NHS
Bury
Clinical Commissioning Group

Meeting: Primary Care Commissioning Committee

Meeting Date	24 July 2019	**Action**	Receive
Item No.	9b	**Confidential**	No
Title	Primary Care Quality Assurance Report		
Presented By	Ann Gough/ Ben Squires, NHS England		
Author	Primary Care Team, NHS England		
Clinical Lead	-		

Executive Summary

Attached is the Greater Manchester Health & Social Care Partnership (GMHSCP) Quality Assurance report submitted to the Greater Manchester Health and Social Care Quality Board on 25 April 2019.

The report outlines a proposal to assure quality in service delivery across Primary Care Dental, Optometry and Pharmacy services and details metrics that can be utilised to determine service quality and identify outliers in terms of high quality or quality concerns.

Recommendations

It is recommended that the Primary Care Commissioning Committee:

- Receive and note the contents of the report.

Links to CCG Strategic Objectives	
To encourage people so that they want to, and do, take responsibility for their own health and well-being.	☐
To drive and support system wide transformation.	☒
To commission joined-up health and social care for people in Bury through a Single Commissioning Framework.	☒
To achieve financial sustainability for the Bury health and social care economy.	☐
To support the Locality Care Alliance to deliver high quality services in line with commissioner intentions.	☐
To be a high-performing, well-run and respected organisation with an empowered workforce	☒
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	
GBAF *[Insert Risk Number and Detail Here]*	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
< *If you have ticked yes,* Insert details of the people you have worked with or consulted during the process :						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
If you have ticked yes provide details here. Delete this text if you have ticked No or N/A						
Has a Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
Is a Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG's risk register?	Yes	☐	No	☐	N/A	☒
If you have ticked yes provide details here. If you are unsure seek advice from Lynne Byers, Email - lynnebyers@nhs.net about the risk register.						

Governance and Reporting		
Meeting	**Date**	**Outcome**
Greater Manchester Health and Social Care Quality Board	25/04/2019	

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Date: **19 March 2019**

Title: GMHSCP Assuring Service Quality across Primary Care Dental, Optometry and Pharmacy Services.

Report of: Laura Browse – Deputy Director of Commissioning (Primary Care)

---

1. PURPOSE

This paper outlines a proposal to assure quality in service delivery across Primary Care Dental, Optometry and Pharmacy services. The paper details metrics that can be utilised to determine service quality and identify outliers in terms of high quality or quality concerns.

Lord Darzi's *High Quality Care for All (2008)*[1] made the argument that quality of care was best understood from the perspective of the patient or service user. It made a clear distinction between access to care – receiving the care required in a timely and convenient fashion – and quality of care. What is more, the 2018 review[2] of the original document it highlights that, given the financial challenges facing the NHS today, it will no longer be enough to deliver good clinical outcomes. The mark of quality for our future health services is to deliver high-value care – that is safe, delivers good outcomes and a positive patient experience, and is cost-effective.

As more services are moved into and commissioned from primary care providers there is increasing recognition that a robust quality assurance process is required with regards to delivery.

The quality domains highlighted by Lord Darzi support the review of service delivery in Primary Care in terms of the following key areas:

- Patient Experience
- Patient Outcomes
- Patient Safety

Building on the principles highlighted by Lord Darzi and incorporating the guiding principles of Taking Charge to deliver the best quality, outcome-based services within the resource available whilst reducing variation of outcomes and service standards within and between organisations will help deliver the foundations for

[1] Lord Darzi High Quality Care for All, 30th June 2008

[2] The Lord Darzi Review of Health & Care Interim Report, Institute for Public Policy Research, Interim Report, April 2018.

quality improvement within our wider primary care services of Dentistry, Pharmacy and Optometry services in Greater Manchester[3]

The proposed quality assurance process is in addition to and will complement the comprehensive contract assurance programmes delivered by the GMHSCP Primary Care Contracting Teams. The proposal process will enable the triangulation and improved utilisation of data gathered via:

- Contract Assurance Programmes
- Patient complaints
- CQC reporting
- Locality Commissioners
- Clinical incident and error reporting. (Including the triangulation of concerns raised regarding primary care providers, performers and joint working with the GM Medical Team. This will also link to the new patient safety reporting tool (DIPSIMS) due to be implemented across Greater Manchester.)

2. Domains

An attempt to describe the domains as common themes across all three contractor areas is outlined below.

Data gathered as part of these processes will be triangulated and assimilated with the other key performance indicators and processes already gathered to deliver the highlighted quality metrics.

2.1 Patient Experience - providing services with compassion, dignity, and respect

This domain can be largely produced via data already held by or accessible to GMHSCP and covers the following metrics which impact upon patient experience:

- Patient complaints.
- Patient satisfaction surveys.
- Access and service availability including referral to treatment data
- Population Health Engagement
- Assurance of service delivery

2.2 Patient Outcomes - providing evidence-based treatments and therapies

This domain will provide information on the quality and clinical effectiveness of patient care that includes diagnosis and provision of treatment. This domain will be made up using the following metrics:

- Assurance Frameworks
- Patient referrals
- Additional and locally commissioned service delivery
- Population Health Engagement

[3] Greater Manchester Quality Improvement Framework, Taking Charge in Greater Manchester

2.3 **Patient Safety** - ensuring the environment is safe and clean and as harm and error-free as possible.

This domain helps identify the processes in place within Practices to identify and prevent errors and adverse effects to patients. This will be made up using the following metrics:

- Safeguarding
- CQC reports
- Performers list information
- Post Payment Verification (PPV)
- Clinical care/errors

3. Metrics

Appendix 1 outlines the range of assurance metrics and processes currently collated and analysed within the Primary Care Dental, Pharmacy and Optometry teams. It was decided that using the three Darzi domains and identifying up to four initial metrics from each contractor area it would provide an overview of quality in Primary Care that would meet those principles. The initial metrics give a broad overview of the three domains and could be implemented in Quarter 1 of 2019/20. These metrics will be reviewed and further developed throughout 2019/20.

3.1 Primary Care Dentistry:

- Complaints
- Extractions vs Endodontic provision – *a low level of endodontic treatment could indicate a number of factors, but possibly indicates a preference to extract rather that root fill or vice versa or treatments being provided privately. Taken from the Dental Assurance framework (appendix 2 describes the framework)*
- Prevention – *Delivering Better Oral Health*[4] *(DBOH) recommends that children aged 3 to young adults should have fluoride varnish applied to teeth twice yearly. A low level of FV applications would suggest that treatment is not being delivered according to DBOH*
- CQC reports – *used to monitor and regulate services where the following indicators are measured:*
    - *Is it safe?*
    - *Is it effective?*
    - *Is it caring?*
    - *Is it responsive?*
    - *Is it well led?*

3.2 Pharmacy

- Complaints

[4] Delivering Better Oral Health: an evidence based toolkit for Prevention, 3rd edition, Public Health England, NHS England, March 2017

- Controlled Drug Error and wider incident reporting
- Advanced Pharmaceutical Service delivery
- Health campaigns outcome reporting / Engagement

3.3 Optometry

- Complaints
- Optometrist Performer concerns related to clinical care / errors
- Locally commissioned service delivery

4. Next Steps

This quality assurance proposal could be implemented via a phased approach throughout 2019/20 and it is recommended that the metrics would be overseen and co-ordinated via the Primary Care Contracting Teams. The reporting route to the GM Health and Care Quality Board will be via the Primary Care Quality Group.

In order to achieve this the primary care teams will work with the partnership to identify opportunities to include the identified metrics within the tableau platform.

The quality assurance metrics will be reviewed throughout 2019/20 and further developed to meet the GM clinical care priorities.

5. Recommendations

The Board are requested:

- to agree the identified metrics for each contractor area
- to input into the ongoing development of the quality indicators / metrics and setting of clinical priorities for GM
- and to support the phased approach to development of reports throughout 2019/20.

Appendix 1 (Part 1)

1. Primary Care Dental Services:

1.1. Background

The commissioning of all NHS Dental services became the responsibility of NHS England on 1st April 2013. Despite national discussions around delegation of commissioning arrangements, similar to those for primary medical care services, regulations within the NHS Act 2012 have prohibited this development nationally. Notwithstanding this legal position, the internal delegation arrangements of NHS England to enable devolution arrangements for Greater Manchester include dental commissioning responsibilities, which are discharged by the dental commissioning team of the Partnership.

The commissioning of Dentistry covers the full pathway of treatment and care that includes the commissioning, contracting and service development for primary, community and specialist / secondary dental care services, in addition to dental urgent care services. The commissioning responsibilities are delivered at a Greater Manchester level, seeking to ensure responsiveness and accountability within localities and neighbourhoods for the local population.

Dental care is not a single specialty, in addition to general primary care services, commissioned services also provide care across:

- Oral surgery and Oral and Maxillofacial surgery
- Orthodontics
- Paediatric dentistry
- Special care dentistry
- Oral medicine
- Restorative dentistry, including endodontics, periodontics and prosthodontics
- Several supporting specialties, including dental and maxillofacial radiology, oral and maxillofacial pathology and oral microbiology.

The specialty of dental public health supports commissioning and redesign of clinical dental services, as well as providing specialist advice and support to Local Authorities in the delivery of their statutory responsibility to improve the oral health of their populations.

1.2. Patient Experience

Considerations are made from:

- **Complaints –** this would include those that have been formally raised via the NHS England complaints process and investigated by the GM Complaints Team. Reported on a quarterly basis.
- **Dental Assurance Framework (DAF) patient satisfaction indicators –** assessed quarterly - % of patients satisfied with dentistry received, % of patients satisfied with wait for appointment

- **Patient Survey -** Adults are asked their views on NHS dentistry as part of the GP Patient Survey. Participants are asked if they had tried to obtain an appointment with an NHS dentist and, if so, whether it was with a practice they had been to before and if they had been successful. They are also asked what their overall experience was of NHS dentistry. Patients who had not tried to obtain an NHS dentist in the previous two years are asked to select the main reason why they had not tried. Reported annually.
- **Numbers of patients accessing NHS Dental Services –** reported quarterly by locality, grouped into adults and children
- **Population Health engagement -** The Healthy Living Framework focuses on improving the health and wellbeing of the local population and helping to reduce health inequalities. The framework helps to recognise the general health messages that need to be delivered by Healthcare professionals and by helping to establish links with other community services demonstrating commitment to patients' overall health and wellbeing.

1.3. Patient Outcomes

The **Dental Assurance Framework (DAF)** produced by the Dental Division of the NHS BSA is considered for dental quality and clinical effectiveness. Currently used to examine the quality and service delivery of the dental care provided, within the constraints of the data available. The DAF report is also available to Providers via the COMPASS system (the electronic dental contracting system for Providers, and Commissioners). The indicators do not in themselves necessarily evidence poor performance or breaches of the regulations, nor do they necessarily identify excellence or best practice. However, they provide an overview of contract performance and assist with identifying areas of potential concern that are explored in more detail with the contractor. The framework has 12 clinical and non-clinical indicators grouped into 4 sub-domains:

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

The DAF reports are assessed quarterly through the following process:

- Practice outliers identified
- Practices contacted via letter
- response received and checked by DPA,
- discussed at quarterly GM Performance and Assessment Review (GMPAR) Meeting
- additional quality indicators such as CQC reports, Year-end performance assessed
- action plan agreed.

1.4. Patient Safety

Considerations are made from:

- **Safeguarding** – Dental Providers must have policies in place that identifies zero tolerance approach to abuse, unlawful discrimination and restraint that includes identification of neglect, subjecting people to degrading treatment, unnecessary or disproportionate restraint, and deprivation of liberty. Assessed at CQC visit.
- **CQC -** monitor, inspect and regulate services. Practices are visited by the CQC inspection team where the following indicators are inspected. *Is it safe?*
    - *Is it effective?*
    - *Is it caring?*
    - *Is it responsive?*
    - *Is it well led?*

Information is shared in four planned ways dependent on the findings of: routine information, emerging and urgent concerns, local liaison, co-ordination of on-going activities.

- **Performers list regulations -** provides an extra layer of reassurance that Dentists Practising in the NHS are: Suitably qualified, have up to date training, have appropriate English language skills, and have passed other checks such as DBS and National Litigation authority checks.

Appendix 1 (Part 2)

2. Primary Care Optometry Services:

2.1. Background

The core terms of service for optometry practices sit under the auspice of the General Ophthalmic Services (GOS) Contract Regulations 2008, commissioned by NHS England. In GM the GMHSCP Optometry and Pharmacy Team are responsible for performing the statutory monitoring function with respect to GOS. Each contractor holds a contract for service. Services commissioned under GOS include only the NHS funded sight test and provision of vouchers to provide a NHS contribution to the cost of corrective lenses for eligible patients. NHS England commissions comparatively little from optometry practices as core activities compared to other primary care providers. The NHS sight test typically requires a 20-minute appointment with an optometrist and the fee for service to the NHS is £21.31 per test. This has been a static fee since 2016.

CCGs also commission services at a local level from optometry practices such as Minor Eye Conditions (MECS), Cataract referral, Glaucoma repeat readings and pressures monitoring. Across Greater Manchester these services are managed by the Primary Eye Care Company (PEC) as a lead provider, who also provide training and support in conjunction with LOCs.

The GMHSCP Optometry and Pharmacy Team are responsible for reviewing and approving applications for contracts to deliver GOS in line with the GOS Contract Regulations. This process includes a premises inspection to ensure that required standards are met and are supported by optometry clinical advisors to review equipment and policies. The Team deliver a programme of contract assurance linked to the national NHS England Quality in Optometry (QiO). The Team manage contractual concerns, review patient complaints and support review of patient safety concerns. The Team are also undertaking a programme of Post Payment Verification (PPV) with optometry practices.

These current processes give assurance as to contract delivery, professional / premises standards and a level of quality assurance. Data gathered as part of these processes can be triangulated and assimilated to deliver the quality metrics outlined below.

2.2. Patient Experience

This domain can be largely produced via data already held by or accessible to GMHSCP and covers 7 key metrics which will impact upon patient experience with regards to optometry services provision. The key metrics are:

- **Patient complaints** – this includes those that have been formally raised via the NHS England complaints process and investigated by the GM Complaints Team. This would be reported quarterly.

- **NHS contracted hours** - GOS contractors are required to provide core hours when NHS sight tests will be available to the Team. These hours can be collated by the Team and reported quarterly to illustrate availability.
- **Contractual concerns / issues** – this includes matters identified via the QiO process or raised directly to the Team as separate issues. Concerns and trends would be collated and reported quarterly.
- Information from the reports would be collated and this would be reported annually.
- **GOS Contract Process / QiO** – the Team undertake a robust review process, including a premises inspection prior to issuing new GOS contracts and the same premises standards are reviewed as part of the QiO programme. The team will collate premises related concerns and report quarterly.
- **Patient satisfaction survey** – this is not currently a contractual requirement for GOS contractors. However, by engagement with contractors and LOCs this could be incorporated into the optometry service transformation work-stream.

2.3. Patient Outcomes

This domain can largely be produced via data produced or data already held by or accessible to GMHSCP. However, as locally commissioned services are commissioned via Locality Commissioners it would be required to obtain information as to who delivers those services and how engaged they are in delivery. The domain has 2 key metrics as follows:

- **Locally commissioned service delivery** – these services are commissioned at a local GM level by the locality commissioners. Locally commissioned services would require joint working with locality commissioners and the PEC / LOCs to obtain delivery data. This component would illustrate engagement with local services where commissioned and be reported quarterly.
- **Healthy Living Optical Practice (HLOP)** – currently, GOS contractors are not required by their core contract to participate in health campaigns or population health activities. However, the HLOP programme is currently being implemented and is an additional accreditation that optical practices obtain following training including health champion leadership and completion of a GM framework. HLOP accreditation would be collated from GMHSCP data sets and reported annually.

2.4. Patient Safety

This domain can largely be produced via data produced already held by or accessible to GMHSCP. However, the data is not current available in a format that can be easily collated form existing datasets. This would require development and resource to enable the data collection. This domain is made up of 4 metrics:

- **Errors / Clinical Care** – GOS contractors have a requirement to ensure that NHS Performers (Optometrists) are appropriately registered, insured and deliver services correctly. Performer issues are managed by the GMHSCP

Medical Team. Working collaboratively with the Medical Team we can identify Performer issues linked to GOS contract delivery. This element could indicate practice concerns. They would be reported monthly.

- **Patient Referrals** - as part of a GM Optometry IT Connectivity work-stream an electric referral system has been developed to support patient referral to Ophthalmology services for urgent and additional care. The system would enable review of referrals at GOS contractor and performer level to identify outliers. Working in conjunction with LOCs this could be collated via GM datasets and reported quarterly.
- **PPV / QiO** – as part of PPV and QiO processes the GMHSCP optometric clinical advisors review patient records and can identify clinical or record keeping concerns. This data can be collated by the Team and reported quarterly.
- **Safeguarding** – whilst it is a requirement for GOS contractors to have safeguarding procedures and local safeguarding lead information; it is not currently a contractual requirement for GOS contractors or Performers to undertake specific safeguarding training. However, with engagement with contractors and LOCs this could potentially be incorporated into the optometry service transformation work-stream. GOS contractors could be required to ensure all Performers and General Optical Council registered employees undertake Level 2 Safeguarding training. This can be reviewed via submission of certifications and reported annually.

Appendix 1 (Part 3)

3. Community Pharmacy services:

3.1. Background

The core terms of service for community pharmacies sit under the auspice of the Pharmaceutical Regulations 2013(as amended), commissioned by NHS England. In GM the GMHSCP Optometry and Pharmacy Team are responsible for performing the statutory monitoring function with respect to community pharmacy services.

There are 3 distinct levels of Pharmaceutical Services.

- Essential Services: All community pharmacies must deliver essential services as a core contractual requirement.
- Advanced Services: Advanced services are commissioned on a national basis by NHS England and in GM are managed by the GMHSCP Optometry and Pharmacy Team.
- Local Enhanced: These are commissioned by NHS England at local team level to meet local needs and in GM are managed by the GMHSCP Optometry and Pharmacy Team.

Locality Commissioners (e.g. CCGs and Local Authorities) will also commission services (including public health and patient population services) depending upon locality needs.

The GMHSCP Optometry and Pharmacy Team delivers an annual contract assurance programme linked to the national NHS England Community Pharmacy Assurance Framework (CPAF). The Team also manage contractual concerns, review patient complaints and support review of patient safety concerns.

Every community pharmacy is required to registered with the General Pharmaceutical Council (pharmacy regulator), who approve pharmacy premises and carry out a robust inspection process; which is akin to CQC.

The NHS Business Services Authority (NHSBSA) delivery a provider assurance programme of post payment verification (PPV) for Advance Pharmaceutical Service delivery. The Team also support several Locality Commissioners with PPV programmes.

These current processes give assurance as to contract delivery, professional / premises standards and a level of quality assurance. Data gathered as part of these processes can triangulated and assimilated to deliver the quality metrics outlined below.

3.2. Patient Experience

This metric can be produced via data already held by or accessible to GMHSCP and covers 6 key metrics which will impact upon patient experience with regards to community pharmacy services provision. The key metrics are:

- **Patient complaints** – this includes those that have been formally raised via the NHS England complaints process and investigated by the GM Complaints Team. This would be reported quarterly.
- **Contractual concerns / issues** – this includes matters identified via the annual CPAF process or raised directly to the Team as separate issues. Concerns and trends would be collated and reported quarterly.
- **Patient satisfaction survey** – this is an annual requirement for every community pharmacy contractor and a report must be published on the NHS profile website. Information from the reports would be collated and this would be reported annually.
- **Consultation room** - community pharmacies are required to have a dedicated consultation room to deliver many Advanced Pharmaceutical Services and locally commissioned services. The room also provides a dedication consultation area for private discussions. The Team can collate data as to which pharmacies have a consultation room and this would be reported annually.
- **GPhC standards / Approved Premises Particulars** – community pharmacies are required to ensure premises meet the standards set by the GPhC to maintain registration. They are also required meet the Approved Premises Particulars as part of the NHS core terms of service. Working in collaboration with the GPhC, locality commissioners and as part of the CPAF process the Team will identify pharmacies that are not meeting standards. This will be reported quarterly.
- **Unplanned closures** – it is a requirement of all community contractors to deliver services during all NHS contracted hours and they should have business continuity arrangements to manage circumstances such as sickness, leave and locum pharmacist cancellations. There is provision in the regulations to allow temporary closures in unforeseen circumstances (e.g. fire, flood, power loss). Closure notices, reasons and trends would be reviewed and reported quarterly.

3.3. Patient Outcomes

This domain can largely be produced via data produced via data already held by or accessible to GMHSCP. However, as locally commissioned services are commissioned via Locality Commissioners it would be required to obtain information as to who delivers those services and how engaged are they in delivery. The metric has 3 key metrics as follows:

- **Advanced Pharmaceutical Service delivery** – these services are managed by the Team in GM and data can be extracted from national NHSBSA datasets to show engagement and delivery and would be reported quarterly.
- **Local Enhanced and locally commissioned service delivery** – these services are commissioned at a local GM level by the Team or via locality commissioners. Locally commissioned services would require joint working with locality commissioners and the LPCs to obtain delivery data. This component would illustrate engagement with local services where commissioned and be reported quarterly.
- **Healthy Living Pharmacy (HLP) Level 1** – HLP is an additional accreditation that community pharmacies obtain following training including health champion leadership and completion of a Royal Public Health Society

endorsed framework. It is not part of core contractual requirements but links to the national Quality Payment Scheme. HLP accreditation would be collated from national data sets and reported annually.

- **Health campaigns outcome reporting / Engagement** – community pharmacies are contractually required to participate in 6 public health campaigns, which for GM are aligned to the GM Population Health Plan. In 2018/19 the Team introduced a reporting process to capture health outcomes following health campaign interventions. This is overseen by the Pharmacy LPN Health and Wellbeing Subgroup. Community pharmacy engagement and outcome data can be collated from current GMHSCP datasets and reported quarterly.

3.4. Patient Safety

This domain can largely be produced via data produced already held by or accessible to GMHSCP. However, the data is not current available in a format that can be easily collated form existing datasets. This would require development and resource to enable the data collection. This metric is made up of 3 metrics:

- **Error / Incident reporting** – reporting from individual pharmacies is contractually required and fed the National Learning Reporting System. Incidents and errors are reported at GM level via locality Datix systems and the GMHSCP controlled drug incidents and recently developed wider error reporting tools. This element would capture reports from pharmacy contractors to support learning across the GM system and those reported by other providers / commissioners to indicate practice concerns. They would be reported monthly.
- **Patient safety report** - as part of the national Quality Payment Scheme community pharmacies are required to produce a practice level patient safety report. This could be collated via national datasets and reported annually.
- **Actions to improve post errors / incidents** - following investigation and review of incidents community pharmacies are required to develop an action plan to improve ongoing service delivery and mitigate risk of repeat incidents. This element would require engagement with contractors and LPCs to obtain data and triangulate with data from incidents investigated by GMHSCP Teams. This would be reported quarterly.
- **Safeguarding** – it is a requirement of the national Quality Payment Scheme and many locally commissioned services for community pharmacies to ensure that pharmacists and pharmacy technicians undertake Level 2 Safeguarding training. This can be reviewed via submission of certifications and reported annually.

Appendix 2

Dental Assurance Framework - Clinical Quality Indicators

Current assurance metrics

The following metrics are currently used to assess the quality of Dental Practices:

Dental Assurance Framework – patient outcomes

Dental Assurance Framework (DAF) – Quality and Clinical Effectiveness. Currently used to examine the quality and service delivery of the dental care provided, within the constraints of the data available. The DAF report is also available to Providers via the COMPASS system. The indicators do not in themselves necessarily evidence poor performance or breaches of the regulations, nor do they necessarily identify excellence or best practice. However, they provide an overview of contract performance and assist with identifying areas of potential concern that are explored in more detail with the contractor.

The framework has 12 clinical and non-clinical indicators grouped into 4 sub-domains – see table 1 below:

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

Table 1 – clinical and non-clinical indicators (DAF)

	Current Quarter		Change from Last Quarter	
Quality Indicators	GM	England	GM	England
Radiographs Rate per 100 FP17s	23.2	24.2		
Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)	66.7	58.1		
Fissure Sealants Rate per 100 FP17s (3-16 yr old patients)	1.3	2.0		
Endodontic Treatment Rate per 100 FP17s	1.2	1.2		
Extractions Rate per 100 FP17s	5.7	6.4		
Extractions as a % of Extractions + Endodontic Treatment- Adults	79.9	81.5		
Inlay Rate per 100 FP17s	0.3	0.2		
Re-attending within 3 months - Child	9.6	7.1		
Re-attending within 3 months - Adults	14.4	12.9		
Average Band 3 to Band 3 Rates	235.8	243.2		

	Current Quarter		Change from Last Qtr	
Patient Satisfaction Indicators	AT	England	AT	England
% satisfied with dentistry received	95.3	93.2		
% satisfied with wait for an appointment	89.1	88.5		

Data is provided on a quarterly basis, benchmarked to identify outliers by comparing individual contract performance against area team and NHS England averages whilst also taking account of contract size. (See table 2; example of flagged contracts)

Table 2 – example of contracts flagged as outliers.

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	Feedback from AT or previous DS exercises
1	001	Practice A	7	N	Y	Y	Y	N	Y	N	N	N	Y	Y	Y	N	N	
2	003	Practice B	6	N	Y	Y	Y	N	Y	N	N	N	Y	Y	N	N	N	
3	0670	Practice E	6	N	Y	N	Y	Y	Y	N	N	N	Y	Y	N	N	N	
4	9800	Practice D	6	N	Y	N	Y	N	Y	N	N	N	Y	Y	Y	N	N	Y

DAF reports assessed quarterly, Practice outliers identified, Practices contacted via letter, response received and checked by DPA, discussed at quarterly GM Performance and Assessment Review (GMPAR) Meeting, alongside additional quality indicators such as CQC reports, Year-end performance, action plan agreed.

Descriptions of each of the indicators within the Dental Assurance Framework are provided in detail below.

Detailed description of each DAF indicator:

Radiographs rate – A low rate could indicate no-compliance with FGDP (UK) good practice guidelines.

Fluoride Varnish rate (3–16 year old patients) – Delivering Better Oral Health (DBOH) recommends that children aged 3 to young adults should have fluoride varnish applied to teeth twice yearly. A low level of FV applications would suggest that treatment is not offered according to DBOH.

Fissure Sealants rate (3–16 year old patients) – DBOH recommends fissure sealants be used on permanent molars on children giving concern. A low level of fissure sealants would suggest that treatment is not being delivered according to DBOH.

Endodontic treatment rate – A low level 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 treatment being provided under a private contract.

Extractions rate – High/low levels could indicate a number of factors including social deprivations, patient choice, a greater preference to extract rather than root fill or vice-versa or treatments being provided under a private contract.

Extractions as a % of (Extractions + Endodontic) Treatment (adults) – A high percentage can show a greater preference to extract rather than root fill or high level of root treatments being provided under a private contract.

Inlay Rate – High levels of inlays with no other treatment items provided in a course of treatment may be an indication of UDA 'optimisation'

Re-attendance within 3 months – (children / adults) – in general, a patient who has completed a course of treatment that renders him/her 'dentally fit' should not need to see a Dentist again within a 3 month period.

Average Band 3 to Band 3 rates – short intervals may suggest possible 'splitting' of courses of treatment.

Patient satisfaction indicators – provides the patients' perception of dental quality. Based on a national random sample of over 20,000 patient questionnaire responses per quarter.