain for those indicators.

How often do I need to exception report?

For the majority of cases, exception codes should be recorded annually. The following only need to be recorded once:

- True drug allergies
- Adverse reactions

'Never Smoked' is also treated as a lifelong record however it is slightly more complicated in that it must be recorded subsequent to the relevant diagnosis. So for a non-smoking patient with angina newly diagnosed on 2nd December 2003 the GP would have to record a 'never smoked' on or after 2nd December 2003 to qualify for the CHS smoking records indicator.

LMCs: what can you do?

- Share this guidance with practices so that some of the confusion surrounding exception codes can be resolved.

Enquiries and Information

- Further information on Read Codes can be found in the Read Code FAQs on the BMA website at: www.bma.org.uk/ap.nsf/Content/readcodesfaqs0104

- A list of exception codes can also be found on the BMA website at: www.dh.gov.uk/assetRoot/04/06/86/23/04068623.PDF

- Please send enquiries and/or information about information management and technology to the GPC office at: rmerrett@bma.org.uk

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