OneRecall Subscriber's Handbook

Updated April 2021

Introduction

Background

We have put together a collection of tools and utilities that will help you to recall a diverse population, with varying health needs, conditions and intervals for their health checks in a way that fits into the workflow of a busy practice. All members of the primary care team have a role and so there are roles for everyone in the smooth running of the **OneRecall** system. No recall system can hope to be all-encompassing or responsive to each of the detailed individual needs of all patients but this system helps to logically address many key health needs included in the NHS England Quality and Outcome Framework and some additional common population areas.

When implementing, care should be taken to understand what the recall system does and doesn't do. Training is essential in each of the key team roles, including Recall Administration Team, Reception, Clinicians and clinical support staff such as Health Care Assistants.

Addressing Pop-Up Fatigue

Pop-ups will appear, they are part of the system but designed to be unobtrusive and efficient. Initially they may feel frustrating. They have been designed to include, in one place, as much relevant information as possible for the patient in front of you. Each is programmed to return different details about your patient and so, whilst on face value they appear similar, they won't contain the same information each time. This is all so that you don't need to go hunting around the records for key facts related to recall and chronic disease status. We have other resources doing similar jobs such as OneResult and OneMonitoring alerts, all designed to give instant access to the rich data in the patient records.

Feedback

As ever, we really value your feedback on our tools, both when things aren't working as expected and with development ideas. Please contact the team on TheTeam@primarycareit.co.uk

We find that often problems come from existing coding issues in the records and our team can help explain these.

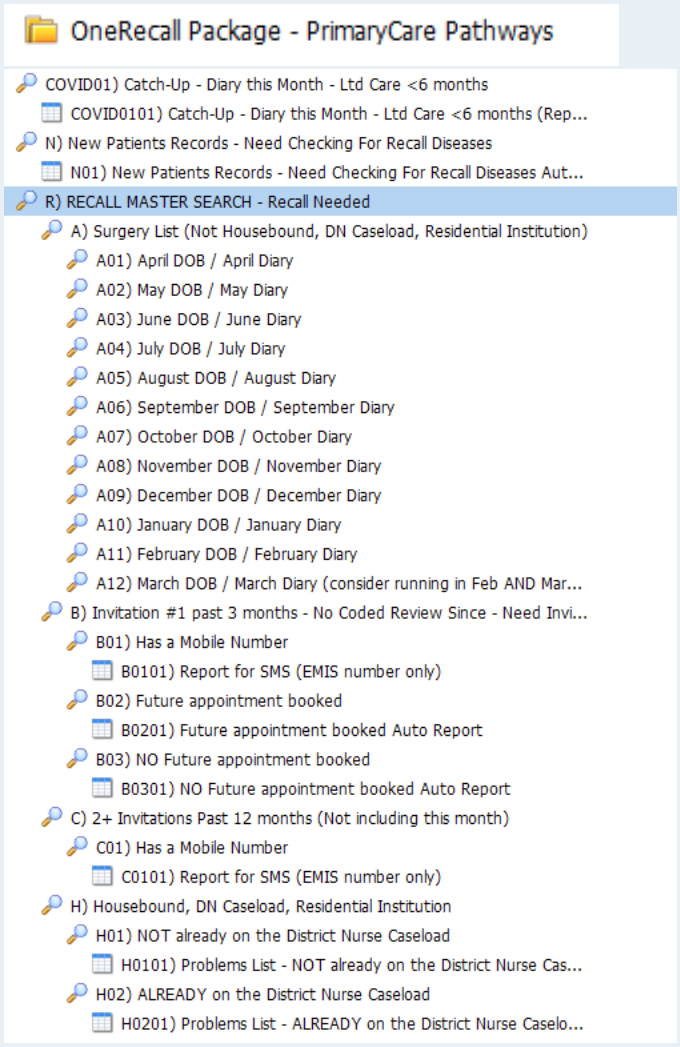
Include your site (cdb) number and the EMIS number for the patient. This has been agreed through the Data Sharing Agreement your team signed up to when asking us to help you process your patient data. If you are at all unsure about this then ask your Data Protection Officer or Caldicott Guardian first.

Disclaimer

We are continually developing and improving our resources. Screenshots and videos are accurate at the time of publishing but may not be an accurate representation of the latest version of the resource.

OneRecall - Key Resources

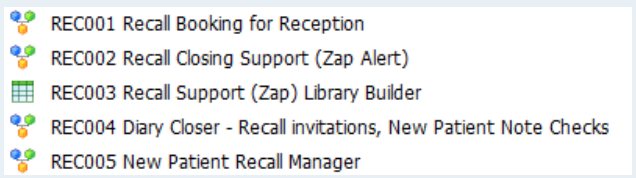
Searches and Reports



Invitation Letter Templates

LET001 - QOF - Chronic Disease Recall Letter 1	Invitation Letter 1 to Chronic Disease Review
LET002 - QOF - Chronic Disease Recall Letter 2	FOR USE IF NO TEXT VIA MJOG IS POSSIBLE - Invitation Letter 2 to Chronic Disease Review
LET003 - QOF - Chronic Disease Recall Letter 3	FOR USE IF NO PHONE CONTACT POSSIBLE - Invitation Letter 3 to Chronic Disease Review
LET004 - QOF - Informed Dissent Exception Reporting notice	When confirming to a patient we have excepted them through non-engagement

Protocols and Data Entry Templates



How-To Guide

Step 0 - Installation and Preparation

Importing Resources

We will Import all of the key resources into your installation of EMIS. This includes:

- Searches and Reports Module
- Template Manager
    - Document templates
    - Data entry templates
    - Protocols

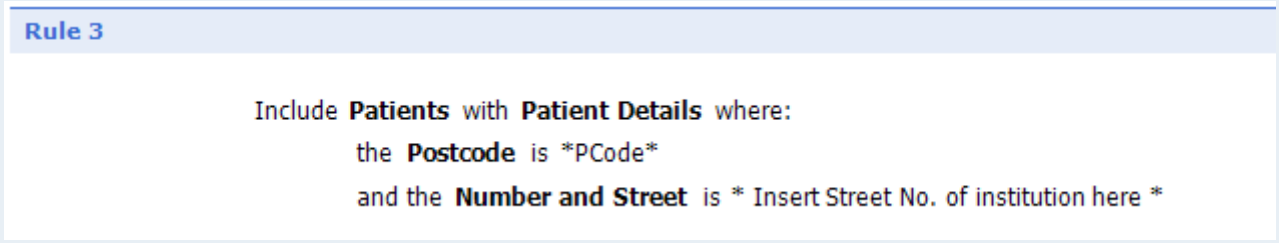
Localise Care Homes

The following searches **both** need to be localised with the details of any care homes, where you would not expect patients to come to the practice, i.e. those who would always have routine care brought to them.

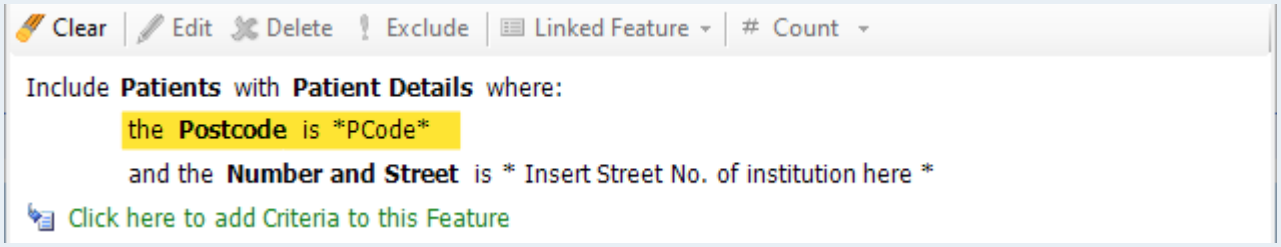
- **A) Surgery List (Not Housebound, DN Caseload, Residential Institution) and**
- **H) Housebound, DN Caseload, Residential Institution**

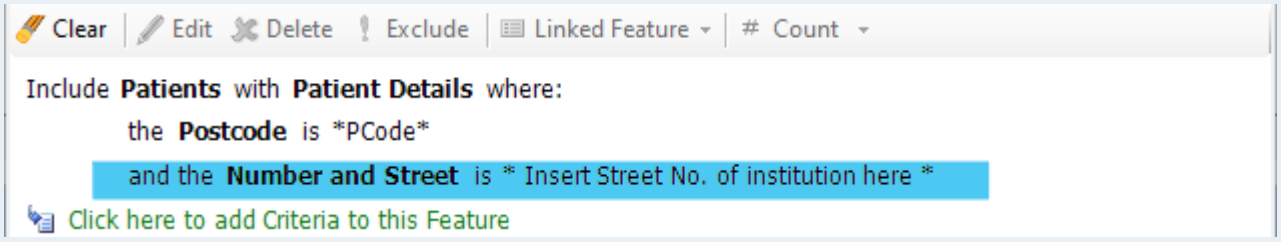
We can localise these for you but we will need the full postal address of each of the care homes where you don't want to send individual patient invitation letters. To localise yourself, right click the search name and click "Edit".

Double click on any of the four rules noted with **Postcode** and **Number & Street** rules:



Then double click on each of the elements and add in the details for one care home:

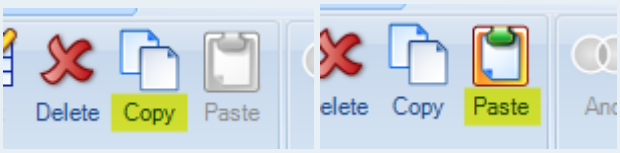




Use one rule for each care home, completing both **Postcode** and **Number & Street**

Adding Additional Care Homes

More rules can be added if you have more than 4 facilities by clicking on one of the rules and pressing copy and paste in the top menu bar



If you do this, make sure you adjust the rules for passing and failing as shown below

Rule: A) Surgery List (Not Housebound, DN Caseload, Residential Institution)

If Rule Passed :	Goto Next Rule	If Rule Failed :	Exclude from final result

Rule: H) Housebound, DN Caseload, Residential Institution

If Rule Passed :	Include in final result	If Rule Failed :	Goto Next Rule

Step 1 - Invitations (Searches, Reports & Letters)

All invitations of any kind (letter, SMS etc) must be coded:
"**QOF (Quality and Outcomes Framework) quality indicator-related care invitation"**

In the **first** week of each calendar month, run the search for that month:

- A01) for April,
- A02) if it is May,
- A03) for June etc...
- Mail merge letter LET001 against the included population for that month's search.
- Save the merged letter to the patient record, to ensure that the following code is recorded in the notes:
  - **QOF (Quality and Outcomes Framework) quality indicator-related care invitation**
  - **Concept**: 1109921000000106
- Run the housebound searches & reports
  - H) Housebound, DN Caseload, Residential Institution
    - H01) NOT already on the District Nurse Caseload
      - H0101) Problems List - NOT already on the District Nurse Caseload (Report)
    - H02) ALREADY on the District Nurse Caseload
      - H0201) Problems List - NOT already on the District Nurse Caseload (Report)

In the **second** (or third week) of the same month, run search

- B) Invitation #1 past 3 months - No Coded Review Since - Need Invitation #2
- If needed, you can also run the sub-search and report to help prepare a text message to use with your choses SMS service, such as MJOG.
  - B01) Has a Mobile Number
    - B0101) Has a Mobile Number (MJOG Report)

In the **third** (or fourth week) of the month run the search

- C) 2+ Invitations Past 12 months (Not including this month)
- You can use the results to consider further contacts or to pass to the clinical team for consideration around formal exception reporting or safeguarding issues. Note, using the invitation SNOMED code above will mean exception reporting is not necessary for the conditions being recalled.

In the **fourth** week of the month run the search and report

- N) New Patients Records - Need Checking For Recall Diseases
  - N01) New Patients Records - Need Checking For Recall Diseases Auto Report
- The report will help you identify those newly registered patients who have neither had their notes summarised yet nor had a GP2GP transfer of records.
- Assess any records you hold, including Lloyd-George Notes, and decide if the person ought to be called for recall the following month with LET001. If unsure, seek a clinical opinion.
- **Complete the Diary Entry "Lloyd George record checked"**, if you no longer need the patient to be captured by this search the following month.

Step 2 - Patient Booking - Protocol REC001

When a patient calls the practice, the administration team responsible for booking the review appointment will need to LOAD THE PATIENT RECORD in order to trigger

- **Protocol REC001 Recall Booking for Reception**

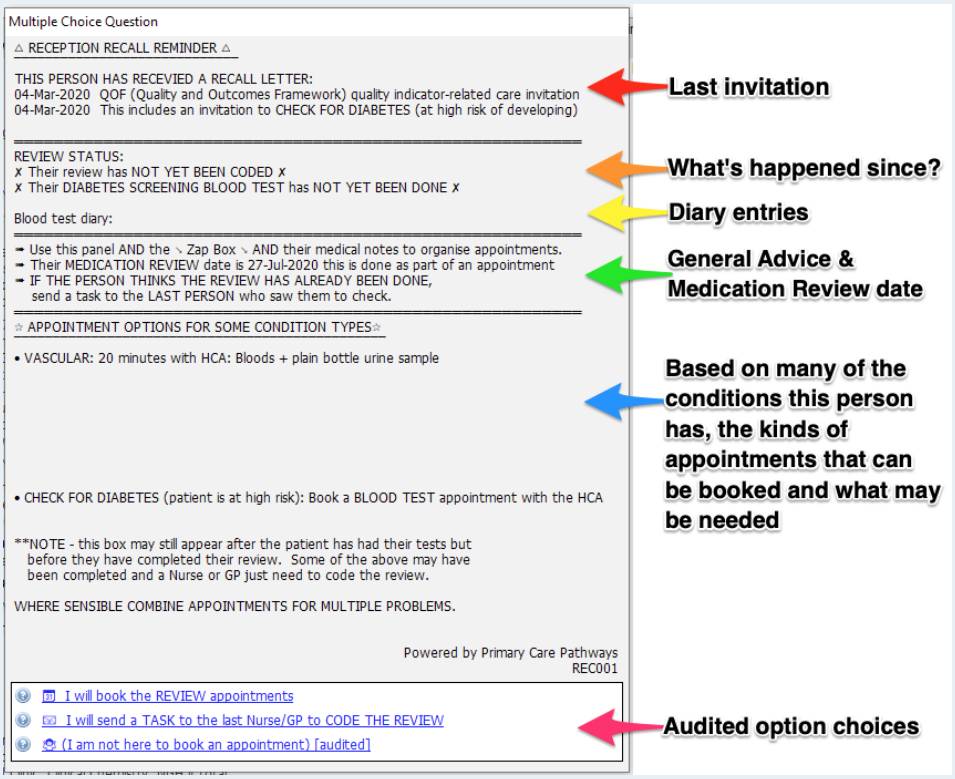
Important note: swapping to the patient is not the same as loading the records. Swapping to the patient changes the name in the precis bar, but does not load the medical record. To load the medical record, the user will have to go to any part of the care history, such as

- Care History,
- Medications,
- Diary etc..

An alternative to this is to ask your admin team to add **REC001 Recall Booking for Reception** to their [F12] quick launcher and run it manually when anyone is booking a review. In this case you can deactivate any automated triggers.

Examples of the information panels the user may see include are listed in Appendix A

Anatomy of REC001 Recall Booking for Reception



Much of the information your care navigator team will need can be found here.

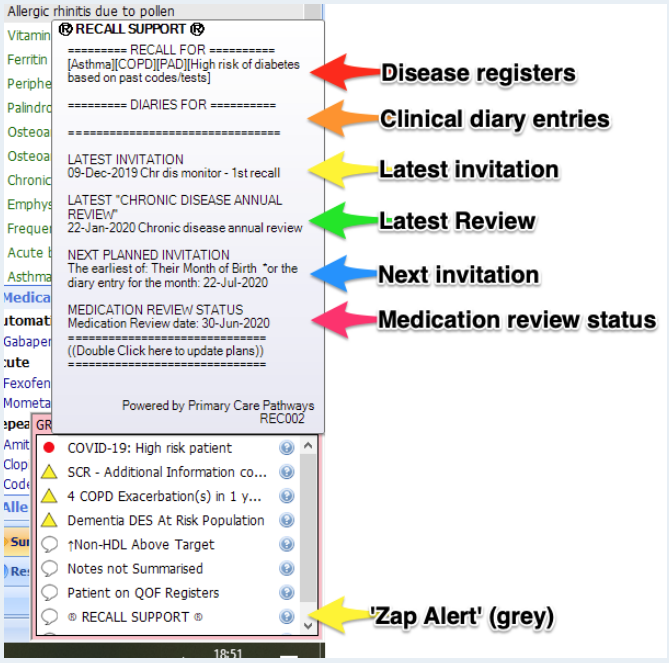
Step 3 - Clinical Appointments

- The principle behind the system is that the clinicians retain complete control over the “recall loop”.
- Once they are satisfied that all elements of care have been attended to, they need to code:
    - **“Chronic disease annual review”**
    - (Concept ID 816421000000101, Description ID 2127501000000113)
- To help with this we have developed REC002 and REC003

REC002 Recall Closing Support (Alert)

- This appears for anyone who is eligible for a Chronic Disease Annual Review - whether QOF related or otherwise.
    - If the review is overdue, this appears as a red ‘Zap Alert’ entry near the top of the alert box.
    - If the review is not-overdue, but there is an opportunity to perform an early review, the alert appears as a grey ‘Zap Alert’ entry near the bottom of the alert box.
    - The alert is designated as overdue if the person has been sent an invitation for a chronic disease annual review but not yet had a review coded since.
- REC002 is an information panel designed to complement the information delivered in our OneResults and OneMonitoring panels.
- Double-clicking on the alert will launch REC003 Recall Support (Template)
- See our supporting video for more information and the Appendix for more screenshot examples

Anatomy of REC002 Recall Support (Alert)

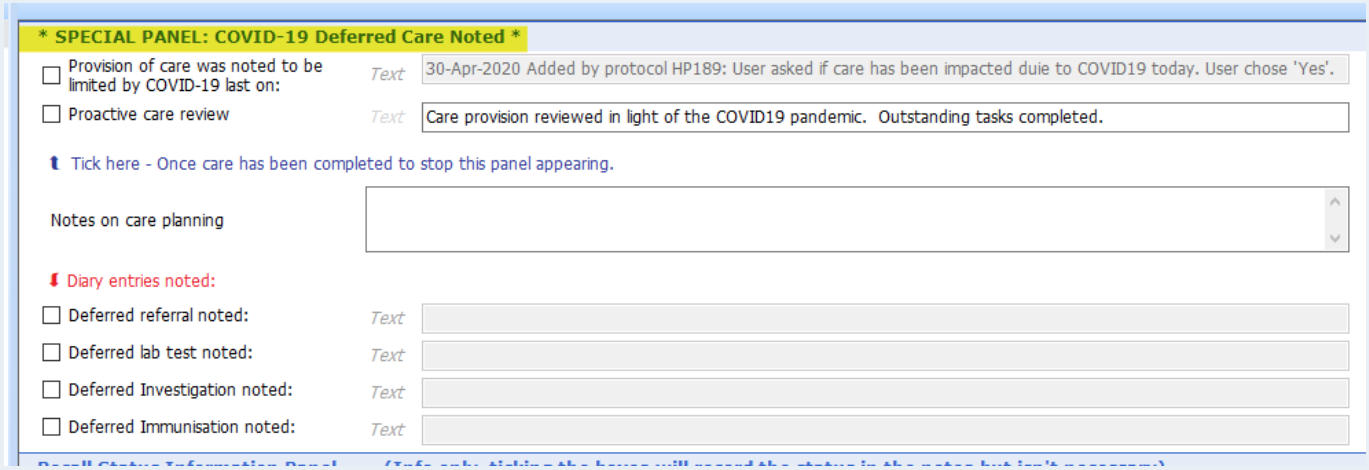


REC003 Recall Support (Template)

- The template is launched by **double clicking** on the REC002 Recall Support (Alert) line.
- This template needs to be run by the clinician to close off the review.
- It provides a consistent and easy way to apply the recall-loop closing code
    - **"Chronic disease annual review"**
    - (Concept ID 816421000000101, Description ID 2127501000000113)
- Engaging with the template will need **specific training** for all your clinical staff, to prevent the continued issuing of reminders.
- REC003 is best launched at the end of a consultation, once the planning ahead section has been considered.
- REC003 gives a clear overview of the patient's place in the recall cycle and the opportunity to record updates and future planning.
- REC003 includes a COVID-19 catch up panel that can be used

Anatomy of REC003 Recall Support (Template)

COVID-19 Catch-up Panel



Appears when the the following code has been used in the record

- **Provision of advice, assessment or treatment limited due to COVID-19 pandemic**
    - **Concept ID:** 1321171000000106
    - **Description ID:** 2827521000000112

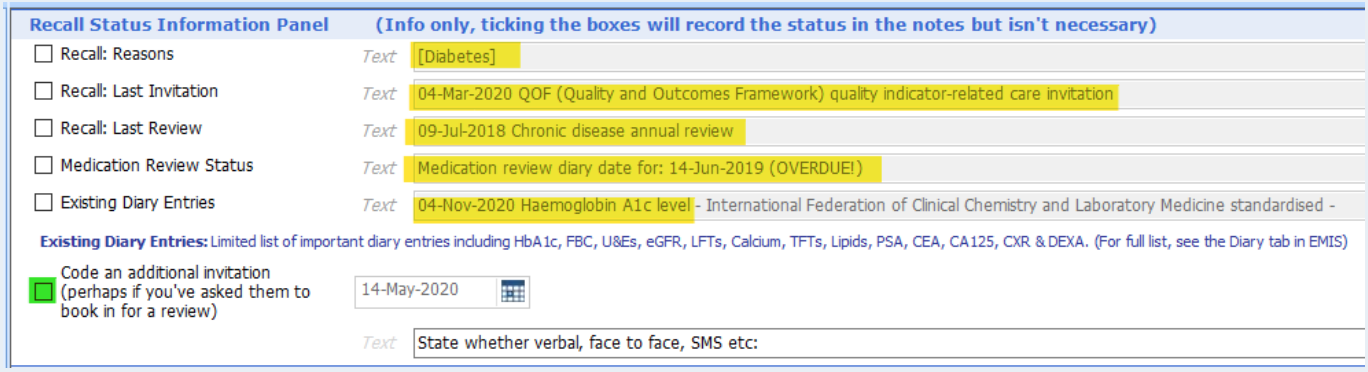
Until this code has been entered into the record

- **Proactive care review**
    - **Concept ID:** 11932131000006101
    - **Description ID:** 11932131000006117

The COVID-19 Catch-up panel allow the user to understand when and why care was limited by the pandemic, to review the notes for outstanding tasks and to close the episode off by coding a **"Proactive Care Review"**.

Recall Status Information Panel

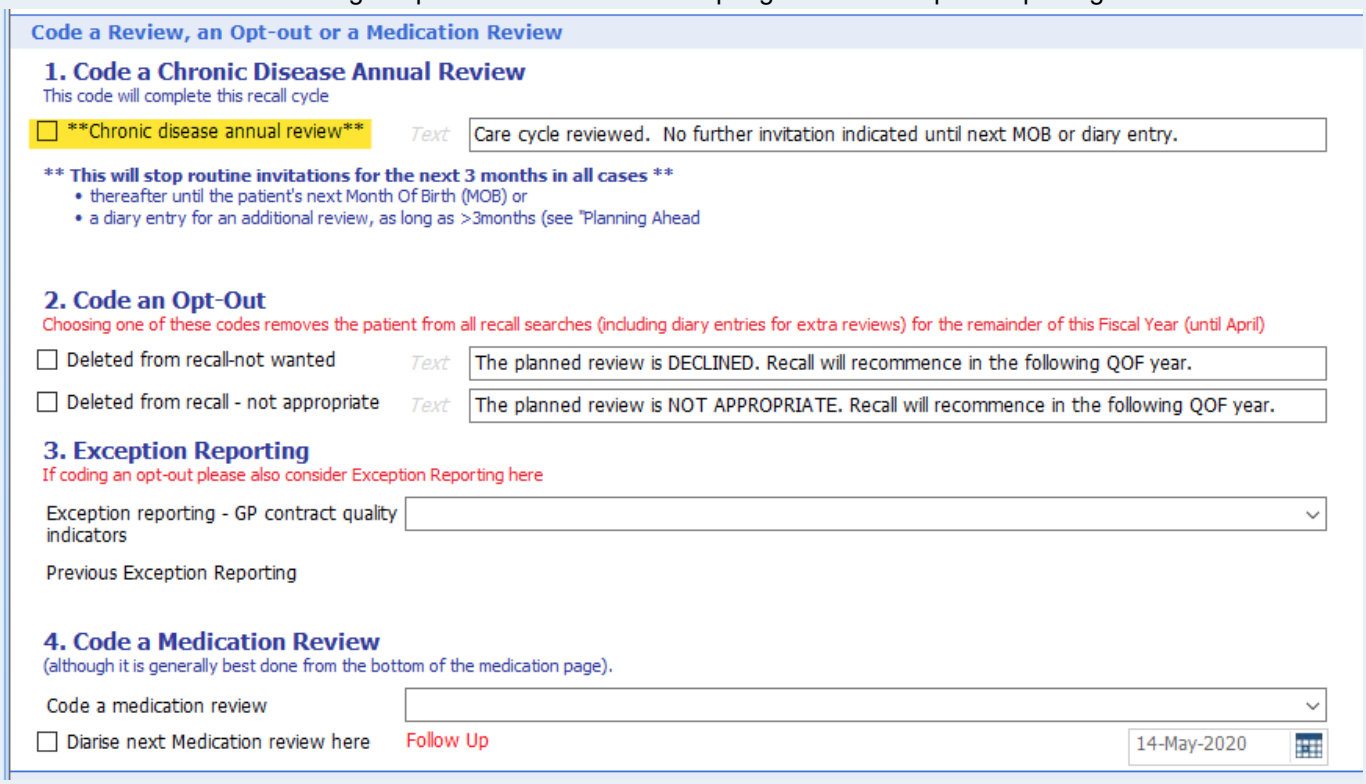
Under normal circumstances, this is the panel that appears at the top of the template to help manage recall. It is a summary of where the patient is up to with recall procedures:



- There is an opportunity to code a verbal QOF invitation in the last check box.

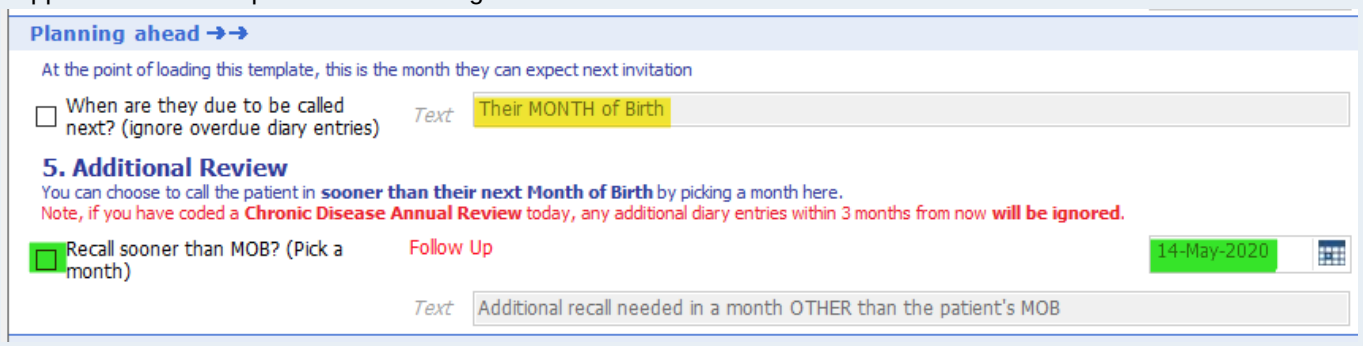
Code the Review, an Opt-Out, Exception Report or Medication Review

The most important code on the template is the code that closes the review. For most users, this is the only box that needs ticking on this panel. Clinicians need to know how to find it and when to use it.
The other boxes are for coding the patient's wishes around opting out and exception reporting.



Planning Ahead - IMPORTANT

This is a very important panel on the template. It allows the <u>clinician to judge</u> when the next review is likely to happen and to make plans that can bring this forwards.

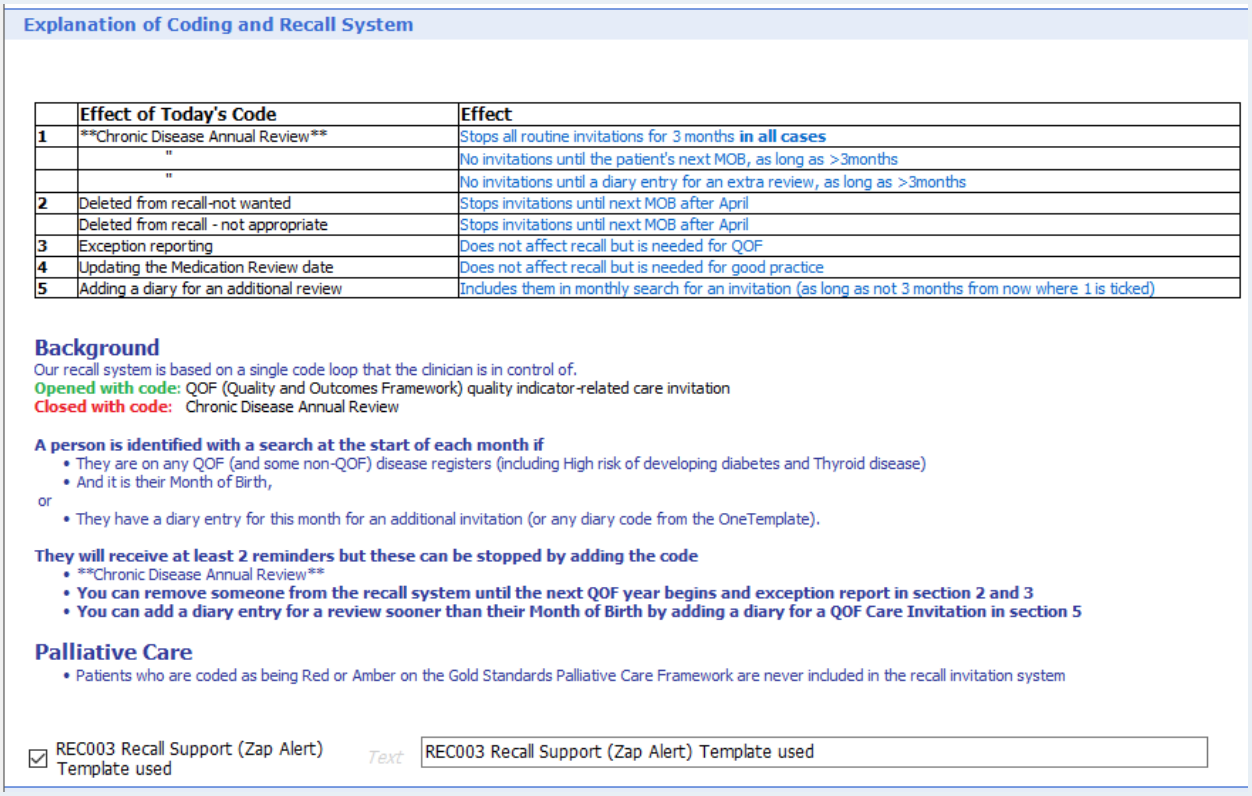


- By default, OneRecall aims to call people **annually** in their month of birth. Additionally the clinician has the option of setting an earlier date by picking a month.
    - Note, when an Annual Review has been coded, this **always prevents further invitations** within the next 3 months, **even if a diary entry has been set in that 3 month window**.
    - This also means that a person born in (for example) June, who had an opportunistic review coded in the April before, will not appear in June's recall search. Potentially that person will wait until June of the following year for another invitation. In this situation, it may be appropriate to set a diary date for an invitation this December.
    - See Appendix for some patient recall scenario calendars

- The diary date is for an invitation letter:
    - QOF (Quality and Outcomes Framework) quality indicator-related care invitation
    - **Concept ID:** 1109921000000106

Explanation of Coding and the OneRecall System

Recall can be a complicated process, there are a number of codes that help it to run and you may not have this handbook to hand, so we have included an explanation panel to advise users about the system. This panel also captures a code to track when the template has been used.



Explanation of Coding and Recall System

	Effect of Today's Code	Effect
1	**Chronic Disease Annual Review**	Stops all routine invitations for 3 months **in all cases**
	"	No invitations until the patient's next MOB, as long as >3months
	"	No invitations until a diary entry for an extra review, as long as >3months
2	Deleted from recall-not wanted	Stops invitations until next MOB after April
	Deleted from recall - not appropriate	Stops invitations until next MOB after April
3	Exception reporting	Does not affect recall but is needed for QOF
4	Updating the Medication Review date	Does not affect recall but is needed for good practice
5	Adding a diary for an additional review	Includes them in monthly search for an invitation (as long as not 3 months from now where 1 is ticked)

Background

Our recall system is based on a single code loop that the clinician is in control of.
Opened with code: QOF (Quality and Outcomes Framework) quality indicator-related care invitation
Closed with code: Chronic Disease Annual Review

A person is identified with a search at the start of each month if
- They are on any QOF (and some non-QOF) disease registers (including High risk of developing diabetes and Thyroid disease)
- And it is their Month of Birth,

or
- They have a diary entry for this month for an additional invitation (or any diary code from the OneTemplate).

They will receive at least 2 reminders but these can be stopped by adding the code
- **Chronic Disease Annual Review**
- **You can remove someone from the recall system until the next QOF year begins and exception report in section 2 and 3**
- **You can add a diary entry for a review sooner than their Month of Birth by adding a diary for a QOF Care Invitation in section 5**

Palliative Care
- Patients who are coded as being Red or Amber on the Gold Standards Palliative Care Framework are never included in the recall invitation system

☑ REC003 Recall Support (Zap Alert) Template used Text | REC003 Recall Support (Zap Alert) Template used

Step 4 - Closing Diary Entries added by OneRecall

REC004 Diary Closer - Recall invitations, New Patient Note Checks

The OneRecall system adds diary entries through its normal operation. EMIS does not automatically complete those diary entries, even if the right code (that the diary entry is looking for) is added to the records. Over time this leads to the build of increasingly out of date diary entries which can be confusing and potentially dangerous. REC004 aims to close off a few of the diary entries entered by OneRecall automatically. Each time a record is loaded is checks for those patients:

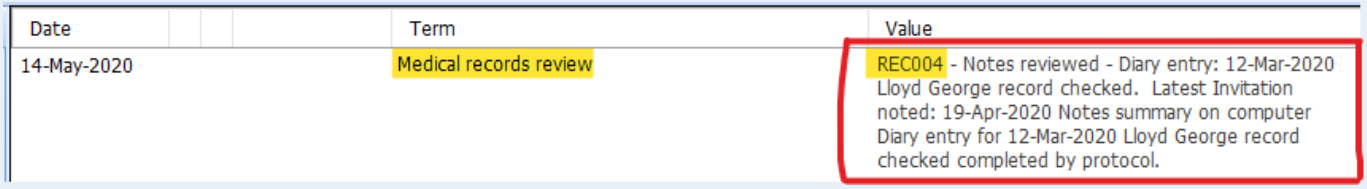
- who have a recent **diary entry for an invitation letter**,
- but who have **received an invitation letter** since that diary date.
- It then completes the diary entry automatically

It also checks for patients:

- Who have an overdue **diary entry for a review of their Lloyd George notes**,
- But who have had their **notes summarised** since that diary date.

- It then completes the diary entry automatically

This particular protocol is set to run automatically (when a record is loaded) and it can be left to complete its work in the background. Where it finds and completes a diary entry it will also add a comment into the care history for you to keep a track.



Date	Term	Value
14-May-2020	Medical records review	REC004 - Notes reviewed - Diary entry: 12-Mar-2020 Lloyd George record checked. Latest Invitation noted: 19-Apr-2020 Notes summary on computer Diary entry for 12-Mar-2020 Lloyd George record checked completed by protocol.

Step 5 - Adding New Patients to OneRecall

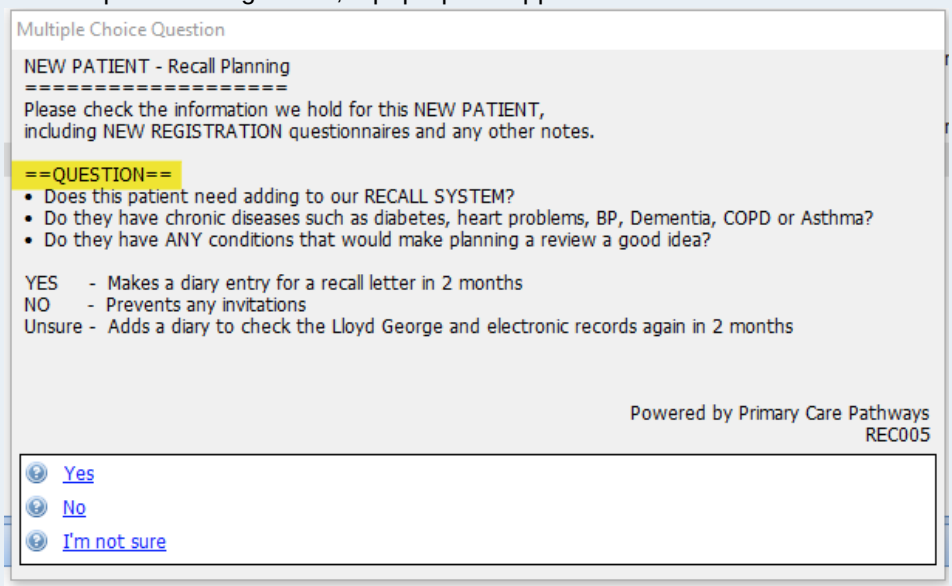
REC005 New Patient Recall Manager

In order to help practices identify patients who need reviewing soon after they register, this protocol flags their records for a review. The main recall search will identify patients based on the contents of their records, (so a GP2GP transfer or a well summarised record will be enough to recall them).

REC005 is triggered by **registering a patient** and it works in tandem with the monthly search:

- N) New Patients Records - Need Checking For Recall Diseases
    - N01) New Patients Records - Need Checking For Recall Diseases Auto Report

When a patient is registered, a pop-up will appear for the admin team:



- **Yes**, adds the patient to the recall list in 2 months, regardless of Month of Birth
- **No**, records that the user feels no recall is needed
- **I'm not sure**, adds the diary code **Lloyd George record checked**

Search and report **N) New Patients Records - Need Checking For Recall Diseases**, identifies the records for review, hopefully once the paper notes or GP2GP transfers have successfully arrived.
The user could opt to run REC005 at that time to re-access these options.

Appendix

Invitation Letter 1 - LET001

Coded as **"QOF (Quality and Outcomes Framework) quality indicator-related care invitation"**

YOUR MEDICAL CENTRE
636 Your Road
Your City
Your County
Your Post Code

Tel: 0118 5559000
Email: YourEmail@nhs.net
Date: 28 May 2020
NHS No: 999 999 9506

Five Leslie Editestpatient
2 Any Street
Dummyville
EX2 1AA

Dear Editestpatient,

Your health review is now due at
YOUR MEDICAL CENTRE.

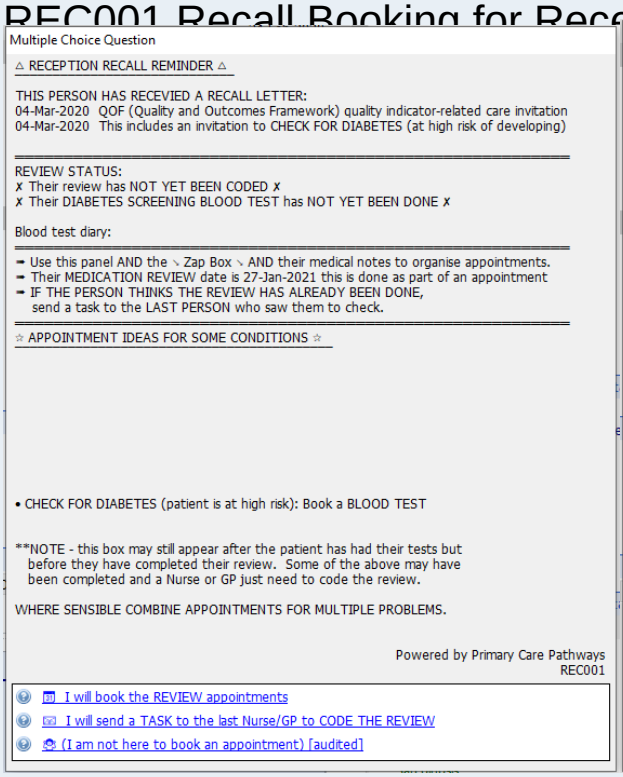
Please contact reception on
0118 5559000
Ask the Reception Care Team to book your appointments.
Please call after 11am to avoid busy periods.

- When you call, our Care Team will look at your records and decide the kind of appointments you will need. If you are unsure, please call.
- They will help you organise any **blood or urine sample tests** when you call. Some people need a breathing test called **Spirometry** booking at the medical centre. We will try to organise these all together if possible
- **We strongly believe in helping you look after your health. This review forms a vital part of that. This letter has been sent because we have identified one or more medical conditions in your medical notes, which need attention.**

Yours sincerely

Your Named GP
YOUR MEDICAL CENTRE

REC001 Recall Booking for Reception - examples



Multiple Choice Question

△ RECEPTION RECALL REMINDER △

THIS PERSON HAS RECEVIED A RECALL LETTER:
04-Mar-2020 QOF (Quality and Outcomes Framework) quality indicator-related care invitation
04-Mar-2020 This includes an invitation to CHECK FOR DIABETES (at high risk of developing)

REVIEW STATUS:
✗ Their review has NOT YET BEEN CODED ✗
✗ Their DIABETES SCREENING BLOOD TEST has NOT YET BEEN DONE ✗

Blood test diary:

➡ Use this panel AND the ↘ Zap Box ↘ AND their medical notes to organise appointments.
➡ Their MEDICATION REVIEW date is 27-Jan-2021 this is done as part of an appointment
➡ IF THE PERSON THINKS THE REVIEW HAS ALREADY BEEN DONE,
send a task to the LAST PERSON who saw them to check.

☆ APPOINTMENT IDEAS FOR SOME CONDITIONS ☆

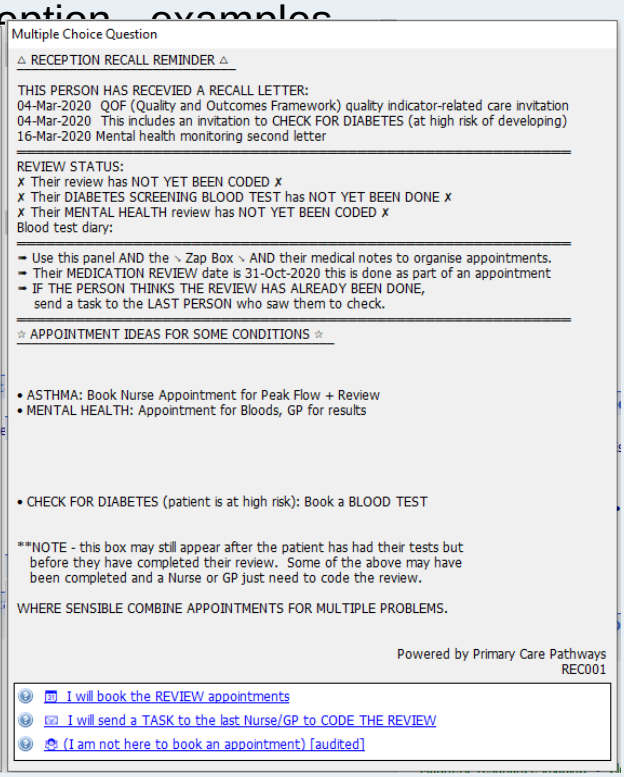
• CHECK FOR DIABETES (patient is at high risk): Book a BLOOD TEST

**NOTE - this box may still appear after the patient has had their tests but before they have completed their review. Some of the above may have been completed and a Nurse or GP just need to code the review.

WHERE SENSIBLE COMBINE APPOINTMENTS FOR MULTIPLE PROBLEMS.

Powered by Primary Care Pathways
REC001

I will book the REVIEW appointments
I will send a TASK to the last Nurse/GP to CODE THE REVIEW
(I am not here to book an appointment) [audited]



Multiple Choice Question

△ RECEPTION RECALL REMINDER △

THIS PERSON HAS RECEVIED A RECALL LETTER:
04-Mar-2020 QOF (Quality and Outcomes Framework) quality indicator-related care invitation
04-Mar-2020 This includes an invitation to CHECK FOR DIABETES (at high risk of developing)
16-Mar-2020 Mental health monitoring second letter

REVIEW STATUS:
✗ Their review has NOT YET BEEN CODED ✗
✗ Their DIABETES SCREENING BLOOD TEST has NOT YET BEEN DONE ✗
✗ Their MENTAL HEALTH review has NOT YET BEEN CODED ✗
Blood test diary:

➡ Use this panel AND the ↘ Zap Box ↘ AND their medical notes to organise appointments.
➡ Their MEDICATION REVIEW date is 31-Oct-2020 this is done as part of an appointment
➡ IF THE PERSON THINKS THE REVIEW HAS ALREADY BEEN DONE,
send a task to the LAST PERSON who saw them to check.

☆ APPOINTMENT IDEAS FOR SOME CONDITIONS ☆

• ASTHMA: Book Nurse Appointment for Peak Flow + Review
• MENTAL HEALTH: Appointment for Bloods, GP for results

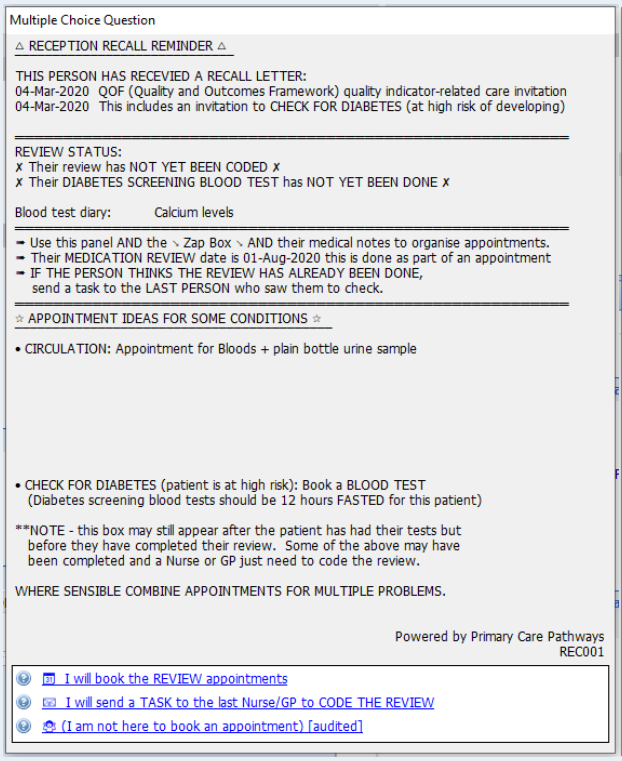
• CHECK FOR DIABETES (patient is at high risk): Book a BLOOD TEST

**NOTE - this box may still appear after the patient has had their tests but before they have completed their review. Some of the above may have been completed and a Nurse or GP just need to code the review.

WHERE SENSIBLE COMBINE APPOINTMENTS FOR MULTIPLE PROBLEMS.

Powered by Primary Care Pathways
REC001

I will book the REVIEW appointments
I will send a TASK to the last Nurse/GP to CODE THE REVIEW
(I am not here to book an appointment) [audited]



Multiple Choice Question

△ RECEPTION RECALL REMINDER △

THIS PERSON HAS RECEVIED A RECALL LETTER:
04-Mar-2020 QOF (Quality and Outcomes Framework) quality indicator-related care invitation
04-Mar-2020 This includes an invitation to CHECK FOR DIABETES (at high risk of developing)

REVIEW STATUS:
✗ Their review has NOT YET BEEN CODED ✗
✗ Their DIABETES SCREENING BLOOD TEST has NOT YET BEEN DONE ✗

Blood test diary: Calcium levels

➡ Use this panel AND the ↘ Zap Box ↙ AND their medical notes to organise appointments.
➡ Their MEDICATION REVIEW date is 01-Aug-2020 this is done as part of an appointment
➡ IF THE PERSON THINKS THE REVIEW HAS ALREADY BEEN DONE,
send a task to the LAST PERSON who saw them to check.

☆ APPOINTMENT IDEAS FOR SOME CONDITIONS ☆

• CIRCULATION: Appointment for Bloods + plain bottle urine sample

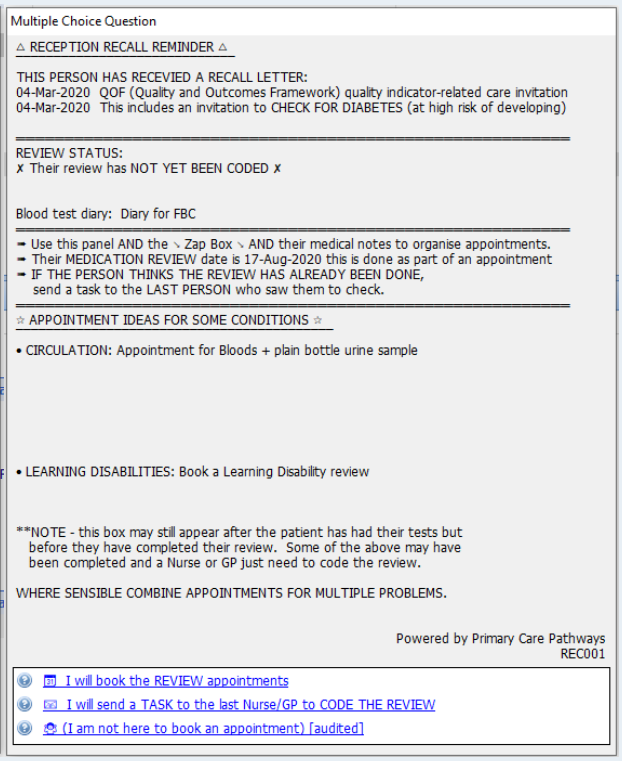
• CHECK FOR DIABETES (patient is at high risk): Book a BLOOD TEST
(Diabetes screening blood tests should be 12 hours FASTED for this patient)

**NOTE - this box may still appear after the patient has had their tests but
before they have completed their review. Some of the above may have
been completed and a Nurse or GP just need to code the review.

WHERE SENSIBLE COMBINE APPOINTMENTS FOR MULTIPLE PROBLEMS.

Powered by Primary Care Pathways
REC001

I will book the REVIEW appointments
I will send a TASK to the last Nurse/GP to CODE THE REVIEW
(I am not here to book an appointment) [audited]



Multiple Choice Question

△ RECEPTION RECALL REMINDER △

THIS PERSON HAS RECEVIED A RECALL LETTER:
04-Mar-2020 QOF (Quality and Outcomes Framework) quality indicator-related care invitation
04-Mar-2020 This includes an invitation to CHECK FOR DIABETES (at high risk of developing)

REVIEW STATUS:
✗ Their review has NOT YET BEEN CODED ✗

Blood test diary: Diary for FBC

➡ Use this panel AND the ↘ Zap Box ↙ AND their medical notes to organise appointments.
➡ Their MEDICATION REVIEW date is 17-Aug-2020 this is done as part of an appointment
➡ IF THE PERSON THINKS THE REVIEW HAS ALREADY BEEN DONE,
send a task to the LAST PERSON who saw them to check.

☆ APPOINTMENT IDEAS FOR SOME CONDITIONS ☆

• CIRCULATION: Appointment for Bloods + plain bottle urine sample

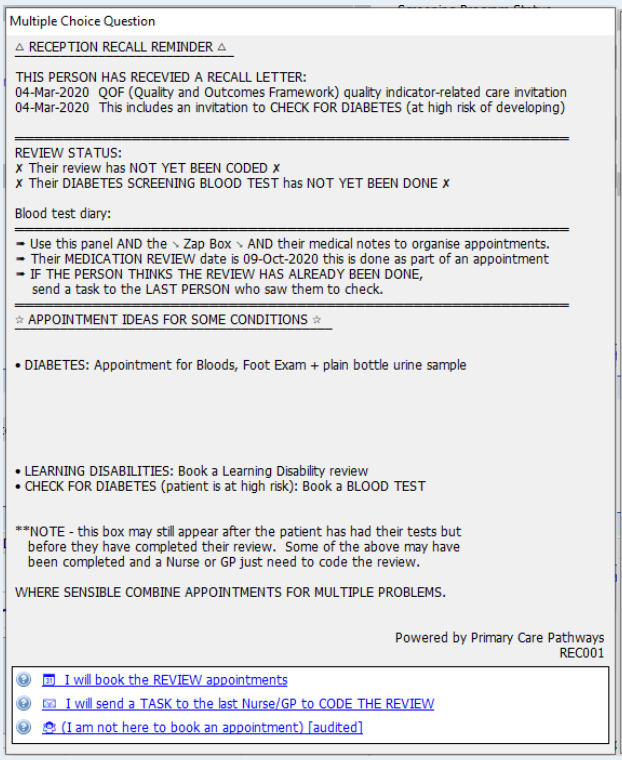
• LEARNING DISABILITIES: Book a Learning Disability review

**NOTE - this box may still appear after the patient has had their tests but
before they have completed their review. Some of the above may have
been completed and a Nurse or GP just need to code the review.

WHERE SENSIBLE COMBINE APPOINTMENTS FOR MULTIPLE PROBLEMS.

Powered by Primary Care Pathways
REC001

I will book the REVIEW appointments
I will send a TASK to the last Nurse/GP to CODE THE REVIEW
(I am not here to book an appointment) [audited]



Multiple Choice Question

△ RECEPTION RECALL REMINDER △

THIS PERSON HAS RECEVIED A RECALL LETTER:
04-Mar-2020 QOF (Quality and Outcomes Framework) quality indicator-related care invitation
04-Mar-2020 This includes an invitation to CHECK FOR DIABETES (at high risk of developing)

REVIEW STATUS:
✗ Their review has NOT YET BEEN CODED ✗
✗ Their DIABETES SCREENING BLOOD TEST has NOT YET BEEN DONE ✗

Blood test diary:

➡ Use this panel AND the ↘ Zap Box ↙ AND their medical notes to organise appointments.
➡ Their MEDICATION REVIEW date is 09-Oct-2020 this is done as part of an appointment
➡ IF THE PERSON THINKS THE REVIEW HAS ALREADY BEEN DONE,
send a task to the LAST PERSON who saw them to check.

☆ APPOINTMENT IDEAS FOR SOME CONDITIONS ☆

• DIABETES: Appointment for Bloods, Foot Exam + plain bottle urine sample

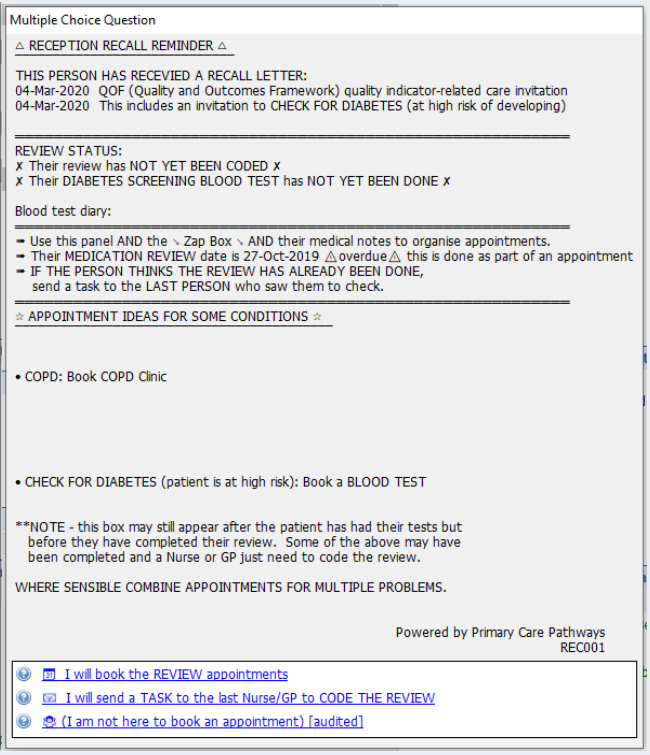
• LEARNING DISABILITIES: Book a Learning Disability review
• CHECK FOR DIABETES (patient is at high risk): Book a BLOOD TEST

**NOTE - this box may still appear after the patient has had their tests but
before they have completed their review. Some of the above may have
been completed and a Nurse or GP just need to code the review.

WHERE SENSIBLE COMBINE APPOINTMENTS FOR MULTIPLE PROBLEMS.

Powered by Primary Care Pathways
REC001

I will book the REVIEW appointments
I will send a TASK to the last Nurse/GP to CODE THE REVIEW
(I am not here to book an appointment) [audited]



Multiple Choice Question

△ RECEPTION RECALL REMINDER △

THIS PERSON HAS RECEVIED A RECALL LETTER:
04-Mar-2020 QOF (Quality and Outcomes Framework) quality indicator-related care invitation
04-Mar-2020 This includes an invitation to CHECK FOR DIABETES (at high risk of developing)

REVIEW STATUS:
✗ Their review has NOT YET BEEN CODED ✗
✗ Their DIABETES SCREENING BLOOD TEST has NOT YET BEEN DONE ✗

Blood test diary:

➡ Use this panel AND the ↘ Zap Box ↙ AND their medical notes to organise appointments.
➡ Their MEDICATION REVIEW date is 27-Oct-2019 △overdue△ this is done as part of an appointment
➡ IF THE PERSON THINKS THE REVIEW HAS ALREADY BEEN DONE,
send a task to the LAST PERSON who saw them to check.

☆ APPOINTMENT IDEAS FOR SOME CONDITIONS ☆

• COPD: Book COPD Clinic

• CHECK FOR DIABETES (patient is at high risk): Book a BLOOD TEST

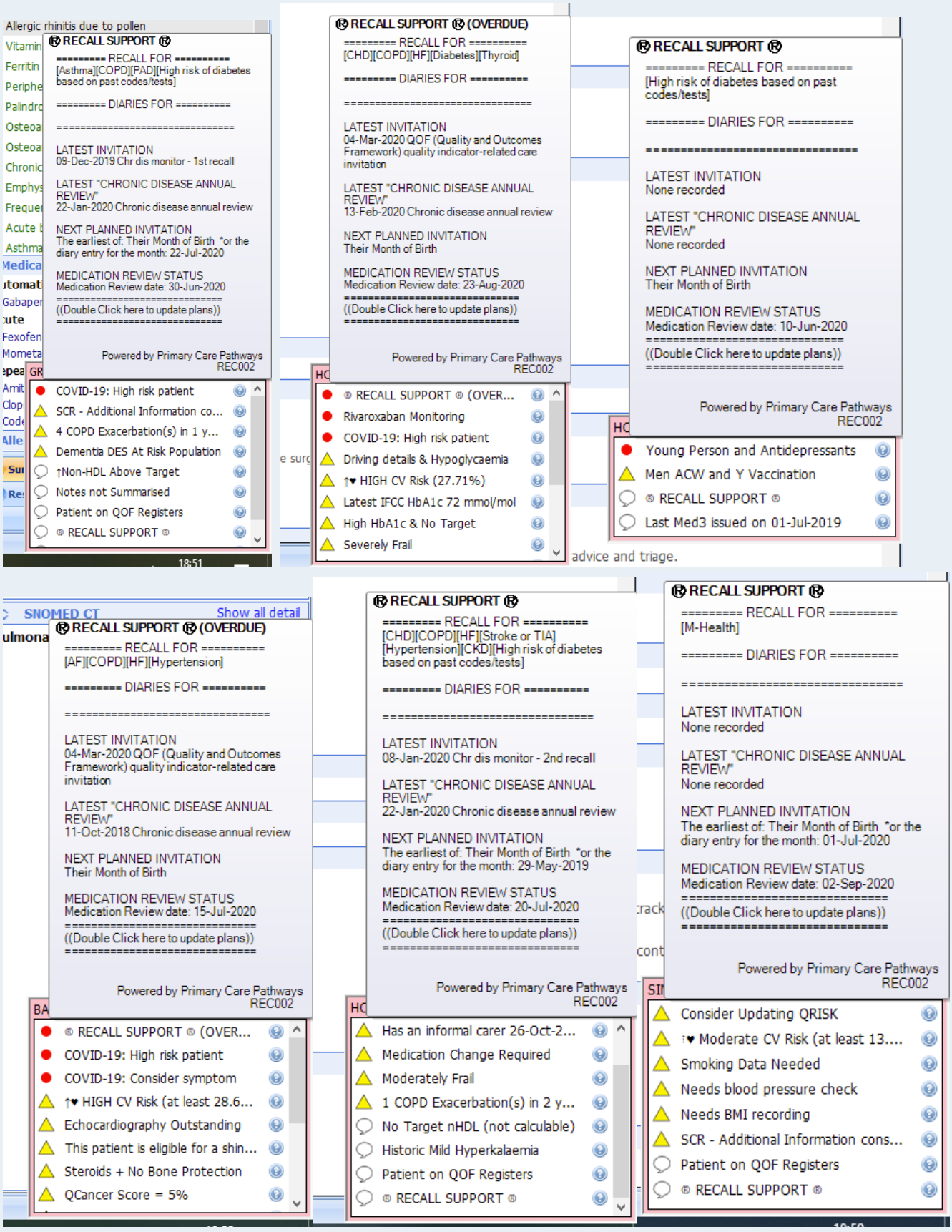
**NOTE - this box may still appear after the patient has had their tests but
before they have completed their review. Some of the above may have
been completed and a Nurse or GP just need to code the review.

WHERE SENSIBLE COMBINE APPOINTMENTS FOR MULTIPLE PROBLEMS.

Powered by Primary Care Pathways
REC001

I will book the REVIEW appointments
I will send a TASK to the last Nurse/GP to CODE THE REVIEW
(I am not here to book an appointment) [audited]

REC002 Recall Closing Support (Alert) - examples



Who does OneRecall Capture?

The main search engine for your recall patients: **Search R) RECALL MASTER SEARCH - Recall Needed**
It is designed to identify all of those patients you would normally aim to review at least annually because of the conditions they have or the drugs they are prescribed.
IMPORTANT: It does not deal with high risk drug monitoring such as Lithium and DMARDs. We have a separate weekly search product for this.
It also picks out certain predefined diary entries that may have been used to plan care in those same conditions. If you are a PrimaryCare IT subscriber you may use these diary codes in our other resources such as the OneTemplate.
Please do not edit these searches as we cannot guarantee their functionality if errors are made.
Do feedback to us at TheTeam@primarycareit.co.uk if you have feedback, ideas and suggestions.

Rule(s)	Situation
1	Commonly used diary entries, including from OneTemplate and for additional recalls
2	Diabetes
3	Ischaemic Heart Disease
4	Heart Failure
5,6	Stroke and TIA, including Haemorrhagic Stroke
7	Hypertension
8	COPD
9	Asthma
10	Dementia
11	Atrial Fibrillation
12	Peripheral Arterial Disease
13	Rheumatoid Arthritis
14, 15	Osteoporosis
16, 17,18	**Pre-diabetes / At risk of diabetes**
19, 20	Severe Mental Health / Lithium (for annual care review)
21	Chronic Kidney Disease

22	Epilepsy
23	**Learning Disabilities**
24	Palliative Care (Not Red / Amber; Days / Weeks of life)
25, 26, 27	Depression, including review after initial diagnosis
28, 29	**Hypothyroidism**
30	Cancer

Recall Scenario Calendars

It is hard to encapsulate all scenarios, but here are some common examples of how a patient mat engage with the OneRecall system, all with different months of birth.

Scenario 1 - Someone who needs 2 reviews a year but only gets the review after several reminders

MOB - April	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Default Recall Invitation 1																				
Reminder 2																				
Reminder 3?																				
Coded Review																				
Removed from Recall				3months from review												3months from review				
Diary for Additional Review																				
Additional Recall Invitation 1																				
Reminder 1																				
Reminder 2																				
Coded Additional Review																				
Removed from Recall										3months from review										

Scenario 2 - Someone who needs 2 reviews a year and who responds to the 1st or second invitation

MOB - June	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Default Recall Invitation 1																				
Reminder 2																				
Reminder 3?			None																	
Coded Review																				
Removed from Recall		3months from review																		
Diary for Additional Review																				
Additional Recall																				
Reminder 1																				
Reminder 2									None											
Coded Additional Review																				
Removed from Recall								3months from review												

Scenario 3 - Someone who needs 1 review a year and who comes in in that month, almost without needing a letter

MOB - August	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Default Recall Invitation 1																				
Reminder 2			None												None					
Reminder 3?				None												None				
Coded Review																				
Removed from Recall		3months from review												3months from review						
Diary for Additional Review																				
Additional Recall																				
Reminder 1																				
Reminder 2																				
Coded Additional Review																				
Removed from Recall																				

Scenario 4 - Someone who needs 2 reviews a year but who is seen opportunistically and early this year and late next year

MOB - January	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Default Recall Invitation 1			None																	
Reminder 2				None																
Reminder 3?					None															
Coded Review																				
Removed from Recall	3months from review																3months from review			
Diary for Additional Review																				
Additional Recall																				
Reminder 1																				
Reminder 2																				
Coded Additional Review																				
Removed from Recall										3months from review										

Recall Codeset (Diary Codes)

Code Term	Concept ID	Description ID
Asthma annual review	394700004	1488421017
Asthma follow-up	394701000	1488422012
Atrial fibrillation monitoring *(except Atrial fibrillation monitoring in secondary care)*	134377004 *(1855511000006104)*	216183015 *(1855511000006115)*
Chronic kidney disease follow-up	1856481000006101	1856481000006117
Chronic obstructive pulmonary disease 3 monthly review	760601000000107	1683181000000112
Chronic obstructive pulmonary disease 6 monthly review	760621000000103	1683221000000119
Chronic obstructive pulmonary disease annual review	394703002	1488424013
Coronary heart disease annual review	315614006	460133017
Dementia annual review	249181000000100	408401000000119
Diabetic annual review	170777000	264727014
Diabetic monitoring *(except Fundoscopy - diabetic check)*	170742000 (170757007)	264676010 *(264701014)*
Epilepsy monitoring	170702005	264629018
Heart failure annual review	390885007	1484918019
Hypertension annual review	401118009	1780319017
Examination of learning disabled patient	442127005	2819976014
Learning disabilities health assessment	413126003	2474674015
Completion of learning disabilities health action plan	712491005	3082259017
Prevention/screening invitation	310422005	453995012
Mental health review follow-up	248691000000104	407421000000110
Peripheral arterial disease	399957001	1787050010
Rheumatology disorder annual review	698706005	2975440014
Rheumatoid arthritis annual review	847261000000104	2196791000000119
Splenectomy	234319005	351029019
CVA annual review	699270006	2983515011
Chronic disease annual review	816421000000101	2127501000000113
Chronic disease monitoring - first recall	185679000	285674013
Raised blood pressure	24184005	1784950015
Diabetic 6 month review	198501000000100	299261000000111
FBC - full blood count	1022441000000101	2566641000000111
Chronic kidney disease monitoring	248721000000108	407481000000111
Urine albumin:creatinine ratio	1023491000000104	2553591000000116
Serum lipids level	1005661000000103	2573511000000110
Liver function monitoring	736164009	2736871000000110
Thyroid disease monitoring	170780004	264730019
At risk of diabetes mellitus	161641009	251884012
Bone profile	1006761000000104	2585971000000116
PSA (prostate specific antigen) monitored in primary care	1822111000006103	1822111000006119
[D]Blood pressure raised, hypertension not diagnosed	502541000000105	8189771000006113
Blood test due	165349007	257112011
Haemoglobin A1c level	1003671000000109	2560611000000113
QOF (Quality and Outcomes Framework) quality indicator-related care invitation	1109921000000106	2777371000000119