PASCOM-10. Invasive domain User Guide

Version 2.0

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Edited by Anthony Maher

Written by the PASCOM Working Party
College of Podiatry

A message from Matthew Fitzpatrick

Dear All,

I am very pleased to be able to announce the new look PASCOM-10 Website is now up and ready to use. You will see a new look welcome page – with scrolling news items as well as more details about accessing PASCOM-10.

There will also be a link to the main website of the College so we can increase the traffic to and from us. It is still a shame that the numbers of those who are using the wonderful FREE resource do not take it up but hopefully this will improve.

Please, please keep up the effort – utilise the new Friends & Family function – this will be a key report that will enable commissioners to be made aware of individual services and how they are making an impact on the local health economy.

You will now see the expanded functions of forms and events that enable you to capture even more data about your patients. There will be one further push to envision surgical colleagues at the Warwick Conference next year (March 2015) and the roll out to non-surgical sites continues.

The ability to have a set of standard reports run automatically each month will come online soon as well. Finally, for now, there will be a new training route in to PASCOM-10 soon that is much less cumbersome and more interactive. It will also provide existing users with a resource to go back to and refresh your skills should you 'forget' some of the features and how to use them.

I will keep in touch with new and developing features of the site but hope you welcome the new look and continue to enjoy PASCOM-10.

Regards,

Matthew Fitzpatrick FRSPH, FCPodMed, FFPM RCPS(Glasg)

Chair of PASCOM-10 Committee

Dean of Podiatric Medicine, College of Podiatry

December 2015

Section i: Foreword by David Tollafield

PASCOM was first conceived in 1986 and went out to professionals in the following year. The Society of Chiropodists and Podiatrists took on responsibility for PASCOM in 2000 from Walsall Community Trust and in 2005 started work on expanding the programme. Some of you will have used PASCOM 2000, a Microsoft database which was a good start but still a far cry from what we really wanted to achieve. This year we have completed our key development work and pass the project over to its new home in the College of Podiatry (R&D Committee).

In 2010 we rolled out the first web based PASCOM system for podiatric surgeons and podiatrists undertaking nail surgery. Last May (2012) we completed our plans set out by the working party to expand the system for ALL podiatrists. This year we have not only established an on-line training programme which makes training much easier, but we have now updated all our information help sheets. These can now be found in the following pages. The new manual can be downloaded from www.PASCOM-10.com

Over the years some 30 people have contributed to the system we have today. It is hoped that all clinicians will want to know more but you can start your own education now with the information that the working party have put together. No-where else do members receive such quality in clinical support for no cost. Please embrace PASCOM within you own practice whether you are in private practice or NHS. I hope all podiatrists will agree this has been a wonderful piece of collaborative work and I hope the members will avail themselves of its' many opportunities.

David R Tollafield
Dean Faculty of Podiatric Surgery and former Chair of PASCOM-10 working party
August 2013.

Section ii: Introduction to version 2.0 June 2018

Version 1.0 of this user guide was published in 2014. Since then PASCOM-10 has been through many changes and developments. The website underwent a major re-development in 2015 and the training process was updated. New users are now required to watch a series of short videos before completing an online assessment. Many new features, subtle edits and corrections have been applied. The most important of these are recorded in the news archive available on the website at: http://www.pascom-10.com/news. We have responded to many requests from users, nowhere more so than in the reports section. Of particular note we have updated our advice on data protection and consent. The list and glossary of sequellae has been revised and updated and the report section details all available reports for the invasive domain.

Section ii: Introduction to version 1.0 August 2013

This guide has been produced for PASCOM users and those podiatrists interested in using PASCOM-10. It incorporates and supersedes all previous guides and manuals issued by the PASCOM Working Party. The table of contents is hyperlinked allowing for rapid access to the relevant information, although you may wish to print the guide and place a copy in your clinic for easy reference. The latest version of the guide will always be made available on the PASCOM-10 website; www.pascom-10.com.

The information in this guide has been written specifically to support the 'invasive domains' of PASCOM. In simple terms those clinicians using PASCOM to record nail surgery, injection therapies and podiatric surgery will find this guide directly applicable to their practice. Clinicians using the non-invasive domains of PASCOM may still find this guide helpful although a subsequent guide will be made available for the non invasive domain.

If you have a question not answered by this guide, please contact a webmaster via the information page on the PASCOM-10 website. Please note that screen shots used in this guide are taken from the PASCOM training website and contain fictional patient data.

Section iii: Table of contents

Section 1: What is PASCOM?

The mnemonic PASCOM stands for *'Podiatric audit of surgery and clinical outcome measurement'*. It was designed in 1996 as a simple Microsoft Access database by Gavin Rudge and David Tollafield. PASCOM has since become a major longitudinal project endorsed by the Society of Chiropodists and Podiatrists and the College of Podiatry who hold the copyright under the title PASCOM-10©. The database was originally intended to collect data relating to podiatric surgery and has since become established as the leading audit system used by Podiatric Surgeons in England.

Over the last few years a major expansion of the system has been underway. The first step was to introduce patient reported outcomes. This important addition allows clinical improvement following treatment to be measured in terms of patients' health related quality of life. The second key development was to begin capturing data relating to therapeutic injections and nail surgery. The third important development (referred to as Phase 2) will see PASCOM offer clinicians the ability to collect data relating to non surgical treatments including general podiatry, wound care, orthotic interventions and other musculoskeletal treatments.

PASCOM is free to all members of the College of Podiatry (COP). Training can also be accessed for free by following the links from the registration page: http://www.pascom-10.com/how-to-access-pascom-10.   For further support trainers can be found at http://www.pascom-10.com/find-a-trainer. Trainers may charge a small fee to cover expenses. A working party coordinates the project for the COP and is accountable to the Research and development committee.

Aims of the Project

PASCOM aims to monitor activity and provide evidence for the benefits of podiatry treatment in the United Kingdom specifically relating to safety, competence, satisfaction, cost effectiveness, and health related quality of life. Ultimately it is hoped that data generated through PASCOM will aid the development of evidence based care pathways for all aspects of podiatry from general practice through to podiatric surgery. Wherever possible PASCOM will utilise robust validated patient reported outcome measures to illustrate improvement in quality of life.

How can PASCOM benefit the Podiatrist?
- Collect CPD evidence for your practice
- Logbook of your clinical activity, outcomes and reflective practice
- Log all of your diagnostic investigations and their outcomes
- Log your use of prescription only medicines
- Instant access to nationally recognised patient reported outcome measures
- Submit evidence for Peer Review or Appraisal
- Use the system as an electronic patient record with free text facility – *in development*
- Build up a picture of clinical and cost effectiveness
- Develop clinical pathways
- Integrate practice with other clinicians
- Benchmark your practise for safety, effectiveness and clinical outcomes
- Demonstrate impact of treatment on health related quality of life
- Recognise and monitor complications affecting your patients

Section 2: Terms of Reference

Webmaster   a member of the PASCOM working party. The webmaster can make adjustments to some but not all website functionality. Any *User* may contact the webmaster to report a problem with the system or request system changes. Such changes will come before the working party for approval.

Administrator   A User of the system who is responsible for managing a registered centre(s). *Administrators* complete additional appropriate training. *Administrators* can approve new users to join their centre. *Administrators* should prevent misuse of the system and undertake regular random checks to ensure that the *Users* are completing data and events appropriately. *Administrators* should deal with errors quickly and support *Users* where necessary. *Administrators* will inform webmasters of any mal use or breach of confidentiality which may in turn be reported to the Professional Conduct Committee of the Society of Chiropodists and Podiatrists. *Administrators* may Interrogate and report ALL DATA in their registered centre(s).

Users   Each *User* is responsible for in-putting audit data for their registered centre(s). *Users* are not able to interrogate data.

Reporter   **A** PASCOM-10 working party member appointed by the College of Podiatry who can analyse and report anonymous data for all centres on a national basis.

Episode   A series of *'events'* makes up an *'episode'* of care. An episode has a direction which commences with referral and finishes with discharge. A patient may have multiple episodes recorded on PASCOM.

An event   Is one part of an episode of care represented by an entry on a specific date.

Sequelae   an expected or potential consequence that may arise occasionally from the process of treatment e.g. nail re-growth following nail surgery.

Complication   a consequence of treatment which carries longer term considerations with greater impact on the patient in terms of cost of care and functionality after recovery. Not all complications are reversible e.g. CRPS II.

Discharge   Part of the clinical pathway that completes an episode of care, typically 6 months following podiatric surgery.

Domains   PASCOM-10 has a structure based on common areas of podiatric practice. There are two domains on PASCOM; **Invasive** for recording nail surgery, injection therapies and podiatric surgery. **Non invasive** for recording general practice, wound care, health promotion and orthotic management.

Report   The section called reports allows data to be extracted from the system in the form of reports. Activity, outcome and research form the main headings with sub groups.

Section 3: Protecting patient data

It is crucially important that users read and agree to the terms and conditions of use before using PASCOM-10. These are available at the end of this document.

 Users must also be aware of and agree to the privacy statement available at http://www.pascom-10.com/privacy

If you would like to change any information we hold about you that has been collected via use of this Website or want to it to be removed from our database, you should contact us at member@scpod.org.

Questions, comments and requests regarding this Privacy Policy should be addressed to feedback@scpod.org.

There are a number of legal requirements users must be aware of when handling patient data. The following pages provide guidance on the appropriate use of and access to PASCOM-10. Further advice can be sought by contacting the PASCOM team via the website.

As healthcare professionals, our duty of care lies with the patient and we have a responsibility to protect identifiable patient data from any unauthorised access. PASCOM-10 allows users to enter a number of identifiable variables for individual patients. These variables assist users in identifying otherwise anonymous audit data and make it possible to enter a series of live 'events' throughout an episode of care.

Table 1. Patient Variables recorded on PASCOM-10:

Optional data includes:	Mandatory data includes:
Surname, Forename, NHS number and Post Code.	DOB, Sex and a record number (this may be a random number of your choosing).

In general terms, patient data must be held securely with password protection and the data should not be accessible for unauthorised use. The eight principles of data protection (appended) should be adhered to and any breach of the General Data Protection Regulations should be avoided. For more information about data protection go to: https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/

Within in PASCOM users have the choice to either collect a limited amount of patient identifiable information or alternatively, patient data can be anonymous. **For users working within the NHS we recommended that only anonymous (i.e. non patient identifiable) data is collected, though ultimately the decision will be made by the host organisation**. PASCOM Users working in the commercial, industrial or private health care sectors will need to register with the information commissioner in advance of any data collection: http://www.ico.org.uk/.

Important Note: the NHS Number is not anonymous. Local record numbers such as those specific to a department or hospital may be considered anonymous if used without other identifiable data such as patient names.

A local record number is defined as a number or series of letters and numbers which only allow identification of a patient when read alongside other external data not included in the database (e.g. name, address, NHS number) and only within a defined organisation or department. If such numbers were viewed by a person outside of the defined organisation or department, they would not allow identification of a patient or personal patient data.

Consent

Patients should be informed of, and give consent to data being collected. Patients should be informed about why the data is being collected and how any data may be used. It is advisable to keep a written record of any consent for data collection. Within the NHS it is advisable to seek further advice on consent from Caldicott Guardians.

Under the Freedom of Information Act 2000 patients can ask to see a copy of any data held on them. Users of PASCOM are required by law to respond to FOI requests and guidance is available from the Information Commissioner's Office:
https://ico.org.uk/for-organisations/guide-to-freedom-of-information/what-is-the-foi-act/

Using PASCOM in the NHS

Prior to using PASCOM-10 in the NHS, users must first discuss its implementation with a line manager. Further approval will likely be required from clinical governance officers locally. Governance officers may wish to undertake a risk assessment and may wish to talk to IT specialists and Caldicott Guardians prior to any approval.

Caldicott Guardians

Within the NHS, a Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012. The mandate covers all organisations that have access to patient records.

Acting as the 'conscience' of an organisation, the Guardian actively supports work to enable information sharing where it is appropriate to share, and advises on options for lawful and ethical processing of information. The Caldicott Guardian also has a strategic role, which involves representing and championing Information Governance requirements and issues at Board or management team level and, where appropriate, at a range of levels within the organisation's overall governance framework. If you need information about a Caldicott Guardian at a particular organisation, please contact your NHS organisation or Local Authority.

PASCOM-10 Database Security

The PASCOM-10 website and database are hosted on secure cloud severs held in Microsoft Azure data centres (https://azure.microsoft.com/en-gb/). This link includes a summary of accreditations that the data centres hold including ISO/IEC 27018 and UK G-Cloud (https://azure.microsoft.com/en-gb/overview/trusted-cloud/). The database is backed up to multiple geographically redundant and encrypted backups within the Microsoft Azure network of data centres on at least a daily basis.

Remote access security

There is no direct remote desktop access available to the webserver as it is running on a Platform As A Service (PAAS) hosting environment. Only website updates can be uploaded,

these is no facility for anyone outside of Microsoft to change non-website related server settings or install other software on the server.

Access to upload website or database changes is controlled by Microsoft Account sign-on security. In addition access to the database is only possible from specific whitelisted IP addresses which are set to the developers office. The website developers, Webfuel (https://www.webfuel.com), use password protected PCs to access the website. Webfuel is based in Loughborough, UK.

Website Security
The application (PASCOM-10) is protected using industry standard ASP.net authentication which is a Microsoft standard security system. The website can only be accessed via secure HTTPS connection.

Password Security
Access to the website is granted via username and password, passwords are held securely hashed (not plain text). Passwords are alpha-numeric, at least 8 characters long and must contain at least one lower case character and at least one upper case character. Users are advised that passwords should be changed regularly and users are not be able to reuse any of their 3 previous passwords. Any IP address making 5 failed password attempts within 5 minutes will be temporarily blocked from trying further passwords to prevent brute force attacks. The website will auto-time out following a period of inactivity. Passwords and usernames must not be shared with colleagues or other users of the system. All users are advised to access the website through password protected PCs.

Table 2. Who can access the database? The table below summarises data access rights:

Access Level	Login to website	Login to a registered centre and add, edit or review patient data	Approve the creation of new centres	Report activity for a registered centre	Review or edit details of registered users at all centres	Access patient data across all centres
User*	✓	✓				
Administrator	✓	✓	✓	✓		
Webmaster	✓	✓	✓	✓	✓	
Reporter	✓	✓	✓	✓	✓	✓
IT Partners**	✓					

***Users must be registered at a centre for any website functionality. Registration at a centre must be approved by a centre administrator or webmaster.
****Webfuel have access to all aspects of the website for developmental and system engineering purposes.

Section 4: Registering a Centre

Before any patients can be registered on P-10, a centre must first be created and registered with the system. Registering Centres is a very important aspect of P-10 and care must be taken to ensure that the details are accurate. All future reports will be linked to specific centres and clinicians.

Some important points
- A centre should only be created by a trainer or a podiatrist who intends to act as centre administrator.
- It is essential that centres are not duplicated. This will result in data inputting and reporting errors.
- Administrators take responsibility for data within the centre.

For further guidance visit YouTube and search PASCOM-10 // Log In
https://youtu.be/5bDxc1WfGxI

You may register at multiple centres, and your roles may differ at each centre. When on the home screen you can easily select which centre you wish to input data for by clicking on the required centre.

Section 5: Data Structure

Before undertaking data collection, it is important to understand the hierarchy of a P-10 record.

At the centre of the record is the patient who is the most basic unit of analysis. Next we have an episode of care. An episode is a period of podiatric care that begins with a referral into a service and ends when the practitioner (or patient) decides to conclude the episode through discharge or onward referral. A patient may enter and exit a service on several occasions perhaps with different problems, a problem on a different foot, or the same problem that recurs and some sort of remedial action is required.

Each episode will consist of a pathway of events. These represent the normal stages of passage through a service usually accompanied by specific clinical interventions such as surgery, or specific clinical decisions such as a decision to refer on or even to do nothing for a while whilst a watching brief is kept on the patient's problem.

As far as P-10 is concerned however, some of these events will also have multiple components. For example, an operation will have several procedures.

It is important not to confuse these layers of data, as these will also determine the basis of analyses that are carried out.

Section 6: Creating a new patient

The central unit of data for the system is the patient, for further guidance visit YouTube and search *PASCOM-10 // Patient Registration*
https://youtu.be/wfRpWeSKzCE

Section 7: Creating a new episode of care

As in the earlier PASCOM system we refer to patient encounters as *'episodes'*. In this new version we are able to capture more types of episodes which we can then use as a unit of analysis. Note that we must select a date for all of our episodes and events. The default date is today's date in each case. It is easy to overlook this and simply carry on inputting and allow the default date to be entered each time. **However, if you are entering data retrospectively there is a source of potential error.** Once an episode has been created with a referral, a drop down box appears allowing individual events within the episode of care to be recorded.

For further guidance go to YouTube and search PASCOM-10 // Consultation, Assessment & Investigation
https://youtu.be/gfNI8ZmZONo

Events within Episodes

Once an episode has been started a series of discrete events will occur along a care pathway. There are not only distinct types of event, but sometimes more than one of each type of event can occur. For example, several separate consultations may occur, or surgery that is staged in a number of operations.

On the patient summary screen, as you enter the events that are discussed in the following sections, you will notice how they appear in chronological order under the episode heading. From the patient screen, having identified the person for whom you wish to add an event; you click *"edit"*. From here a new event can be created. By selecting an event from the drop down menu and double clicking, you will open a new screen to capture all of the data that relate to the event that you intend to record.

The Consultation Event and Recording of Diagnoses

If we select 'consultation' as our first event on the pathway, we see a screen that allows us to collect diagnostic information (new to this version of P-10) as well as the clinical decision taken as a result of this consultation. Within the Consultation Event, both medical and podiatric diagnoses can be entered utilising the ICD-10 data set. The full list of codes used on P-10 is available on the website.

It is important to consider the purpose of these data. They are used to classify the patient into case mix groups. If the patient has more than three significant diagnoses it is better to limit the list to the most significant to the patient's clinical management at the time of consultation.

Section 8: Investigations

Users of previous versions of PASCOM will recall that an investigation was simply a data item attached to the surgical episode and did not have any outcome attached to it. Now it is captured as an event in its own right. The advantage of this approach is that the record can reflect a complex investigative pathway that may develop between the initial presentation and the ultimate treatment regime that is carried out.

For further guidance go to YouTube and search PASCOM-10 // Consultation, Assessment & Investigation
https://youtu.be/gfNI8ZmZONo

Section 9: The Treatment Event

To enter the data, remember that 'Treatment' is just like any other event on the patient pathway; you create it from the *'new event'* drop down from the episode history part of the patient's screen (see figures above).

If a patient has re-entered your service and needs a second operation, perhaps for a new diagnosis **then** the operation will be part of a new episode of care but with its own pathway including a referral entry and presumably consultation and diagnostic events of its own.

Initially, the treatment event screen just has a few boxes to collect some basics such as what type of surgery was scheduled and whether the patient turned up (see below).

All elements of the extended treatment event can be accessed by clicking on *"Add"* to the right hand sign of the screen. This will open a pop up screen for data entry. Alternatively data may be edited or deleted by following the links.

Fixations, diagnostic services and medication all work in the same way. Each is clicked from a list and they all have some additional data items attached to them that have to be captured before the record can be saved

Another innovation is to be able to associate named clinicians to treatment events and determine their role. When inputting the procedure, individuals can also be recorded for each procedure associated with the treatment event.

Podiatric surgeons and surgical trainees providing treatment can have a training level associated with their input in the patient's procedure as per guidance from the Faculty of Podiatric Surgery. Please see the following section for further details.

For further guidance go to YouTube and search PASCOM-10 // Treatment Event
https://youtu.be/ILidum3wD1s

Section 10: Training levels and the Treatment Event

The following guidance was written for podiatric surgery trainees but the levels described can be applied to all those involved in providing Podiatry.

Table 3. Levels of surgical activity as defined by the Faculty of Podiatric Surgery

Level 1 "KNOWS ABOUT"	Trainee knows about the operation in general terms including its indications, contra-indications, complications etc
Level 2 "HAS SEEN"	Trainees are present during the whole of the operation and may or may not be scrubbed in to the field.
Level 2"b"	Experience of and satisfactory completion of the procedure on a cadaver
Level 3 "CAN DO WITH HELP"	Trainees are scrubbed-in acting as 1st or 2nd assistant during the operation. The trainee may complete elements of the case according to experience / training. The components undertaken by the trainee are logged using the standardized sheets provided
Level 4 "CAN DO"	Trainees act as principal surgeon for more than 90% of the key elements of the case. Guidance is provided by the tutor as appropriate with some aspects of the surgery being under-taken / checked by the tutor. Key elements is a term intended to avoid the trainees input being over-estimated. For example a candidate may complete all of a scarf akin but the fixation. This would not constitute a level 4 input
Level 5 "CAN DO" "CAN MANAGE COMPLICATIONS"	The entire case including all the surgery "skin to skin" is conducted by the trainee under the direct supervision of the tutor. The candidate is able to manage successfully intra-operative complications if they arise.

Section 11: ASA Grades; A PASCOM Users guide

The **ASA physical status classification system** was developed by the American Society of Anaesthesiologists (ASA) in 1963. It comprises a simplified five-category physical status classification system; a sixth category was later added. The grades are listed below, with examples to assist you in practice.

Table 4. ASA Grades

ASA Grade	Definition	Example
1	A normal healthy patient.	A patient taking no regular medication and with no systemic disease.
2	A patient with mild systemic disease.	Mild systemic diseases include mild hypertension, controlled asthma, and osteoarthritis. Such conditions may or may not be medicated.
3	A patient with severe systemic disease.	Severe systemic illness includes complicated diabetes, autoimmune diseases, and unstable cardiac disease.
4	A patient with severe systemic disease that is a constant threat to life.	Not applicable to Podiatry
5	A moribund patient who is not expected to survive without the operation.	Not applicable to Podiatry
6	A declared brain-dead patient whose organs are being removed for donor purposes.	Not applicable to Podiatry

Section 12: Injections

Therapeutic injections may be recorded within the treatment event although many of the menus here will not be relevant. As such a separate Event has been created for inputting therapeutic injections as a distinct type of episode (see below). As in other screens a box to record free text comments has been provided. Once the save button has been hit a further menu appears allowing you to record the specific drug administered in more detail. This data must then be saved in the usual fashion. When saved the injection type and date appears in the patient summary screen as an Event.

Section 13: Post-operative Assessment – Post Treatment Event

The post operative assessment is a very simple screen. Again it is added as an event on the pathway from the patient information screen as seen in the figures above, and is selected from the drop-down list of events like all of the others. Like the *'consultation'*, it consists mainly of a place to record a clinical decision and has the same list of options.

For further guidance go to YouTube and search PASCOM-10 // Follow Up Appointment
https://youtu.be/JBRCHjhFiMQ

Clinicians Analysis of Outcome (CAO)

To account for the clinician's ability to evaluate treatment outcomes, P-10 includes the CAO which is completed at the end point of a treatment episode. The available options for the clinician are *Aims Wholly Met; Aims Partly Met; Aims Not Met; Lost to follow up; cannot be assessed at this time.* Which option is chosen will depend primarily on the answer to question one of the PSQ-10 but also on the clinical and radiographic appearance, the post operative recovery and any recorded Sequelae or complications. Alongside the MOXFQ and PSQ-10, the CAO should be completed at 6 months post intervention.

CAO is only available when certain *'clinical decisions'* are selected (see below). These work like any other drop-down in the system in that the user double-clicks the outcome and saves the record. The relevant decisions which give access to the CAO are as follows:

- Referral: acute surgical
- Referral: orthotist/footwear
- Referral: physiotherapy
- Referral: podiatry
- Status: discharge
- Status: post operative care podiatric surgery

Section 14: Sequelae – Post Treatment Event

When the post treatment data has been saved an additional menu will appear for sequelae, click *'add'* to open a pop up containing a list of possible sequelae which may be associated with the episode of care (see below). The user can not only associate a specific outcome to the episode but can choose the surgical event which, in their clinical opinion, the outcome arose from. Also, in episodes involving more than one podiatrist, the person whose work is associated with the outcome can be selected.

About Clinical Sequelae, Complications and Risk

The clinician should record post-operative problems and events as part of routine practice and therefore these pages lay out a wide range of the common terms. Fifty plus terms and statements replace the previous thirty-eight terms covering the post operative period of recovery in the 2002 version of the PASCOM handbook. We have applied the terms Sequelae and complications to fit the specific types of post operative problems. Together, sequelae and complications can be considered as *negative performance indicators*.

Sequelae (sek-kwelly – pl.) is a term relating to a consequence which might be expected. These carry low risk and imply low cost treatment. A sequela (sing.) is a potentially expected single consequence *following on from* surgical treatment; Sequelae: multiple consequences.

Complications give rise to consequences carrying longer term considerations with greater impact and cost. We have therefore used the term **complication** to carry longer periods of healing, periods of recovery, mobility and pain relief. Loss of tissue, function or a part of the foot carries a greater impact on economy for the healthcare provider and patient.

Grading the impact (severity) of a post operative occurrence

Each time a sequela arises it must be recorded. Each sequela or complication is given a risk rating 1 to 5. A risk rating of 5 relates to a complication or sequela with serious or life threatening consequences or indeed death.

Where available, using reports from PASCOM[2000], we have been able to cite typically reported results to help provide some idea of the risk of such an event occurring. In 2008 our report contained outcomes for 6050 patients.

Three tables are provided below. The first summarises the risk ratings, the second table offers a quick reference chart while the third lists the various sequela with a detailed definition. Colours, green for low to red for high through blue, yellow and orange are used as an extended traffic light system.

Table 5. Risk ratings and their definitions

Risk level	Expectation of event: sequela or complication	Features of Risk
1	Expected frequently *(Sequela)*	Features are short lived and do not involve surgery or significant interventions
2	Expected but less frequently *(Sequela)*	May remain over 3-12 months and then disappear slowly
3	Not expected – but could happen; borderline sequela but *complication may arise*	May have consequences. Longer treatment times and possible surgery may be required
4	Not expected, low chance of occurring - always known as a *complication*	Consequences for function and mobility, some permanent loss possible. Loss of part, surgery required. Usually containable. Usually requires further surgery
5	Difficult to predict, very low likelihood of arising - serious *Complication*	Direct effect on life, possible death, hospitalisation with attendant secondary problems

Table 6. Quick reference chart; example negative performance Indicators associated with foot surgery

Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Sensory loss (NS)	Incision line healing (dehiscence) (DHC)	Non compliance (NCP)	Haematoma (HTM) Deep vein thrombosis (DVT)	Serious infection (INF+2) Severe wound (SWB)
Footwear return <3/12 (FWR)	Medication side effect (RxSE)	Joint pain and stiffness (JPS)	Skin necrosis (SNEC)	Pulmonary embolus (PE)
Transfer metatarsalgia (TMET)	Thickened scar line or painful (SCR)	Suture abscess or reaction (SABR)	Avascular necrosis (AVN)	Complex regional pain syndrome(CRPS)
Callus development (CAL)	Poor pain control (RxP)	Pain at site of surgery PNSS)	Delay in bone healing (BUND)	Mortality (MORT)
	Local anaesthetic failure (LAF)	Abnormal swelling (OED)	Osteomyelitis (OML)	Mortality delayed 3/12 (MORT+3)
Steroid flare (STF)	Infection suspected (INFS)	Fracture of metatarsal (FMET)	Deformity reoccurrence or failure of surgical procedure (FTX)	

Post operative nausea & vomiting (PONV)	Injection following surgery (TXI)	Fracture of screw (FXFR)	Infection proven (INF+)	
	Digital periostitis (DPRT)	Nail regrowth (NRG)	Sensory loss large >5cm (NS+1)	
		Inclusion cyst (INCL)	Motor power loss (MPL)	
		Fixation movement (IMPL) Stump neuroma (ENS) Neuropraxia (NPRAX)	Breakdown of wound (BKD)	

Table 7. Negative performance indicators, Definitions, abbreviations and risk ratings

Pink coloured banding below is associated with wound healing problems from minor to severe. Cardinal signs in wound healing should not be recorded unless the wound deteriorates and requires attention outside normal expectations. This commences with dehiscence (DHC).

Note that the following table was compiled in 2010 by Mr David Tollafield and is not a complete list of all sequela that may now be recorded on PASCOM. Wherever possible incidence data is included from the PASCOM 2000 system 2008 report.

Code number	Category	Definition
NA	None	No observed Sequelae, a null result desired from all surgery. Exclude the usual cardinal signs in data capture **Risk 0**
1. NS-0	Sensory loss small	Arises in many cases and usually settles. This is not a complication but frequently seen for short periods. Common examples are surgery performed near to cutaneous nerves. This may not be avoided; The area of sensory change covers a small area distal to or immediately proximal the incision area. This is not considered a complication but frequency should be recorded. *0.4% reported 2008* **Risk 1**
2.OED	Abnormal swelling	Swelling is an expected outcome and may arise after surgery. Of course if swelling is present pre operation this should be documented and does not constitute a sequela or complication. Abnormal swelling or post operative oedema is ***defined where there is distension within the tissue of the foot, away from the surgical site for a period of greater than 16 weeks.*** Localised swelling may be associated with infection or periostitis and should therefore be recorded under infection or

		periostitis. It should be pointed out that general swelling is NOT included. Most surgeries will take longer than 4 months to settle for example first ray 12 months, mid foot 15-18 months and hind foot 24 months. *1.1% reported in 2008 is almost certainly lower than could be expected. Anything up to 20 is more likely.* **Risk 3**
3.DHC	Incision line healing	Wounds may dehisce and the skin edges separate. The wound should not be wide enough to require any surgical intervention; If this happens then it should be recorded under poor healing as this risk rating goes from 1 to 2. This is a minor inconvenience and is predictable in events where wires are fixed percutaneously and casts additionally occlude the skin. All such wounds should be recorded under **DHC** provided that an <u>**infection is not**</u> present, when they should be recorded accordingly**.** *1.7% incidence (Report 2008)* **Risk 2**
4.FWR	Footwear return delay under three months as marker. *See PSQ-10 scores for question (6)*	As a result of swelling and pain mainly it is not expected that a patient returns to footwear immediately except maybe after an injection. Post-operative or recovery shoes are not included, neither are sandals. A closed in shoe is not a slipper but may be a trainer, canvas shoes or shoe bought for the purpose and may be a size larger than usual. Bear in mind following surgery older shoes may not fit as the foot will have deliberately changed shape i.e. narrower, shorted, less flat foot, less bony projections. *93% return to shoes by 12 weeks (2008 report. N=6501 patients, for predominantly forefoot surgery)* **Risk 1**
5.TMET	Transfer metatarsalgia	This condition is common and we regard it as a risk of 20%. Most TMET clears with education and return to normal working so may be under reported. The incidence must be recorded even if mild. There are more specific causes which should be kept separate to be recorded in other parts. Joint pain, fracture or callus. Neuromata may be made worse where present or an unknown neuroma may arise or active bursa. Both these can be recorded under TMET. *0.7% reported 2008. Likely to have been interpreted as severe. This does not account for minor occurrences which are reversible.* **Risk 1**
6.CAL	Callus development	Thickening of the top layer of skin or epidermis or where more complex patterns exist such as IPK. This should always be recorded where no callus has been seen before. Do not record under TMET. Standard preoperative notation would include any pre-operative callus in the records. *0.3% reported 2008.* **Risk 1**

7.STF	Steroid flare	Steroid injections are known to cause a flare or reaction which has no consequence long term but may provoke some considerable pain. Estimated at 3-4%. This settles down within a week. **Risk 1**
8.PONV	Post operative nausea and vomiting	Post operative nausea and vomiting arises with a wide range of drugs, especially with **general anaesthetic episodes**. This should also be recorded where a patient feels sickly and cannot use the medication provided, or where analgesic medication has to be changed because of nausea. Note this if the patient feels sick, or vomits or requires an anti-emetic to settle PONV. *0.4% reported 2008* **Risk 1**
9.LAF	Local Anaesthetic failure	When conducting surgery with sedation or without sedation the patient should be aware of the fact the local anaesthetic can fail. Estimated at 2-5% for lower limb/foot and ankle procedures. The data should be collected for audit purposes. It is only applicable where the treatment (surgery) is impeded in part or whole from being completed. *Data unavailable at this time.* **Risk 2**
10.FTX	Failure of surgical intervention	This may be simply return of a bunion (2-5% risk) or perhaps further surgery being necessary. Over correction or under correction fall into this category. The time frame however is important and for this reason only complete failures should be recorded. Nail regrowth is captured separately under **NRG**. Clinicians make this judgement not patients. *Data unavailable at this time.* **Risk 4**
11.FMET	Fracture of metatarsal	Pain in the forefoot after surgery may be associated with this occasional complication. MUST be confirmed by x-ray. Stress fracture of a lesser metatarsal due to transfer of load. Do not record under TMET. *0.1% risk (2008 report)* **Risk 3**
12.PNSS	Pain at site of surgery beyond 6 weeks	Continuous or frequent pain **beyond six weeks**, requiring low dose analgesics. We do not consider that acute pain should be experienced at the surgical wound site once skin has healed. This is distinct from tenderness to touch, which may be normal for some weeks. This does not include joint movement as this comes under joint pain specifically. Twinges of discomfort or tenderness may be present up to 12 months and should not be recorded as abnormal. Further investigations will be considered. *1.9% (Report 2008)* **Risk 3**
13.TXI	Injection after surgery completed	This does not mean giving a 'top up anaesthetic' but providing the patient with an injection as a defined treatment. It may constitute any anaesthetic agent and can be conducted in clinic or anaesthetic room or theatre, with or without GA or

		sedation. E.g. spasm of muscles, manipulation under anaesthetic of a joint or under scar tissue. Steroid or saline may be used with the local anaesthetic. **Risk 2**
14.NCP	Non-compliance	The patient does not rest or follow instructions. This action is considered to lead to any of the listed complications. Non compliance should only be noted if the records show *two or more* entries to this effect or where a patient continually misses appointments following surgery and where there is evidence of self harm with regard to lack of following instructions. The use of smoking or alcohol or recreational drugs would also be considered harming where advised not to use such items. Then risk could be higher depending upon effect. It is rated for the likely cause and interventions required. 0.6*% risk (Report 2008).* Probably under reported **Risk 3**
15.RxSE	Medication side effect	All medications will from time to time produce several types of side effects. This data is essential to measure the effectiveness of podiatric supply, administration or prescribing. 1.*2% risk (Report 2008).* **Risk 2**
16.SCR	Scar line	The wounds having healed may do so in a thickened or worm like manner and may be unsightly. There is a greater likelihood in the younger patient. If the scar forms more than 0.2 mm either side of the wound then this should be recorded as a thickened scar. If the scar line is painful, irrespective of the scar size, this should be recorded. Keloid is determined by an irregular raised progressive scar which forms more than 0.5mm either side of the wound. 1.*4% risk (Report 2008).* **Risk 2**
17.JPS	Joint and pain stiffness	This problem shows up as swelling and pain beyond a period of time expected for that procedure. Pain must be of sufficient note that the patient has difficulty with shoes, cannot climb stairs or undertake normal social duties or return to work or cannot drive and may be using pain medication still. The joint cannot be moved without pain. A stiff asymptomatic joint should not be recorded. Note some procedures may be expected to leave a stiff but not swollen joint. An estimated 2-5% of patients may experience this problem in the forefoot. Most go onto settle but in some cases revision surgery is required. 0.8*% risk (Report 2008).* **Risk 3**
18.INFS	Infection suspected (not proven)	An infection is suspected on the basis of the wound macerating, showing signs of inflammation and oedema but not necessarily having a discharge. A suspected infection applies to any wound that has the cardinal signs of inflammation with pain but has no exudate that can be

		cultured. Macerated wounds alone should not be included under infection but *delayed healing.* 0*.2% risk (Report 2008).This is under reported.* **Risk 2**
19.INF+	Infection proven	A patient has an inflamed wound with sufficient purulent discharge to provide a sample for culture and sensitivity. A positive culture is recorded as proven otherwise no infection is recorded. This could demonstrate an early cellulitis but would not be regarded as a cellulitis which would be recorded under INF+. If surgical management was required then consider BKD for debridement. Tissue destruction may be present but would not suggest serious spread as in INF++. Where there is extensive loss though do not use BKD but **skin necrosis, or INF+2**. 0.1*% risk (Report 2008).* This is likely to be under reported. **Risk 4**
20.BKD	Poor healing should be considered as a breakdown	This is more extensive than dehiscence. The wound edges cannot be closed and rely on secondary intention infill (dressings) or fresh surgical closure or debridement. 0.1*% risk (Report 2008).* **Risk 4**
21.RxP	Poor pain control	Some 10% of patients may experience this. Postoperative medication given after day three to assist the patient should be noted if their pharmaceutical strength is greater or stronger than that previously used. **Risk 2**
22.SABR	Suture abscess or reaction	Sutures can cause sensitivity below the skin or above the skin depending upon material. Prolene, poylglactin 910 and PGA are the most common materials. Any SABR may contribute to the problem of wound healing. Local infection and dehiscence and so it makes sense to record SABR if one or more are present. Deeper suture problems may only come to light after several weeks where **PNSS** may be recorded or suggested first. An initial PNSS may give way on the pathway process to a SABR 0.6*% risk (Report 2008).* **Risk 3**
23.ENS	Stump neuroma	Entrapment of scar around nerve arises following surgery. Previous injury to the area or where previous surgery has been encountered raises this possibility. Pain may continue to reach an intensity that is the same as or more than the original lesion 0.1% *risk (Report 2008).* **Risk 3**
24.SNEC	Skin necrosis	This condition is a precursor to infection and identifies poor tissue healing after surgery. The risk is still regarded as 2. The risk is 0.13% (2009). The skin shows increased turgor and colour change; *deep red of congestion*. If this changes from red to black or sloughs this will be recorded. If the wound

		granulates with delayed healing record this as **BKD** healing problem. Infection is recorded separately as well to cover the whole complexity. For larger areas use **SWB** which may tie in with **INF+2** 0.08% *risk (Report 2008)*. **Risk 4**
25.DPRT	Digital periostitis	This condition relates to digital swelling often known as *sausage toe* but it can be used to include the great toe. Slight swelling will not be regarded as abnormal and is expected unless intractable pain exists. The skin will be distended and highly coloured with otherwise normal vascular supply. *0.1% risk (Report 2008).* **Risk 2**
26.NRG	Nail regrowth	Following any nail surgery the nail plate may be observed as returning with or without consistent nail. Spicules or partial nail bulk should be noted from 12 weeks onwards as a negative result. **Risk 3**
27.INC	Inclusion cyst	Applicable only with Winograd incisional nail surgery. Swelling with redness or tenderness at the eponychium. With or without discharge. White thick material may be evacuated**.** May require further surgery. **Risk 3**
28.DVT	Deep vein thrombosis (DVT)	DVT is recorded where the circumference of the ipsilateral side of the calf is greater, where the foot is swollen and where the patient is in pain. Presentation should be noted confirmed by D-dimer and Duplex ultrasound. DO NOT record DVT if all these factors are not present. DVT does carry the higher risk grade because of the need for warfarin management. *0.01% risk (Report 2008). May be under reported and could be as high as 1%* **Risk 4**
29.FXFR	Fracture of fixation screw, plate or prosthesis	A plate, screw or implant may break within the bone or soft tissue. Fracture is recorded instead of just fixation movement. The additional risk may arise from greater removal difficulty and need for image intensifier increasing the cost of management, as well as greater period of recovery for the patient. **Risk 3.**
30.IMPL	Fixation movement	This problem is usually diagnosed by x-ray except where skin penetration makes this obvious. Surgery is usually indicated with minor consequences. Any implanted material that requires removal is included here whether the skin is partial or total breached. The occurrence is confirmed as a complication if it arises within three months or prior to usual discharge to differentiate such movement from normal migration, which normally arises in the first two years or more after surgery. *0.04% risk (Report 2008).*

		Risk 3
31.AVN	Avascular necrosis	Bone at the site of surgery collapses or loses part of its normal density. X-rays are required. Surgery is required using a graft or excision of the part of bone. My have longer term effect. Can be used with problem with prosthetic joint as well. *0.01% risk (Report 2008).* **Risk 4.**
32.BUND	Delay in bone union	At three months bone should have shown radiographic evidence of provisional callus or bridging across an osteotomy site in the presence of symptoms. Non union after nine months is regarded as a failure in healing. Record positive **BUND** at 6 months or beyond. *0.08% risk (Report 2008).* **Risk 4**
33.PE	Pulmonary embolus	Signs of chest pain following any surgical event should be recorded. The patient will be admitted to hospital for investigation and treatment. *0.01% risk (Report 2008).* **Risk 5**
34.OML	Osteomyelitis	C&S, blood profile changes will assist defining the lesion but x-ray suspicion alone is acceptable. **Risk 4**
35.HTM	Haematoma	Hard and hot area following surgery around the surgical site. The wound may be under tension and infection may arise which must also be separately recorded. This is an early complication and may cause dehiscence followed by an infection. *0.1% risk (Report 2008).* **Risk 4**
36.INF+2	Serious infection	Fulminating infection with gangrene wet or dry, spreading with limb in peril. Includes Necrotising fasciitis. Data unavailable. **Risk 5**
37.SWB	**Severe wound healing**	More extensive than SNEC which relates to skin wounds only but includes elements of ischemia and necrosis. Loss is outside the wound margins and could lead to delayed healing, loss of foot, skin grafting, heavy scarring and loss of function. INF+2 coincide usually. Data unavailable **Risk 5**
38.CRPS	Complex regional pain syndrome types I or II.	It is indicated by the following criteria. Arises insidiously but suspect from week 6 onwards. While rare, it is more common with nerve surgery or trauma to foot, often pre-existing and not obvious in presence of injury. Impact on life is so serious**.** *0.06% risk (Report 2008).* **Risk 5**
39.NPRAX	neuropraxia	Due to surgery, or **injection of nerves Often** gets better but may take 9 months. Data unavailable. **Risk 3**
40.NS+1	Sensory loss (large)	The area of sensory loss is associated with >5cm^2. Larger areas than just the operative site *0.04% risk (Report 2008).* **Risk 4**

41.MPL	Motor power loss	Using the Medical Research Council's grading 0-5 where full power is equal to 5 and complete paralysis of motor function equals 0, abnormal post operative findings would be associated with diminution of power associated with surgery. *0.02% risk (Report 2008).* **Risk 4**
42.MORT	Mortality	This is recorded if the patient dies as a result of podiatric surgical intervention. *0.02% risk (Report 2008). 2 patients for 6050 patients. Probably outlier statistics and 1 included in 3 month coroner request where surgery was not the cause see under MORT+3* **Risk 5**
43.MORT +3		If patient dies within three months of podiatric surgery, may include causes unrelated to foot surgery. See notes above on reporting **Risk 5**

Section 15: Manchester-Oxford Foot & Ankle Questionnaire (MOXFQ)

Background to outcome measurement

Outcome measures provide a scale for measuring the effect of an intervention. We routinely utilise outcome measures in clinical practice, perhaps without realising. An example of this would be the visual analogue scales (VAS) which provide a patient friendly scale for pain which can be applied before and after treatment. Outcome measures allow clinicians to monitor their own practice and to compare their practice with that of their peers. The use of outcome measures represents an opportunity to fulfil the requirements of clinical governance and peer review.

MOXFQ

There was for sometime, a general interest in developing a questionnaire which was patient administered and constructed specifically for the measurement of foot surgery outcomes. The Manchester-Oxford Foot questionnaire (MOXFQ) is the consequence of that interest. You can read more about the MOXFQ at the official website: https://innovation.ox.ac.uk/outcome-measures/manchester-oxford-foot-questionnaire-moxfq/

Important note: The MOXFQ is intended to measure the effect on health status of a single pathology or related pathologies affecting a single foot. Furthermore, the MOXFQ will subsequently test the benefit of any treatment for the effected foot. The MOXFQ has not been developed, tested or validated for the assessment of bilateral foot complaints. Symptoms and severity can vary greatly between feet; as such it is not considered appropriate to assess both lower a limbs as a single unit.

If you wish to assess MOXFQ outcomes in the context of bilateral treatment, it is recommended that each foot treatment is recorded as a separate episode with each episode containing the relevant pre and post treatment MOXFQ.

Advice on implementing the MOXFQ in your practice
- Request a copy of the MOXFQ from the webmasters.
- Print out the latest version of the MOXFQ.
- Ensure the MOXFQ is applied at the same point pre and post intervention. Ideally, the questionnaire should be completed following the new patient assessment and subsequently at 6 months post intervention.
- Avoid clinician bias; have patients complete the questionnaire away from clinicians. The waiting room may be considered acceptable. Also avoid giving patients too much guidance on completing the questionnaire, simply ask patients to read the instructions on the first page.

Inputting MOXFQ data into P-10

Select the relevant patient and on the *Patient History* screen select *Add New Event* and either *Pre_MOXFQ* (pre-intervention) or *Post_MOXFQ* (post intervention). This will bring up the MOXFQ data screen which allows you to transfer data from your hard copy onto the online system.

Having entered the data make sure you hit the save button at the bottom of the screen!
Now note that as you return to the patient summary screen, the MOXFQ scores are available to you *(WS= walking and Standing. P= Pain. SI= Social interaction).*

Section 16: Patient Satisfaction (PSQ-10) for podiatric surgery (including nail surgery)

Used only for surgery

'Patient satisfaction' probably offers the most powerful indicator regarding the effectiveness of treatment from the service user's viewpoint. It is usually honest and acceptably accurate in terms of whether the problem has been managed adequately. By and large most services want to know if they have provided adequate care.

It is best that the patient satisfaction questionnaire is either sent to the patient or an independent person such as a nurse assists the patient fill this in. It is important to obtain unsolicited answers.

The PSQ-10 should be **completed at six months post operation.** Once the form has been completed the system will populate the event immediately with a score from 0-100 (Note: this is not a % of improvement).

PSQ-10 score interpretation

It is not based on percentage per se. There are some surgeries that naturally take longer to recover from and so not all surgical treatment will represent the same score. Accuracy is based on individual users collecting data at appropriate and repeatable times; Six months post treatment for bone and joint surgery. Three months for injections & nail surgery.

- A score **under 50** suggests more strongly that complete resolution was either not met, or that the patient was unsatisfied with their treatment outcome.

- A score **lower than 70** usually means that there is some room for improvement or further recovery, or that surgery was staged to include unfinished treatment.

- A score **over 70** broadly implies that the patient was satisfied and made a good recovery without any long term problems.

- There are cases where scores may be higher e.g **over 75**. These are more likely, but not exclusively for specific procedures such as injections, nail surgery, biopsy, neuromata and amputations and single hammer toe correction.

- Scores of **100** do exist but these are not absolute indicators of best practise and are more typical of minor procedures such as non-incisional nail surgery. **The general benchmark considered to represent satisfactory surgical treatment is between 70-75**

- The larger and more complicated surgeries are expected to attract lower scores as they take longer to recovery from and return to footwear.

Disclaimer: Any inferences taken from the system may not be the view held by the College of Podiatry without reference to the appropriate officer(s). Data interpretation requires considerable skill and knowledge of the system. PSQ can only be held as a guide in the absence of professional interpretation.

NB the hind foot has not been tested or validated. Majority data refers to forefoot treatment.

The questions for PSQ-10 are described below. A copy of the questionnaire can be downloaded here: **http://www.pascom-10.com/information-resources**

Question (1) briefly state what you expect to gain from treatment.

This is a free text response which is referred back to in question 10. There is no score for this question.

Question (2) Were the risks and complications of surgery explained to you before you had your operation?

The extent to which patients answer 'no' or 'not sure' may reflect the proportion of patients with whom there has been a failure of communication and understanding, rather than where this matter has actually been overlooked.
The marks for the responses are:

No	0
Not sure	2
Yes	5
Not stated (blank)	0

Question (3) Did you know what to do if you had a problem after your operation?

This question seeks to establish the extent to which the patient felt that this had been made clear to them.

The marks for the responses are:

No	0
Not sure	2
Yes	5
Not stated (blank)	0

Question (4) Did you have a problem after your operation?

This question tries to establish whether the patient felt that they had an unexpected adverse outcome after surgery. The marks for the responses are:

No problem	15
Yes minor problem	6
Yes major problem	0
Not stated (blank)	0

Question (4a) When you had your problem, how did you seek help?

This question, like **(4b)** – **(4d)**, should only be answered by those patients who had indicated in question (4) that they had a problem. Where this is the case, the number of total marks that can be achieved is reduced (by up to 15 points), compared to a problem-free episode. Some of these marks can be regained if the problem did not appear serious and its consequences were well managed. Question 4a attempts to grade the severity of the problem by looking at the kind of help that the patient accessed. The marks for the responses are:

Waited until next appointment	4
Telephoned and given earlier appointment	3
Called out the podiatrist	2
Contacted podiatrist and received verbal advice	4
Called out GP	0
Went to casualty	0
Other	0
Not stated (blank)	0

Questions (4b) and (4c) were created to assess out-of–hours response in the pilot site. Although it does not contribute to the final score, it has been kept as some centres find this information useful for local management purposes.

Question (4d) Overall, how would you say that your problem was dealt with?

The scores are designed so that problems which appear not to be severe and which are handled well in the view of the patient will not significantly reduce the overall score, whereas a severe problem with poor management will always score poorly. The marks for the responses are:

Poorly	0
Cannot say as still under management	0
Satisfactorily	3
Excellently	5
Not stated (blank)	0

Question (5) after the operation, how effective was your pain control?

The effective control of pain is one of the most significant indicators of the patient's experience, as pain is a universally understood concept and freedom from pain is an understandable aspiration of all patients. The marks for the responses are:

Pain control did not work	0
Some pain but I coped	10
Minimal or no pain	15
Not stated (blank)	0

Question (6) When could you get back into your regular shoes?

The question does not ask what type of shoe the patient cannot wear. Patients will have different attitudes toward *what is a good shoe* just as a podiatrist knows that some shoes

should not be used with already deformed feet. A small number of patients may feel that their daily functioning is being impaired because they cannot use shoes which are clinically not suitable for use anyway, so Q6 can only be validated by other questions such as (9) and (10). The marks for the responses are:

By 2 weeks	10
By 4 weeks	10
By 6 weeks	8
By 8 weeks	6
By 12 weeks	3
By 6 months	2
After 6 months	0
Still can't wear shoes	0
Not stated (blank)	0

Question (7) Do you still have discomfort from your original foot condition?

Given that the questionnaire is presented to the patient six months following surgery, for the majority of cases, severe pain or discomfort from the original presenting condition should have been resolved. For more invasive and complex procedures a degree of discomfort may still be present. This is graded in severity by the circumstances in which the patient feels that it arises. The marks for the responses are:

At rest	0
When standing	0
Standing for a long period	6
Occasional twinges	8
No discomfort at all	10
Not stated (blank)	0

Question (8) How would you describe your original foot condition since treatment?

In this question the patient is invited to assess the extent to which they feel that the intervention has impacted upon their original complaint. The marks for the responses are:

Deteriorated	0
A little worse	0
The same	0
Better	7
Much better	10
Not stated (blank)	0

Question (9) Would you be prepared to have surgery performed under the same conditions again?

This question, originally adapted from Tibrewal and Floss (1991), can be used in many clinical settings. It is not unusual to find that not all patients wish to have the same experience repeated. The marks for the responses are:

Yes	15
No	0
Not stated (blank)	0

Question (10) Were the original expectations that you stated at the beginning of this questionnaire met?

This question relates back to the patient's original statement of their expectations of treatment in Q1. The patient is invited to assess whether these have been met or not. The marks for the responses are:

No	0
In part	10
Yes	15
Not stated (blank)	0

Blank responses
Blank responses automatically create a zero score for that question. Significant numbers of blank responses will lower average scores, and users may wish to exclude responses with missing answers from their datasets.

For further guidance go to YouTube and search PASCOM-10 // Proms:

https://youtu.be/3wl25Mak4Ag

Also search PASCOM-10 // Proms, FFT & Patient Summary:

https://youtu.be/lVHMZN7yN_U

Section 17: Reporting

PASCOM Reporting: The basics
The following pages explain the operation of the PASCOM reporting suite.

Filters
The first step in running any report is to set the filters for the report on the report configuration screen. This section explains how these filters work.

Note: Not every report uses every filter, and the way in which each filter is applied can vary by report (for example the date range filter could be applied to treatment events in one report and to consultation events in a different report). The application of each filter is explained in the report descriptions below.

Date Range Filter

The date range filter simply filters a report's results by date (the specific date that the filter is applied to can vary by report). Start Date or End Date can be left blank, in which case no filter is applied.

For example:
- Start Date = nothing, End Date = nothing : Do not filter dates
- Start Date = 22/12/10, End Date = nothing : All dates >= 22/12/10
- Start Date = nothing, End Date = 22/12/10 : All dates <= 22/12/10
- Start Date = 22/12/10, End Date = 31/01/11 : All dates >= 22/12/10 and <= 31/01/11

Centre Filter

The centre filter restricts the results of the report based on centre. If the centre filter is blank the report will be run on all permitted centres. Permitted centres (i.e. the centres that a user is permitted to report on) are:
- all centres where the user is an administrator, or is a user with a surgical role
- or; every centre in the system if the user is a reporter

If the centre filter is populated then the permitted centres are further restricted by the filter.
If one or more centres are added to the 'Centres included in the filter' section then the permitted centres are restricted to these centres.

If any of the check boxes in the 'Region', 'Deanery' or 'Speciality' sections are selected then permitted centres are restricted to centres that are within the selected regions, deaneries or specialities.

If multiple sections are populated then the resulting filter is additive (i.e. the result is the union of the selection, not the intersection). For example:

- **Centres included in filter = 'Test Centre', Region = <none>, Deanery = <none>, Speciality = <none>**
Permitted centres is restricted to just one centre 'Test Centre'

- **Centres included in filter = 'Test Centre', Region = 'Region 1', Deanery = <none>, Speciality = <none>** Permitted centres is restricted to any centres in 'Region 1', plus 'Test Centre'

- **Centres included in filter = <none>, Region = 'Region 1', Deanery = 'Deanery 1', Speciality = <none>**
Permitted centres is restricted to any centres in 'Region 1' and any centres in 'Deanery 1'

Clinician Filter

The clinician filter restricts the results of the report based on clinician. If the clinician filter is blank the report will be run on all permitted clinicians. Permitted clinicians (i.e. the clinicians that a user is permitted to report on) are:
- the user, and all surgical users at centres where the user is an administrator
- or; every clinician in the system if the user is a reporter

If the clinician filter is populated then the permitted clinician are further restricted by the filter.

Treatment Filter

The treatment filter identifies a selection of procedures, and how to apply these procedures to filter treatments. If no procedures are selected in the 'Procedures included in the filter' section then the report is not filtered by procedure/treatment.

If procedures are selected then the way these procedures are applied in the filter depends upon the setting in the 'Filter combination' section. There are 4 possible combinations:

- **Procedure Mentions:** Treatment must include at least one of the procedures in the selection
- **Limit to List:** Treatment must include only procedures in the selection
- **Combo All:** Treatment must include all procedures in the selection
- **Combo Limited:** Treatment must include all procedures, and only procedures in the selection

These combinations are represented graphically below:

Finally if the 'Exclude injection only' flag is set then any treatment event where all procedures are flagged as injection procedures are excluded.

Invasive Domain Reports
This section explains each report. The focus is on the way in which filters are applied and how calculations are performed. Many reports start by applying the specified filters to all treatment events to arrive at a population of treatment events. This is a very common pattern so it is important to understand how the filters are applied in this case. The application of the date range and centre filters is self explanatory. The treatment filter is explained above. For the clinician filter the treatment events are filtered to events where at least one of the clinicians listed in the clinicians' section of the event is included in the permitted clinicians.
Note: The clinicians attached to individual procedures are not taken in to consideration, as every clinician attached to a procedure should also exist in the clinicians' section of the treatment event.

It is also important to remember that injection and investigation events are also treatment events, and are generally included in the treatment event population unless otherwise stated.

Activity Reports

Invasive ASA Grade
All filters can be applied (date range, centre, clinician and treatment). The output of the report is the ASA grade of all patients selected by the above filters.

Invasive Anaesthesia
The filters are applied to treatment events to arrive at a population of treatment events.
The output of the report is all anaesthetic within these treatment events grouped by anaesthetic type

Invasive Awaiting MOXFQ
The filters are applied to treatment events to arrive at a population of treatment events.
The treatment events are restricted to those where there are no MOXFQ events in the same episode. The output of the report is each treatment along with patient details, and centre details. So if a patient has multiple treatment events in episodes without MOXFQ events they will appear multiple times in this report.

Invasive Awaiting PSQ10
The filters are applied to treatment events to arrive at a population of treatment events.
The treatment events are restricted to 'real' treatment events (i.e. not injection or investigation events).

The treatment events are further restricted to those where there are no PSQ10 events in the same episode. The output of the report is each treatment along with patient details, and centre details. So, if a patient has multiple treatment events in episodes without PSQ10 events they will appear multiple times in this report.

Invasive Awaiting Sequellae

The filters are applied to treatment events to arrive at a population of treatment events.

The treatment events are restricted to 'real' treatment events (i.e. not injection or investigation events). The treatment events are further restricted to those which have no post-treatment Sequelae associated with them.

The output of the report is each treatment along with patient details, and centre details. So if a patient has multiple treatment events awaiting Sequelae they will appear multiple times in this report.

Invasive Cancellations

The filters are applied to treatment events to arrive at a population of treatment events.

The output of the report is all attendance within these treatment events grouped by attendance type.

Invasive Clinical Contacts

Click 'clinical contacts' under the Activity tab to run a report which summarises all episodes for each patient and shows the total number of each event type using the usual P-10 filters.

Invasive Clinician Procedures

The filters are applied to treatment events to arrive at a population of treatment events. The output of the report is a count of all procedures codes undertaken by included clinician(s) and the associated level of practice. Note this report is only of interest if a single clinician is selected in the clinician filter. It will be of particular interest to podiatric surgical trainees.

Invasive Demographics

The filters are applied to treatment events to arrive at a population of treatment events.

The patients associated with these treatment events are grouped to arrive at a population of distinct patients (i.e. if a single patient has multiple treatments in the treatment population they will only be counted once in the report).

The output of the report is the age, and sex of these patients, grouped by age band.

Invasive Fixations

The filters are applied to treatment events to arrive at a population of treatment events.

The output of the report is all fixations within these treatments grouped by the type of fixation.

Invasive Investigations

The filters are applied to treatment events to arrive at a population of treatment events.

The output of the report is all investigations recorded on these treatment events, grouped by investigation type and result type.

Invasive Medical Diagnoses

The date range, centre and clinician filter are applied to consultation events to arrive at a population of consultation events (the treatment filter is not relevant to this report).

The output of the report is all medical diagnoses within these consultations grouped by the type of the diagnosis.

Invasive Medications

The filters are applied to treatment events to arrive at a population of treatment events.
The output of the report is all medications within these treatment events grouped by the type of medication.

Invasive Podiatric Diagnoses

The date range, centre and clinician filter are applied to consultation events to arrive at a population of consultation events (the treatment filter is not relevant to this report).
The output of the report is all podiatric diagnoses within these consultations grouped by the type of the diagnosis.

Invasive Procedures

The filters are applied to treatment events to arrive at a population of treatment events.
The output of the report is all procedures within these treatment events grouped by the type of procedure.

Invasive Providers

The filters are applied to treatment events to arrive at a population of treatment events. The output of the report is a count of the provider locations as recorded in the referral event.

Invasive Referrals

New report function added to PASCOM in June 2013. Click 'referrals' under the Activity tab to run a report detailing the referral source using the usual P-10 reporting filters.

Outcome reports

Invasive Clinical Outcomes

The filters are applied to treatment events to arrive at a population of treatment events.
All post treatment events which any post treatment Sequelae which are associated with any of these treatment events are selected to arrive at a population of distinct post treatment events.
The output of the report is clinician's analysis of outcome on these post treatment events grouped by clinical analysis.

Invasive MOXFQ

The filters are applied to treatment events to arrive at a population of treatment events.
All Pre and Post MOXFQ events within the episodes relating to this population of treatment events are selected to arrive at a population of distinct Pre and Post MOXFQ events. Only episodes which have both a Pre-MOXFQ and Post-MOXFQ event are considered.
The output of the report is the average MOXFQ scores and standard deviation of these scores from Pre and Post MOXFQ events (allowing a comparison of Pre to Post scores).

Invasive MOXFQ Raw Data

The filters are applied to treatment events to arrive at a population of treatment events.
This new report allows for the exporting of raw MOXFQ data for each patient in a cohort so that users can do further statistical analysis (e.g. in Excel). The reports output the individual MOXFQ events that meet the filter criteria, with the following fields for each event (or pair of pre/post events); PASCOM Patient Reference; Pre-Op Date; Pre-Op WS; Pre-OP P; Pre-OP SI; Post-OP Date; Post-OP WS; Post-OP P; Post-OP SI; PSQ-10 Score [If there is a PSQ10 on

the same episode]; Treatment [The title of the relevant treatment]. Note that the PSQ-10 score is not available in the non-invasive domain.

Invasive PSQ10 Expectation

The filters are applied to treatment events to arrive at a population of treatment events. The output of this report is simply the free text response to question 1 of the PSQ-10 questionnaire.

Invasive PSQ10 Response

The filters are applied to treatment events to arrive at a population of treatment events.

All PSQ10 events within the episodes relating to this population of treatment events are selected to arrive at a population of distinct PSQ10 events.

The output of the report is a list of all questions in the PSQ10 questionnaire, along with the average score and standard deviation of scores within the selected population of PSQ10 events.

Invasive PSQ10 Score Distribution

The filters are applied to treatment events to arrive at a population of treatment events.

All PSQ10 events within the episodes relating to this population of treatment events are selected to arrive at a population of distinct PSQ10 events.

The output of the report is the score on these PSQ10 events, grouped by band.

Invasive Post Treatment Sequalae

The filters are applied to treatment events to arrive at a population of treatment events.

All post treatment Sequelae associated with any of the treatment events in this population are selected to arrive at a population of post treatment Sequelae. The population of Sequelae is grouped by the type of the Sequelae, and for each Sequelae the number of times is occurs in the population is counted. The number of distinct episodes in which it occurs is also counted. The output is a list of Sequelae. The count and percentage of each type of Sequelae is shown (percentage is out of the total count of all Sequelae in the report so should add up to 100%). The count and percentage of the number of distinct episodes in which the Sequelae occurs is shown (percentage is out of total distinct episodes within the population of treatment events and so does not add up to 100%).

Invasive Post Treatment Sequalae By Level

This is the same as the Post Treatment Sequelae report except that the output is grouped by the level of the Sequelae (not by the type of the Sequelae).

Invasive Time to Healing

The filters are applied to treatment events to arrive at a population of treatment events. The output of the report is the time to healing in weeks following treatment (surgery). This report may be of more interest to those treating complex wounds and is available in both the invasive and non-invasive domains.

Research Reports

Invasive Cohort By Sequalae Generator

The date, centre and clinician filters are applied. The treatment filter available elsewhere is replaced with a sequalae filter listing all current negative performance indicators. The output of the report is the PASCOM record number, date of birth, procedure, gender, foot, revision status of all treatments associated with the defined sequalae.

Invasive Cohort Generator

The filters are applied to treatment events to arrive at a population of treatment events.
The output if the report is every patient associated with these treatment events, and all procedures recorded on these treatment events.

Invasive Duration of Surgery

The filters are applied to treatment events to arrive at a population of treatment events.
The output of the report is the time recorded on the tourniquet minutes field of the treatment events grouped by band.

Invasive Medication Cohort Generator

The date, centre and clinician filters are applied. The output of the report is the PASCOM reference, date of birth, gender, medication name and code, route (of administration) and method (of supply).

Invasive Revision Cohort Generator

The filters are applied to treatment events to arrive at a population of treatment events.
The treatment events are restricted to those that are flagged as a revision.
The output of the report is all procedures within these treatment events grouped by the type of procedure.
This is the same output as the Procedures Report except that this report restricted to only revision treatments, and the report outputs the type of revision against every procedure.

Invasive Revision Treatments Count

This report is the same as the cohort generator report except that the treatment events are further restricted to those that are flagged as a revision.

Centre Reports

Centre friends and family

The date and centre filters are applied. The output of the report is the count for each of the possible friends and family test responses.

Webmaster Reports

Empty Centres

The output of the report is the centre name, email address and clinic address, date of creation. This report identifies centres for deletion.

Inactive Users

The output of the report is the name, email address and SCP membership number of the inactive user along with date of last login and the number of days inactive.

Unused Procedures

The output of the report is all unused procedure codes.

Non-invasive domain reports

For those podiatrists using the non-invasive domain, a further series of reports are available specific to non-invasive episodes of care. The reports follow the same format at those mentioned above.

If further advice is required regarding any of these reports, please contact the team
http://www.pascom-10.com/contact-us

Section 18: Minimum data set for podiatric surgery

All podiatric surgery teams using PASCOM will automatically contribute anonymous activity and outcome data for the purpose of benchmarking and quality assurance. To allow for accurate reporting of outcomes nationally it is important that all podiatric surgery teams contribute an essential minimum data set for each episode of care:

Table 8. Essential & minimum data collection

1	Consultation Event: Podiatric diagnosis
2	Treatment Event: surgical procedure
3	Treatment Event: Anaesthetic
4	Treatment Event: Operative times (time patient on table start to finish)
5	Treatment Event: Fixation
6	Treatment Event: Imaging
7	Treatment Event: Cancellations
8	Post Treatment Event: Sequelae and complications. If no complication occurs post operation it is important that this is captured as: **NA No observed sequela**
9	Revision surgery broken down into podiatric and orthopaedic categories
10	MOXFQ: Pre and six months post operation
11	Patient Satisfaction: PSQ-10

Section 19: Frequently asked questions

What is the new PASCOM?
PASCOM or P-10 as we now call it is the latest version of a database based on an early Microsoft Access database package by Rudge and Tollafield in 1996, known as PASCOM 2000. It allows podiatrists to collect activity data and provides outcomes analysis. Additionally, this will provide a measure of personal and national performance

What does PASCOM-10 stand for?
Podiatric audit in surgery and clinical outcome measures. It is known as PASCOM-10 (P-10) because the latest version was launched in 2010 and marks a new decade of quality measurement for podiatric healthcare in the UK. P-10 is the short hand.

Do I have to pay for PASCOM?
NO this is free to all members of the COP.

Will I have to download any software?
No, this was only for the old Access database version. You do require internet access with Internet explorer 7 or higher. P-10 also works on MAC computers.

Does PASCOM-10 break Data protection rules?
It is easy to misinterpret the Data Protection Act 1998. Above all patient data must be held securely, password protected, and the data should not be left around for unauthorised use. Patient data can be anonymous. Patients should be informed of, and consent to, data being collected. They should be informed about how any data will be used. Under the Freedom of Information Act 2000 patients can ask to see the data held on them. We comply with all these requirements.

Do I have to inform my NHS trust?
It is important that your register that you are a data holder for patients. In the NHS it is essential to inform the local Caldicott Guardian who will work with Clinical Governance. Those working in private hospitals should make the Manager or Director aware. *COP takes no responsibility for PASCOM-10 being implemented without permission.*

What do I do with old data from the original PASCOM 2000 system?
You must keep your old data as it still is valuable. This will only apply to surgeons associated with the Faculty of Podiatric Surgery.

Can I backdate input data?
Data cannot be transferred from PASCOM (2000) to PASCOM-10.

What are the next steps to register and use P-10?
Go to http://www.pascom-10.com/how-to-access-pascom-10 and follow the links to complete the registration process.

Do I have to be a Podiatric Surgeon?
Surgeons were involved in the original work with PASCOM 2000 because no data existed on their activity. P-10 will expand to meet the needs of all podiatrists by 2013. We therefore want all members of the Society to enjoy the full benefits.

I am a podiatric surgeon and have used PASCOM before; can I just register as I have been on the previous workshops?

No, P-10 is entirely different engaging patients from their first appointments to discharge. Outcome measures and reporting is slightly different and the conception of moving from page to page consequently different. You must follow the path that any new user follows.

Who owns P-10?

The system and access, maintenance and hosting is the responsibility of the COP who hold copyright for PASCOM-10. Data, when collected in the NHS data belongs to the NHS. For further information please read the privacy statement and section three of this user guide. The terms and conditions are listed on the following pages.

Section 20: PASCOM-10 Database Terms & Conditions of Use

IMPORTANT NOTICE: PLEASE READ THESE TERMS CAREFULLY AS BY PROCEEDING TO USE PASCOM-10 YOU AGREE TO THESE TERMS. IF YOU DO NOT AGREE TO THESE TERMS, PLEASE DO NOT ACCESS PASCOM-10.

Reference in these terms & conditions to "**Terms**" means to these terms & conditions of use, to "PASCOM-10" means to the PASCOM-10 software database available via our website, to "**Data**" means the information, data, results, findings, opinions, patient comments, materials and all other content from time to time accessible to you via PASCOM-10 (including, without limitation, such content that you from time to time input into PASCOM-10), to **we**, **us** and **our** means to the Society of Chiropodists and Podiatrists of 1 Fellmongers Path, Tower Bridge Road, London SE 3LY, and to **you** and **your** means to you, the user of the PASCOM-10.

1   Grant and scope of licence

1.1   In consideration of your agreement to abide by the Terms, we grant to you a personal, non-exclusive and non-transferable licence to use PASCOM-10 and the Data in accordance with these Terms.

1.2   You are entitled to access PASCOM-10 as you have received the relevant training to do so and have gained registered approval from us. In order to retain your rights of access you must undertake any further training and accreditation that we from time to time deem necessary. Should you fail to do so, we reserve the right to withdraw your registered approval and remove your access to PASCOM-10 and the Data.

1.3   You agree that you shall only submit Data into PASCOM-10 which is true, accurate and up-to-date in all respects and which is applicable to podiatry treatment. You shall not alter, amend, vary or improve any Data from the actual results that you have obtained from your work.

1.4   You acknowledge and agree that the Data is compiled and recorded within PASCOM-10 by our members and that we do not edit or control, and are not liable for, the content of the Data. The Data does not necessarily reflect our opinions and we give no recommendation or endorsement in respect of such Data.

1.5   Without limitation to the other provisions of these Terms, we reserve the right for any reason whatsoever and in our sole discretion to remove Data from PASCOM-10 at any time and without notice.

1.6   We give no guarantee or warranty as to the accessibility or availability of PASCOM-10 and/or the Data. We may, in our sole discretion and at any time without notice, discontinue access temporarily or permanently to the whole or any part of PASCOM-10 and/or the Data by you and/or any other users and we shall not be liable to you or any third party in respect of any losses, liabilities or damages suffered on incurred in respect of such actions.

1.7   You acknowledge and agree that:

(a)   PASCOM-10 AND THE DATA ARE SUPPLIED FREE OF CHARGE AND ON AN "AS IS" AND "AS AVAILABLE" BASIS AND HAVE NOT BEEN DEVELOPED TO MEET YOUR INDIVIDUAL REQUIREMENTS OR THOSE OF ANY OTHER MEMBER OF THE SOCIETY FOR CHIROPODISTS AND PODIATRISTS;

(b)   YOU USE AND RELY UPON PASCOM-10 AND/OR THE DATA ENTIRELY AT YOUR OWN RISK;

(c)   We make no warranty that access to PASCOM-10 and/or the Data will be uninterrupted, timely, secure, or free of bugs or errors. You further agree that should you become aware of any such issue with PASCOM-10 and/or the Data you will advise us of the same as soon as possible by e-mail at enq@scpod.org or by telephone at 0845 450 3720;

(d)   We make no warranty as to the availability with PASCOM-10 or of any Data that you or any other person submits to PASCOM-10.

1.8   Should you breach these Terms and/or otherwise misuse PASCOM-10 and/or the Data, we shall be entitled at our discretion to prevent your further use of PASCOM-10 and the Data and to report your actions to the Professional Conduct Committee and/or the Health Professions Council for disciplinary action pursuant to our Code of Conduct.

2   Your undertakings

2.1   In consideration for us granting you access to PASCOM-10 and the Data, you shall:

(a)   keep your user log-in details and password secret and confidential and not disclose them to any other person whatsoever;

(b)   not permit any other person to use PASCOM-10 unless we agree otherwise in writing;

(c)   ensure that all Data that you from time to time input or enter into PASCOM-10 is true, accurate and up-to-date in all respects and that you shall immediately correct any errors or inaccuracies made within such Data;

(d)   ensure all Data is entered on an anonymous basis as provided for within PASCOM-10's options so as to provide for patient confidentiality;

(e)   obtain and maintain separate consent from your patient before inputting or entering into PASCOM-10 any Data concerning that patient's condition;

(f)   only use PASCOM-10 in respect of podiatric information;

(g)   notify your hospital/NHS organisation that you are submitting Data to PASCOM-10, including by notifying the data compliance officer for your hospital/NHS organisation;

(h)   for so long as any Data that you have created is accessible within PASCOM-10, retain written evidence and documentation which fully supports all statements that you make within such Data and, subject to appropriate confidentiality obligations and compliance with relevant laws and medical practices and procedures, permit us to access such written evidence and documentation to verify your statements;

(i)   not copy the whole or any part of PASCOM-10, except where such copying is incidental to the normal use of PASCOM-10;

(j)   not sub-license, loan, translate, merge, adapt, vary, modify, disassemble, decompile, reverse engineer or create derivative works based on the whole or any part of PASCOM-10, or attempt to undertake any such activities.

2.2   You expressly grant to us a worldwide, royalty free, perpetual and irrevocable right and licence to use and make available for our own purposes, and for those of any other person or entity, all Data that you from time to time input into PASCOM-10. You further agree that all such Data may be freely used, copied, published, translated and distributed in any and all mediums and for any and all purposes whatsoever, including (without limitation) for advertising and promotional purposes by others.

2.3   You hereby waive all moral rights in connection with the copyright in the Data that you input into PASCOM-10.

2.4   You agree that in accessing and using PASCOM-10 you shall NOT:

(a)   defame, abuse, harass, stalk, threaten or otherwise violate the rights (such as rights of privacy and publicity) of others;

(b)   publish, distribute and/or disseminate any harmful, obscene, indecent, unlawful, libellous, profane, defamatory, infringing, inappropriate, hateful, or racially, ethnically or otherwise objectionable material or information;

(c)   input Data that infringes (or is likely to infringe) any patent, trade mark, trade secret, copyright, rights of privacy or publicity, or other intellectual property rights of any other person or entity;

(d)   input any personal data whatsoever of any person or any other details from which the identity of a person can be ascertained, other than your own personal details as requested in relevant fields;

(e)   input Data that you do not have the right to disclose or make available under any law or under contractual or fiduciary relationships, including Data concerning an individual for which you have not obtained the individual's prior consent to disclosure;

(f)   transmit, email or post any material that contains in any form software viruses or other harmful programs such as Trojan horses, worms, time bombs, cancel-bots, computer code, files or other programs designed to interrupt, destroy or limit the functionality of PASCOM-10 or the hardware or telecommunications equipment used in connection with it;

(g)   remove any copyright, trade mark or other proprietary rights notices contained in or on PASCOM-10, the Data and our website;

(h)   falsely state, impersonate, or otherwise misrepresent your identity, including without limitation by using a pseudonym, or misrepresenting your current or previous positions and qualifications, or your affiliations with a person or entity, past or present.

2.5   You agree that we shall be entitled to monitor and audit your use of PASCOM-10 for the purpose of ensuring that you are complying with these Terms.

2.6   You shall indemnify us and hold us harmless against any and all actions, claims, proceedings, costs, expenses and damages (including reasonable legal and other professional fees) that we suffer or incur due to your failure to comply with and/or breach of contract in respect of, the provisions in Terms 2.1 and 2.4.

3   Support

3.1   Should you have any queries as to the use of PASCOM-10, please contact us by e-mail at enq@scpod.org or by telephone at 0845 450 3720 and we will use out reasonable endeavours to respond to your support request within a reasonable time period.

4   Intellectual property rights

4.1   You acknowledge and agree that all and any intellectual property rights subsisting in PASCOM-10 and the Data belong to us and our licensors and that you have no rights in, or to, PASCOM-10 or the Data other than the right to use them in accordance with these Terms.

4.2   You acknowledge that PASCOM-10 is made available to you via the Internet and that you have no right to have access to PASCOM-10 in source code or object code form.

4.3   Your use of PASCOM-10 in accordance with these Terms shall not infringe the intellectual property rights of a third party.

5   Exclusion of liability

5.1   Nothing in these Terms shall limit or exclude the liability of either party for death or personal injury resulting from negligence, or for fraud or fraudulent misrepresentation.

5.2   Subject to Term 5.3, we shall not be liable to you for any of the following losses suffered by you, your employer, your patients or any other person or entity arising out of or in connection with your use of PASCOM-10:

   (a)   loss of income;

   (b)   loss of business profits or contracts;

   (c)   business interruption;

   (d)   loss of the use of money or anticipated savings;

   (e)   loss of information;

   (f)   loss of opportunity, goodwill or reputation;

   (g)   loss of, damage to or corruption of data; or

   (h)   any indirect or consequential loss or damage of any kind howsoever arising and whether caused by tort (including negligence), breach of contract or otherwise.

5.3   Subject to Terms 5.1 and 5.2, our maximum aggregate liability under or in connection with these Terms whether in contract, tort (including negligence) or otherwise, shall be limited to the sum of £50,000.

5.4   These Terms set out the full extent of our obligations and liabilities in respect of the supply of PASCOM-10 and the Data. In particular, there are no conditions, warranties, representations or other terms, express or implied, that are binding on us except as specifically stated in these Terms.

5.5   Any condition, warranty, representation or other term concerning the supply of PASCOM-10 and/or the Data which might otherwise be implied into, or incorporated in, these Terms, whether by statute, common law or otherwise, is hereby excluded to the fullest extent permitted by law.

5.6   We will not be liable or responsible for any failure to perform, or delay in performance of, any of our obligations under these Terms that is caused by events outside our reasonable control.

6   Termination

6.1   We terminate your use of PASCOM-10 at any time in the following circumstances:

   (a)   you breach any of these of Terms and you fail to remedy (if remediable) such breach within 7 days after the service of written notice requiring you to do so;

   (b)   you cease to be a member of the Society of Chiropodists and Podiatrists, or in the circumstances that you are a non-podiatrist approved user you leave the organisation as an officer of the SCP or a clerical officer under the purview of a member of the Society for Chiropodists and Podiatrists;

(c)   you cease to maintain the relevant training and registration requirements for use of PASCOM-10;

(d)   a petition for a bankruptcy order to be made against you has been presented to the court; or

(e)   any company of which you are director, officer or employee becomes insolvent or unable to pay its debts (within the meaning of section 123 of the Insolvency Act 1986), enters into liquidation, whether voluntary or compulsory (other than for reasons of bona fide amalgamation or reconstruction), passes a resolution for its winding-up, has a receiver or administrator manager, trustee, liquidator or similar officer appointed over the whole or any part of its assets, makes any composition or arrangement with its creditors or takes or suffers any similar action in consequence of its debt, unable to pay your debts (within the meaning of section 123 of the Insolvency Act 1986).

6.2   Upon termination for any reason:

(a)   all rights granted to you under these Terms shall cease;

(b)   you must cease all use of PASCOM-10 and the Data and all other activities authorised by these Terms. The licence that you grant us pursuant to Term 2.2 to use your Data shall survive the termination of your right to use PASCOM-10 and the Data.

7   Transfer of rights and obligations

7.1   These Terms are binding on you and us, and on our and your respective successors and assigns.

7.2   You may not transfer, assign, charge or otherwise dispose of these Terms, or any of your rights or obligations arising under them, without our prior written consent.

7.3   We may transfer, assign, charge, sub-contract or otherwise dispose of these Terms, or any of our rights or obligations arising under them.

8   Notices

All notices given by you to us must be given in writing for the attention of the Company Secretary at the Society of Chiropodists and Podiatrists, 1 Fellmongers Path, Tower Bridge Road, London SE 3LY or by e-mail to [*xxx*]. We may give notice to you either by e-mail or post at the e-mail or postal address that we have on record for you as a member of the Society of Chiropodists and Podiatrists. Notice will be deemed received and properly served 24 hours after an e-mail is sent (provided no failure to transmit response is received) or three days after the date of posting of any letter. In proving the service of any notice, it will be sufficient to prove, in the case of a letter, that such letter was properly addressed, stamped and placed in the post and, in the case of an e-mail, that such e-mail was sent to the specified e-mail address of the addressee and no failure to transmit response was received.

9   General

9.1   If we fail at any time to insist upon strict performance of any of your obligations under these Terms, or if we fail to exercise any of the rights or remedies to which we are entitled under these Terms, this shall not constitute a waiver of such rights or remedies and shall not relieve you from compliance with such obligations. A waiver by us of any default shall not constitute a waiver of any subsequent default. No waiver by us of any of these terms and conditions shall be effective unless it is expressly stated to be a waiver and is communicated to you in writing.

9.2   If any of these Terms are determined by any competent authority to be invalid, unlawful or unenforceable to any extent, such term, condition or provision will to that extent be severed from the remaining terms, conditions and provisions which will continue to be valid to the fullest extent permitted by law.

9.3   These Terms and any document expressly referred to in them represents the entire agreement between us in relation to the licensing of PASCOM-10 and the Data and supersedes any prior agreement, understanding or arrangement between us, whether oral or in writing. You acknowledge that, in entering into these Terms, you have not relied on any representation, undertaking or promise given by us or implied from anything we have said prior to you agreeing to these Terms, except as expressly stated in these Terms.

9.4   Neither you nor we shall have any remedy against the other in respect of any untrue statement made by the other, whether orally or in writing, prior to the date you agreed to these Terms (unless such untrue statement was made fraudulently) and the only remedy in respect thereof shall be for breach of contract as provided in these Terms.

10   Law and jurisdiction

These Terms and their subject matter (including non-contractual disputes or claims) shall be governed by and construed in accordance with English law and submitted to the exclusive jurisdiction of the English courts.

End of manual.
www.pascom-10.com