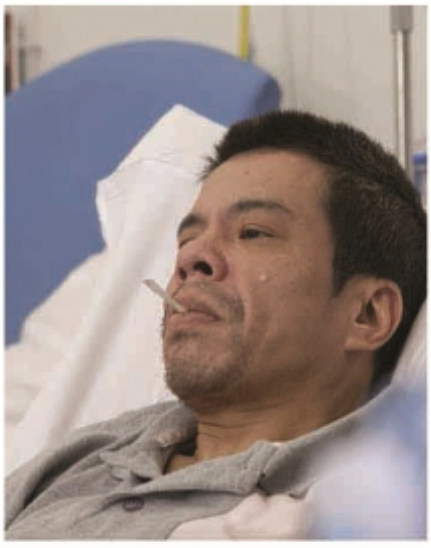
NHS England

Dental Assurance Framework



THE NHS CONSTITUTION
the NHS belongs to us all

Dental Assurance Framework

Policy & Corporate Procedures

Issue Date: March 2014

Document Number: OPS_01272

Prepared by: Primary Care Commissioning (PCC)

NHS England INFORMATION READER BOX		
Directorate		
Medical	**Operations**	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**01272**
Document Purpose	Guidance
Document Name	Dental Assurance Framework Policy
Author	NHS England
Publication Date	March 2014
Target Audience	All NHS England Employees
Additional Circulation List	
Description	Policy and high level procedures to allow Area Teams to be able to assure themselves of the quality of primary care of dental services being delivered in their Area Team.
Cross Reference	
Superseded Docs (if applicable)	
Action Required	To note.
Timing / Deadlines (if applicable)	
Contact Details for further information	Primary Care Commissioning Team 1N04 Quarry House Leeds england.primarycareops@nhs.net

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

Contents

	Introduction
1	From 1 April 2013, the NHS Commissioning Board adopted the name NHS England, a name that gives people a greater sense of our role, scope and ambitions - as the organisation responsible for allocating the NHS budget, working to improve outcomes for people in England and ensuring high quality care for all, now and for future generations. Our legal name remains the NHS Commissioning Board as set out in our establishment orders. While the NHS Commissioning Board will be known as NHS England in everything that we do, there are times when the statutory name is required for legal and contractual transactions. The following list provides some key examples of legal documentation which requires us to use our full legal name: • Human resources contract of employment; • Any documentation involving a court of law, eg litigation claims • Contracts for directly commissioned services. For ease of reference NHS England is the generic term used throughout this policy.
2	**Policy statement** NHS England is responsible for planning, securing and monitoring services commissioned by them in respect of primary care, offender health, military health and specialised commissioning. This document forms part of a suite of policies and procedures to support NHS England with its direct commissioning responsibilities in relation to primary care. The suite of documents will form NHS England's single operating policy. This policy is the national dental assurance framework. The policies and procedures underpin NHS England's commitment to a single operating model for primary care – a "do once" right approach intended to ensure consistency and eliminate duplication of effort in the management of the four primary care contractor groups from 1 April 2013. The development process for the document reflects the principles set out in Securing excellence in commissioning primary care, including the intention to build on the established good practice of predecessor organisations. Primary care professional bodies, representatives of patients and the public and other stakeholders were involved in the production of these documents. NHS England is grateful to all those who gave up their time to read and comment on the draft documents.

	The authors and reviewers of these documents were asked to keep the following principles in mind: • wherever possible to enable improvement of primary care • to balance consistency and local flexibility • alignment with policy and compliance with legislation • compliance with the Equality Act 2010 • a realistic balance between attention to detail and practical application • a reasonable, proportionate and consistent approach across the four primary care contractor groups. This suite of documents will be refined in light of feedback from users.
3	It is the policy of NHS England that: Area teams will use the indicators outlined in the policy alongside other information they have about their contractors such as exception reports, vital signs and any soft intelligence to undertake an assurance process regarding the quality of the delivery of their general and personal dental services portfolio of primary care dental contracts and agreements. This policy is not to be used for assurance of practices participating in the NHS dental contract reform programme as these have a separate framework.
4	**Scope**
	Officers of the following NHS England areas are within the scope of this document: • NHS England: o National teams; o Regional teams; and o Area teams. • All commissioning support units (CSUs) • NHS leadership academy • NHS improving quality • NHS sustainable development unit • Strategic clinical networks • Clinical senates.
5	This policy is not to be used for assurance of practices participating in the NHS dental contract reform programme as these have a separate framework.

6	**Roles and responsibilities** **The area team must:** Advise all of its general dental services (GDS) contract and personal dental services (PDS) agreement holders, excluding practices which are participating in the NHS dental contract reform programme, of the NHS dental assurance framework policy and inform them if the policy is amended. **The contractor must:** Ensure that it adheres to policy and meets any requirements and timeframes specified within it.
	Corporate level procedures
7	NHS England central and regional teams will use this policy for any audit purpose or where a challenge from a contractor arises from the implementation of this policy.
	Distribution and implementation
8	This document will be made available to all staff via the NHS England internet site.
9	Notification of this document will be included in the all staff email bulletin.
10	A training needs analysis will be undertaken with staff affected by this document.
11	Based on the findings of that analysis appropriate training will be provided to staff as required.
	Monitoring
12	Compliance with this policy will be monitored via the primary care oversight group*, together with independent reviews by internal and external audit on a periodic basis*.
13	The Primary care policy ratification a formal sub-group of the primary care oversight group will have responsibility for reviewing and updating the policy. *The document should be reviewed in 24 months unless guidance or legislation requires an earlier review.*
	Equality impact assessment
14	Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.
15	As part of its development this document and its impact on equality has been analysed and no major impact has been identified.
	Associated documents

16	The assurance framework should be read alongside the dental contractual management policies: Mid-year and end of year Incorporation Variations PDS to GDS
17	**References**
	GDS Contracts Regulations 2005 PDS Agreements Regulation 2005 The Dentist Act 1984 The Dentist Act 1984 (Amendment Order) 2005 The National Health Service (England) Performers Lists Regulations 2013 NHS Act 2006 Health and Social Care Act 2012

Background

1. Between November 2011 and December 2012 a task and finish group was set up to make recommendations to NHS England about the development of a dental assurance framework for area teams to follow. This policy is based upon their recommendations. The membership of the task and finish group included members from public health, primary care trusts, the British Dental Association (BDA), local dental networks and the NHS Business Services Authority (NHS BSA).

2. The group made recommendations regarding a set of indicators that provide high level assurance for area teams, whilst recognising that no one set of indicators could, in itself, provide absolute assurance of quality, nor could it necessarily identify best practice.

3. The recommendations have been formally adopted by NHS England.

4. The indicators regarding patient safety reflected discussions between NHS England and the Care Quality Commission (CQC).This aspect of the framework will require development as discussions between NHS England and CQC further develop joint arrangements. In addition, the clinical indicators are expected to require refreshing after an initial period of use.

5. This policy provides a basis for commencing assurance processes for dental services but will need developing over time. This policy is intended to set out initial expectations for dental service assurance and will itself need to evolve or be replaced by a new policy within the first six months.

6. The policy is designed to provide a basis for area teams to engage with providers and performers to secure and improve service quality. It is designed to assure commissioners that contract holders and providers are on course to meet their obligations under their general and personal dental services contract(s) and agreement(s). This policy should be read alongside the other NHS England dental policies. It should be noted that this policy does not apply to practices participating in the NHS dental contract reform programme as these have a separate framework.

7. The indictors have been taken from existing data sets so commissioners, providers and performers will be familiar with the content. The analyses and presentation are new as is the accompanying narrative and users will need some time to become familiar with these.

8. While the indicators are informative about overall dental health system performance, they do not give a complete picture and other information will be needed to inform a wider appreciation; such as the 24 month access indicator, patient survey data and the public health outcomes indicator for dental health.

9. This policy sets out expectations regarding:
    a. Arrangements for assurance to be in place from October 2013
    b. How the dental assurance framework should be put into effect.

10. The framework has the following components:

    a. Process the area team will follow
    b. A summary of the indicators
    c. Supporting narrative on how indicators should be interpreted and how concerns might be further explored
    d. Example reports from NHS BSA with guidance on how the indicators are calculated

Timetable for the publishing of area team reports

11. Reports will be available for area teams via the NHS BSA e-reporting contract management link for area teams and once available will be accessible to providers via the dental portal on the following quarterly timetable:

Quarter one (April – June)	End of first week in July
Quarter two (July – September)	End of first week in October
Quarter three (October – December)	End of first week in January
Quarter four (January – March)	End of first week in April

Area team processes:

October 2013 onwards

12. Area teams should ensure they are familiar with:

    a. The format of the NHS BSA report for their area team (Annex 4)
    b. The indicators and guidance that make up the NHS BSA generated report (Annex 5).
    c. The narrative accompanying the indicators (Annex 2).

13. Are teams should also be able to amend and include other relevant information (Annex 6).

14. The reports can be accessed through e-reporting under the contract management link and are called: Q(xx) Dental assurance framework (month year) general report

and called Q(xx) Dental assurance framework (month year) ortho report. Example reports are available in Annex 4

15. Area teams should ensure that, patient safety arrangements as set out in the recommendations (Annex 2 Domain 2) are in place.

16. Area teams should ensure that processes for monitoring patient experience as set out in the recommendations (Annex 2 Domain 3) are in place.

17. Area teams should ensure that there are arrangements in place for receiving and assessing statutory notification reports from the General Dental Council (GDC), for assurance that performers are registered with the GDC and that performers have adequate professional indemnity.

18. Area teams should appreciate that clinical input into performers list processes and ensuring that providers comply with regulations when engaging performers are also part of ensuring patient safety.

19. As soon as possible area teams should review the reports in relation to their contracts, amending and triangulating with other relevant information available to area teams ensuring that clinical advice is part of this process.

20. These reports should also be informed by other relevant information examples of which are outlined in the narrative in Annex 2 and incorporated in an example report in Annex 6.

21. For the year 2013/14, area teams should run individual reports for each of their contracts and share these with their contract holders. From 2014/15, (or as soon as they are available) contract holders should download their own individual practice reports. Contractors and performers should be encouraged to access the report from the NHS BSA portal.

22. Area teams are to ask contractors to review these with their performers and ask them to engage with the area team if they have any questions.

23. Area teams should review the Q1 and Q2 2013/14 reports alongside the Q3 & Q4 2012/13 reports and identify contracts where further follow-up is appropriate. The area team can set the number of flags which would prompt follow up action locally to reflect local contracting pressures.

24. Run a tier 2 report for the individual contract where they have concerns regarding individual practices for further information. This report is available on e-reporting

under contract management link and the reports are called: Dental assurance framework (general) tier 2 – single contract or Dental assurance framework (ortho) tier 2 – single contract. Example reports are available in Annex 7.

25. Have processes in place to escalate any serious concerns, especially where there are legacy concerns prior to April 2013, or apparent serious threats to patient safety.

26. Ask contractors to submit a written explanation or action plan around their interpretation of the reports where there are concerns but an urgent visit or escalation is not appropriate. This should be reviewed by the area team with appropriate clinical advice. Clinical advice can be sought through the medical directorate of the area team. Area teams are also able to access clinical support from NHS BSA clinical advisers where there are high level concerns. NHS BSA has instigated quarterly meetings with the area team where concerns can be covered.

27. Begin considering how services not adequately covered by the indicators should be monitored, such as domiciliary, sedation, advanced mandatory, public health or trust-based services.

28. Structured arrangements for monitoring services not adequately covered by the indicators should be in place.

29. Area teams should follow the mid-year policy for 2013-14 contractual year and where appropriate link the mid-year visit with the latest assurance reports from NHS BSA.

January 2014 onwards (Q3 reports available)

30. Area teams should have established processes for reviewing and responding to reports and should commence contract review visits where appropriate.

31. Similar arrangements should be in place for services not adequately covered by the indicators.

32. Area teams should start to develop a timetable for visiting practices that have been flagged for follow up or where action plans have been received but no improvements found. Visits should include appropriate clinical input as required.

Annex 1: Abbreviations and acronyms

A&E	accident and emergency
APHO	Association of Public Health Observatories (now known as the Network of Public Health Observatories)
APMS	Alternative Provider Medical Services
Area Team	area team (of the NHS Commissioning Board)
AUR	appliance use reviews
BDA	British Dental Association
BMA	British Medical Association
CCG	clinical commissioning group
CD	controlled drug
CDAO	controlled drug accountable officer
CGST	NHS Clinical Governance Support Team
CIC	community interest company
CMO	chief medical officer
COT	course of treatment
CPAF	community pharmacy assurance framework
CQC	Care Quality Commission
CQRS	Calculating Quality Reporting Service (replacement for QMAS)
DAC	dispensing appliance contractor
Days	calendar days unless working days is specifically stated
DBS	Disclosure and Barring Service
DES	directed enhanced service
DH	Department of Health
EEA	European Economic Area
ePACT	electronic prescribing analysis and costs
ESPLPS	essential small pharmacy local pharmaceutical services
EU	European Union
FHS	family health services
FHS AU	family health services appeals unit
FHSS	family health shared services
FPC	family practitioner committee
FTA	failed to attend
FTT	first-tier tribunal
GDP	general dental practitioner
GDS	General Dental Services
GMC	General Medical Council
GMS	General Medical Services

GP	general practitioner
GPES	GP Extraction Service
GPhC	General Pharmaceutical Council
GSMP	global sum monthly payment
HR	human resources
HSE	Health and Safety Executive
HWB	health and wellbeing board
IC	NHS Information Centre
IELTS	International English Language Testing System
KPIs	key performance indicators
LA	local authority
LDC	local dental committee
LETB	local education and training board
LIN	local intelligence network
LLP	limited liability partnership
LMC	local medical committee
LOC	local optical committee
LPC	local pharmaceutical committee
LPN	local professional network
LPS	local pharmaceutical services
LRC	local representative committee
MDO	medical defence organisation
MHRA	Medicines and Healthcare Products Regulatory Agency
MIS	management information system
MPIG	minimum practice income guarantee
MUR	medicines use review and prescription intervention services
NACV	negotiated annual contract value
NCAS	National Clinical Assessment Service
NDRI	National Duplicate Registration Initiative
NHAIS	National Health Authority Information System (also known as Exeter)
NHS Act	National Health Service Act 2006
NHS BSA	NHS Business Services Authority
NHSCB	NHS Commissioning Board
NHS CfH	NHS Connecting for Health
NHS DS	NHS Dental Services
NHS LA	NHS Litigation Authority
NMS	new medicine service
NPE	net pensionable earnings

NPSA	National Patient Safety Agency
OJEU	Official Journal of the European Union
OMP	ophthalmic medical practitioner
ONS	Office of National Statistics
OOH	out of hours
PAF	postcode address file
PALS	patient advice and liaison service
PAM	professions allied to medicine
PCC	Primary Care Commissioning
PCT	primary care trust
PDS	personal dental services
PDS NBO	Personal Demographic Service National Back Office
PGD	patient group direction
PHE	Public Health England
PLDP	performers' list decision panel
PMC	primary medical contract
PMS	Personal Medical Services
PNA	pharmaceutical needs assessment
POL	payments online
PPD	prescription pricing division (part of NHS BSA)
PSG	performance screening group
PSNC	Pharmaceutical Services Negotiating Committee
QOF	quality and outcomes framework
RCGP	Royal College of General Practitioners
RO	responsible officer
SEO	social enterprise organisation
SFE	statement of financial entitlements
SI	statutory instrument
SMART	specific, measurable, achievable, realistic, timely
SOA	super output area
SOP	standard operating procedure
SPMS	Specialist Personal Medical Services
SUI	serious untoward incident
UDA	unit of dental activity
UOA	unit of orthodontic activity

Annex 2 Domain Narrative

NHS England has formally accepted the recommendations of the task and finish group regarding the indicators and supporting narrative on how they should be interpreted and how concerns might be further explored. These are set out below:

1. Background and context of the task and finish group

1.1. A task and finish group was asked to make recommendations regarding an assurance framework for primary care dental services that might be adopted by NHS England.

1.2. The framework has, during development, had considerable input from a number of organisations including the BDA, BOS several PCT clusters and local dental networks who were involved in developing the indicators and undertook local testing. There has been extensive support from NHS BSA who have modelled and tested different indicators and presentational formats.

1.3. The purpose of the framework is to support a more standardised approach to assurance and to make best use of the extensive data currently available. It is designed to assure commissioners that contract holders and providers are on course to meet their obligations under their GDS contracts and PDS agreements. This policy should be read alongside the other NHS England dental policies to understand NHS England's single operating model for dental contract management.

1.4. This framework sits within the context of the five clinical outcome domains of the NHS Outcomes Framework 2013/14:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care, including improving access to dental care, and
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

1.5. The framework is intended to complement the oral health indicator in the public health outcomes framework 2013-2016.

2. Principles underpinning the framework

2.1. The framework is designed to be used with current GDS and PDS contracts and agreements. It is likely to have some limitations if applied to PDS plus, contracts with provider NHS trusts, although some of the indicators and much of the accompanying narrative and principles will retain usefulness. The framework is not to be used for practices participating in the NHS dental contract reform programme as they have a separate framework.

2.2. There is a considerable amount of information already available on NHS dental contracts and this framework was developed with the objective of giving dental commissioners, contractors and performers as simple a set of indicators as possible along with narrative on how they might be interpreted and how any concerns can be followed up. This means that further analysis will often be necessary if there are concerns but also reflects the principles that no set of indicators, however comprehensive, can avoid the need for triangulation and further analysis where there are concerns, nor can the indicators in themselves be definitive of overall excellence.

2.3. An early decision was to work with existing datasets and not place new requirements on contractors to submit data over and above that already captured through FP17 forms and their electronic equivalents. It was also agreed that, where possible, the framework should avoid requiring contractors to submit information to NHS England that has already been submitted to other regulators. The framework therefore seeks to provide a balance between being fit for purpose (including being clinically ambitious) and not being over-burdensome for contractors and commissioners.

2.4. Discussions with potential users and the experience of testing have underpinned the principle that no set of indicators derived from reported data can in itself identify excellent or poor clinical practice. The indicators are therefore designed to produce “flags” for following up with other information available, further analysis and, if necessary, discussions with contractors and performers. Equally, concerns may arise from other sources that require investigation and comparison with the data contained in the indicators.

2.5. While it is not the purpose of this framework to advise on the management of poor performance by contractors or performers and NHS England has a specific set of policies to deal with these matters, it is worth emphasising that

assurance processes may require careful triangulation and interpretation, including reviewing patterns of provision over time.

Area teams should be assisted by appropriate clinical advice in the interpretation of indicators and the development of appropriate next steps.

In terms of commissioning responses to the indicators, there should be an underlying approach of encouraging quality improvement and a stepped response to concerns in most cases.

For example, through the quarterly report and additional information the area team could assemble a profile for the contract, highlighting the issues identified and make it available to the provider and performers, inviting their comments after review, or could set up a review meeting. Where residual concerns remain the area team should follow the sanctions and breaches policy.

An initial action plan should provide assurance of the response to identified concerns, and subsequent reporting periods will need to provide follow up assurance of change where appropriate. Clinical advice from within area teams and NHS BSA, deaneries and National Clinical Assessment Service (NCAS) may all play a role in diagnosing the nature of any problem and developing any remediation plans.

2.6. The indicators are also intended for use by contractors and performers to aid reflective consideration of their own performance and, for larger contracts particularly, analysis by individual performer appears to have considerable merit.

2.7. It has become apparent in testing the indicators that identifying outliers can be useful in highlighting excellent or poor performance, whilst recognising that being an outlier is not necessarily definitive of either. Care has been taken, through modelling with NHS BSA, to adopt statistical methods to show true outliers and, where possible, ensure that comparisons are made with peers.

3. Framework domains

3.1. This framework is presented in four domains:

1. **Delivery** - centred around the present contract currencies of UDAs and UOAs for standard GDS and PDS contracts
2. **Patient safety** – based on discussions with CQC

3. **Patient experience**- including patient reported experience through NHS BSA data, and other sources of information such as complaints and other information

4. **Quality/clinical effectiveness** - including both process and outcome measures.

There is a subset of indicators for orthodontic contracts.

4. Future development of the framework

4.1. The framework will be developed in light of initial use and feedback from users. There was considerable feedback in relation to orthodontics, where commissioners and providers felt that more detail was needed.

4.2. This framework is intended to evolve in response to feedback from users and to refresh any indicators that may lose relevance. The future introduction of any new dental contract will likely necessitate substantial revision of this framework.

5. Domain 1: Delivery

See Annex 3 for a summary of the indicators

See NHS BSA report guidance sections 5 and 8 (Annex 4):

5.1. This domain is focussed on the delivery of the commissioned levels of activity and is guided by the GDS and PDS regulations. The regulations allow commissioners to take action if a contractor under-delivers more than 4% of the contracted activity in any year and allow agreement for delivery of under-delivered activity in the following year.

5.2. The regulations require a mid-year review if less than 30% of the contracted activity has been delivered by month 6. These regulatory thresholds therefore set the flags for consideration and follow-up at month 6 and month 12.

5.3. Area teams should have regard to the regulations and to the mid-year and year end policies when determining the appropriate actions in response to under-delivery at month 6 and year end

5.4. In-year agreed changes to the level of contracted activity may affect the apparent level of delivery and commissioners should take care to ensure that the % delivered is accurately calculated.

5.5. Repeated under-delivery (>4%) at year end may mean that it is appropriate to discuss re-basing a contract to allow resources to be committed recurrently elsewhere. Repeated under-delivery within the 4% contract tolerance may still reflect considerable activity for larger contracts and the area team may wish to discuss this with the contractor to see if re-basing is appropriate and can be agreed. For example, 3% of a 30,000 UDA contract represents 900 Units of Dental Activity (UDAs). The area team should cross reference with mid-year and year end policy.

5.6. Where there are concerns over the level of delivery a decision can be made by the area team to move towards a more regular interval of monitoring of the delivery of UDA/ Units of Orthodontic Activity(UOAs). The pattern of delivery over the year should be looked at against that for previous years to see if there are changes and to better inform any forecasting of the likely year end position. Months where there is little or no activity reported should be of concern. A clinical opinion may be required when discussing concerns with the contractor.

5.7. In some circumstances it may be appropriate to allow new practices a stepped activity contract in their first year.

5.8. This framework is designed to assure commissioners that contract holders and providers are on course to meet their obligations under their general and personal dental services contract(s) and agreement(s).

5.9. Arrangements will be needed to monitor delivery of advanced mandatory, sedation, domiciliary or dental public health services where commissioned through primary care contracts.

5.10. This assurance framework sits within the context of the five clinical outcome domains of the NHS Outcome Framework 2013/4 Domain 4 includes improving access to dental care. It is essential that delivery within contracts is viewed in the context of the numbers of patients accessing care and whether the numbers are being maintained and increasing. The numbers of patients seen in a given two year period which can be accessed via vital sign reports should be viewed in the context of the overall contract value and the UDA value as compared to area team and national average.

6. Domain 2: Patient safety

6.1. The GDS and PDS regulations require the contractor to ensure that the premises, facilities and equipment are suitable for the delivery of services, comply with legislation and have regard to relevant NHS guidance. All dental providers are required to be registered with the CQC.

6.2. Discussions between NHS England and CQC are on-going and this domain is likely to require revision in the short-term. It is clear that NHS England retains responsibility for ensuring that patients are safe when cared for under contracts that it commissions and area teams will need to ensure that they liaise with CQC locally to share information and develop coordinated responses where there are concerns.

6.3. As with the other domains, a concern may arise regarding patient safety that needs referencing with other information available to the area team.

6.4. Pending further discussions between NHS England and CQC, area teams are advised to ensure the following minimum arrangements are in place:

1. Up-to-date contact details for local CQC contacts and know of providers who hold contracts in more than one area teams geography.
2. Processes to check that all contractors are registered with CQC and remain so, including when ownership of a practice changes or where there are changes in contract holder.
3. Dates when a provider was last inspected by CQC and the outcome of this inspection.
4. If a CQC inspection has identified that standards are not being met, the area team is to liaise with CQC locally and with the provider to ensure that the necessary improvements are in place to the required timescales.
5. Have arrangements in place to share any concerns with CQC, for example concerns raised by patients or colleagues.
6. Have arrangements in place to escalate urgent concerns where there may be an immediate threat to patient safety, such as an apparent failure in infection control processes or where. Clinical advice and the engagement of other agencies such as Public Health England (PHE) may be appropriate.

7. Domain 3: patient experience

7.1. See Annex 3 for summary of the indicators

7.2. See Annex 4 NHS BSA report guidance sections 7 and 8

7.3. This part of the guidance is divided into two sections; the first introduces the patient experience indicators and suggests how they might be interpreted. The second describes possible sub-analyses to give greater scrutiny of individual contractual performance and suggests how it might be investigated and managed.

7.4. Like other indicators in this framework, these indicators do not in themselves necessarily evidence poor performance or breaches of the regulations. They do however provide an insight into contract performance and assist with identifying areas of potential concern that should be explored in more detail with the contractor.

7.5. As part of its risk management role NHS BSA carries out a range of activities to monitor the quality and integrity of NHS dentistry services. One of those activities is to write to a random sample of patients asking them to complete a brief questionnaire. The questionnaire seeks to establish:

- That the patient exists
- That the patient attended the dentist on the dates reported
- That treatment appropriate to the band claimed was provided
- That the patient paid an appropriate charge and understands the charge bands
- Overall levels of satisfaction with NHS treatment received

7.6. The information collected from this survey is used to provide reports to the NHS England and area teams to help them to review the quality of the services and patient satisfaction in their areas. It does not include any information that can identify the patient.

7.7. Practices participating in the NHS dental contract reform programme have been excluded as a different patient survey based on outcomes is used. There is the

potential for additional national patient survey indicators dependent on the content of the new dental contract in future. At present, there are separate questionnaires for general dentistry and orthodontics. The questionnaires for patients in receipt of mandatory services can be found at:

http://www.nhsbsa.nhs.uk/DentalServices/Documents/DentalServices/Quest_England_Adult_(18-3-2011).pdf

and

http://www.nhsbsa.nhs.uk/DentalServices/Documents/DentalServices/Quest_England_Child_(18-03-2011).pdf

The questionnaires for patients who are reported to have recently commenced a course of orthodontic treatment can be found at:

http://www.nhsbsa.nhs.uk/DentalServices/Documents/DentalServices/Quest_Ortho_Adult_English_(18-03-2011).pdf

and

http://www.nhsbsa.nhs.uk/DentalServices/Documents/DentalServices/Quest_Ortho_Child_English_(18-03-2011).pdf

7.8. Where the area team has concerns it may wish to access other sources of information available on patient experience such as CQC inspection reports, complaints and comments on NHS Choices. These other sources may collectively present just as valid an indicator of patient experience as the data from the NHS BSA surveys. Systems should be in place to identify patterns and trends as well as contracts and performers of concern. Practices may carry out their own patient surveys and record patient comments and these data could be made available to commissioners upon request if there are concerns.

7.9. As outlined in the patient safety domain, discussions between NHS England and CQC are on-going and this domain is likely to require revision. At this stage it is clear area teams need to liaise with CQC locally to share information and develop coordinated responses where there are concerns.

7.10. **The Indicators**. These are derived from the results of the NHS BSA routine random patient questionnaires. The results of these are presently reported quarterly and provide the patient's view of dental quality.

7.11. The analysis each quarter is based on responses to questionnaires sent to a random sample of over 20,000 patients. The national response rate (the proportion of questionnaires completed and returned by patients) is currently around 50%. The sample is stratified by organisation (to ensure the same number of cases are selected from each organisation) and charge band (to over-sample the higher charge bands).

7.12. Indicator E1 – percentage of patients satisfied with the dentistry they have received

The question asked in Q10 general dentistry survey or Q5 orthodontics survey is as follows:

"How satisfied are you with the NHS dentistry you received? (Tick one box)"

- Completely satisfied
- Fairly satisfied
- Fairly dissatisfied
- Very dissatisfied

7.13. The figure reported is the percentage of respondents who stated that they were either completely or fairly satisfied with the NHS dentistry they received. This is presented as a percentage of the number of responses for each contract, based on a 12 month rolling period. For general dentistry, a percentage is calculated only for contracts with 10 or more responses in the rolling year.

7.14. The points at which a contract might be flagged as an outlier for further investigation have been identified using a statistical methodology that accounts for the size of contract. By doing this, issues associated with contracts of different sizes should be adjusted for.

7.15. Indicator E2 – percentage of patients satisfied with the time they had to wait for an appointment.

The question asked for general dentistry (Q9) is as follows:

"How do you feel about the length of time taken to get an appointment with the dentist? (Tick one box)"

- It was as soon as was necessary

- It should have been a bit sooner
- It should have been much sooner

7.16. The figure reported is the percentage of respondents who stated that the length of time taken to get an appointment was as soon as was necessary. This is presented as a percentage of the number of responses for each contract, based on a 12 month rolling period. A percentage is calculated only for contracts with 10 or more responses in the rolling year.

7.17. **Further investigation of outliers identified by the Indicators**

7.18. When an outlier is identified, it may be appropriate to undertake further analysis. Inevitably, there may be aspects of local service arrangements which influence the position of local services and present natural outliers within reporting. The local system, local intelligence, as well as local contracts, should be considered against the national position when identifying cases of concern. Contracts in the bottom 5% nationally will be flagged for attention.

7.19. It is expected that the patient satisfaction indicators will be reviewed at mid-year and annually in line with the contract review. The information will be provided by NHS BSA on a quarterly basis to enable area teams to identify trends and look back over time to assess if the outliers identified are indicative of a protracted pattern or are a temporary effect. However, it should be noted that as this indicator is on a rolling 12 month period it may take a longer period of time to highlight a change.

7.20. Bear in mind that these indicators may be on a relatively small number of responses and there may be a response bias.

7.21. Just as concerns arising from the indicators should be referenced with information from other sources concerns arising from these other sources should be triangulated with the indicators to develop as informed a picture as possible of patient experience in relation to a contract or performer. Depending upon the particular concerns, other indicators in this framework may inform consideration of patient experience, particularly the clinical quality indicators.

8. Domain 4a: Clinical Quality – mandatory services

See Annex 3 for summary of the indicators

See NHS BSA report guidance sections 6 and 8

8.1. **Introduction.** This part of the framework seeks to examine the quality of dental care provided, within the constraints of the data available. Like other indicators in this framework, the indicators in this domain do not in themselves necessarily evidence poor performance or breaches of the regulations, nor do they necessarily identify excellence or best practice. They do, however, provide an overview of contract performance and assist with identifying areas of potential concern that should be explored in more detail with the contractor.

8.2. Like all indicators in this framework, they should be considered alongside other routine contract monitoring provided by the NHS BSA and other information available to the area team. Similarly, these indicators should be used to reference any concerns arising from other sources. Area teams should bear in mind that there may be local factors or considerations around individual contracts which may in part explain a particular pattern of provision an example of this could be that a practice provides urgent access slots.

8.3. Where a contract and/ or performer are identified as an outlier and a decision is made to further explore performance, this process should include supporting clinical where appropriate.

8.4. Contracts showing as outliers on more than one indicator are likely to be a priority, but area teams can set locally the number of flags against indicators which would prompt any follow up. Although local clinical advice and triangulation with other concerns may prioritise some indicators over others, there may also be occasions where an indicator does not flag a contract as an outlier, the contract's performance may still justify further analysis.

8.5. Examples of other possible sources of information relevant to this domain include NHS BSA reports, patient experience indicators such as enquiries or complaints, referral data where available.

8.6. While it is not the purpose of this framework to advise on the management of poor performance by contractors or performers as there are separate NHS England policies to deal with these issues, it is worth stating that the clinical indicators may require careful triangulation and interpretation, including reviewing patterns of provision over time. Clinical advice and other agencies may all play a role in diagnosing the nature of any problem and developing any remediation plans.

8.7. Testing has identified that some variation in reporting may be due to differing interpretations of information required from providers when completing the fields in the FP17. In particular there are some indicators, such as radiographs, fluoride varnish and sealants, where there is not necessarily an incentive for performers to report these. Therefore an apparent under-provision might in fact reflect under-reporting.

8.8. A description of the requirements completion of FP17s can be found in the NHS BSA "completion of FP17" guidance.

http://www.nhsbsa.nhs.uk/Documents/DentalServices/Completion_of_form_guidance_-_FP17_-_England_(V2)_-_09.2012.pdf

8.9. It is intended that this framework will evolve in response to feedback from users and to refresh any indicators that may lose their usefulness. This is likely to apply to the clinical quality indicators for mandatory services.

8.10. **The Indicators.** The indicators are grouped into four sub-domains:

- Diagnosis
- Prevention
- Provision of Treatment
- Outcome, including re-attendance and need for repeated complex care.

8.11. **Diagnosis**

8.12. Indicator M1 – radiographs

8.13. This indicator is the rate of reported radiograph provision per 100 FP17s (or electronic equivalents).

8.14. An apparent low rate could indicate non-compliance with best practice as outlined in FGDP (UK) good practice guidelines – "Selection Criteria for Dental Radiography" (2004).

8.15. There might be heightened concern where there is a high level of provision of more advanced treatment such as endodontics, inlays, crowns or bridges combined with an apparent low rate of radiographs.

8.16. **Prevention**

8.17. Indicator M2 – fluoride varnish application
8.18. Indicator M3 – fissure sealant application

8.19. These indicators are the rate of reported provision per 100 FP17s for patients aged from 3 years up to and including 16 years which included a reported fluoride varnish/ fissure sealant provision.

8.20. A low rate of provision could indicate that treatment is not being offered according to best practice as outlined in "Delivering Better Oral Health" (Department of Health 2009 as updated), though contracts providing care mainly for adults might tend to report lower rates.

8.21. There might be heightened concern where there is a high reported level of provision of operative dental treatment to children such as fillings or extractions combined with an apparent low rate of provision of preventative care.

8.22. **Provision of treatment**

8.23. Indicator M4 – extractions (all patients)

8.24. This indicator is the rate of reported provision per 100 FP17s for all courses of treatment provided for all patients which included an extraction.

8.25. High or low rates of provision in relation of similar contracts could reflect a range of factors associated with the patients being treated, including disease levels and patients' own treatment choices. Treatment choices offered by performers under the contract could also be a factor. Comparison with other contracts caring for similar population groups may be helpful.

8.26. High referral rates to secondary care providers may explain low rates of reported extraction and high reported extraction rates might justify a discussion with providers and performers on encouraging appropriate attendance, prevention, treatment choices offered to patients and appropriate referral. This indicator however should also be interpreted alongside indicator M5.

8.27. Indicator M5 – extractions v endodontic treatment (adults)

8.28. This indicator is the percentage of total FP17s for adult patients (aged 18 years and over) with either an extraction and/ or endodontic treatment that contained an extraction. For clarity, the rate of endodontic treatment for all patients is also presented.

8.29. Like indicator M4, there could be a number of reasons behind a low proportion of endodontic provision. For example, extractions may be reported more readily if there are courses of treatment where an extraction was the only operative treatment whereas endodontic treatment may also be associated with a filling and the latter may be reported by the performer and contractor instead of the endodontic treatment.

8.30. Other factors could be associated with the patients being treated, including disease levels and patients' own treatment choices. Treatment choices offered by performers under the contract may also be a factor. Comparison with other contracts caring for similar population groups may be helpful.

8.31. High referral rates to other providers or private provision of endodontics may explain low rates of endodontic provision and high extraction rates compared to endodontics might justify a discussion with providers and performers on treatment choices offered to patients and treatment planning.

8.32. Indicator M6 – provision of inlays

8.33. This indicator is the percentage of total FP17s for all patients with an inlay reported.

8.34. A high level of provision may be of concern, particularly as feedback during testing often cited inlays as being a common treatment that was provided inappropriately, since it was one of the simplest treatments justifying a band 3 course of treatment.

8.35. Where there are concerns over high rates of inlay provision it would be appropriate to look at overall crown and inlay provision to see if the combined inlay and crown rate of provision for the contractor and/ or performer remain high. There might be heightened concerns where there are low levels of reporting of other treatments such as radiographs, which might naturally accompany provision of inlays or crowns, or provision of other aspects of care such as scaling and polishing which might indicate an inappropriate focus on high value treatments.

8.36. It is possible to obtain patient-based data from NHS BSA and look at the treatment history of individual patients. This can help build a picture of any issues that might explain the apparent high rates of inlay provision and see

whether other treatments are being provided alongside inlays within courses of treatments.

8.37. Repeated courses of inlay treatment can also be usefully examined by looking at patient level data (see indicator M9).

8.38. **Outcome including re-attendance and need for repeated complex care**

8.39. Indicator M7 – re-attending within 3 months – children
8.40. Indicator M8 – re-attending within 3 months – adults

8.41. The indicators reflect the percentage of FP17s where a patient with the same identity was the subject of a reported course of treatment under the same contract within the previous three months.

8.42. A high percentage of treatments within three months of a previous course of treatment is of concern since it may reflect failed care or an intentional policy of fragmenting care over more than one course of treatment to maximise activity, sometimes referred to as “splitting”. The issue is complex and further investigation would be justified.

8.43. These indicators are complex in interpretation but highly relevant to the outcomes of courses of treatment and the efficiency of service provision.

8.44. Where patients have to return for further care within a short period this is obviously less efficient for the NHS than if all treatment had been provided in the first course of treatment and the patient had not returned until their personal recall interval was due, as defined by National Institute for Health and Care Excellence (NICE) guidance on dental recall (CG19, Oct. 2004).

8.45. It would be unusual for a patient to be intentionally recalled for further examination within three months of a course of treatment being completed. Furthermore, there may be cost and inconvenience implications for patients.

8.46. It is possible to obtain patient-based data from NHS BSA and look at the treatment history of individual patients. This can help build a picture of any issues that might explain the apparent high rates of repeated courses of treatment and also allow examination of the nature of those courses of treatment.

8.47. Reporting of multiple band 2 or band 3 courses of treatment within short timescales is likely to be of concern (see also indicator M10). It may also be

useful to see whether exempt adult patients are more likely to have a subsequent course of treatment within three months compared to fee-paying adults.

8.48. Where there are continued concerns a NHS BSA record card review of patients who were the subject of multiple courses of treatment can be useful to help evidence the underlying reasons.

8.49. Indicator M9 – band 3 to band 3 interval (all patients)

8.50. This indicator is the average number of days between band 3 courses of treatment for the same patient identity. This indicator should be interpreted alongside indicators M7, M8 and M6.

8.51. A low average interval may be of concern because band 3 courses of treatment are normally associated with more advanced care and it is likely to be inefficient for the NHS and potentially costly for patients where repeated advanced care is provided within short timescales.

8.52. Similar considerations underpinning high percentages under indicator M7 or M8 may apply (see paragraph 11.9 above) and, as with inlays (indicator M6) it may be useful to see whether other treatments are being provided alongside the treatments that justify the band 3 and whether single items of treatment are being provided, such as single inlays or crowns, or multiple items of treatment.

8.53. Where there are continued concerns a NHS BSA record card review of patients who were the subject of multiple courses of treatment can be useful to help evidence the underlying reasons.

9. Domain 4b: clinical quality – orthodontics

See Annex 3 for summary of the indicators

9.1. **Introduction.** This part of the framework is divided into two sections; the first introduces the orthodontic assurance indicators and suggests how they might be interpreted.

9.2. The second describes possible sub-analyses to give greater detail around individual contractual performance and suggests how any concerns that arise from the indicators might be further explored. This section should be read alongside the general principles relating to the framework and the sections for

delivery, patient satisfaction and patient safety, since these also apply to contracts providing orthodontics.

9.3. Like other indicators in this framework, they do not in themselves necessarily evidence poor performance or breaches of the regulations, nor do they necessarily identify excellence or best practice. They do, however, provide an overview of contract performance and assist with identifying areas of potential concern that should be explored in more detail with the contractor. Like all indicators in this framework, they should be considered alongside other routine contract monitoring provided by the NHS BSA and other information available to the area team.

9.4. Where a contract/performer is identified as an outlier and a decision is made to further explore performance, this process should include supporting clinical advice. Equally there may also be occasions where although an indicator does not flag a contract as an outlier, the contract's performance may still justify further analysis. The relatively small number of orthodontic contracts in each area team may make the identification and comparison of indicator data between contracts relatively straightforward.

9.5. These indicators have been developed on the presumption that the existing sources of orthodontic data, derived from completed fields in FP17Os submitted to the NHS BSA, are not going to change. As a result, some indicators already utilised in the orthodontic vital signs have been re-assessed for suitability and adopted without change in this framework, while others are new.

9.6. Testing has identified that some variation in reporting may be due to differing interpretations of the information required from providers when completing the fields in the FP17O as well as when FP17Os should be submitted. A description of the requirements and timing for orthodontic data submission made on FP17O can be found in the NHS BSA "Completion of FP17O guidance" and "Orthodontic Treatment Completion; FP17O Guidance".

http://www.nhsbsa.nhs.uk/DentalServices/Documents/DentalServices/Completion_of_forms_guidance_FP17O_England-_1_April_2010_onwards.pdf

and

http://www.nhsbsa.nhs.uk/DentalServices/Documents/DentalServices/Orthodontic_Treatment_Completion-_FP17O_Guidance.pdf

9.7. Indicators have been developed to try and identify contracts where there may be under-reporting. Use of this framework will also encourage increased levels of reporting, since this is key to understanding patient outcomes.

9.8. The current system of orthodontic reporting allocates 21 UOAs upon commencement of treatment when the appliance is fitted. Although an FP17O should also be submitted within two months of completing, discontinuing or abandoning treatment, no additional UOAs are allocated for making this submission.

9.9. NHS BSA estimates that approximately 30% of orthodontic treatments commenced are not reported as complete, discontinued or abandoned. This is supported by data recently published for Wales which revealed some 32.5% of treatments started were never reported complete. (Richmond S and Karki A, "Complexities associated with orthodontic services in the National Health Service", BDJ Feb 2012, 212/3(E5))

9.10. In addition to these indicators and the other domains, area teams should be sensitive to the workforce models and skill mix used by contractors to deliver activity.

9.11. There are a variety of workforce models and some contracts may use a skill mix model whereby a small (sometimes sole) number of dentists with orthodontic skills, oversee work carried out by orthodontic therapists or other performers. Some feedback has highlighted the potential fragility of highly devolved arrangements and area teams should be satisfied that the workforce model is appropriate to ensure the necessary oversight and supervision of both treatment and outcomes.

9.12. Within this guidance, the following definitions have been used:

"Completed" refers to the situation where all of the orthodontic treatment described in the treatment plan has been delivered. This definition aligns with that in both the NHS (General Dental Services Contract) Regulations 2005 and the NHS (Personal Dental Services Agreements) Regulations 2005.

"Concluded" describes the collective outcomes that can occur after a course of treatment has been started. This includes "completed" as well as those courses of treatment that were discontinued or abandoned.

"Discontinued" refers to the termination of treatment where the performer decides, for whatever reason, it is in the patient's best interest to cease treatment.

"Abandoned" refers to the termination of treatment where the patient requests it.

9.13. The points at which a contract might be flagged as an outlier for further investigation have been identified using a statistical methodology that accounts for the size of orthodontic contract. By doing so, issues associated with contracts of different sizes should be adjusted for. Even so, there are likely to be differences in patterns of activity between contracts which are exclusively orthodontic and those which are mixed GDS.

9.14. Area teams are advised to obtain and regularly update waiting time data for their contractors and develop an understanding of patient pathways within and between practices, as well as how waiting lists are managed so that waiting times can be effectively interpreted.

9.15. **The Indicators.** The indicators are grouped into 3 sub-domains: assessment, treatment and outcomes.

9.16. **Assessment**

9.17. When a patient undergoes an assessment, it can be reported as one of three outcomes:

- Assess and fit appliance
- Assess and refuse
- Assess and review

9.18. Assessment of orthodontic cases is defined in both GDS and PDS regulations as: "a clinical examination of the patient, including the taking of such radiographs, colour photographs and models as are required in order to determine what orthodontic treatment (if any) is to be provided to the patient".

9.19. Indicator O1– assessment by category

9.20. **Percentage of all assessments that are assess and fit appliance (rolling 12 month period)**

9.21. The initial assessment is an essential part of the orthodontic treatment process; at this point, the orthodontist should be able to assess whether it is appropriate

to start treatment, refuse or if it or wait until further dental / skeletal growth has occurred.

9.22. “Assess and fit appliance” refers to the situation where the patient has been assessed and treatment is commenced. The assessment and fit of appliance need not happen on the same day for a patient who is ready to enter into treatment.

9.23. This indicator demonstrates efficiency of treatment delivery, with a higher proportion of assessments with a decision to provide treatment being arguably more efficient than a high proportion of assessments that are not. Previous analysis has shown that approximately one in three assessments is an “assess and fit appliances”.

9.24. A low proportion of assess and fit appliances may indicate that a contract is demonstrating poor value for money where assessment is not being translated into treatment. Equally, it may be a reflection of a very small orthodontic contract or individual local circumstances; in any one economy, some providers may attract more referrals than others, which drives a higher ratio of assess and reviews to assess and fit appliance.

9.25. **Percentage of all assessments that are assess and refuse (rolling 12 month period)**

9.26. The initial assessment is an essential part of the orthodontic treatment process; at this point, the orthodontist should be able to assess whether it is appropriate to start treatment, refuse or wait until further dental/skeletal growth has occurred.

9.27. Assess and refuse refers to the situation where a patient is examined and a decision is made that the patient is ineligible or unsuitable for a course of NHS-funded orthodontic treatment.

9.28. Testing has shown that practitioners have varying interpretations of what is meant by “refuse”, with some regarding it as meaning “not now”, some regarding it as meaning “not ever” and some regarding it as the appropriate response when the patient is referred for treatment in secondary care.

9.29. NHS BSA has previously issued guidance on completing form FP17O confirming that “assess and refuse” claims should only be submitted for cases where “NHS orthodontic treatment is deemed unnecessary or inappropriate”.

9.30. In this context ‘unnecessary’ refers to where a patient is deemed to be ineligible for NHS-funded orthodontics’ (Ref. NHS GDS Regulations 2005 Schedule 1

Part 2). 'Inappropriate' refers to where, in the opinion of the performer, the risks of orthodontic treatment would always outweigh the benefits

9.31. For a practice that takes referrals from other practices, a high percentage of assess and refuse could indicate inappropriate referrals and perhaps an absence of effective referral guidelines.

9.32. Where they do not exist and inappropriate referral is identified as a problem, area teams will need to develop referral guidelines which support effective and appropriate referrals for orthodontic treatment.

9.33. For a practice that mainly takes referrals from within the practice, then a high level of reported assess and refuse is more difficult to explain and may reflect poor internal processes, particularly if the referring and receiving performer is the same. Differences between practices may also reflect differences in applying IOTN criteria, particularly around the threshold IOTN 3.6.

9.34. A very low percentage on the other hand may indicate adherence to rigorous and appropriate referral criteria or may reflect that patients who are unsuitable or ineligible, are being treated rather than refused.

9.35. Area teams, in conjunction with LPNs and their local postgraduate deanery, may wish to explore the provision of training and education for referring practitioners, including identifying eligibility for NHS treatment, when to refer and how to apply referral guidelines.

9.36. **Percentage of all assessments that are assess and review (rolling 12 month period)**

9.37. The initial assessment is an essential part of the orthodontic treatment process; at this point, the orthodontist should be able to assess whether it is appropriate to start treatment, refuse or if it is appropriate to wait until further dental / skeletal growth has occurred. Where NHS treatment is indicated, but the patient is not ready to start, this is recorded on the FP17O as "assess and review". There is no prescribed limit on the number of times a patient can be assessed and reviewed before treatment is commenced.

9.38. It would be unusual for any patient to need more than one "assess and review" claim before treatment commenced. A high percentage of "assess and review" claims potentially represents poor value for money.

9.39. It may indicate acceptance of patients who are too young or simply the repeated submission of "assess and review" claims for patients without a clear clinical justification. Some providers may be more popular than others,

receiving a greater number of referrals and others may operate a policy whereby they strive to see all new patients within a certain timeframe; some may provide a useful service to the local dental community by giving expert opinion before returning the patients to the referring practitioner for treatment. These could all result in an increased proportion of assess and reviews.

9.40. The impact of the allocation of non-recurrent funding must also be considered for all the assessment indicators. This can cause in year spikes in both assess and review/refuse and assess and fit appliances as well as an increased number of completions in following years. Area teams should be aware of this and interpret the indicators accordingly.

9.41. Indicator O2 - age at assessment

9.42. **Percentage of reported assessments and review where patient is 9 years old or younger (rolling 12 month period)**

9.43. The BOS recommends in 'Guidelines for Referrals for Orthodontic Treatment' that most orthodontic treatment should be commenced in the late mixed / early permanent dentition which is typically around the age of 11 to 13 years.

9.44. There are many occasions where early referral is entirely appropriate for interceptive treatment and to delay referral may affect outcomes, for instance in the use of functional appliances or where there are impacted teeth.

9.45. However, a very high proportion of children accepted for assessment at a much younger age when they are likely to be too young to benefit, potentially represents inefficient use of resource, particularly if repeated "assess and review" claims are submitted until they are old enough to commence treatment.

9.46. Testing has suggested that reviewing the number of reports for patients aged nine years or younger may be useful in identifying contracts where assessments may have been carried out without a great prospect of a useful outcome or, for a referral practice, where there is a particular problem with inappropriate referrals. The age profile of patients seen is included in the contract profile data report.

9.47. **Treatment**

9.48. When a patient undergoes orthodontic treatment, there is an expectation that the treatment should be carried out efficiently and effectively, and that the patient should benefit from that treatment. The outcome for each course of

treatment commenced should be reported, whether completed, abandoned or discontinued.

9.49. An early requirement will be to identify contractors who are not reporting all data and support them in achieving adequate data submission to allow area teams to assess the nature of treatment provided and outcomes achieved.

9.50. **Indicator O3- cases reported concluded (completed, abandoned or discontinued) as a function of reported assess and fit appliance**

9.51. This indicator gives the ratio of treatments reported as completed, abandoned or discontinued to those started (assess and fit appliance).

9.52. In a mature contract, with a steady flow of cases, this figure should be close to 1; in other words the number of cases started is roughly equal to the number of cases concluded. One would not expect to see the ratio approaching one in a contract under three years old.

9.53. The table below gives a ready-reckoner as to reporting rates according to the ratio calculated.

9.54. Under-reporting of concluded cases may mask poor clinical outcomes or high numbers of discontinued or abandoned treatments and will distort quality monitoring.

Ratio	**Interpretation**
Approx 1	For every case started, an FP17O is submitted recording the case as complete, discontinued or abandoned
Approx 0.75	For every four cases started, only three are reported as complete, discontinued or abandoned
Approx 0.5	For every four cases started, only two are reported as complete, discontinued or abandoned
Approx 0.25	For every four cases started, only one is reported as complete, discontinued or abandoned

9.55. As previously mentioned the impact of the allocation of non-recurrent funding must be considered for all the assessment indicators. For this indicator, previous allocation can result in a ratio of well above one in later years as the

cases reach completion. Area teams should be aware of this and interpret the indicators accordingly.

9.56. As an aid to exploring un-reported cases, NHS BSA can provide lists of incomplete treatments on request as part of sub-layer analysis, although certain caveats will apply to this data.

9.57. **Indicator O4 – type of appliance used**

9.58. It is widely accepted that optimal orthodontic results are seldom obtained by using removable orthodontic appliances alone as seen in Tang EL, Wei SH. "Assessing treatment effectiveness of removable and fixed orthodontic appliances with the occlusal index. "American journal of orthodontics and dentofacial orthopaedics: official publication of the American Association of Orthodontists, its constituent societies, and the American Board of Orthodontics, December 1990, vol. /is. 98/6(550-6. A high proportion of courses of treatment reported using only removable appliances may represent poor technique, reduced efficiency and effectiveness and poor outcomes for patients.

9.59. **Outcomes**

9.60. The indicators for outcome aim to give a sense of whether patients are experiencing good outcomes and the overall efficiency of the service.

9.61. **Indicator O5 - UOA reported per completed case (rolling 12 month period)**

9.62. UOAs reported per completed case gives a sense of overall utilisation of UOAs to complete one course of orthodontic treatment. As UOAs have a broadly uniform value, this allows a rough estimate of the cost per contract to complete one case. A high number of UOAs per completed case may suggest under-reporting of completions or a high number of discontinued or abandoned treatments. It may also suggest a high number of assess and review/refusals.

9.63. Area teams may wish to explore educational work with referring dentists to try and improve the quality and timing of referral, reducing the number of multiple "assess and review" claims before treatment starts. Where under reporting is identified, NHS BSA can provide lists of incomplete treatment to area teams on request which can be used in discussion with the provider.

9.64. **O6 - Reported PAR scoring**

9.65. 13.19 PAR scoring refers to the "Peer Assessment Rating Index" which is a way of assessing orthodontic outcomes using pre and post treatment models of the teeth to assess improvement.

9.66. Where the total number of cases provided is 20 or fewer in any one year, contractors are required under the GDS and PDS Regulations to report a PAR score for every case. Where the total number of cases provided is greater than 20 in any one year then contractors should report a PAR score on 20 completed cases plus score an additional 10 percent of all other cases completed.

9.67. The process can be undertaken in-house by the contractor or preferably by a suitably qualified external provider.

9.68. “Completion” of treatment is defined in the regulations (both NHS GDS and PDS regulations part 1 (general) interpretation paragraph 2). Despite this there may be provider variations in interpretation of whether a case should be reported as complete or discontinued/abandoned (see O7).

9.69. This indicator is simply a report of the expected number of PAR scores that should have been undertaken, based on the number of completions reported. This analysis does not include abandoned or discontinued courses of treatment. The indicator only examines whether a PAR score has been reported; it does not indicate the nature of the PAR scores or the degree to which the orthodontic treatment was deemed successful.

9.70. Area teams, possibly supported by NHS England nationally, will need to develop processes with appropriate clinical support which support contractors in demonstrating the clinical success of their orthodontic treatment as measured by PAR scores to area teams. This should assure area teams that not only are the required number of cases being PAR scored, but that the outcomes achieved show a significant improvement as a result of the treatment.

9.71. In terms of complying with contractual obligation, it is possible to estimate the expected number of completed treatments which require a PAR score. This data is readily available from existing orthodontic vital signs information and can be based on the “contract base number” for the orthodontic vital sign, “percentage of completed treatments indicating that PAR score was taken (year to date)”. For example, if the contract base number is given as 320, then this means that 320 cases have been reported to the BSA as complete. It would therefore be expected that the contract quantity to be PAR scored would be 20 plus 10% of 300 i.e. 50 cases overall.

9.72. The indicator does not examine the percentage of cases PAR scored for the following reason. In the example above, the corresponding percentage PAR scored for that contract would be 50/320 x 100 = 16.7%. A contract which reports 10 cases complete but only PAR scores 5 would score 50%. Although

the second example has not fulfilled its contractual obligation, the reported percentage PAR score appears superior to the contract that has. It is not possible to tell which percentage is better without knowing the expected and actual number of cases PAR scored.

9.73. A lower than expected number of PAR scores reported could indicate poor contractor monitoring of outcomes, or under-reporting of PAR scores that have been calculated. As such this indicator informs an assessment of compliance with Regulation 7 of the GDS or PDS Regulations but is not a direct measure of compliance, since Regulation 7 refers to the "calculation" of a PAR score for "provided" courses of treatment and not the reporting of PAR scores for completed cases.

9.74. **Indicator O7 - percentage of terminated courses where treatment was abandoned or discontinued (rolling 12 month period)**

9.75. Treatment which is terminated (either abandoned or discontinued) represents a waste of resources and suggests poor outcomes for the patient. The current rate of termination in England is 9.3% which translates to approximately £24m per annum invested in orthodontic treatment that was not completed. The true figure is likely to be higher than this with the current rate of incomplete reporting.

9.76. There will always be occasions where cases are discontinued or abandoned due to patients moving, having health issues or being unable to comply with the treatment programme. It may also prove difficult for practitioners to predict with certainty who will not complete their treatment.

9.77. High levels of abandoned or discontinued treatment may indicate poor case selection, an attempt to hide poorly treated cases or an attempt to maximise UOA allocation in the pre-motivated knowledge that treatment will be abandoned. Equally, some practitioners may declare a case discontinued where although a significant improvement has been achieved, they do not feel the outcome has been optimal. Very low levels of reported terminations may be indicative of overall under-reporting and should be cross checked against indicators O3 and O5. In patients where the treatment is terminated and extractions have been performed as part of the treatment plan then the individual may suffer a long term detriment.

9.78. **Further investigation of contracts identified as outliers by the Indicators or where the data raises concerns**

9.79. When a contract is identified as an outlier or the data raises other areas of concern, it may be appropriate to undertake further layers of analysis. These are outlined by domain below, with possible additional action points.

9.80. There may be aspects of local service arrangements which influence the position of local services and produce outliers within reporting. The local system, as well as local contracts, should be considered against the national position when identifying cases of concern.

9.81. A look back over time of contractual performance should also be undertaken to try and assess if the outliers identified are indicative of a protracted pattern or are a one off. It is important that the indicators are triangulated with other information available to the area team. This may include other information from NHS BSA regarding characteristics shared with other outliers, the performance of similar contracts within the same area team, Dental Reference Service (DRS) reports, feedback from DPA visits, CQC visit reports, complaints, satisfaction data or any other information that you may have regarding the contract.

9.82. In all cases where the indicators and sub-analysis reveal a concern, it is suggested that the area team assembles a personal prescribing profile for the contract, highlighting the issues identified and makes it available to the performers and provider(s), inviting their comments, using tier 2 reports.

9.83. Where this confirms a contract / performer is an outlier of concern, it should initiate a performance review which must include clinical advice that supports any management intervention regarding the appropriateness of clinical decisions and behaviours.

9.84. Any performance management intervention should normally allow for a period of remedy and change to be observed within a specified period. An initial action plan should provide assurance of response to identified concerns, and subsequent reporting periods will need to provide follow up assurance of change where appropriate. Where there are outstanding concerns the area team should follow the sanctions and breaches policy.

9.85. **Suggestions for further investigation and triangulation when an outlier is flagged in the assessment domain or where the data raises concerns**

9.86. A low proportion of assess and fit will almost always be balanced by a correspondingly high proportion of assess and review and/or assess and refuse.

9.87. Area teams should explore whether any of the factors outlined in the narrative above under O1 are influencing this.

9.88. Where high proportions of assessment other than assess and fit appliance are encountered, these can be readily investigated by tracking individual patients

through claim data to examine whether there are multiple claims for assessment and review/refusal for the same patient, or whether there are coincident reported assessments alongside mandatory courses of treatment for a high proportion of cases.

9.89. Both high and low levels of assessment and review/refuse should be cross referenced with individual patient IOTNs and ages.

9.90. A high proportion of refusal with index of orthodontic treatment need (IOTN)s of below 3(6) suggests inappropriate referrals or referral management.

9.91. Key trends for further investigation include repeated claims for assessment and review/refusal occurring at 6 monthly intervals with a borderline IOTN score and no claim made for treatment start. This is especially relevant if the child is under 9 at the start.

Where a high proportion of claims for assess and review for those aged nine years and under is identified, the profile of the ages of patients can be reviewed in the table included in the contract profile. This also gives details on number of cases of assess and refuse and assess and fit appliance in the children aged nine and under.

9.92. Where concerns remain or it is apparent that there are a high number of claims in the very young, the patients assessed should be identified using individual claim data. A retrospective analysis should be undertaken to examine whether patients are being serially assessed and reviewed from a young age. It may be most appropriate to request a record card and study model check by a DRS clinician. These can be requested by completing form D7a, available from the NHS BSA (www.nhsbsa.nhs.uk/848.aspx)

9.93. The ages of patients who receive assessments may also be investigated to include claims made for patients over the age of 18 (depending on the contract awarded) as one would normally expect relatively few claims for patients over this age.

9.94. Area teams may wish to investigate whether individual patients have been assessed under different orthodontic contracts and if so whether any unusual pattern is apparent e.g. review followed by refusal followed by review.

9.95. It may also be appropriate to examine the pattern of claims made for assessment and review, particularly in a mixed GDS contract to ensure activity is spread throughout the year and not concentrated in the final months of the contractual year.

9.96. Where the performance of a contract has been highlighted for further investigation, claim data should also be examined for multiple treatment starts (more than one claim for assess and fit appliance) on the same patient, assess and review claims made after treatment has been started and assess and review claims after treatment has been reported as complete.

9.97. **Suggestions for further investigation and triangulation when an outlier is flagged in the treatment domain or where the data raises concerns**

9.98. Where the ratio of conclusions to case starts is identified as an outlier, then the age of the contract should first be examined or whether the contract has been the recipient of any non-recurrent funding in the past three years.

9.99. As orthodontic treatment commonly takes 18 month to three years to complete, contracts under three years old may not have achieved a steady state where treatments reported as complete, discontinued or abandoned might be expected to approximate to treatment starts.

9.100. Equally, contracts which are the recipients of non-recurrent funding in any particular year may be able to take on additional patients en bloc which then appear as a peak in completions several years later. This may increase the ratio of completions to starts well above one in a particular year. In this case, the ratio over a number of years should be examined as it is obviously impossible to complete more treatments than are started.

9.101. Where there are concerns, tracking of individual patients via assessment and reported treatment start is recommended. NHS BSA can provide lists of incomplete courses of treatment for sub-analysis on request.

9.102. Where a high proportion of courses of treatment reported using removable appliances only is observed, then individual claims should be examined to reconcile the time taken to complete the treatment, corresponding changes in the recorded IOTN at the start and completion of treatment and any PAR score suggesting that a beneficial outcome has occurred.

9.103. Where there are concerns, for instance where a course of treatment appears to have been completed in just a few weeks, it may be most appropriate to request a record card and study model check by a Dental Reference Service clinician. These can be requested by completing form D7a, available from the NHS BSA (http://www.nhsbsa.nhs.uk/848.aspx)

9.104. Suggestions for further investigation and triangulation when an outlier is flagged in the outcome domain or where the data raises concerns

9.105. A high number of UOAs per completed case may suggest under-reporting of completions or a high number of discontinued or abandoned treatments. It may also suggest a high number of assess and review/refusals. This can be cross referenced against other indicators: for high levels of under- reporting, a low ratio under O3 would be expected; a high level of discontinued/abandoned would appear under O7 and a high number of assess and reviews/refusals should cross check against O1.

9.106. Low levels of reporting of PAR scores should be cross checked with the ratio of case starts to conclusions. Under-reporting of PAR/conclusions may suggest poor contractor monitoring or the possibility of masking poor treatment outcomes.

9.107. Where the level of reported PAR scoring or the ratio of starts to conclusion is a concern, it is suggested that cases started more than 36 months previously and for whom no outcome has been reported are identified from NHS BSA data.

9.108. This should include cases where the treatment has been recorded as commenced (assess and fit appliance) but where no FP17O has been submitted recording completion, discontinuation or abandonment. Contract holders should be invited to audit these cases and report the nature of the outcome for the patient (complete/discontinued/ abandoned), the type of appliance(s) used to undertake the treatment and the PAR scores for all those completed. They should be invited to submit a breakdown to the area team for scrutiny by their dental advisor and offer an explanation why an FP17O has not been submitted.

9.109. Where concerns still exist it may be appropriate to request a record card and study model check by a clinical adviser.

9.110. High levels of abandonments/discontinuations should be investigated. Although in some cases this will be outside the practitioner's control, regulations provide for asking the provider to explain the reasons for terminations.

9.111. If there are low levels of abandonments/discontinuations but the ratio of treatment starts to conclusion (O3) suggests under-reporting then this should also be investigated. Using claim data from the NHS BSA, the investigation should include age of patient, IOTN, whether extractions were performed, whether removable or fixed appliances were fitted, time between fit appliance and termination and the reason for termination. Where concerns still exist it may be most appropriate to request a record card and study model check by a DRS clinician.

9.112. Where the explanation for the high number of terminations is unsatisfactory or the DRS identify sub-optimal outcomes, further action may be needed under contract or performers list regulations. If there is evidence of patients not being treated in their best interest then it may be appropriate to refer to the case to the General Dental Council (GDC). It may be appropriate to engage with the National Clinical Advice Service (NCAS) for support.

9.113. Other factors to be considered during additional analysis

9.114. Where a contract has been identified as being of concern, there are other additional areas which may point towards issues associated with quality of service and outcome.

9.115. IOTN

9.116. All patients who are assessed and reviewed/refused, assessed and treatment started or who are recorded as completed, abandoned or discontinued should have an IOTN score recorded. IOTN 3(6) is the gateway score to eligibility for orthodontic treatment under the NHS contract.

9.117. Where IOTN has not been recorded, the area team loses sight of the eligibility of people being treated and whether or not any harm or benefit may have accrued in those patients treated, abandoned or discontinued. Where contracts of concern have been identified, reporting of IOTN may be examined via claim data and the contract holder challenged if appropriate.

9.118. Radiographs

9.119. An essential part of orthodontic assessment is the taking of radiographs. Where concerns have been identified concerning quality of service, examining claim data to assess whether radiographs have been taken as part of the assessment may be of value. These may be low where the contractor has used an external provider to provide lateral cephalograms or orthopantograms.

9.120. Restarts

9.121. In some cases, it may be appropriate to examine claim data to examine whether there has been more than one claim for “assess and fit appliance” on the same patient ID. When this is identified, claim data should be analysed to assess if the patient has been reported as having the treatment terminated previously, the time period between treatment starts, the age of

patient, the type of appliance used and the IOTN. This may help area teams decide whether to challenge practitioners on individual cases.

9.122. Repairs and regulation 11

9.123. When a claim is made to repair an appliance made by another provider, 0.8 UOAs are allocated. Testing has shown some contracts have a much higher number of claims for repairs than others, totalling a significant number of UOAs. Where this occurs, the provider may have misinterpreted the regulations and be claiming inappropriately, may be offering a service to local practitioners who cannot deal with their own problems or may rarely have agreed with another provider to mutually repair each other's appliances. Area teams may wish to engage the provider in discussion when a high number of regulation 11 claims have occurred.

9.124. Additional suggestions on how area teams could use BSA data to monitor waiting times in referral practices

9.125. Part 5 of the FP17O is to be completed either on assessment or at the fitting of the first appliance. This box has entries for "date of referral", "date of assessment" and "date appliance fitted". In terms of assessing access, a possible indicator might be average number of days from referral to assessment or average number of days from referral to appliance fit or average number of days from assessment to appliance fit. This will be of greatest relevance in practices accepting referrals.

Annex 3 Contract and Domain Summaries

Context information that should be accessed for each contract

Contract value £XX	Number of patients attending In last 24 months = XXX	Trend? Is that increasing, same or decreasing	UDA Value = £XX Area team average UDA value = £XX

Delivery

Summary of domain indicators

	Delivery at month 6		Delivery at year end	
Indicator	**Minimum expected standard**	**Flag for further investigation**	**Minimum expected standard**	**Flag for further investigation**
DG1 Units of dental activity DO1 Units of orthodontic activity	At least 30% delivery*	<30% delivery	At least 96% delivery	<96% delivery

Patient Experience

Indicator	Data flag for further investigation
E1. NHS BSA Dental Services patient survey - % of patients satisfied with the time they had to wait for an appointment	% satisfaction score below outlier threshold (see NHS BSA report for detail)
E2. NHS BSA Dental Services patient survey - % of patients satisfied with the dentistry that they have received	% satisfaction score below outlier threshold (see NHS BSA report for detail)

Clinical quality – General dental services

Indicator	Metric	Flag for further investigation
Diagnosis		
M1. Radiographs	Rate per 100 FP17s which included a radiograph for all courses of treatment and patients.	Rate is below outlier threshold (see NHS BSA report guidance for detail)
Prevention		
M2. Fluoride Varnish	Rate per 100 FP17s for patients aged from 3 up to and including 16 which included a fluoride varnish treatment	
M3. Fissure Sealants	Rate per 100 FP17s for patients aged from 3 up to and including 16 which included a fissure sealant treatment	
Provision of Treatment		
M4. Extractions (all patients)	Rate per 100 FP17s with extractions included (all patients)	
M5. Endodontics and extractions v endodontic treatment (Adults only)	Extractions as a percentage of extractions + endodontic treatment (adults only)	
M6. Inlays	Rate per 100 FP17s with inlays (all patients)	
Outcomes		
M7. Re-attending within 3 months - Children	Same patient ID re-attending within 3 months	
M8. Re-attending within 3 months - Adults	Same patient ID re-attending within 3 months	
M9. Band 3 to Band 3 interval	Average intervals (days) between band 3 courses of treatment for the same patient ID	

Clinical quality - Orthodontics

Indicator	Metric	Flag for further investigation
Assessment		
O1. Assessments by category	% of assessments that are: - Assess and fit - Assess and refuse - Assess and review	(see NHS BSA report guidance for detail)
O2. Age at assessment	% of reported assessments and review where patient is aged 9 years or younger	
Treatment		
O3. Cases reported concluded as a function assess and fit appliance	Ratio of reported concluded (completed, abandoned or discontinued) courses of treatment to reported assess and fit appliance.	
O4. Type of appliance used	% of concluded (completed, abandoned or discontinued) courses of treatment reported as using removable appliances only (all outcomes, including completed, abandoned or discontinued)	
Outcomes		
O5. UOAs reported per completed case	Ratio of the number of UOAs reported per reported completed case (not including abandoned or discontinued cases)	
O6. Reported PAR scoring	Expected number of cases PAR scored based on completed courses of treatment reported versus actual number of cases reported PAR scored (year to date).	
O7. Abandoned or discontinued care	% of concluded (completed, abandoned or discontinued) courses of treatment where treatment is reported as abandoned or discontinued	

Patient safety

i. Area teams should ensure that they have up-to-date contact details for local CQC contacts and have an appreciation of providers who hold contracts in more than one area teams geography.

ii. Area teams should have processes to check that all contractors are registered with CQC and remain so, including when ownership of a practice changes or where there are changes in contract holder.

iii. Area teams should be aware of when a provider was last inspected by CQC and the outcome of this inspection.

iv. If a CQC inspection has identified that standards are not being met, the area team is to liaise with the CQC locally and with the provider to ensure that the necessary improvements are in place to the required timescales.

v. Area teams should have arrangements in place to share any concerns with CQC, for example concerns raised by patients or colleagues.

vi. Area teams should have arrangements in place to escalate urgent concerns where there may be an immediate threat to patient safety, such as an apparent failure in infection control processes. Clinical advice and the engagement of other agencies such as PHE may be appropriate.

Annex 4

Sample Reports for General and Orthodontic contracts (Tier 1)

NHS BSA reports are available through e-reporting under the Contract Management link and are called Q(xx) Dental Assurance Framework (Month Year) General report and called Q(xx) Dental Assurance Framework (Month Year) Ortho report.

Screenshots of report are shown below

Q(xx) Dental Assurance Framework (Month Year) General report
Tab: Overall Rates

Area Rates & Comparison **A** **July to Sept 2012**

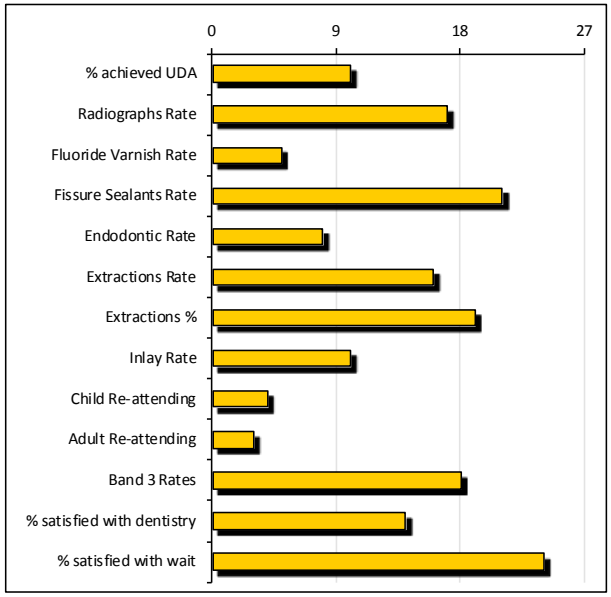
LAT compared to England (red worse performing , green better performing than national level)

Delivery Indicators	LAT	England
% of Contracted UDA Delivered	39.0	39.6

	Current Quarter		Change from Last Qtr	
Quality Indicators	LAT	England	LAT	England
Radiographs Rate per 100 FP17s	17.3	17.6	▼	▼
Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)	10.9	18.1	▲	▲
Fissure Sealants Rate per 100 FP17s (3-16 yr old patients)	0.6	1.0	▲	▲
Endodontic Treatment Rate per 100 FP17s	1.4	1.5	▼	▼
Extractions Rate per 100 FP17s	6.4	6.6	▲	▼
Extractions as a % of Extractions + Endodontic Treatment- Adults	80.0	78.9	▲	▲
Inlay Rate per 100 FP17s	0.3	0.6	▼	◀ ▶
Re-attending within 3 months - Child	8.5	8.9	▼	▼
Re-attending within 3 months - Adults	17.4	17.9	▼	▼
Average Band 3 to Band 3 Rates	208.4	216.6	▲	▲

	Current Quarter		Change from Last Qtr	
Patient Satisfaction Indicators	LAT	England	LAT	England
% satisfied with dentistry received	94.2	93.8	▼	▼
% satisfied with wait for an appointment	89.4	89.3	▼	▼

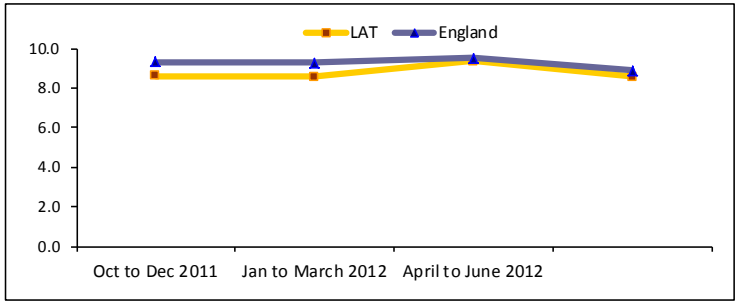
Rank compared with all LATs (1 = highest rate)



Quarterly Trend by Individual Indicator

Child Re-attending ◀Choose measure from drop down to change table and chart

Report Period	Oct to Dec 2011	Jan to March 2012	April to June 2012	July to Sept 2012
LAT	8.6	8.6	9.4	8.5
England	9.3	9.3	9.5	8.9



Q(xx) Dental Assurance Framework (Month Year) General report
Tab: Summary & Priority Contracts

Summary & Priority Contracts **July to Sept 2012**

Comparison with National Results

Measures	LAT vs National Rate	How defined	% Flagged Contracts	How defined
% of Contracted UDA Delivered	Y		N	
Radiographs Rate per 100 FP17s	Y	if lower	Y	
Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)	Y	than	Y	
Fissure Sealants Rate per 100 FP17s (3-16 yr old patients)	Y	national	Y	
Endodontic Treatment Rate per 100 FP17s	Y	rate	Y	If % of
Extractions Rate per 100 FP17s	N		Y	contracts
Extractions as a % of Extractions + Endodontic Treatment- Adults	Y	if higher	N	flagged
Inlay Rate per 100 FP17s	N	than	Y	higher than
Re-attending within 3 months - Child	N	national	N	national %
Re-attending within 3 months - Adults	N	rate	N	
Average Band 3 to Band 3 Rates	Y	if lower	N	
% satisfied with dentistry received	N	than	N	
% satisfied with wait for an appointment	N	national	N	

Contracts by number of flags

Number of Flags	Number of Contracts
0	31
1	111
2	80
3	47
4	35
5	13
6	5
7	1
8	1
9	0
10	0
11	0

Priority Contracts (by number of flags then size)

Priority?	Contract	Name or Company Name	Total Flags	Under-delivering UDA	Radiograph Rate	Fluoride Varnish Rate	Fissure Sealant Rate	Endodontic Rate	Extraction Rate Low	Extraction Rate High	Extraction % Rate	Inlay Rate	Child Re-attendance %	Adult Re-attendance %	Band 3 to Band 3	% Satisfied Dentistry	% Satisfied with wait
1	Contract 290	Provider 290	8	N	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	N	N
2	Contract 106	Provider 106	7	N	Y	Y	Y	N	Y	N	N	N	Y	Y	N	N	Y
3	Contract 139	Provider 139	6	N	Y	Y	N	N	Y	N	N	N	Y	Y	Y	N	N
4	Contract 5	Provider 5	6	N	N	Y	Y	N	N	Y	N	Y	N	Y	Y	N	N
5	Contract 75	Provider 75	6	N	Y	Y	Y	Y	Y	N	N	Y	N	N	N	N	N
6	Contract 282	Provider 282	6	N	N	Y	Y	N	N	Y	Y	N	Y	Y	N	N	N
7	Contract 135	Provider 135	6	N	N	Y	Y	Y	N	Y	Y	N	Y	N	N	N	N
8	Contract 293	Provider 293	5	N	Y	Y	Y	N	N	Y	N	N	N	N	Y	N	N
9	Contract 35	Provider 35	5	N	N	N	Y	N	N	Y	N	Y	N	N	N	Y	Y
10	Contract 208	Provider 208	5	N	Y	Y	N	Y	N	N	Y	N	N	N	Y	N	N

Q(xx) Dental Assurance Framework (Month Year) General report
Tab: Flagged totals

Contracts Flagged for Attention — **July to Sept 2012**

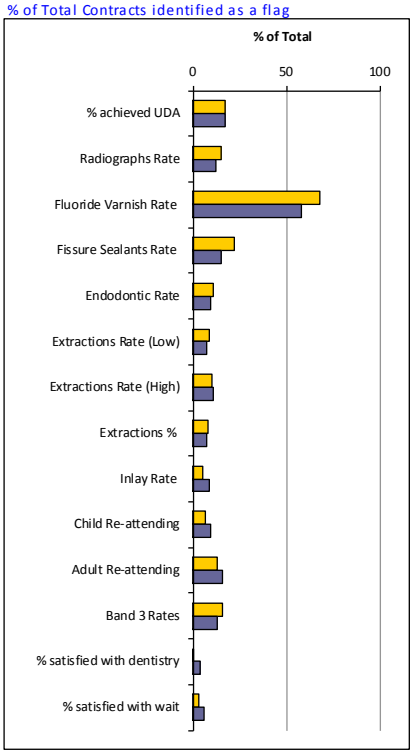
LAT compared to England (red worse performing, green better performing than national level)

Delivery Indicators	Current Quarter: Flagged Contracts LAT	% of Total LAT	% Total England	
% of Contracted UDA Delivered	55	17.0	17.1	View contracts

Quality Indicators	Current Quarter: Flagged Contracts LAT	% of Total LAT	% Total England	
Radiographs Rate	49	15.1	12.3	View contracts
Fluoride Varnish Rate	220	67.9	57.9	View contracts
Fissure Sealants Rate	71	21.9	15.4	View contracts
Endodontic Rate	35	10.8	9.6	View contracts
Extractions Rate (Low)	28	8.6	7.3	View contracts
Extractions Rate (High)	33	10.2	10.7	View contracts
Extractions % (Adult Extractions/Endodontic)	26	8.0	7.7	View contracts
Inlay Rate	16	4.9	8.9	View contracts
Re-attending within 3 months - Child	22	6.8	9.4	View contracts
Re-attending within 3 months - Adults	42	13.0	16.0	View contracts
Average Band 3 to Band 3 Rates	52	16.0	13.2	View contracts

Patient Satisfaction Indicators	Current Quarter: Flagged Contracts LAT	% of Total LAT	% Total England	
% satisfied with dentistry received	2	0.6	3.9	View contracts
% satisfied with wait for an appointment	11	3.4	5.8	View contracts

% of Total Contracts identified as a flag



Number of Contracts Flagged	Qtr ending: Oct to Dec 2011	Jan to March 2012	April to June 2012	July to Sept 2012	
Radiographs Rate	39	37	36	49	Increase from last quarter
Fluoride Varnish Rate	189	193	193	220	Increase from last quarter
Fissure Sealants Rate	60	66	48	71	Increase from last quarter
Endodontic Rate	38	40	30	35	Increase from last quarter
Extractions Rate (Low)	33	22	24	28	Increase from last quarter
Extractions Rate (High)	32	24	28	33	Increase from last quarter
Extractions % (Adult Extractions/Endodontic)	27	32	31	26	Decrease from last quarter
Inlay Rate	8	11	12	16	Increase from last quarter
Re-attending within 3 months - Child	13	15	17	22	Increase from last quarter
Re-attending within 3 months - Adults	29	43	36	42	Increase from last quarter
Average Band 3 to Band 3 Rates	53	50	48	52	Increase from last quarter
% satisfied with dentistry received	10	14	10	2	Decrease from last quarter
% satisfied with wait for an appointment	19	17	13	11	Decrease from last quarter

Q(xx) Dental Assurance Framework (Month Year) General report
Tab: Contract Data

Contract	Name or Company Name	Contract & Name	PCT Code	Contract Type Name	Contract Sub Type	Contract Start Date	Contract End Date	Purpose of Contract	Total Contracted UDA	Total Carry Forward UDA	Total Contracted UDA	UDA Equivalent	Total Contracted Value	Cost per UDA Equivalent	Total Flags	UDA Scheduled	Adjusted scheduled UDA	% of Contracted UDA Delivered	Flag Under-delivering UDA	Total FP17s	Radiograph FP17s
Contract 290	Provider 290	Contract 290 Provider 290	PCT1	GDS	Normal	01/04/2006	no end date	General	9,313	0	0	9,313	£216,363	£23.23	8	5,300	5,300	56.9		1,517	111
Contract 106	Provider 106	Contract 106 Provider 106	PCT1	GDS	Normal	01/04/2010	no end date	General	22,500	0	0	22,500	£738,859	£32.84	7	8,557	8,557	38.0		2,061	37
Contract 139	Provider 139	Contract 139 Provider 139	PCT3	GDS	Normal	01/02/2012	no end date	General	45,100	0	0	45,100	£1,113,741	£24.69	6	19,769	19,769	43.8		5,330	448
Contract 5	Provider 5	Contract 5 Provider 5	PCT5	GDS	Normal	01/04/2010	31/03/2013	General	44,000	223	0	44,000	£1,027,726	£23.36	6	18,678	18,455	41.9		5,014	721
Contract 75	Provider 75	Contract 75 Provider 75	PCT3	GDS	Normal	01/02/2012	no end date	General	37,140	985	0	37,140	£875,644	£23.58	6	17,754	16,769	45.2		4,306	282
Contract 282	Provider 282	Contract 282 Provider 282	PCT5	GDS	Normal	01/04/2006	no end date	General and Ortho	24,945	0	2,064	29,899	£833,650	£27.88	6	13,873	13,873	55.6		3,335	425
Contract 135	Provider 135	Contract 135 Provider 135	PCT1	PDS	Normal	01/04/2010	no end date	General and Ortho	23,865	0	420	24,873	£2,883,345	£115.92	6	13,082	13,082	54.8		4,891	663
Contract 293	Provider 293	Contract 293 Provider 293	PCT3	GDS	Normal	01/04/2006	no end date	General	46,679	1,605	0	46,679	£1,204,682	£25.81	5	24,055	22,450	48.1		5,959	799
Contract 35	Provider 35	Contract 35 Provider 35	PCT2	GDS	Normal	01/04/2009	no end date	General	49,225	0	0	49,225	£1,223,894	£24.86	5	22,305	22,305	45.3		5,234	1,551
Contract 208	Provider 208	Contract 208 Provider 208	PCT3	GDS	Normal	01/04/2006	no end date	General	33,332	580	0	33,332	£989,430	£29.68	5	14,214	13,634	40.9		3,923	487
Contract 194	Provider 194	Contract 194 Provider 194	PCT3	GDS	Normal	01/04/2008	no end date	General	33,567	0	0	33,567	£813,695	£24.24	5	14,017	14,017	41.8		4,306	296
Contract 118	Provider 118	Contract 118 Provider 118	PCT4	GDS	Normal	01/08/2006	no end date	General	27,990	0	0	27,990	£612,981	£21.90	5	10,979	10,979	39.2		4,150	431
Contract 93	Provider 93	Contract 93 Provider 93	PCT3	GDS	Normal	01/08/2011	no end date	General	27,680	445	75	27,860	£631,071	£22.65	5	10,580	10,135	36.6		3,786	595
Contract 32	Provider 32	Contract 32 Provider 32	PCT1	GDS	Normal	08/04/2011	no end date	General	17,913	0	0	17,913	£498,447	£27.83	5	9,287	9,287	51.8		2,683	341
Contract 2	Provider 2	Contract 2 Provider 2	PCT3	GDS	Normal	01/04/2006	no end date	General and Ortho	22,519	752	383	23,438	£515,263	£21.98	5	8,958	8,206	36.4		3,365	221
Contract 210	Provider 210	Contract 210 Provider 210	PCT4	GDS	Normal	01/06/2008	no end date	General	21,687	477	0	21,687	£479,057	£22.09	5	6,906	6,429	29.6	Y	2,062	407
Contract 225	Provider 225	Contract 225 Provider 225	PCT1	GDS	Normal	03/12/2007	no end date	General	10,000	0	0	10,000	£234,427	£23.44	5	4,639	4,639	46.4		1,390	344
Contract 54	Provider 54	Contract 54 Provider 54	PCT3	GDS	Normal	01/11/2010	no end date	General and Ortho	16,500	0	0	16,500	£365,481	£22.15	5	3,856	3,856	23.4	Y	1,215	144
Contract 242	Provider 242	Contract 242 Provider 242	PCT4	GDS	Normal	01/04/2006	no end date	General	9,810	207	0	9,810	£198,167	£20.20	5	3,718	3,511	35.8		1,216	12
Contract 240	Provider 240	Contract 240 Provider 240	PCT1	GDS	Normal	01/04/2006	no end date	General	5,240	0	0	5,240	£159,380	£30.42	5	1,021	1,021	19.5	Y	712	24
Contract 13	Provider 13	Contract 13 Provider 13	PCT1	GDS	Normal	01/04/2006	no end date	General	144,576	5,362	0	144,576	£3,516,167	£24.32	4	60,885	55,523	38.4		19,456	2,670
Contract 207	Provider 207	Contract 207 Provider 207	PCT3	GDS	Normal	01/04/2006	no end date	General and Ortho	52,975	514	518	54,218	£1,100,916	£20.31	4	20,351	19,837	37.4		6,599	1,579
Contract 42	Provider 42	Contract 42 Provider 42	PCT4	GDS	Normal	01/04/2007	no end date	General and Ortho	42,501	812	7,184	59,743	£1,451,317	£24.29	4	16,804	15,992	37.6		5,144	1,539
Contract 176	Provider 176	Contract 176 Provider 176	PCT5	GDS	Normal	01/04/2006	no end date	General and Ortho	42,279	160	1,200	45,159	£1,084,589	£24.02	4	16,429	16,269	38.5		5,608	1,041
Contract 41	Provider 41	Contract 41 Provider 41	PCT1	GDS	Normal	01/07/2011	no end date	General	35,852	326	0	35,852	£856,734	£23.90	4	15,455	15,129	42.2		5,047	954
Contract 17	Provider 17	Contract 17 Provider 17	PCT3	GDS	Normal	01/04/2006	no end date	General	34,178	362	0	34,178	£711,385	£20.81	4	14,601	14,239	41.7		3,332	1,027
Contract 224	Provider 224	Contract 224 Provider 224	PCT1	GDS	Normal	01/04/2006	no end date	General	31,500	0	0	31,500	£855,455	£27.16	4	14,185	14,185	45.0		4,540	892
Contract 162	Provider 162	Contract 162 Provider 162	PCT1	GDS	Normal	01/04/2006	no end date	General	28,201	0	0	28,201	£906,601	£32.15	4	11,109	11,109	39.4		3,786	398

Q(xx) Dental Assurance Framework (Month Year) General report
Tab: Contract Profile

Contract Data & Profile

July to Sept 2012

Contract Number & Name	Contract 290 Provider 290

◀Choose contract from drop down to change data below

Contract Type Name	GDS
Contract Sub Type	Normal
Contract Start Date	01/04/2006
Contract End Date	no end date
Purpose of Contract	General
PCT	PCT1
Principal Practice & Correspondence Address	Address 290

		LAT	England
Total Contracted UDA Activity	9,313		
Total Carry Forward UDA	0		
Total Contracted UOA Activity	0		
UDA Equivalent	9,313		
Total Contracted Value	£216,363		
Cost per UDA Equivalent	£23.23	£25.47	£25.57

Current Quarter Indicators

Contract & LAT compared to England (red worse performing, green better performing than national level)

Delivery Indicators	Contract	Flagged?	LAT	England
% of Contracted UDA Delivered	56.9	N	39.0	39.6
Quality Indicators	**Contract**	**Flagged?**	**LAT**	**England**
Radiographs Rate per 100 FP17s	7.3	Y	17.3	17.6
Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)	0.0	Y	10.9	18.1
Fissure Sealants Rate per 100 FP17s (3-16 yr old patients)	0.0	Y	0.6	1.0
Endodontic Treatment Rate per 100 FP17s	0.5	Y	1.4	1.5
Extractions Rate per 100 FP17s (Low)	2.9	Y	6.4	6.6
Extractions Rate per 100 FP17s (High)		N		
Extractions % of Extractions + Endodontic Treatment- Adults	69.6	N	80.0	78.9
Inlay Rate per 100 FP17s	0.3	N	0.3	0.6
Re-attending within 3 months - Child	15.0	Y	8.5	8.9
Re-attending within 3 months - Adults	32.5	Y	17.4	17.9
Average Band 3 to Band 3 Rates	56.6	Y	208.4	216.6
Satisfaction Indicators	**Contract**	**Flagged?**	**LAT**	**England**
% satisfied with dentistry received	96.8	N	94.2	93.8
% satisfied with wait for an appointment	90.3	N	89.4	89.3
Number of Flags		**8**		

Contract Trend Indicators

Highlighted red indicates that the contract was flagged for attention in that quarter

Quality Indicators	Oct to Dec 2011	Jan to March 2012	April to June 2012	July to Sept 2012
Radiographs Rate per 100 FP17s	10.7	10.6	8.2	7.3
Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)	0.0	0.0	0.0	0.0
Fissure Sealants Rate per 100 FP17s (3-16 yr old patients)	0.0	0.0	0.0	0.0
Endodontic Treatment Rate per 100 FP17s	0.9	0.9	0.4	0.5
Extractions Rate per 100 FP17s	5.3	4.3	3.7	2.9
Extractions % of Extractions + Endodontic Treatment- Adults	74.3	73.5	81.5	69.6
Inlay Rate per 100 FP17s	0.0	0.1	0.2	0.3
Re-attending within 3 months - Child	13.6	12.4	12.6	15.0
Re-attending within 3 months - Adults	32.9	26.0	30.0	32.5
Average Band 3 to Band 3 Rates	133.4	146.0	98.5	56.6
Satisfaction Indicators				
% satisfied with dentistry received	100.0	100.0	100.0	96.8
% satisfied with wait for an appointment	93.8	91.9	91.2	90.3

Contract Profile of Activity in latest quarter

	Contract	LAT	England
UDA Per Patient	2.0	2.2	2.4

Patients ◀Choose from drop down to chose FP17, UDA or Patient figures for the tables below

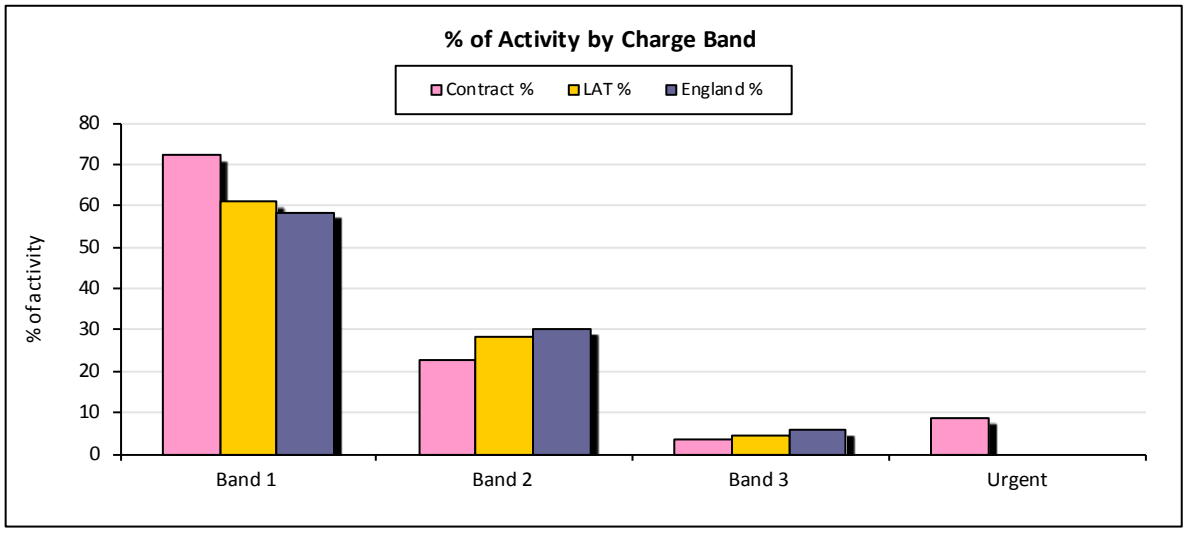
Totals for Quarter	Contract
Total Patients	1,363

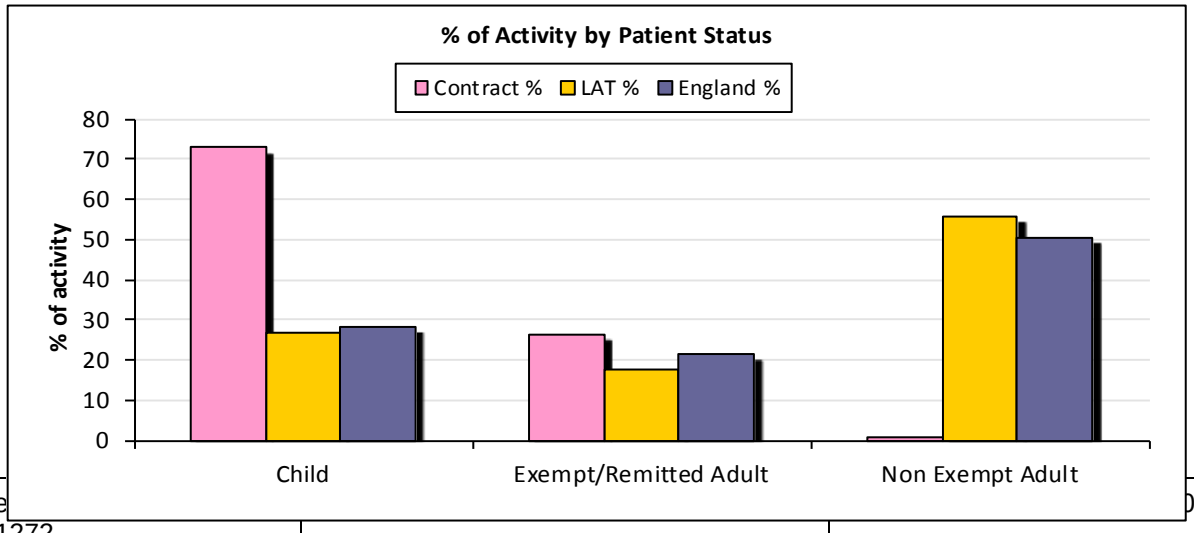
Totals for Quarter	Contract
Domiciliary	0
Sedations	0

The number of patients includes patients for whom a FP17 has been withdrawn or deleted, and so may exceed the number of FP17s. The number of patients treated within each category will not necessarily sum to the total for the contract as the same patient ID may appear in more than one category.

Patient Charge Band	Contract	Contract %	LAT %	England %
Band 1	983	72.1	61.0	58.5
Band 2	308	22.6	28.5	30.3
Band 3	51	3.7	4.6	5.9
Urgent	121	8.9	5.5	8.8
Free	4	0.3	2.0	2.4

Patient Charge Status	Contract	Contract %	LAT %	England %
Child	992	72.8	26.6	28.4
Exempt/Remitted Adult	361	26.5	17.7	21.4
Non Exempt Adult	11	0.8	55.9	50.4





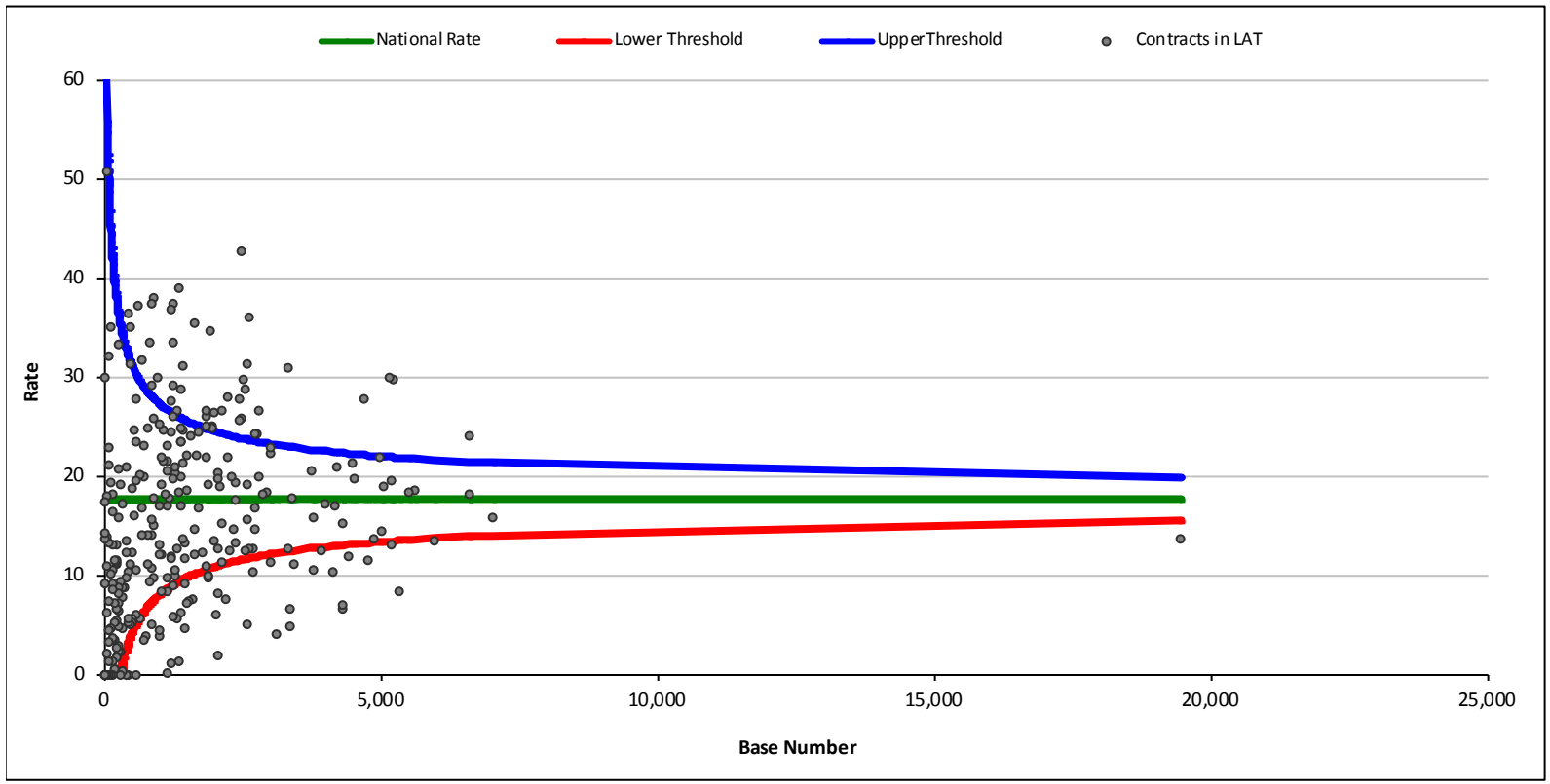
Q(xx) Dental Assurance Framework (Month Year) General report
Tab: Funnel Plots

AT Funnel Plots **July to Sept 2012**

As used to determine whether a contract is an outlier

Radiographs Rate per 100 FP17s ◀Choose indicator to chart from drop down list

All Contracts in LAT



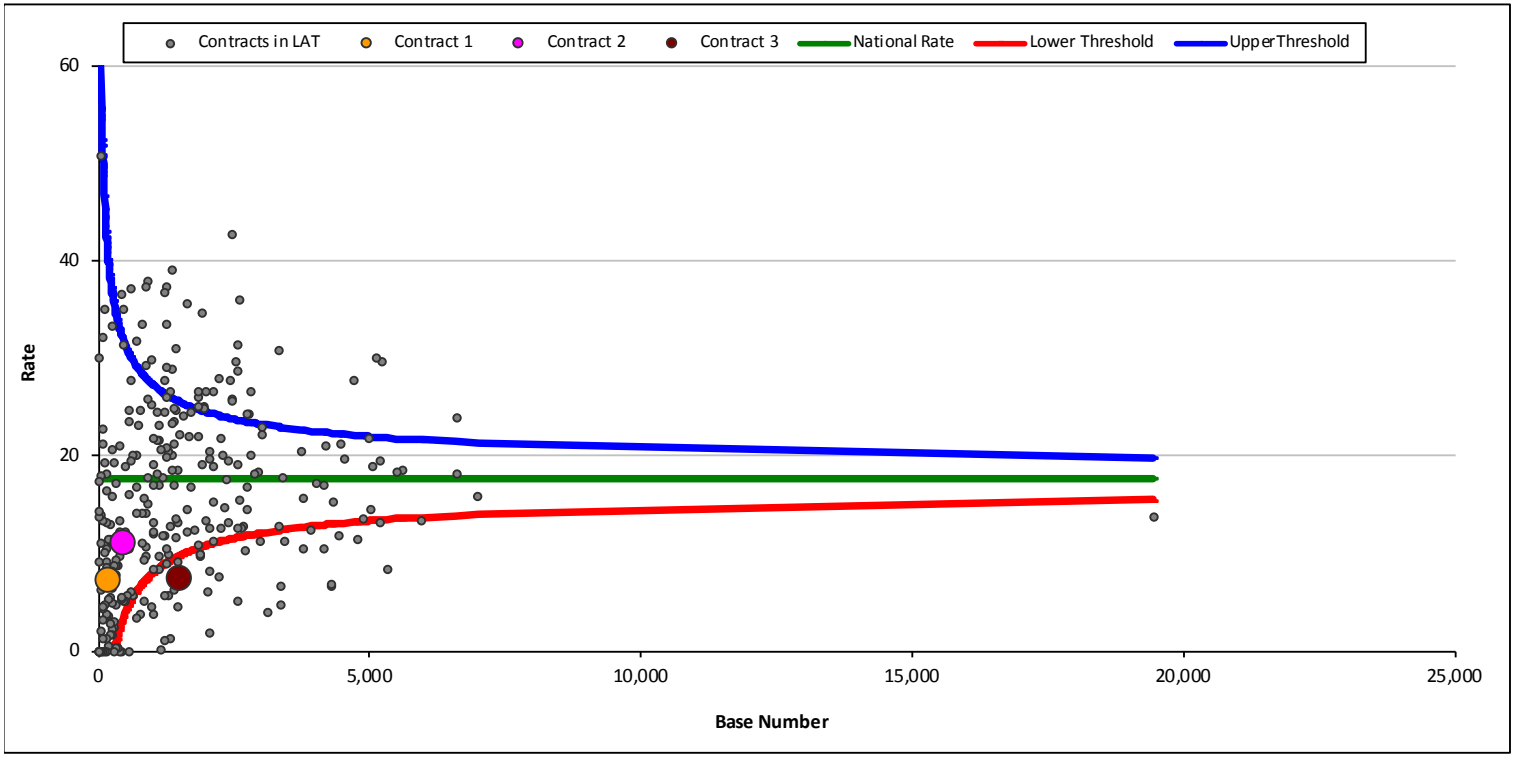
AT Funnel Plots **July to Sept 2012**

Selected Contract to show on the chart below

Select a Contract 1	Base Number	Rate
Contract 294 Provider 294	182	7.1

Select a Contract 2	Base Number	Rate
Contract 289 Provider 289	473	11.0

Select a Contract 3	Base Number	Rate
Contract 290 Provider 290	1,517	7.3



Q(xx) Dental Assurance Framework (Month Year) General report
Tab: Scatter Plot

AT Scatter Plots **July to Sept 2012**

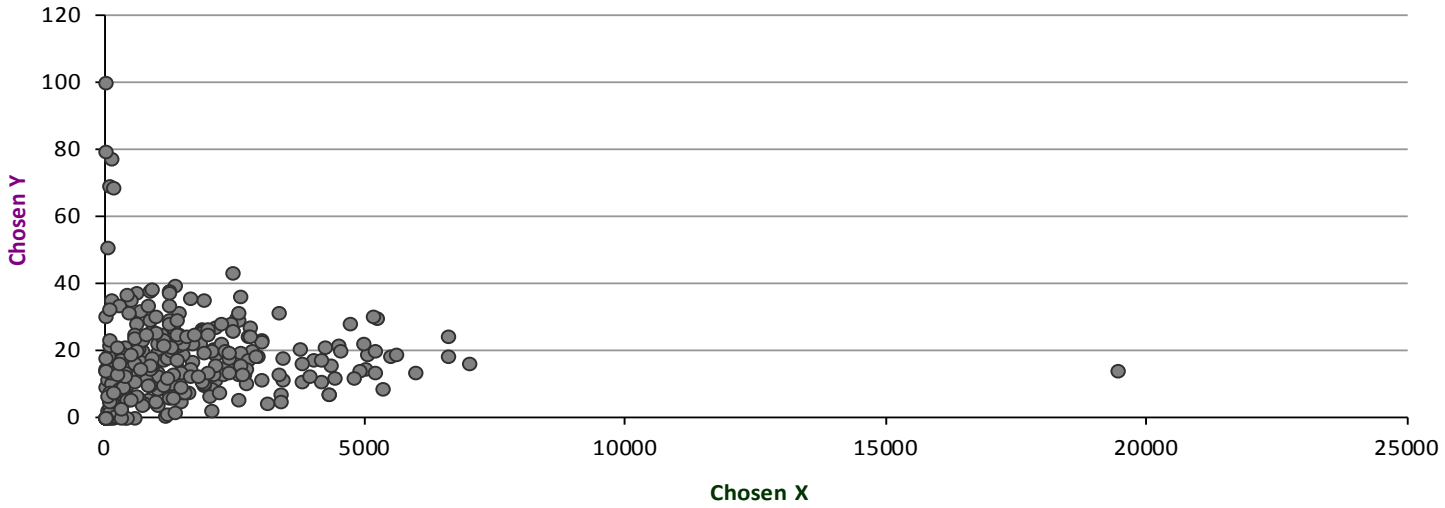
Choose data to chart from drop down for each axis. Suggested combinations would be Flouride Varnish & Fissure Sealant, Re-attendance Child & Adult, Radiographs and Total FP17s, Endodontic Treatment and Extractions Rates

X (horizontal) Axis	Total FP17s (Current Quarter)
Y (vertical) Axis	Radiograph Rate (Current Quarter)

◄Choose indicator to chart from drop down list

All Contracts in AT

Total FP17s (Current Quarter) Vs Radiograph Rate (Current Quarter)



Trend between the two datasets is a line on a scatter plot which can be drawn near the points to more clearly show the trend between two sets of data.
A line that rises quickly from left to right is called a **positive correlation** i.e when the x value increases , the y value also increases
A line falls down quickly from left to the right is called a **negative correlation** i.e when the x value increases, the y value decreases
Strong positive and negative correlations have data points very close to the line. Weak correlations have data points that are not clustered near or on the line.

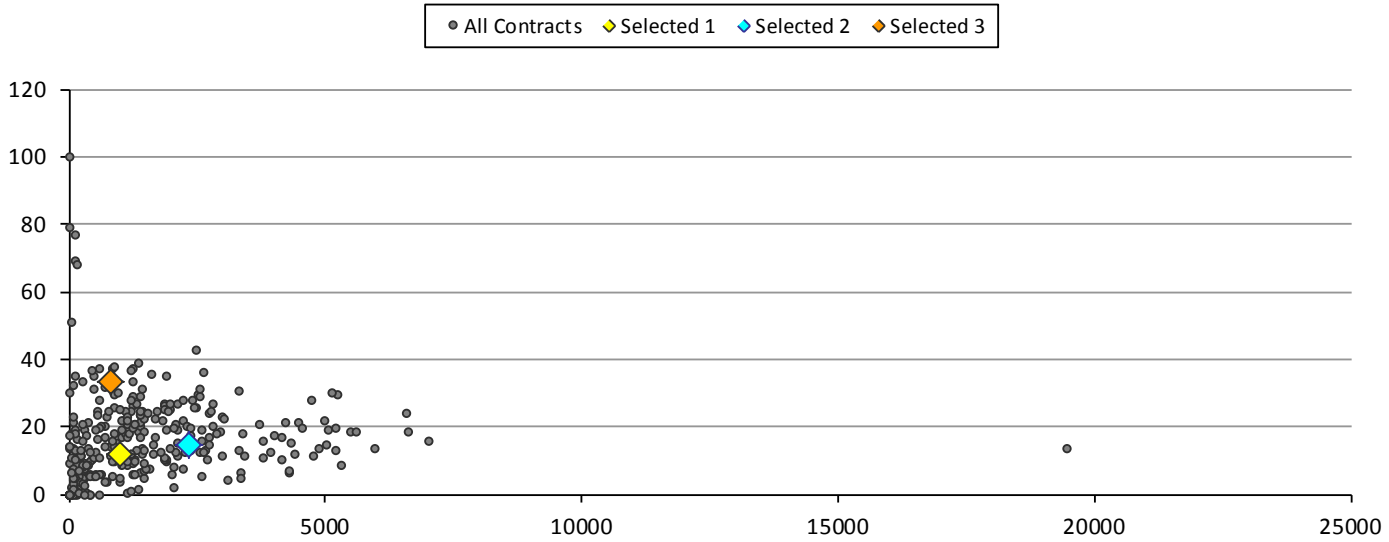
AT Scatter Plots **0** **July to Sept 2012**

Selected Contract(s) to show on the chart below

Select a Contract 1	X	Y
Contract 1 Provider 1	1010.0	12.1

Select a Contract 2	X	Y
Contract 4 Provider 4	2332.0	14.6

Select a Contract 3	X	Y
Contract 227 Provider 227	818.0	33.5



Trend between the two datasets is a line on a scatter plot which can be drawn near the points to more clearly show the trend between two sets of data.

A line that rises quickly from left to right is called a **positive correlation** i.e when the x value increases , the y value also increases

A line falls down quickly from left to the right is called a **negative correlation** i.e when the x value increases, the y value decreases

Strong positve and negative correlations have data points very close to the line. Weak correlations have data points that are not clustered near or on the line.

Q(xx) Dental Assurance Framework (Month Year) General report
Tab: Area Team Feedback

AT Feedback **July to Sept 2012**

This is an opportunity to feed "local" knowledge into the process of identifying flagged contracts. Please complete where necessary,copy the sheet and e-mail it to : xxxx@aaa.com. This can then be fed into future reports

Contract	Name or Company Name	Comments on Contract	Previous Comments on Contracts	DS Comments on Contract
Contract 1	Provider 1			
Contract 2	Provider 2			
Contract 3	Provider 3			
Contract 4	Provider 4			
Contract 5	Provider 5			
Contract 6	Provider 6			
Contract 7	Provider 7			
Contract 8	Provider 8			
Contract 9	Provider 9			
Contract 10	Provider 10			
Contract 11	Provider 11			
Contract 12	Provider 12			
Contract 13	Provider 13			
Contract 14	Provider 14			
Contract 15	Provider 15			
Contract 16	Provider 16			
Contract 17	Provider 17			
Contract 18	Provider 18			
Contract 19	Provider 19			
Contract 20	Provider 20			
Contract 21	Provider 21			
Contract 22	Provider 22			
Contract 23	Provider 23			
Contract 24	Provider 24			
Contract 25	Provider 25			
Contract 26	Provider 26			
Contract 27	Provider 27			
Contract 28	Provider 28			
Contract 29	Provider 29			
Contract 30	Provider 30			
Contract 31	Provider 31			
Contract 32	Provider 32			
Contract 33	Provider 33			
Contract 34	Provider 34			
Contract 35	Provider 35			
Contract 36	Provider 36			
Contract 37	Provider 37			
Contract 38	Provider 38			
Contract 39	Provider 39			
Contract 40	Provider 40			
Contract 41	Provider 41			
Contract 42	Provider 42			
Contract 43	Provider 43			
Contract 44	Provider 44			
Contract 45	Provider 45			
Contract 46	Provider 46			
Contract 47	Provider 47			
Contract 48	Provider 48			
Contract 49	Provider 49			
Contract 50	Provider 50			

Q(xx) Dental Assurance Framework (Month Year) Ortho report
Tab: Overall Rates

Area Rates & Comparison | Anon AT | 12 months Jan 2012 to Dec 2012

Area compared to England (red worse performing, green better performing than national level)

Delivery		England	AT
UOA Delivered	% of Contracted UOA Delivered (2012-13 Yr to Date)	70.4	61.9
Assessment		**England**	**AT**
Assessments by category	% of assessments that are Assess and fit appliance	40.3	38.5
Assessments by category	% of assessments that are Assess and refuse	12.5	11.8
Assessments by category	% of assessments that are Assess and review	47.2	49.7
Age at assessment	% of reported assessments and review where patient is 9 years old or under	13.0	16.6
Treatment		**England**	**AT**
Cases reported complete as a function assess and fit appliance	Ratio of reported **concluded** (completed, abandoned or discontinued) courses of treatment to reported assess and fit appliance.	0.8	0.9
Type of appliance used	% of **concluded*** (completed, abandoned or discontinued) courses of treatment reported as using removable appliances only. * currently only using completed	2.1	1.4
Outcomes		**England**	**AT**
UOAs reported per completed case	Ratio of the number of UOAs reported per reported **completed** case (not including abandoned or discontinued cases)	29.8	28.3
Reported PAR Scoring: actual versus expected	% of contracts meeting their expected reporting of PAR scores	55.4	43.3
Abandoned or discontinued care	% of **concluded** (completed, abandoned or discontinued) courses of treatment where treatment is reported as abandoned or discontinued	8.6	12.1

Q(xx) Dental Assurance Framework (Month Year) Ortho report
Tab: Flagged Totals

Contracts Flagged for Attention | Anon AT | 12 months Jan 2012 to Dec 2012

Area compared to England (red worse performing , green better performing than national level)

Delivery		England %	AT Total	AT %	
UOA Delivered	% of Contracted UOA Delivered (Year to Date)	27.3	9	30.0	View contracts
Assessment		**England %**	**AT Total**	**AT %**	
Assessments by category	% of assessments that are Assess and fit appliance	9.0	3	10.0	View contracts
Assessments by category	% of assessments that are Assess and refuse	4.1	1	3.3	View contracts
Assessments by category	% of assessments that are Assess and review	10.9	4	13.3	View contracts
Age at assessment	% of reported assessments and review where patient is 9 years old or under	4.3	2	6.7	View contracts
Treatment		**England %**	**AT Total**	**AT %**	
Cases reported complete as a function assess and fit appliance	Ratio of reported **concluded** (completed, abandoned or discontinued) courses of treatment to reported assess and fit appliance.	19.8	7	23.3	View contracts
Type of appliance used	% of **concluded*** (completed, abandoned or discontinued) courses of treatment reported as using removable appliances only. * currently only using completed	1.8	0	0.0	View contracts
Outcomes		**England %**	**AT Total**	**AT %**	
UOAs reported per completed case	Ratio of the number of UOAs reported per reported **completed** case (not including abandoned or discontinued cases)	13.5	8	26.7	View contracts
Reported PAR Scoring: actual versus expected	% of contracts not meeting their expected reporting of PAR scores	39.9	16	53.3	View contracts
Abandoned or discontinued care	% of **concluded** (completed, abandoned or discontinued) courses of treatment where treatment is reported as abandoned or discontinued	2.6	2	6.7	View contracts

Q(xx) Dental Assurance Framework (Month Year) Ortho report
Tab: Summary

Comparison with National Results

Measures	AT vs National Rate	How defined	% Flagged Contracts	How defined
% of Contracted UOA Delivered	Within Expected levels	If between expected levels	Y	If % of contracts flagged higher than national %
% of assessments = Assess and fit appliance	Y	if lower than national rate	Y	
% of assessments= Assess and refuse	N	if higher than national rate	N	
% of assessments= Assess and review	Y	if higher than national rate	Y	
% of reported assessments and review where patient is 9 years	Y	if higher than national rate	Y	
Ratio of **concluded** treatment to assess and fit	N	if lower than national rate	Y	
% of **concluded*** using removable appliances only.	N	if higher than national rate	N	
Ratio of UOAs per **completed** case	N	if higher than national rate	Y	
% of contracts not meeting their expected reporting of PAR scores	Y	if lower than national rate	Y	
% of **concluded** CoTs where treatment abandoned or discontinued	Y	if higher than national rate	Y	

* currently only using completed

Contracts by number of flags

Number of Flags	Number of Contracts
0	0
1	10
2	9
3	4
4	2
5	1
6	0
7	0
8	0
9	0
10	0

Priority Contracts (by number of flags then size)

Priority?	Contract & Name or Company Name	Total Flags	Under-delivering UOA	% Assess and fit appliance	% Assess and refuse	% Assess and review	% assessments & review where patient is 9 years old or under	Ratio of **concluded** treatment to assess and fit	% of**concluded*** using removable appliances only.	Ratio of UOAs per**completed** case	Reported PAR Scoring: actual versus expected	% of**concluded** CoTs where treatment abandoned or discontinued
1	Contract & Company 24	5	Y	Y	N	Y	N	N	N	Y	Y	N
2	Contract & Company 9	4	Y	N	N	N	Y	N	N	Y	N	Y
3	Contract & Company 11	4	N	N	N	N	N	Y	N	Y	Y	Y
4	Contract & Company 5	3	Y	N	N	N	Y	N	N	N	Y	N
5	Contract & Company 10	3	N	N	N	N	N	Y	N	Y	Y	N

Q(xx) Dental Assurance Framework (Month Year) Ortho report
Tab: Contract Data

Contract & Name or Company Name	PCO Code	Contract	Name or Company Name	Purpose of Contract	Contract Type	Contract Sub Type	Contract Start Date	Contract End Date	Years Contract Open	Total Flags	Contracted UOA
Contract & Company 24	PCT	Contract 24	Name or Company Na	Orthodontic	PDS	Normal	01/04/2006		6.8	5	709
Contract & Company 9	PCT	Contract 9	Name or Company Na	Orthodontic	PDS	Normal	01/04/2006		6.8	4	31,126
Contract & Company 11	PCT	Contract 11	Name or Company Na	Orthodontic	PDS	Normal	01/04/2009		3.8	4	4,051
Contract & Company 5	PCT3	Contract 5	Name or Company Na	Orthodontic	PDS	Normal	01/01/2008		5.0	3	25,364
Contract & Company 10	PCT	Contract 10	Name or Company Na	Orthodontic	PDS	Normal	01/04/2009		3.8	3	3,080
Contract & Company 27	PCT	Contract 27	Name or Company Na	Orthodontic	PDS	Normal	01/09/2009		3.3	3	3,500
Contract & Company 2	PCT	Contract 2	Name or Company Na	General and Orthodontic	GDS	Normal	01/04/2006		6.8	3	1,035
Contract & Company 13	PCT	Contract 13	Name or Company Na	Orthodontic	PDS	Normal	01/04/2006	31/03/2014	6.8	2	11,060
Contract & Company 16	PCT	Contract 16	Name or Company Na	Orthodontic	PDS	Normal	01/04/2006		6.8	2	12,219
Contract & Company 3	PCT	Contract 3	Name or Company Na	Orthodontic	PDS	Normal	01/09/2009		3.3	2	8,430
Contract & Company 25	PCT	Contract 25	Name or Company Na	Orthodontic	PDS	Normal	01/04/2006	31/03/2014	6.8	2	8,703
Contract & Company 1	PCT	Contract 1	Name or Company Na	General and Orthodontic	GDS	Normal	01/04/2006		6.8	2	2,029
Contract & Company 8	PCT3	Contract 8	Name or Company Na	General and Orthodontic	GDS	Normal	04/04/2011		1.8	2	1,436
Contract & Company 20	PCT	Contract 20	Name or Company Na	Orthodontic	PDS	Normal	01/10/2009		3.3	2	1,500
Contract & Company 18	PCT3	Contract 18	Name or Company Na	Orthodontic	PDS	Normal	01/04/2006		6.8	2	1,493
Contract & Company 23	PCT3	Contract 23	Name or Company Na	General and Orthodontic	GDS	Normal	06/09/2012		0.3	2	207
Contract & Company 6	PCT3	Contract 6	Name or Company Na	Orthodontic	PDS	Normal	01/09/2007		5.3	1	20,293
Contract & Company 22	PCT	Contract 22	Name or Company Na	Orthodontic	PDS	Normal	01/04/2006	31/03/2014	6.8	1	9,370
Contract & Company 4	PCT3	Contract 4	Name or Company Na	Orthodontic	PDS	Normal	01/04/2008		4.8	1	5,796
Contract & Company 17	PCT	Contract 17	Name or Company Na	Orthodontic	PDS	Normal	01/09/2009		3.3	1	5,000
Contract & Company 26	PCT	Contract 26	Name or Company Na	Orthodontic	PDS	Normal	01/04/2006		6.8	1	2,044
Contract & Company 30	PCT3	Contract 30	Name or Company Na	General and Orthodontic	GDS	Normal	28/08/2007		5.3	1	1,275
Contract & Company 12	PCT3	Contract 12	Name or Company Na	General and Orthodontic	GDS	Normal	01/04/2006		6.8	1	534
Contract & Company 29	PCT3	Contract 29	Name or Company Na	General and Orthodontic	GDS	Normal	01/04/2006		6.8	1	306
Contract & Company 28	PCT3	Contract 28	Name or Company Na	General and Orthodontic	GDS	Normal	01/04/2006		6.8	1	223
Contract & Company 15	PCT4	Contract 15	Name or Company Na	Orthodontic	PDS	Normal	01/04/2008	30/09/2013	4.8	1	1
Contract & Company 7	PCT4	Contract 7	Name or Company Na	Orthodontic	PDS	Normal	01/09/2007		5.3		9,110
Contract & Company 14	PCT4	Contract 14	Name or Company Na	Orthodontic	PDS	Normal	01/04/2006		6.8		4,498
Contract & Company 21	PCT4	Contract 21	Name or Company Na	Orthodontic	PDS	Normal	01/04/2006		6.8		3,829
Contract & Company 19	PCT4	Contract 19	Name or Company Na	General and Orthodontic	GDS	Normal	01/04/2006		6.8		3,561

Q(xx) Dental Assurance Framework (Month Year) Ortho report
Tab: Contract Profile

Contract Data & Profile | **Anon AT** | **12 months Jan 2012 to Dec 2012**

Contract & Company 24 ◀Choose contract from drop down to change data below

PCT Code	PCT3
Contract Number	Contract 24
Name or Company Name	Name or Company Name 24
Purpose of Contract	Orthodontic
Contract Type	PDS
Contract Sub Type	Normal
Contract Start Date	01/04/2006
Contract End Date	none
Years open	6.8
Contracted UOA	709
Carry Forward UOA	0

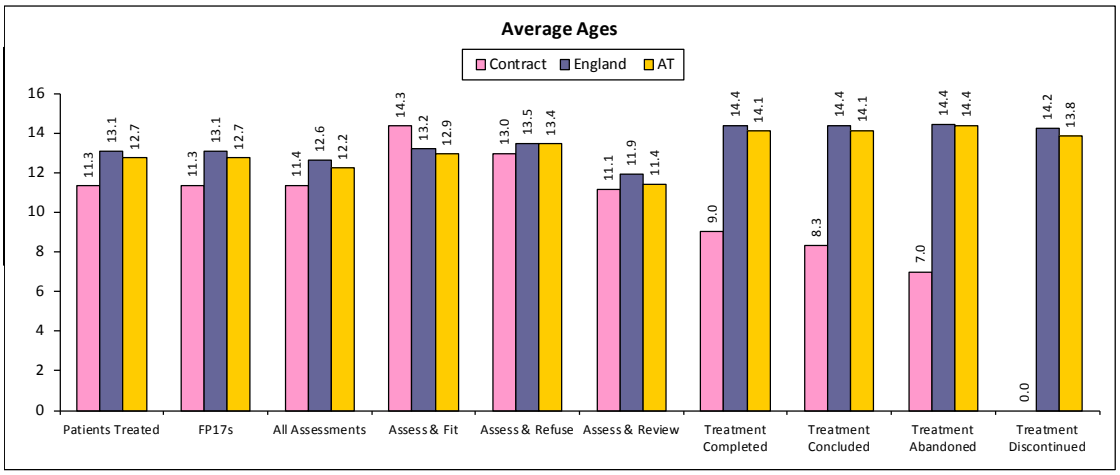
Year To Date	
UOA Scheduled	334
Adjusted Scheduled UOA	334
Delivery Level	Risk of Under Delivery

Contract compared to England ; red worse performing , green better performing than national level (see Overall Rates tables for description)

Indicator	Measure	Contract	Flagged?	England	AT
Delivery	% of Contracted UOA Delivered (PY to Date)	47.1	Y	70.4	61.9
Assessment	% of assessments that are Assess and fit appliance	0.7	Y	40.3	38.5
	% of assessments that are Assess and refuse	11.0	N	12.5	11.8
	% of assessments that are Assess and review	88.4	Y	47.2	49.7
	% of assess and review where patient is 9 years old or under	1.7	N	13.0	16.6
Treatment	Ratio of concluded CoT to reported assess and fit appliance	1.3	N	0.8	0.9
	% of concluded CoT reported as using removable appliances only.	0.0	N	2.1	1.4
Outcomes	Ratio of UOAs reported per reported completed case	166.0	Y	29.8	28.3
	Reported PAR Scoring: actual versus expected	0(3)	Y	n/a	n/a
	% of concluded CoT reported as abandoned or discontinued	25.0	N	8.6	12.1
	Total Flags	5			

Based on 12 months Jan 2012 to Dec 2012

Age Profile (FP17s)	Contract FP17s	Contract %	England %	AT %
Age 0 to 2 FP17s	6	1.4	0.0	0.0
Age 3 to 5 FP17s	3	0.7	0.1	0.1
Age 6 to 7 FP17s	17	3.9	0.9	1.0
Age 8 to 9 FP17s	56	12.7	5.0	6.3
Age 10 to 12 FP17s	221	50.1	34.3	38.5
Age 13 to 17 FP17s	137	31.1	58.1	53.4
Age 18 to 24 FP17s	1	0.2	1.5	0.7
Age 25 to 34 FP17s	0	0.0	0.0	0.0
Age 35+ FP17s	0	0.0	0.0	0.0
Total FP17s	441	100.0	100.0	100.0



Based on 12 months Jan 2012 to Dec 2012

Assess and Fit FP17s & IOTN	Contract FP17s	Contract %	England %	AT %
Assess and Fit FP17s IOTN Eligible	1	33.3	97.3	96.4
Assess and Fit FP17s IOTN Ineligible	0	0.0	0.4	0.2
Assess and Fit FP17s IOTN Missing	2	66.7	2.4	3.3
Total Assess and Fit FP17s	3	100.0	100.0	100.0

Assess and Refuse FP17s & IOTN	Contract FP17s	Contract %	England %	AT %
Assess and Refuse FP17s IOTN Eligible	6	12.5	2.4	10.1
Assess and Refuse FP17s IOTN Ineligible	20	41.7	0.0	45.1
Assess and Refuse FP17s IOTN Missing	22	45.8	21.5	44.8
Total Assess and Refuse FP17s	48	100.0	23.8	100.0

Assess and Review FP17s & IOTN	Contract FP17s	Contract %		LAT Area %
Assess and Review FP17s IOTN Eligible	122	31.5	8.3	51.4
Assess and Review FP17s IOTN Ineligible	20	5.2	0.0	9.1
Assess and Review FP17s IOTN Missing	245	63.3	69.9	39.5
Total Assess and Review FP17s	387	100.0	78.2	100.0

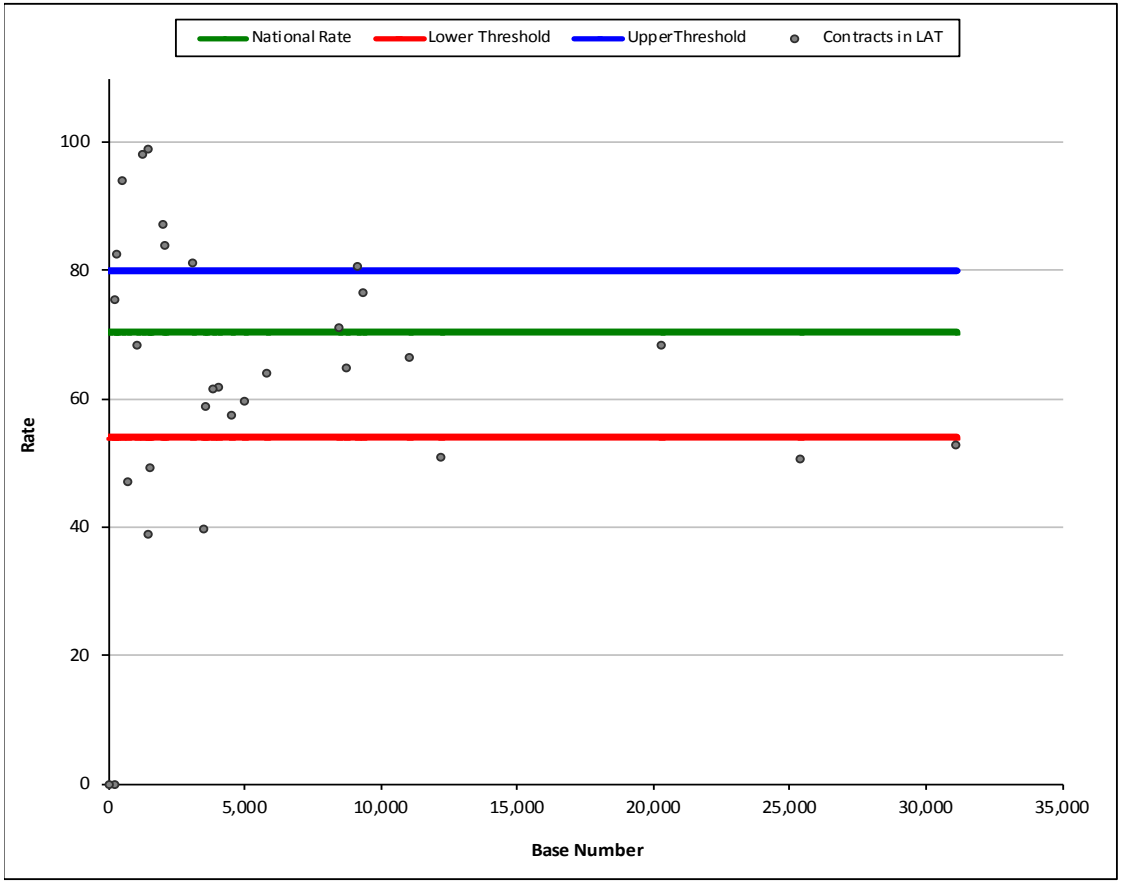
Par Scoring	
Treatment Completed FP17s	3
Actual	
Reported PAR scoring	0
% of completed CoT where a PAR score	0.0
Expected*	
"Expected"completed CoT reported PAR	3
"Expected" % completed CoT reported PAR	100.0

* 20 or fewer in any one year, then contractors are required to report a PAR score for every case. Where the total number of cases provided is greater than 20 in any one year then contractors should report a PAR score on the first 20 cases plus score an additional 10 percent of all other provided cases

Q(xx) Dental Assurance Framework (Month Year) Ortho report
Tab: Funnel Reports

Funnel Plots **Anon AT** **12 months Jan 2012 to Dec 2012**

% Contracted UOA Delivered (PY to Date)



Flagged for Attention	Total	
Contract & Name or Company Name	Flags	Value
Contract & Company 24	5	47.11
Contract & Company 9	4	52.94
Contract & Company 5	3	50.59
Contract & Company 27	3	39.71
Contract & Company 16	2	51.01
Contract & Company 20	2	49.33
Contract & Company 18	2	38.78
Contract & Company 23	2	0.00
Contract & Company 15	1	0.00

Funnel Plots **Anon AT** **12 months Jan 2012 to Dec 2012**

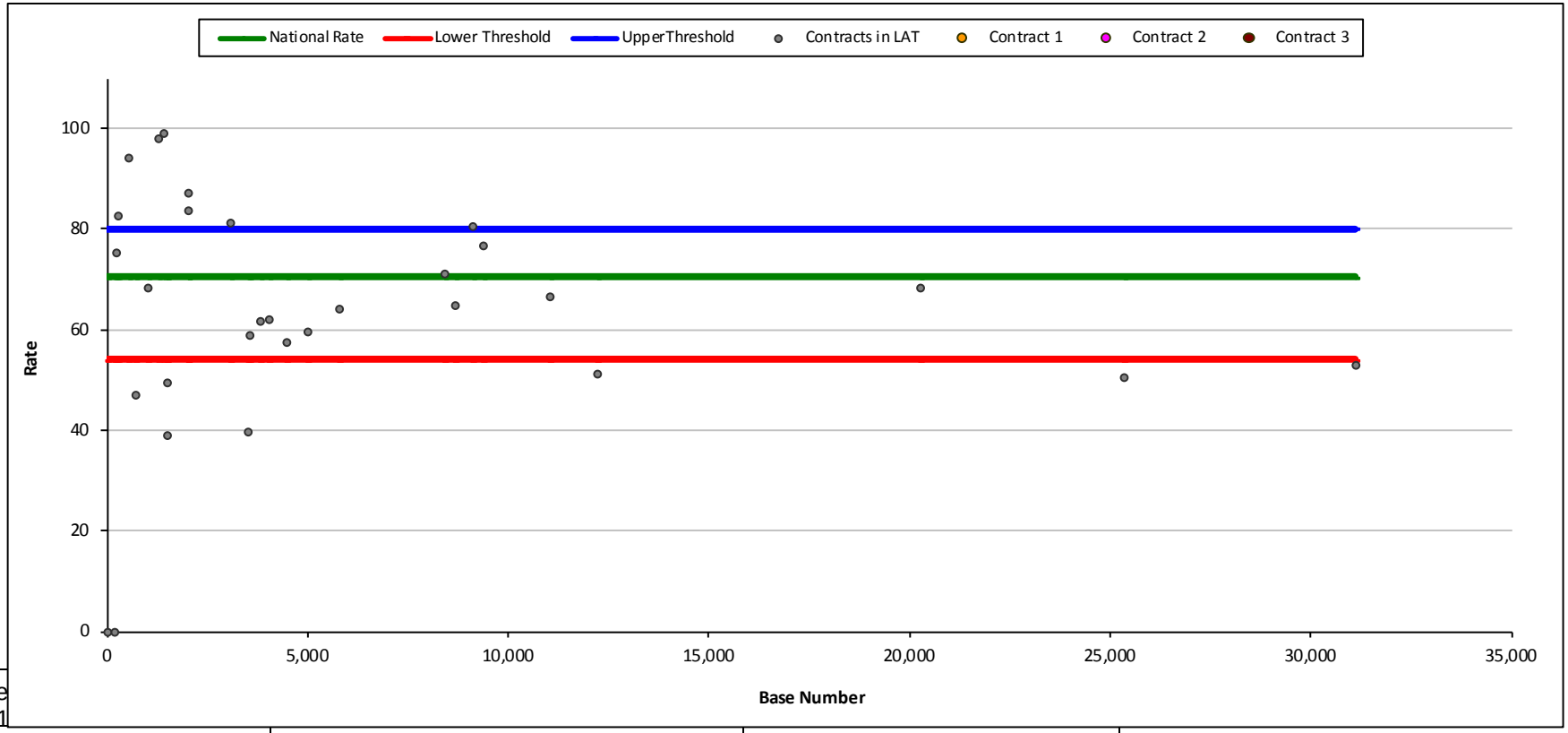
Select a Contract 1	Base Number	Rate
Contract & Name or Company Name	#N/A	#N/A

◀Choose contract from drop down to change data below

Select a Contract 2	Base Number	Rate
Contract & Name or Company Name	#N/A	#N/A

Select a Contract 3	Base Number	Rate
Contract & Name or Company Name	#N/A	#N/A

% Contracted UOA Delivered (PY to Date)



Q(xx) Dental Assurance Framework (Month Year) Ortho report
Tab: Area Team Feedback form

Feedback **Anon AT** **12 months Jan 2012 to Dec 2012**

This is an opportunity to feed "local" know ledge into the process of identifying outlier contracts. Please complete w here necessary,copy the sheet and e-mail it to : xxxx@aaa.com. This can then be fed into future reports

Contract	Name or Company Name	Comments on Contract	Previous Comments on Contracts
Contract 1	Name or Company Name 1		
Contract 2	Name or Company Name 2		
Contract 3	Name or Company Name 3		
Contract 4	Name or Company Name 4		
Contract 5	Name or Company Name 5		
Contract 6	Name or Company Name 6		
Contract 7	Name or Company Name 7		
Contract 8	Name or Company Name 8		
Contract 9	Name or Company Name 9		
Contract 10	Name or Company Name 10		
Contract 11	Name or Company Name 11		
Contract 12	Name or Company Name 12		
Contract 13	Name or Company Name 13		
Contract 14	Name or Company Name 14		
Contract 15	Name or Company Name 15		
Contract 16	Name or Company Name 16		
Contract 17	Name or Company Name 17		
Contract 18	Name or Company Name 18		
Contract 19	Name or Company Name 19		
Contract 20	Name or Company Name 20		
Contract 21	Name or Company Name 21		
Contract 22	Name or Company Name 22		
Contract 23	Name or Company Name 23		
Contract 24	Name or Company Name 24		
Contract 25	Name or Company Name 25		
Contract 26	Name or Company Name 26		
Contract 27	Name or Company Name 27		
Contract 28	Name or Company Name 28		
Contract 29	Name or Company Name 29		
Contract 30	Name or Company Name 30		

Annex 5

Report Guidance – A pdf document is available on e-reporting at http://www.nhsbsa.nhs.uk/DentalServices/3396.aspx

NHS BSA Dental Services Dental Assurance Framework Report Guidance

Introduction

This guidance provides information on the measures used in the Dental Assurance Framework Reports. This guidance is intended to aid understanding of the reports; separate documents have been produced by NHS England to outline the Assurance Framework itself.

General Report

The report covers the following:

- PDS & GDS Contracts Only
- Excluded VDP Activity
- Excludes pilot contracts (as identified from POL).
- Only Open contracts have been analysed. An open contract is defined as one that has a start date less than the data extraction date and an end date after the data extraction date or no end date
- Contracts shown only if they have Contracted UDA in the current year and/or scheduled UDA in the current quarter
- Contracted activity is as stated on Payments on Line (POL) on the data extraction date. The usefulness and accuracy of this measure is, therefore, dependent on the corresponding details being updated on POL when any change is made to the contract.
- The delivered activity is taken from the information submitted on scheduled FP17s.

Structure of Report

The report is built in excel in a dashboard style. Therefore several parts are derived from calculations carried out once a drop down has been selected. If cells are altered or deleted then the report may not function correctly. If it is necessary to alter the report then it is recommended that this is done by making a copy of the report, leaving the original intact. There are nine tabs in the report:

I. Notes: This is not full guidance but will be used to inform users of any changes in the report or comments made.
II. Area Rates & Comparison: the indicator levels for the Area Team (AT) area as a whole.

III. Summary & Priority Contracts: a visualisation of the comparison with national results as well as a list of contracts with the most flags for attention.
IV. Contracts Flagged for Attention: the number and proportion of contracts in the AT areas that have been flagged for attention. This sheet contains a link to identify specifically those contracts flagged.
V. Contract Data: a spread sheet of the data used for all contracts.
VI. Contract Profile: indicator data for an individual contract including trend data and an overall profile.
VII. Funnel Plots: these charts aid explanation of how flags for attention have been calculated (a more detailed explanation is included further on in this guidance). They show all contracts simultaneously, with information about whether each point is significantly above or below the expected, or average, value.
VIII. Scatter Charts: Relational scatter charts between two measures
IX. AT Feedback: an opportunity to feed "local" knowledge into the process.

Time Periods Used

- The report is produced on a quarterly basis. Therefore activity data shown is for the three months in that quarter.
- UDA and UOA delivered numbers are based on the performance year to date (therefore a report in December will contain delivered UDA for the period April to December).
- Contracted UDA and UOA levels on which delivered activity are measured against are for the contract year as stated on POL.
- Patient Questionnaire data is, as in Vital Signs reports, based on a 12 month rolling period.

Benchmarks

Area Team (AT) totals and individual contract performance has been compared to England; where appropriate those performing worse are highlighted in red and those performing better than national level highlighted green. A comparison between ATs is shown where appropriate.

Trend data

Data is shown for contracts, ATs and England over previous quarters. The same methodology is used in all measures including time periods used. Therefore delivered data will be based on the year to date and so will not be comparable each quarter.

Delivery Indicators
% of Contracted UDA Delivered

- Percentage of contracted activity delivered shows the units of activity scheduled (minus any carry forward from the previous year) as a percentage of contracted units for the contract year.
- Activity scheduled for each quarter covers the year to date period, for example in December this will cover the scheduled months of April to December.
- Contracts have been identified where their level delivered activity is lower than expected. The expected range is based on the pattern of delivery of contracts nationally which delivered 96% to 104% in previous years.

Quality Indicators
Radiographs Rate

- Rate per 100 FP17s which included a radiograph for all courses of treatment and patients. The number of FP17s which included a radiograph is based on the general clinical data set as recorded in part 5a of the FP17.
- The rate is calculated as the number of FP17s which included a radiograph divided by the total number of FP17s, and then expressed as a rate per 100 FP17s (i.e. multiplied by 100).
- A low rate could indicate non-compliance with FGDP (UK) Good Practice Guidelines – “Selection Criteria for Dental Radiography”.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Fluoride Varnish Rate (3-16 yr. old patients)

- Rate per 100 FP17s for patients aged from 3 up to and including 16 which included a fluoride varnish treatment. The number of FP17s which included fluoride varnish is based on the general clinical data set as recorded in part 5a of the FP17.
- Patient age is based on the age on the date of acceptance as recorded on the FP17.
- Delivering Better Oral Health recommends that children aged 3 to young adults should have fluoride varnish applied to teeth twice yearly, therefore the patient age range used in this indicator has been restricted.
- The rate is calculated as the number of FP17s which included fluoride varnish for patients aged 3 to 16 divided by the total number of FP17s for that age range, and then expressed as a rate per 100 FP17s (i.e. multiplied by 100).
- A low level of fluoride varnish applications would suggest that treatment is not being offered according to “Delivering Better Oral Health”

- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below) but also includes contracts with a rate of zero.

Fissure Sealants Rate (3-16 yr old patients)

- Rate per 100 FP17s for patients aged from 3 up to and including 16 which included a fissure sealant treatment. The number of FP17s which included fissure sealant treatment is based on the general clinical data set as recorded in part 5a of the FP17.
- Patient age is based on the age on the date of acceptance as recorded on the FP17.
- Delivering Better Oral Health recommends fissure sealant be used on permanent molars on children giving concern aged 6 to young adults. Therefore the patient age range used in this indicator has been restricted and kept consistent with the age range used in the Fluoride Varnish indicator.
- The rate is calculated as the number of FP17s which included fissure sealant for patients aged 3 to 16 divided by the total number of FP17s for that age range, and then expressed as a rate per 100 FP17s (i.e. multiplied by 100).
- A low level of fissure sealant would suggest that treatment is not being offered according to “Delivering Better Oral Health”
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Endodontic Treatment Rate

- Rate per 100 FP17s which included endodontic treatment for all courses of treatment and patients. The number of FP17s which included endodontic treatment is based on the general clinical data set as recorded in part 5a of the FP17.
- The rate is calculated as the number of FP17s which included endodontic treatment divided by the total number of FP17s, and then expressed as a rate per 100 FP17s (i.e. multiplied by 100).
- Low levels of endodontic treatment could indicate a number of factors but possibly a greater preference to extract rather than root fill or a high level of root treatments being provided under private contract.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Extractions Rate

- Rate per 100 FP17s which included an extraction for all courses of treatment and patients. The number of FP17s which included an extraction is based on the general clinical data set as recorded in part 5a of the FP17.

- The rate is calculated as the number of FP17s which included an extraction divided by the total number of FP17s, and then expressed as a rate per 100 FP17s (i.e. multiplied by 100).
- High/low levels could indicate a number of factors including social deprivation, patient choice, a greater preference to extract rather than root fill or vice versa or treatments being provided under a private contract.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Extractions % (Adults)

- Extractions as a % of Extractions + Endodontic Treatment- Adults are a percentage of total FP17s for adult patients with either an extraction and/or endodontic treatment that were made up of extractions.
- Adult patients defined as those aged over 18 years at the date of acceptance of their treatment.
- Number of FP17s which included an extraction and/or endodontic treatment is based on the general clinical data set as recorded in part 5a of the FP17.
- The percentage is calculated as the number of FP17s for adult patients which included an extraction divided by the number FP17s for adult patients which included either an extraction and/or endodontic treatment, expressed as a percentage of that total.
- A high percentage can show a greater preference to extract rather than root fill or a high level of root treatments being provided under private contract.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Inlay Rate

- Rate per 100 FP17s which included an inlay for all courses of treatment and patients. The number of FP17s which included an inlay is based on the general clinical data set as recorded in part 5a of the FP17.
- The rate is calculated as the number of FP17s which included an inlay divided by the total number of FP17s, and then expressed as a rate per 100 FP17s (i.e. multiplied by 100).
- High levels of inlays with no other items provided in a course of treatment may be an indication of UDA “optimisation”.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Re-attending within 3 months – Child/Adult

- The percentage of FP17s involving children/adults for the same patient identity (surname, initial, gender and date of birth) where the previous

course of treatment for that patient identity at the same contract ended 3 months or less prior to the most recent course of treatment.
- Child patients are defined as those aged under 18 years at the date of acceptance of their treatment. Adult patients defined as those aged over 18 years at the date of acceptance of their treatment.
- Please note that AT area figures are aggregates of contract totals therefore reflect the measures used in terms of a patient attending the same contract. This differs to Vital Signs where PCO levels are based on a patient attending a contract at the same PCO.
- Data (re-attendance and patient satisfaction) in the report can differ from vital signs reports due to when the reports were run.
- In general, a patient who has completed a course of treatment that renders him or her “dentally fit” should not need to see a dentist again within the next three months.
- A high rate would indicate that further treatment has been provided outside the recall interval but could include urgent treatment etc.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Average Band 3 to Band 3 Rates
- The average intervals (in days) between attendances where the current and previous charge band are both band 3 treatments.
- This interval is measured as the period between the earliest date of acceptance and the most recent date of completion (or date of acceptance if the date of completion is missing) from the FP17s scheduled in the same or a previous schedule month).
- An FP17 is regarded as “previous” only if its date of completion (or date of acceptance if the date of completion is missing) is before the current FP17's date of acceptance - so the interval will always be at least one day. Withdrawn FP17s are excluded. An FP17 would not have its re-attendance intervals recalculated if another FP17 for an earlier course of treatment is scheduled at a later date. If two FP17s have the same acceptance date, they are both treated as entirely separate FP17s and both are allocated the same re-attendance interval. All dates and FP17 details are as recorded on the NHS Dental Services database.
- Short intervals may suggest possible “splitting” of courses of treatment.

Patient Satisfaction Indicators
- These metrics are derived from the BSA Dental Services routine patient survey. It provides the patients’ perception of dental quality. The analysis is based on a national random sample of over 20,000 patient questionnaire responses per quarter. The sample is stratified by health body (to ensure the same number of cases are selected from each health body) and charge band (to over-sample the higher charge bands).

- Patient questionnaire data is, as in Vital Signs reports, based on a 12 month rolling period.
- A percentage is calculated only for contracts with 10 or more responses in the rolling year.

A percentage is calculated only for contracts with 10 or more responses in the rolling year. Percentage of patients satisfied with the dentistry they have received

- The figure reported is the percentage of respondents who stated that they were either completely or fairly satisfied with the NHS dentistry they received.
- This is presented as a percentage of the number of responses for each contract.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Percentage of patients satisfied with the time they had to wait for an appointment.

- The figure reported is the percentage of respondents who stated that who stated that the length of time taken to get an appointment was as soon as was necessary.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Ortho Report

The report covers the following:

- PDS & GDS Contracts Only
- Excludes pilot contracts (as identified from POL).
- Only Open contracts have been analysed. An open contract is defined as one that has a start date less than the data extraction date and an end date after the data extraction date or no end date
- Contracts shown only if they have Contracted UOA in the current year and/or scheduled UOA in the current 12 month period.
- Contracted activity is as stated on Payments on Line (POL) on the data extraction date. The usefulness and accuracy of this measure is, therefore, dependent on the corresponding details being updated on POL when any change is made to the contract.
- The delivered activity is taken from the information submitted on scheduled FP17s.

Structure of Report

The report is built in excel in a dashboard style. Therefore several parts are derived from calculations carried out once a drop down has been selected. If cells are altered or deleted then the report may not function correctly. If it is

necessary to alter the report then it is recommended that this is done by making a copy of the report, leaving the original intact. There are eight tabs in the report:

I. Notes: This is not full guidance but will be used to inform users of any changes in the report or comments made.
II. Area Rates & Comparison: the indicator levels for the Area Team (AT) area as a whole.
III. Contracts Flagged for Attention: the number and proportion of contracts in the AT area that has been flagged for attention. This sheet contains a link to identify specifically those contracts flagged.
IV. Summary & Priority Contracts: a visualisation of the comparison with national results as well as a list of contracts with the most flags for attention.
V. Contract Data: a spread sheet of the data used for all contracts.
VI. Contract Profile: indicator data for an individual contract including trend data and an overall profile.
VII. Funnel Plots: these charts aid explanation of how flags for attention have been calculated (a more detailed explanation is included further on in this guidance). They show all contracts simultaneously, with information about whether each point is significantly above or below the expected, or average, value.
VIII. AT Feedback: an opportunity to feed "local" knowledge into the process.

Time Periods Used

- The report is produced on a quarterly basis.
- Activity data shown is for a rolling 12 month scheduled period.
- UOA delivered numbers are based on the performance year to date (therefore a report in September will contain delivered UOA for the period April to September).
- Contracted UOA levels on which delivered activity are measured against are for the contract year as stated on POL.

Benchmarks

Area Team (AT) totals and individual contract performance has been compared to England; where appropriate those performing worse are highlighted in red and those performing better than the national level highlighted green. A comparison between ATs is shown where appropriate.

Delivery Indicators

% of Contracted UOA Delivered

- Percentage of contracted activity delivered shows the units of activity scheduled (minus any carry forward from the previous year) as a percentage of contracted units for the contract year.

- Activity scheduled for each quarter covers the year to date period, for example in December this will cover the scheduled months April to December.
- Contracts have been identified where their level delivered activity is lower than expected. The expected range is based on the pattern of delivery of contracts nationally which delivered 96% to 104% in previous years.

Assessment Indicators

% of assessments that are Assess and fit appliance

- There are three options available to report on an orthodontic assessment (refuse treatment, review, fit appliances).
- Assess and fit appliance defined as FP17s where the assess and accept box has been ticked and the date treatment began has been entered. In effect, this is the number of treatment starts.
- Shows the proportion of all assessments that are assess and fit appliance (rolling 12 month period), calculated by dividing the number of assess and fit appliance FP17s by the number of all assessment FP17s then expressed as a percentage.
- Contracts are highlighted if the % is at a low level.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

% of assessments that are Assess and refuse

- There are three options available to report on an orthodontic assessment (refuse treatment, review, fit appliances).
- Assess and refuse defined as FP17s where the assess and refuse treatment box in part 5 has been ticked.
- Shows the proportion of all assessments that are assess and refuse (rolling 12 month period), calculated by dividing the number of assess and refuse FP17s by the number of all assessment FP17s then expressed as a percentage.
- Contracts are highlighted if the % is at a high level.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

% of assessments that are Assess and review

- There are three options available to report on an orthodontic assessment (refuse treatment, review, fit appliances).
- Assess and review defined as FP17s where the assessment and review box in part 5 has been ticked.
- Shows the proportion of all assessments that are assess and review (rolling 12 month period), calculated by dividing the number of assess and review FP17s by the number of all assessment FP17s then expressed as a percentage.

- Contracts are highlighted if the % is at a high level.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

% of reported assessments and review where patient is 9 years old or under

- Patient age is derived from the patient date of birth as recorded on the FP17. A patient is defined as 9 years old or under if their age at the date of acceptance was 9 years or under.
- Shows the proportion of all assess and reviews where the patient was aged 9 or under (rolling 12 month period), calculated by dividing the number of assess and review FP17s for patients aged 9 or under by the number of assess and review FP17s for all patient ages then expressed as a percentage.
- Contracts are highlighted if the % is at a high level.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Treatment Indicators

Ratio of concluded courses of treatment to assess and fit appliance.

- The outcome for each course of treatment commenced should be reported, whether completed, abandoned or discontinued.
- Concluded Treatment is defined as Treatment Abandoned (FP17s where the treatment abandoned box in part 3 has been ticked), Treatment Completed (FP17s where the treatment completed box in part 3 has been ticked) and Treatment Discontinued (FP17s where the treatment discontinued box in part 3 has been ticked).
- The ratio of reported concluded courses of treatment to reported assess and fit appliance is calculated by dividing the number of concluded treatment FP17s by the number of assess and fit appliance FP17s.
- A low ratio is highlighted
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

% of concluded* (completed, abandoned or discontinued) courses of treatment reported as using removable appliances only. * Currently only using completed

- A high proportion of courses of treatment reported using solely removable appliances may represent poor technique, reduced efficiency and effectiveness and suboptimal outcomes for patients.
- Currently only completed treatments are being used in this indicator, concluded is being developed as a new measure.

- Indicator calculated as the number of completed courses of treatment with removable appliances only divided by the number of treatment completed FP17s then expressed as a percentage.
- Contracts are highlighted if the % is at a high level.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Outcome Indicators

Ratio of the number of UOAs reported per reported completed case

- UOA reported per completed case (rolling 12 month period), therefore this does not include abandoned or discontinued cases
- Indicator calculated as the number UOA scheduled in the rolling 12 month period divided by the number of treatment completed FP17s then expressed as a percentage.
- Contracts are highlighted if the % is at a high level.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

% of contracts meeting their expected reporting of PAR scores

- PAR scoring refers to the “Peer Assessment Rating Index” which is a way of assessing orthodontic outcomes using pre and post treatment models of the teeth to assess improvement.
- The indicator assess whether a contract’s actual number of PAR scores taken is equal to or above the expected number of PAR scores. This does not include abandoned or discontinued courses of treatment. The indicator only examines whether a PAR score has been reported; it does not indicate the nature of the PAR scores or the degree to which the orthodontic treatment was deemed successful.
- Where the total number of completed cases provided is 20 or fewer in any one year, then contractors are required under the GDS and PDS Regulations to report a PAR score for every case.
- Where the total number of cases provided is greater than 20 in any one year then contractors should report a PAR score on 20 completed cases plus score an additional 10 percent of all other cases completed.
- Actual PAR scores is the number of treatment completed FP17s with Par Score taken.
- Expected PAR scoring has been calculated based on the number of completed courses of treatment. If the number of completed courses of treatment is less than or equal to 20 then the expected level is the same as the number of completed courses of treatment. If the number of completed courses of treatment is greater than 20 then expected levels are calculated as 20 plus 10% of the remaining completed courses (i.e. 10% of completed FP17s minus 20).

- Contract highlighted if the expected level of PAR scoring is below the expected level. Contracts with no completed courses of treatment can be included in the flags.

% of concluded courses of treatment where treatment is reported as abandoned or discontinued

- The outcome for each course of treatment commenced should be reported, whether completed, abandoned or discontinued.
- Treatment Abandoned defined as FP17s where the treatment abandoned box in part 3 has been ticked.
- Treatment Discontinued defined as FP17s where the treatment discontinued box in part 3 has been ticked.
- Concluded Treatment is defined as Treatment Abandoned (FP17s where the treatment abandoned box in part 3 has been ticked), Treatment Completed (FP17s where the treatment completed box in part 3 has been ticked) and Treatment Discontinued (FP17s where the treatment discontinued box in part 3 has been ticked).
- Indicator calculated by dividing the number of treatment abandoned plus treatment discontinued FP17s by the number of concluded treatment then expressed as a percentage.
- Contracts are highlighted if the % is at a high level.
- The method used to identify contracts to be flagged for attention is the standard error of the rate (see detailed guidance below).

Methodology for identifying flags for attention (contracts)

The methodology used to identify "flags for attention" has been chosen based on the contract's reported rate compared with the overall (England) rate whilst also taking into account the size of the contract's dataset. It is important to stress that, whilst identifying statistical outliers is an important part of monitoring contract performance, commissioners should not be wholly reliant upon this and should be triangulating data indicators with other available information regarding a contract. In addition, local knowledge about a contract may allow identification of similar contracts in terms of factors such as setting, population or services delivered to allow comparison of contracts with peers.

The method chosen uses the measure "Standard Error of the rate". The calculation is related to the standard deviation which indicates on average how spread-out the data is from an established baseline (mean, aggregate rate, national rate). However the standard error is inversely related to the size of each practice's dataset. This means that the size of the contract can be taken into account and the very variable small contracts will not necessarily

all feature as outliers, in other words negating the effect of small contracts appearing as outliers just because of the effect of a small number of claims. Basically what this means is that the size of the contract can be taken into account and the very variable small contracts will not necessarily all feature as outliers.

Worked Example:
The following is an example using the rate of radiographs per 100 FP17s. This indicator would be used to asses which contracts have a low rate which could indicate non-compliance with FGDP (UK) Good Practice Guidelines – "Selection Criteria for Dental Radiography". A high rate therefore could be seen as identifying good practice.

Step by Step Guide:

1. Number of FP17s and Number of FP17s with Radiographs Taken (as recorded in the Clinical Data set part of the FP17) are extracted for each contract over the analysed period.
2. For each contract a rate is calculated (FP17s with Radiographs Taken per 100 FP17s)
3. A national rate is calculated based on all contracts

Contract	FP17s	Radiograph FP17s*	National Rate
A	345	28	17.85
B	1,392	109	17.85
C	2,470	179	17.85

*i.e. an FP17 or electronic equivalent where a radiograph has been reported as provided during the course of treatment

4. Standard error from the radiograph rate is calculated for each contract as follows:

Square root of (national rate*(1-national rate/total FP17s for the contract)

Contract	FP17s	Radiographs FP17s	Rate	National Rate	Standard error	Calculation
A	345	28	8.12	17.85	0.021	=√(17.85*((1-17.85)/345
B	1,392	109	7.83	17.85	0.010	=√(17.85*((1-17.85)/1392
C	2,470	179	7.25	17.85	0.008	=√(17.85*((1-17.85)/2470

5. We can now easily establish a threshold by using a fixed number of standard errors and work out how many standard errors the practice is above or below the national rate; applying this to each contract. Lower & Upper Outlier Threshold is calculated for each contract as follows@

National rate – (Multiplier*Standard error for contract)

National rate + (Multiplier*Standard error for contract)

Note the fixed multiplier has been used to identify very extreme variations from the national rate. In this example 8 standard errors have been used. Such variations are extremely unlikely to be the result of sampling variation.

Contract	FP17s	Radiographs FP17s	Rate	National Rate	Standard error	Lower Outlier Threshold	Calculation	Upper Outlier Threshold	Outlier?
A	345	28	8.12	17.85	0.021	1.36	=17.85-(8*0.021)	34.34	=17.85+(8*0.021)
B	1,392	109	7.83	17.85	0.010	9.64	=17.85-(8*0.010)	26.06	=17.85+(8*0.010)
C	2,470	179	7.25	17.85	0.008	11.69	=17.85-(8*0.08)	24.02	=17.85+(8*0.008)

5. Identify if contract falls below the Lower Outlier Threshold as follows:

Contract	FP17s	Radiographs FP17s	Rate	National Rate	Standard error	Lower Outlier Threshold	Upper Outlier Threshold	Outlier?
A	345	28	8.12	17.85	0.02	1.36	34.34	N
B	1,392	109	7.83	17.85	0.01	9.64	26.06	Y
C	2,470	179	7.25	17.85	0.01	11.69	24.02	Y

You will see that although the three contracts have rates considerably lower than the national rate only contract B and C have been identified as outliers. This is due to the size of these contracts, with Contract A being relatively small therefore when calculating the standard error the fact that the contract is small results in a higher standard error and subsequently a lower threshold level for that contract. This enables a prioritization of larger contracts and reduces

smaller contracts skewing results as may happen if thresholds for all contracts were calculated.

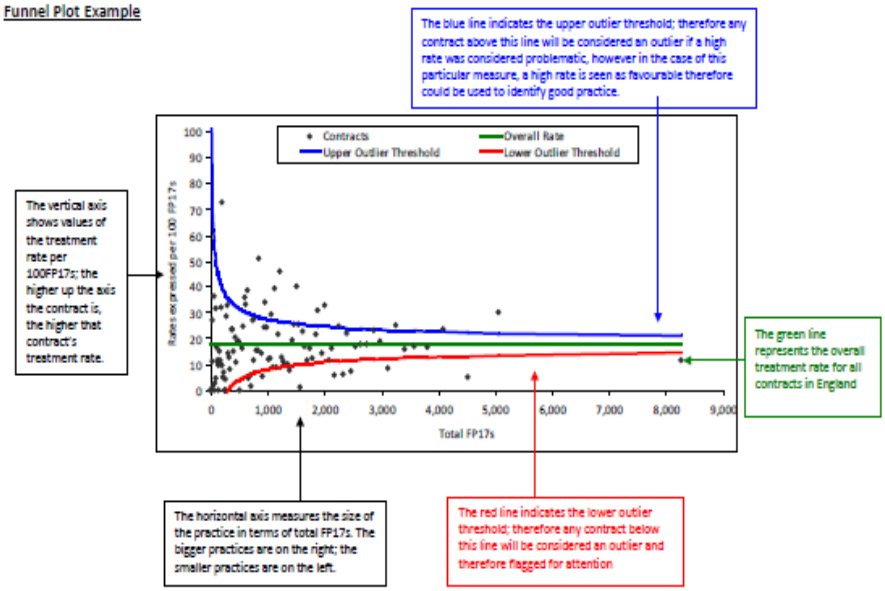
This methodology can perhaps best be presented by showing a chart called a “Funnel Plot”. Funnel plots allow many points to be plotted simultaneously, with information about whether each point is significantly above or below the expected, or average, value. They are scatter plots of the treatment rates estimated from individual contracts against a measure of size.

Below is an example of a funnel plot based on the rate of radiographs per 100 FP17s. This indicator would be used to assess which contracts have a low rate which could indicate non-compliance with FGDP (UK) Good Practice Guidelines – “Selection Criteria for Dental Radiography”. A high rate therefore could be seen as identifying good practice.

The chart show individual contracts, the national average rate and the upper/lower thresholds. It is worth noting that these outlier limits are not a straight line but curved, hence the name funnel plot, demonstrating how size has been incorporated into the measure.

Contracts that fall outside the funnel boundaries are deemed to be ‘special cause’ variation and constitute a ‘significant’ difference from the base line value and may benefit from further investigation.

Funnel Plot Example



Annex 6 – Example general report with additional indicators

(Please note that annex 6 is also attached as a separate document to enable area teams to access working versions of the excel spreadsheets).

Summary & Priority Contracts **Anon LAT** **July to Sept 2012**

Comparison with National Results

Measures	LAT vs National Rate	How defined	% Flagged Contracts	How defined
% of Contracted UDA Delivered	Y		N	
Radiographs Rate per 100 FP17s	Y	if lower	Y	
Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)	Y	than	Y	
Fissure Sealants Rate per 100 FP17s (3-16 yr old patients)	Y	national	Y	
Endodontic Treatment Rate per 100 FP17s	Y	rate	Y	If % of contracts flagged higher than national %
Extractions Rate per 100 FP17s	N		Y	
Extractions as a % of Extractions + Endodontic Treatment- Adults	Y	if higher	N	
Inlay Rate per 100 FP17s	N	than	Y	
Re-attending within 3 months - Child	N	national	N	
Re-attending within 3 months - Adults	N	rate	N	
Average Band 3 to Band 3 Rates	Y	if lower	N	
% satisfied with dentistry received	N	than	N	
% satisfied with wait for an appointment	N	national	N	

Contracts by number of flags

Number of Flags	Number of Contracts
0	31
1	111
2	80
3	47
4	35
5	13
6	5
7	1
8	1
9	0
10	0
11	0

Priority Contracts (by number of flags then size)

																	Additional Indicators - to be populated by Area Team									
																	Patient Safety	Patient Safety	Patient Safety	All	All	Patient Experience	Patient Experience	All	Patient Experience	Patient Experience
Priority?	Contract	Name or Company Name	Total Flags	Under-delivering UDA	Radiograph Rate	Fluoride Varnish Rate	Fissure Sealant Rate	Endodontic Rate	Extraction Rate Low	Extraction Rate High	Extraction % Rate	Inlay Rate	Child Re-attendance %	Adult Re-attendance %	Band 3 to Band 3	% Satisfied Dentistry	% Satisfied with wait	Contract is registered with CQC appropriately	Date of last inspection	Where conditions imposed or standards required to be raised working with CQC and provider	Exception reporting	Vital Sign reports	Complaints	PALS	Legacy Issues	CQC Inspection reports	NHS Choices - comments
1	Contract 290	Provider 290	8	N	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	N	N										
2	Contract 106	Provider 106	7	N	Y	Y	Y	N	Y	N	N	N	Y	Y	N	N	Y										
3	Contract 139	Provider 139	6	N	Y	Y	N	N	Y	N	N	N	Y	Y	Y	N	N										
4	Contract 5	Provider 5	6	N	N	Y	Y	N	N	Y	N	Y	N	Y	Y	N	N										
5	Contract 75	Provider 75	6	N	Y	Y	Y	Y	Y	N	N	Y	N	N	N	N	N										
6	Contract 282	Provider 282	6	N	N	Y	Y	N	N	Y	Y	N	Y	Y	N	N	N										
7	Contract 135	Provider 135	6	N	N	Y	Y	Y	N	Y	Y	N	Y	N	N	N	N										
8	Contract 293	Provider 293	5	N	Y	Y	Y	N	N	Y	N	N	N	N	Y	N	N										
9	Contract 35	Provider 35	5	N	N	N	Y	N	N	Y	N	Y	N	N	N	Y	Y										
10	Contract 208	Provider 208	5	N	Y	Y	N	Y	N	N	Y	N	N	N	Y	N	N										

Annex 6 – Example Sample General report with additional indicators (link to excel spreadsheets)

Summary & Priority Contracts | Anon AT | 12 months Jan 2012 to Dec 2012

Comparison with National Results

Measures	AT vs National Rate	How defined	% Flagged Contracts	How defined
% of Contracted UOA Delivered	Within Expected levels	If between expected levels	Y	If % of contracts flagged higher than national %
% of assessments = Assess and fit appliance	Y	if lower than national rate	Y	
% of assessments= Assess and refuse	N	if higher than national rate	N	
% of assessments= Assess and review	Y	if higher than national rate	Y	
% of reported assessments and review where patient is 9 years	Y	if higher than national rate	Y	
Ratio of **concluded** treatment to assess and fit	N	if lower than national rate	Y	
% of **concluded*** using removable appliances only.	N	if higher than national rate	N	
Ratio of UOAs per **completed** case	N	if higher than national rate	Y	
% of contracts not meeting their expected reporting of PAR scores	Y	if lower than national rate	Y	
% of **concluded** CoTs where treatment abandoned or discontinued	Y	if higher than national rate	Y	

* currently only using completed

Contracts by number of flags

Number of Flags	Number of Contracts
0	0
1	10
2	9
3	4
4	2
5	1
6	0
7	0
8	0
9	0
10	0

Priority Contracts (by number of flags then size)

Priority?	Contract & Name or Company Name	Total Flags	Under-delivering UOA	% Assess and fit appliance	% Assess and refuse	% Assess and review	% assessments & review where patient is 9 years old or under	Ratio of **concluded** treatment to assess and fit	% of **concluded*** using removable appliances only.	Ratio of UOAs per **completed** case	Reported PAR Scoring: actual versus expected	% of **concluded** CoTs where treatment abandoned or discontinued
1	Contract & Company 24	5	Y	Y	N	Y	N	N	N	Y	Y	N
2	Contract & Company 9	4	Y	N	N	N	Y	N	N	Y	N	Y
3	Contract & Company 11	4	N	N	N	N	N	Y	N	Y	Y	Y
4	Contract & Company 5	3	Y	N	N	N	Y	N	N	N	Y	N
5	Contract & Company 10	3	N	N	N	N	N	Y	N	Y	Y	N

Additional Indicators - to be populated by Area Team

Priority?	Contract & Name or Company Name	Patient Safety	Patient Safety	Patient Safety	All	All	Patient Experience	Patient Experience	All	Patient Experience	Patient Experience	Assessment (O3)	Outcomes (O5)	investigation	Further investigation Asesments	investigation	investigation	investigation Asesments	investigation Asesments	investigation	investigation Asesments	investigation Asesments	investigation Treatment	investigation	Further investigation Treatment	Further investigation Outcomes	Further investigation Outcomes	Further investigation Outcomes	Further investigation Outcomes	Further investiation Others	Further investiation Others	Further investiation Others	Further investiation Others	Further investiation Waiting times
		Contract is registered with CQC appropriately	Date of last inspection	imposed or standards required to be raised working	Exception reporting	Vital Sign reports	Complaints	PALS	Legacy Issues	CQC Inspecition reports	NHS Choices - comments	Incomplete treatments	Incomplete treatments	assessment and	reported assessments alongside	for assessment	patients	and review of patients at a	patients under different	submission of	Multiple treatment starts	study model of individual patient	Incomplete treatments	short time period	Patient record and study model of individual patient	longer than 36months ago with no outcome	completions suggests under reporting levels of	Patient record and study model of individual patient	Completed PAR reports	IOTN	Radiographs	Restarts	Repairs and regulation 11	Waiting times
1	Contract & Company 3																																	
2	Contract & Company 25																																	
3	Contract & Company 1																																	
4	Contract & Company 8																																	
5	Contract & Company 20																																	

Annex 7 Example Dental Assurance Framework (General) Tier 2 – Single Contract

(attached separately)

Version control tracker

Version Number	Date	Author Title	Status	Comment/Reason for Issue/Approving Body
1	February 2013	Primary Care Commissioning	Approved	New document
2	March 2014	Primary Care Commissioning	Approved	Revised document

First published March 2014
Published in electronic format only.