DENTAL ASSURANCE FRAMEWORK FOR PROTOTYPES

APRIL 2016
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Section 1: Document Framework

1.1 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 set 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 for prototype practices.

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.

It is the policy of NHS England that local teams will use the indicators outlined in the policy alongside other information they have about their contractors such as e reporting 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 assurance policy is specifically for practices participating in the NHS dental contract reform programme.

1.2 Scope

To outline a consistent approach to assurance or NHS England Commissioners and Practices operating under prototype arrangements, by defining the responsibilities of both NHS England and providers.

1.3 Roles and responsibilities

The local team must:
Advising all of its general dental services (GDS) contract and personal dental services (PDS) agreement holders, participating in the dental contract reform programme, of the NHS dental assurance framework policy for prototypes 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.
1.4 Corporate level procedures

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.

1.5 Distribution and implementation

This document will be made available to all staff via the NHS England intranet and highlighted to Heads of Primary care and Dental Commissioners in local teams in the appropriate forums.

Notification of this document will be included in the staff email bulletin

1.6 Monitoring

Compliance with this policy will be monitored via the dental contract reform programme board and primary care oversight group.

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 12 months unless guidance or legislative change requires an earlier review.

1.7 Equality impact assessment

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 the Equality Act 2010) and those who do not share it. As part of its development this document and its impact on equality has been analysed and no major impact has been analysed and no major impact has been identified.

1.8 Associated documents

The assurance framework for prototype practices should be read alongside related dental management policies.

1.9 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
Section 2: Background

2.1 Dental Contract Reform Programme

The piloting of key elements needed to design a reformed dental system began in 2011. 70 high street dental practices began as pilot practices during the summer of 2011. In 2013 these were joined by around 20 further sites including some community dental services (CDS).

The principle of the reformed system has three elements:

- A clinical approach focussed on thorough assessment and prevention as well as treatment, and which supports a pathway approach to care
- Measurement and remuneration for quality of care
- Remuneration that supports continuing care and a focus on prevention as well as treatment / activity

During 2014 the Department of Health announced that the next stage of the dental contract reform would commence in 2015/16 with the introduction of prototype practices. The introduction of prototype practices will test whole versions of a possible new system, rather than, as in the pilots, key elements needed to design a new system.¹

The prototypes will consist of:

- A clinical pathway
- A set of clinical measures (DQOF)
- Remuneration aligned with access and clinical outcomes (a blend of quality, capitation and activity)
- Registration in shadow form

The selection process for prototypes commenced in early 2015 with expressions of interest sought from existing pilot practices and also UDA practices.

All practices holding a general dental services (GDS) contract or PDS agreement to deliver mandatory services were eligible to express an interest, subject to meeting basic eligibility criteria. The selection process was not a merit exercise and the pre-determined selection criteria focussed on the need to create a balanced group, which took into consideration factors such as geography, practice size and patient mix.

Existing pilots were also invited to express an interest in becoming a prototype practice. Pilots were not guaranteed entry to prototyping and were also subject to eligibility criteria.

The conditions for entry were different for existing pilots and UDA practices, to reflect the formers’ participation in three years of piloting and the risks they took in doing this.

The aim of the prototype stage is to develop a robust model fit for roll out, and there are now a mix of former pilot practices and UDA practices now operating under prototype arrangements.

2.2 Prototype agreements

The prototypes are based on a blended remuneration system where a practice’s contract value and remuneration will be split between:

- A capitation element for which the practice is expected to have a minimum number of capitated patients on their list, and
- An activity element for which the practice is expected to deliver a minimum level of activity.

Further to this there will be a quality remuneration adjustment based on relative performance against the Dental Quality and Outcomes Framework (DQOF). However, the dental contract reform programme has confirmed (December 2015) that the intention is that the first time financial adjustments will be applied for DQOF will be in 2017/18. No financial adjustments will be applied for DQOF performance in 2016/17 however DQOF performance will be reported in shadow form.\(^2\)

There are two blends of remuneration being tested in the prototypes:

- **Blend A** – Capitation is used as the basis of remuneration for oral health reviews and preventative care (currently band 1 associated care) and activity payments are used for all treatment (current band 2 and band 3 associated care)

- **Blend B** – Capitation is used as the basis of remuneration for oral health reviews, preventative care and routine treatment (current band 1 and band 2 associated care) and activity payments are used for more complex treatment (current band 3 associated care).

Practices continue to be paid 1/12\(^{th}\) of their annual contract value in equal monthly instalments. At financial year-end an assessment will be made of a practice’s delivery against:

- Expected patient numbers (capitation)
- Expected activity levels

The Statement of Financial Entitlements (SFE) for Prototype Agreements sets out how the year-end assessment is undertaken.\(^3\)

The SFE states that a financial adjustment will be made if the combined performance is above or below the expected levels, with a number of tolerances:

- The maximum financial recovery that can be made at year-end for under-delivery is 10% of the contract value (that is subject to capitation and activity adjustments).
- However, a practice can carry forward up to 4% under-delivery.
- This under-delivery is carried forward as a monetary value rather than activity and / or patients.


• Up to 2% of the contract value (that is subject to capitation and activity adjustments) can be recognised for over-delivery.
• The value of over-delivery can be either carried forward or paid to the practice

For 2015/16 alternative arrangements have been agreed for managing year-end adjustments as a one-off as practices commence the prototype arrangements, and further details are set out in Annex 3.

Section 3: Introduction to the Dental Assurance Framework for Prototype Agreements

This framework has been developed to provide commissioners with an assurance framework specifically for practices operating under prototype arrangements as part of the dental contract reform programme. The document has been mirrored on the main Dental Assurance Framework Policy produced by NHS England to manage UDA contracts.

This policy has been formally adopted by NHS England. It provides a basis for commencing assurance processes for dental prototypes but will need developing over time as the prototype stage progresses. This policy is intended to set out the expectations for prototype assurance for the initial months of prototypes.

It is designed to provide a basis for NHS England local offices to engage with providers and performers operating under the dental prototype arrangements. It recognises that practices are working under separate regulations and are voluntarily participating in testing whole versions of a possible new system.

The framework only applies to practices operating under the prototype scheme as part of the NHS dental contract reform programme.

Prototype practices and commissioners should not use any UDA system reports for assurance. These reports do not correctly reflect the indicators under the prototype scheme and if used could result in incorrect analysis and assessment.

This policy sets out:

1. Arrangements for assurance to be put in place from the commencement of the prototype scheme.
2. How the prototype dental assurance framework should be put into effect.

The framework has the following sections:

1. Process commissioners will follow
2. A summary of the indicators to be used under each domain
3. Supporting narrative on how the indicators should be interpreted and how concerns may be explored
4. Example reports from NHS Business Services Authority (NHS BSA) with guidance on how the indicators are calculated

Annex 1 sets outs some principles for NHS England and the dental contract reform programme to work together applying the assurance framework and supporting prototype practices.
Section 4: Purpose of the Dental Assurance Framework for Prototypes

The framework is designed to be used with current GDS and PDS contractors, participating in the NHS dental contract reform programme.

The purpose of the framework is to support a more standardised approach to assurance for practices operating in the prototype scheme, with NHS England local offices taking the lead with support from the dental contract reform programme.

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 a simple suite of reports and metrics, 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 reports or metrics are fully comprehensive.

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.

Local offices should be assisted by clinical advice in the interpretation of indicators and the development of next steps as appropriate.

Consideration should also be given to the objectives of the programme including:

- Delivery
- Patient Safety
- Patient experience
- Quality/clinical effectiveness

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.

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.

Section 5: Process for assurance

Prototype practices are operating as part of the Dental Contract Reform Programme and whilst NHS England are the contract holders, and will hold the responsibility for the management of these contracts it is important that the programme team are kept closely involved and updated on issues raised through the assurance process. This is to inform the learning from the prototype practices and help develop the final contract model for wider rollout.
5.1 Key considerations

Where prototype practices also provide orthodontic services as part of their overall contract this element of the contract should be managed in accordance with the orthodontic section of the main Dental Assurance Framework which focusses on practices operating under the UDA system. This is not covered in this framework.

Where prototype practices also provide additional services such as domiciliary, sedation, advanced mandatory, dental public health or trust based services these elements should be monitored in line with existing arrangement already in place for these services. These are not covered in this framework.

The dental contract reform programme must always be informed of any changes to services commissioned either on a recurrent or non-recurrent basis. This is to ensure that any changes are appropriately reflected in the different commissioning basis that the prototypes operate under.

Reports are made available to practices and commissioners on a monthly basis. Section 8 provides more details on the reports available and how to access them.

5.2 Process steps

1. Commissioners should ensure they are familiar with the specific prototype reports available and how to access them.

2. Whilst these reports are available on a monthly basis it is recognised that commissioners may not have the capacity to review these in detail at this frequency. However, it is expected that this be done at the very least on a quarterly basis.

3. Commissioners should review the reports of the prototype practices, using local knowledge and input from colleagues and wider stakeholders where appropriate. This may include members of the dental contract reform programme if necessary.

4. Contractors should also review these reports with their performers and be invited to engage with the local office and / or dental contract reform programme if they have any questions.

5. There should be processes in place to escalate any serious concerns, including patient safety.

6. Where concerns are identified the commissioner should ask the practice to submit a written explanation or action plan around the key concerns and provide details of how the issue is to be addressed, and over what timeframe. A template action plan is included in Annex 2 which can be used for this purpose.

7. Any responses should be reviewed by the commissioner with appropriate clinical advice. Clinical advice can be sought through the medical directorate of the local office. Specialist clinical advise relating to prototypes is also available via the dental contract reform programme. Clinical support is also available from NHS BSA clinical advisors where there are high level concerns.

8. Periodic feedback should be made to the dental contract reform programme. This can be done via the central mailbox dentalcontractreform@pcc.nhs.uk
9. Commissioners should start to develop a timetable for engaging with practices that have been flagged up or where action plans have been received but no improvements found. Where follow up is deemed necessary, this may be done in a face to face meeting or telephone meeting, to be determined locally. The commissioner may wish to invite a member of the dental contract reform programme team. Where this is not possible commissioners should ensure a written report of the meeting is submitted to the dental contract reform programme to support the wider learning from the prototypes.

Section 6: Framework domains

In line with the UDA dental assurance framework this framework will be presented in four domains covering

- **Delivery**: this is centred on the prototype deliverables which is the expected patient numbers (CECP) using a three year patient list and the expected minimum activity level (EMA) measured in UDAs.

- **Patient safety**: requirements for this section will be aligned with the UDA dental assurance framework.

- **Patient experience**: this will include the patient reported experiences collated through patient questionnaires issued by NHS BSA, which cover the patient experience indicators set out in the DQOF for prototypes. This domain will also include information from other sources of information such as complaints and other locally held information.

- **Quality / clinical effectiveness**: this will include the clinical measures set out in the DQOF for prototypes, and will be developed further during 2016/17.

These four domains cover the over-arching objectives of the dental contract reform programme.

Section 7: How the indicators should be interpreted and concerns dealt with:

7.1 **Delivery**

This domain is focussed on two indicators:

- Delivery of the expected patient numbers (CECP) and
- Delivery of the expected minimum activity level (EMA)

These are formally measured at 31 March each financial year.

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5 One-off arrangements for handling year-end delivery in 2015/16 financial year have been agreed. Further details are included in Annex 3
The table below sets out the triggers for further investigation:

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<th>Indicator</th>
<th>In-year monitoring</th>
<th>Delivery at year-end</th>
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<td>Expected minimum activity level (EMA)</td>
<td>Forecast position less than 96%</td>
<td>Less than 96%</td>
</tr>
<tr>
<td>Expected patient numbers (CECP)</td>
<td>Forecast position less than 96%</td>
<td>Less than 96%</td>
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The monthly reports provided by NHS BSA set out the reported position for both activity levels and patient numbers. Therefore commissioners and practices will be able to detect and monitor trends for both indicators.

Transitional arrangements have been agreed for pilot practices transferring to prototype arrangements to recognise the changes made to the way in which patient numbers are counted under prototypes. This arrangement includes counting “legacy” patients for a period of time. Further details are included in Annex 3 on this. However, for the purposes of reviewing patient numbers commissioners should ensure that this transitional allowance is included in any assessment, details of which are reported in the capitation remuneration report.

Where practices are experiencing problems with either or both activity and patient numbers commissioners should work with practices to explore the reasons for this, adopting the process set out in section 6 above.

Some of the questions / considerations may include:

- Are appointment transmissions and FP17s being submitted in a timely fashion?
- Have appointment times for OHA / OHR been reviewed across the practice?
- Are there problems / issues implementing the pathway?
- Is skill mix in the practice (where appropriate) being appropriately utilised??
- Are appropriate recall intervals being applied across the practice?
- A review of the average NHS hours undertaken by the practice

The contractor may wish to explore some of these questions with their performers to better understand any problems / issues with meeting the delivery indicators for the prototype agreement.

The prototype agreement does offer some flexibility around the delivery of activity and patient numbers, which are set out below.

1. Unless a commissioner has indicated otherwise, practices may over-deliver on expected patient numbers to off-set any under-delivery in expected levels of activity.

2. However, practices do not have the same flexibility to over-deliver on activity to offset any under-delivery in expected patient numbers:
   - If patient numbers are less than or equal to 100% of expected levels, then any adjustment relating to activity delivery will be capped at 100%
   - If patient numbers are more than 100% of the expected level, then any adjustment relating to activity will be capped at the same percentage as the achieved level for the patient numbers
There is no requirement for a mid-year review under the prototype agreement. Therefore the commissioner cannot undertake any action in response to under-delivery at month 6.

The SFE states that a financial adjustment will be made if the combined performance is above or below the expected levels, with a number of tolerances:

- The maximum financial recovery that can be made at year-end for under-delivery is 10% of the contract value (that is subject to capitation and activity adjustments).
- However, a practice can carry forward up to 4% under-delivery.
- This under-delivery is carried forward as a monetary value rather than activity and/or patients.
- Up to 2% of the contract value (that is subject to capitation and activity adjustments) can be recognised for over-delivery.

Any year-end delivery below 96% is classed as a breach of contract and commissioners may invoke a breach notice in accordance with NHS England’s dental policies.\(^6\)

The prototype directions\(^7\) set out the circumstances that NHS England may consider the withdrawal of a practice from the prototype agreement. These circumstances are:

“(a) where, in the view of the Board, there has been a significant reduction in average weekly time given to appointments in which an element of NHS care is delivered and reported to the NHS Business Services Authority during the financial year;

(b) where a contractor’s overall capitation and activity performance level is less than 90% at the end of the financial year, or where, during the financial year, it is forecast by the NHS Business Services Authority to be likely to be less than 90% at the end of the financial year;

(c) where, in the view of the Board, there has been a significant failure to return the information required under direction 13, or any other information required by the Board for the purposes of evaluating and managing the prototype agreement, or in the view of the Board, a significant number of late returns of such information;

(d) where the contractor has not continued to provide services under the prototype agreement to capitated patients for the duration of that prototype agreement as required under direction 15; or

(e) where a breach notice has been issued to the contractor in accordance with paragraph 73 of Schedule 3 to the GDS Contracts Regulations (other contractual terms – termination by the Board: remedial notices and breach notices) or paragraph 71 of Schedule 3 to the PDS Agreements Regulations (other contractual terms – termination by the Board):

It is expected that commissioners would not seek to exit a practice from the prototype arrangements without consultation with the dental contract reform programme.

If in exceptional circumstances this option is agreed then the formal exit process set out by NHS England and the dental contract reform programme should be followed.


7.2 Patient Safety

Patient safety assurance under the prototype agreements should not differ to that of the UDA system. The underlying 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.

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.

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

Local offices 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.

7.3 Patient Experience

The indicators for patient experience focus on the patient reported experiences collated through patient questionnaires issued by NHS BSA, set out in the DQOF for prototypes. This domain will also include information from other sources of information such as complaints and other locally held information.

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

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8 DQOF 2015/16:
possible sub-analyses to give greater scrutiny of individual contractual performance and suggests how it might be investigated and managed.

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.

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

Specific questionnaires have been designed to send to patients of practices operating under the prototype arrangements and these are sent out randomly to the patients of prototype practices following their treatment. Approximately 770 questionnaires per practice are sent out each year with an overall response rate (the proportion of questionnaires completed and returned by patients) is currently around 31%. The information collected from this survey will be used as part of the DQOF reports to prototype practices and commissioners 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. These reports will be available during the summer of 2016.

Where concerns are identified commissioners 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. Prototype 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.

**The indicators:** There are seven indicators set out in the DQOF relating to patient questionnaire worth a total of 300 points out of a possible 1,000 points.

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<th>Indicator</th>
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<tr>
<td>PE.02</td>
<td>Patients satisfied with the cleanliness of the dental practice</td>
</tr>
<tr>
<td>PE.03</td>
<td>Patients satisfied with the helpfulness of practice staff</td>
</tr>
<tr>
<td>PE.04</td>
<td>Patients reporting that they felt sufficiently involved in decisions about their care</td>
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9 Prototype patient questionnaire:
PE.05 Patients who would recommend the dental practice to a friend

PE.06 Patients reporting satisfaction with NHS dentistry received

PE.07 Patients satisfied with the time to get an appointment

PE.01 - Patient Experience Indicator 1: Patients reporting that they are able to speak and eat comfortably

Definition: Percentage of patients who respond positively to survey question “Are you able to speak and eat comfortably?” Result is based on all surveys returned where completion date of course of treatment was within the financial year. Numerator is number of survey responses where the answer is “Yes”. Denominator is total number of survey responses - “Yes” or “No”.

PE.02 - Patient Experience Indicator 2: Patients satisfied with the cleanliness of the dental practice

Definition: Percentage of patients who respond positively to survey question “How satisfied were you with the cleanliness of the practice?” Result is based on all surveys returned where completion date of course of treatment was within the financial year. Numerator is number of survey responses where the answer is either “Very satisfied” or “Quite satisfied”. Denominator is total number of survey responses - “Very satisfied”, “Quite satisfied”, “Quite unsatisfied” or “Very unsatisfied”.

PE.03 - Patient Experience Indicator 3: Patients satisfied with the helpfulness of practice staff

Definition: Percentage of patients who respond positively to survey question “How helpful were the staff at the practice?” Result is based on all surveys returned where completion date of course of treatment was within the financial year. Numerator is number of survey responses where the answer is either “Very helpful” or “Quite helpful”. Denominator is total number of survey responses - “Very helpful”, “Quite helpful”, “Quite unhelpful” or “Very unhelpful”.

PE.04 - Patient Experience Indicator 4: Patients reporting that they felt sufficiently involved in decisions about their care

Definition: Percentage of patients who respond positively to survey question “Did you feel sufficiently involved in decisions about your care?” Result is based on all surveys returned where completion date of course of treatment was within the financial year. Numerator is number of survey responses where the answer is “Yes”. Denominator is total number of survey responses - “Yes” or “No”.

PE.05 - Patient Experience Indicator 5: Patients who would recommend the dental practice to a friend

Definition: Percentage of patients who respond positively to survey question “Would you recommend this practice to a friend?” Result is based on all surveys returned where completion date of course of treatment was within the financial year. Numerator is number of survey responses where the answer is “Yes”. Denominator is total number of survey responses where the answer is either “Yes” or “No”.

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PE.06 - Patient Experience Indicator 6: Patients reporting satisfaction with NHS dentistry received

Definition: Percentage of patients who respond positively to survey question “How satisfied are you with the NHS dentistry received?” Result is based on all surveys returned where completion date of course of treatment was within the financial year. Numerator is number of survey responses where the answer is either “Very satisfied” or “Quite satisfied”. Denominator is total number of survey responses - “Very satisfied”, “Quite satisfied”, “Quite unsatisfied” or “Very unsatisfied”.

PE.07 - Patient Experience Indicator 7: Patients satisfied with the time to get an appointment

Definition: Percentage of patients who respond positively to survey question, “How do you feel about the length of time taken to get an appointment?” Result is based on all surveys returned where completion date of course of treatment was within the financial year. Numerator is number of survey responses where the answer is “As soon as necessary”. Denominator is total number of survey responses – “As soon as necessary”, “Should have been a bit sooner” or “Should have been a lot sooner”.

Further investigation of outliers identified by the Indicators

Following the publication of the DQOF reports in the summer of 2016 where 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 other prototype practices when identifying cases of concern.

It is expected that the patient satisfaction indicators will be reviewed periodically throughout the year. Over time commissioners will be able 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.

Consideration must also be made to the fact these indicators may be on a relatively small number of responses and there may be a response bias.

Section 8: Reports to support assurance

A suite of reports has been developed for the purposes of prototypes. Practices and commissioners should not use any UDA system reports for assurance. These reports do not correctly reflect the indicators under the prototype scheme and if used could result in incorrect analysis and assessment.

The following reports will be made available to providers and commissioners. The timetable for the production of these reports is monthly, and will usually be available by the end of the first week of the following month. For example May reports will be available early June.

1) Remuneration report – see Annex 3
2) Vital Signs report (available from summer 2016)
3) DQOF Report (available from summer 2016)
4) Operational reports
   • Patient list
Performer level reports will also be made available, namely:

1) Capitation and activity (UDA) reports
2) DQOF report – excluding Patient satisfaction indicators (available from summer 2016)
3) Operational reports
   • Patient list
   • Leavers and joiners report
   • Imminent lapsers report

Reports are available for NHS England local offices and practices via the Compass system. Guidance on how to access these reports is available via the dental contract reform website.

**Section 9: Future development of the Dental Assurance Framework for Prototypes**

This draft of the Dental Assurance Framework has been developed for the initial months of the prototype stage.

It is anticipated that this document will be developed over coming months particularly the clinical / quality domain, and once further reports become available.

A working group has been set up, and this group will focus on the development of this assurance framework over the coming months. The group includes members from the dental contract reform programme, dental commissioners from NHS England local offices, prototype practices and representatives from NHS BSA.
ANNEX 1

Working principles for NHS England and the dental contract reform programme

Introduction:

Prototype practices are operating as part of the Dental Contract Reform Programme and whilst NHS England are the contract holders, and will hold the responsibility for the management of these contracts it is important that the programme team are kept closely involved and updated on issues raised through the assurance process. This is to inform the learning from the prototype practices and help develop the final contract model for wider rollout. It is therefore important that local offices and the dental contract reform programme keep in regular contact, including:

- Regular updates from the dental contract reform programme in the dental leads meeting.

- Any correspondence being sent to practices by the dental contract reform programme to be copied to local offices.

- Where calls / meetings are set up by the dental contract reform programme on prototype matters this should include commissioners from the local office team where possible. Where this is not possible the dental contract reform programme should keep the local team informed of issues discussed.

- Local office to inform the dental contract reform programme of any changes to services commissioned either on a recurrent or non-recurrent basis. This is to ensure that any changes are appropriately reflected in the different commissioning basis that the prototypes operate under.

- Where follow up is required as part of the assurance process the local office may wish to invite a member of the dental contract reform programme team. Where this is not possible commissioners should ensure a written report of the meeting is submitted to the dental contract reform programme to support the wider learning from the prototypes.
# ANNEX 2

## Dental Assurance Process for Prototypes

### Improvement Action Plan

<table>
<thead>
<tr>
<th>Practice name:</th>
<th>Prototype reference number</th>
<th>Prototype blend</th>
<th>Financial year</th>
<th>Position at [insert date]</th>
<th>% Position at [insert date]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Expected minimum activity level (EMA)
- Expected patient numbers (CECP)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Proposed Actions (to be undertaken by practice)</th>
<th>Milestones and review by practice (key tasks that need to be carried out to implement actions and how this will be measured)</th>
<th>Lead</th>
<th>Timescales (start date)</th>
<th>Timescales (completion date)</th>
<th>Practice to record progress (at review stage)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: .............................................................. (on behalf of NHS England)

---

10 Any costs associated with delivering the actions identified in the improvement plan will be borne by the provider
**Example of a completed Improvement Action Plan**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Proposed Actions (to be undertaken by practice)</th>
<th>Milestones (key tasks that need to be carried out to implement actions and how this will be measured)</th>
<th>Lead</th>
<th>Timescales (start date)</th>
<th>Timescales (completion date)</th>
<th>Practice to record progress (at review stage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient numbers are consistently falling and currently 8% below the expected patient level (CECP)</td>
<td>To see x new NHS patients each month</td>
<td>Practice team meeting held to discuss strategy and reinforce importance of increasing access, and flow of patient through the practice</td>
<td>Principal</td>
<td>Immediate</td>
<td>By March 2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Standard time for OHAs / treatment appointments to be agreed across practice, and reception staff to book appointments accordingly</td>
<td>Principal</td>
<td>Immediate</td>
<td>By April 2016</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Place signs outside practice and in waiting room saying that practice is taking on new NHS patients</td>
<td>Practice manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liaise with AT to ensure that NHS.uk and local waiting list records are updated to note that practice taking on patients</td>
<td>Practice manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>x afternoons each week set aside in appointment book for OHAs</td>
<td>Head receptionist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To reduce current lapse rate by x%</td>
<td>Head receptionist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reception staff reminded to ask patients routinely for mobile numbers and email addresses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use portal report to identify upcoming</td>
<td>Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>lapses</td>
<td>manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement “email – text – letter” strategy for recalling patients identified imminent lapses</td>
<td>Practice manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transmissions:**

| To ensure that all appointment data is transmitted within 7 days of appointment | Ensure that all performers are undertaking daily transmissions | Transmission lead |
| All transmission errors and rejections are reviewed and actioned within x working days | Transmission lead |
ANNEX 3

The capitation remuneration report

Introduction

The capitation remuneration report is produced monthly for all prototype practices as part of the suite of bespoke reports specifically designed to support the prototype arrangements.

This report provides monthly information on the reported position against expected patient numbers (CECP) and activity levels (EMA).

Additional reporting field for capitation transitional allowance – former pilot practices only

Transitional arrangements have been agreed for pilot practices transferring to prototype arrangements to recognise the changes made to the way in which patient numbers are counted under prototypes11.

Details of how the transitional allowance has been calculated are included in the guidance note to accompany the report (see below). The transitional allowance figure (which has been individually calculated for each former pilot practice) is reported in section 1 – delivery requirements for 2016/17. For practices that did not take part in the pilot phase of contract reform, the transitional allowance will be zero.

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11 Further information on how patient numbers are counted is included in the remuneration training pack found at http://www.pcc-cic.org.uk/article/remuneration
## 2016-17 Capitation remuneration report - Prototype 100/YYYY - April 2016

### Practice XXX

<table>
<thead>
<tr>
<th>Provider name or company name</th>
<th>Practice XXX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prototype reference number</td>
<td>YYYY</td>
</tr>
<tr>
<td>Start date for prototype</td>
<td>01/12/2015</td>
</tr>
<tr>
<td>Prototype Blend</td>
<td>A</td>
</tr>
</tbody>
</table>

### Actual Annual Prototype Value

<table>
<thead>
<tr>
<th>ATG Measure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATG Measure C</td>
<td>£719,056</td>
</tr>
<tr>
<td>ATG Measure A</td>
<td>£483,046</td>
</tr>
<tr>
<td>Total</td>
<td>£1,202,101</td>
</tr>
</tbody>
</table>

### 2016-17 delivery requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractor's Expected Capitated Population</td>
<td>10,209</td>
</tr>
<tr>
<td>Required patients at March 2017</td>
<td>11,319</td>
</tr>
<tr>
<td>Activity and Capitation Performance Tolerance</td>
<td>No limit</td>
</tr>
<tr>
<td>Contract Value Carried Forward - Previous Year</td>
<td>TBC</td>
</tr>
</tbody>
</table>

### Capitated patient list - patients seen in 36 months

<table>
<thead>
<tr>
<th>Month</th>
<th>36-month actual capitated patient numbers</th>
<th>New joiners needed per remaining month</th>
<th>New joiners needed plus consistent losses</th>
<th>% of expected patient numbers currently delivering</th>
<th>% of expected patient numbers currently delivering including transitional allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 16</td>
<td>11,500</td>
<td>01</td>
<td>61</td>
<td>101%</td>
<td></td>
</tr>
<tr>
<td>Feb 16</td>
<td>11,505</td>
<td>03</td>
<td>61</td>
<td>101%</td>
<td></td>
</tr>
<tr>
<td>Mar 16</td>
<td>11,505</td>
<td>05</td>
<td>61</td>
<td>101%</td>
<td></td>
</tr>
<tr>
<td>Apr 16</td>
<td>11,458</td>
<td>01</td>
<td>61</td>
<td>101%</td>
<td></td>
</tr>
<tr>
<td>May 16</td>
<td>11,458</td>
<td>01</td>
<td>61</td>
<td>101%</td>
<td></td>
</tr>
<tr>
<td>Jun 16</td>
<td>11,458</td>
<td>01</td>
<td>61</td>
<td>101%</td>
<td></td>
</tr>
<tr>
<td>Jul 16</td>
<td>11,458</td>
<td>01</td>
<td>61</td>
<td>101%</td>
<td></td>
</tr>
<tr>
<td>Aug 16</td>
<td>11,458</td>
<td>01</td>
<td>61</td>
<td>101%</td>
<td></td>
</tr>
<tr>
<td>Sep 16</td>
<td>11,458</td>
<td>01</td>
<td>61</td>
<td>101%</td>
<td></td>
</tr>
<tr>
<td>Oct 16</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>Nov 16</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>Dec 16</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>Jan 17</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>Feb 17</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>Mar 17</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

### Activity - Prototype UDAs delivered

<table>
<thead>
<tr>
<th>Month</th>
<th>Prototype UDAs worked out in month</th>
<th>Prototype UDAs cumulative total</th>
<th>Expected Prototype UDAs</th>
<th>% of expected Prototype UDAs achieved</th>
<th>RAG Grade 100% or more</th>
<th>Amber 95%</th>
<th>Red less than 90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 16</td>
<td>4,320</td>
<td>4,320</td>
<td>4,549</td>
<td>95%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>May 16</td>
<td>5,412</td>
<td>5,733</td>
<td>5,958</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Jun 16</td>
<td>9,184</td>
<td>9,584</td>
<td>9,961</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Jul 16</td>
<td>18,146</td>
<td>18,328</td>
<td>18,789</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Aug 16</td>
<td>22,745</td>
<td>23,034</td>
<td>23,477</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Sep 16</td>
<td>27,294</td>
<td>27,566</td>
<td>27,971</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Oct 16</td>
<td>31,843</td>
<td>32,062</td>
<td>32,474</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Nov 16</td>
<td>36,392</td>
<td>36,643</td>
<td>37,041</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Dec 16</td>
<td>36,958</td>
<td>37,250</td>
<td>37,608</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Jan 17</td>
<td>45,458</td>
<td>45,777</td>
<td>46,104</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Feb 17</td>
<td>50,055</td>
<td>50,382</td>
<td>50,711</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Mar 17</td>
<td>54,505</td>
<td>54,840</td>
<td>55,168</td>
<td>85%</td>
<td>100%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Total UDAs delivered - Scheduled activity vs. activity completed in month

(These UDAs figures are for information only - see guidance)

<table>
<thead>
<tr>
<th>Month</th>
<th>Total scheduled UDAs</th>
<th>Total UDAs completed in month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 16</td>
<td>6,500</td>
<td>3,457</td>
</tr>
<tr>
<td>May 16</td>
<td>4,776</td>
<td>3,071</td>
</tr>
<tr>
<td>Jun 16</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Jul 16</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Aug 16</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Sep 16</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Oct 16</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Nov 16</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Dec 16</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Jan 17</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Feb 17</td>
<td>New</td>
<td>New</td>
</tr>
<tr>
<td>Mar 17</td>
<td>New</td>
<td>New</td>
</tr>
</tbody>
</table>

(Total UDAs figures are for information only - see guidance)
2016-17 Prototype remuneration report guidance

This guidance note accompanies the remuneration report for Prototype practices, and is intended to inform readers about the content and context of the data contained within the report. The remuneration report is tailored to each Prototype practice.

Important Changes for 2016-17:

1) Inclusion in the report of 2016-17 delivery criteria:

The reports have been refreshed for the new financial year. This includes the level of expected capitated patients (CECP) and activity (EMA) to be delivered by year end at March 2017.

Financial values for 2016-17, have not yet been adjusted to reflect DDRB uplift. Values will be uplifted once the size of the uplift has been announced.

2) Capitation transitional allowance

For former pilot practices only:

From 2016-17, the rules that trigger capitation are changing. For example, band 1 urgent courses of treatment will not trigger capitation. The reports for this financial year will, therefore, report capitated patient numbers using the prototype rules.

As previously communicated, in order to smooth the move from rules for counting capitated patients during the pilot arrangements to the rules for the prototype arrangements, pilot practices will have a capitation transitional allowance. The transitional allowance is designed to allow practices who need it time to adjust to the prototype capitation trigger rules.

The calculation of this allowance will determine is tailored to each practice depending on the number of patients under capitation at March 16. The transitional allowance can only be finalised once the 2015-16 year data has been processed.

Therefore this is a provisional number until then.

Please see annexe for details of calculations.

For practices that did not take part in the pilot phase of contract reform, the transitional allowance will be zero.

A. Introduction to Remuneration for Prototype practices

The report presents key data on a Prototype practice across 4 sections:

- Background
- Capitated patient list – patients seen in 36 months
- Activity - Prototype UDAs delivered
- Activity – total scheduled UDAs vs. total UDAs completed in month

This guidance note describes the data used in each of these sections.
Section 1 – Background

The report first provides an overview of the Prototype contract, and includes, in addition to Provider name and Prototype reference number, the following fields:

**Start date for Prototype**
This is the effective date of the Prototype Agreement, as set out in your Contract Variation Notice.

**Prototype Blend**
This indicates whether your Prototype has been allocated to Blend A or Blend B. Blend A Prototypes will have more of their contract value associated with activity and less associated with capitation than a Blend B Prototype.

**Actual Annual Prototype Value (AAPV)**
This is the annual amount payable for the general dentistry element of the Prototype practice’s overall contract value. This figure does not guarantee the final amount awarded to the practice. The term AAPV is derived from the Statement of Financial Entitlements (SFE) and is part of the baseline contract value.

The AAPV is split between:
- a Capitation Element (AAPV-C) for which the practice would be expected to provide services to the Contractor’s Expected Capitated Population (CECP)
- by the end of the financial year; and
- a Activity Element (AAPV-A) for which the practice would be expected to deliver the Expected Minimum Activity (EMA), by the end of the financial year.

Section 1 – 2016-17 delivery requirements

**Contractor’s Expected Capitated Population (CECP)**
This is the contractor’s expected number of patients as stated in the contract variation to be achieved by year-end.

**2016-17 transitional allowance (provisional)**
For former Pilots only:
This is the transitional allowance in patients being given to your practice for this year. See annex for more information on transitional allowance calculation.

**Required patients at March 2017 (minus transitional allowance)**
This is the contractor’s expected number of patients (CECP) as stated in the contract variation to be achieved by year-end, less transitional allowance.

**Expected Minimum Activity (EMA)**
This is the contractor’s expected activity as stated in the contract variation to be achieved by year-end at March 2017.

Each Prototype has been given these background values in their contract variation and accompanying finance schedule. Schedule 1 A/B of the Contract Variation for 2016-17 will be re-issued with these figures.

**Activity and Capitation Performance Tolerance**
This is a fixed value, which limits the degree to which performance in terms of capitation can differ from performance in terms of activity. In most cases this will be set as “no limit”.
Section 2 – Capitated patient list – Patients seen in 36 months

This section compares the patient numbers a practice is currently delivering to the expected patient numbers. The comparison is made for each month and for the Financial Year to date, and presented as a percentage.

36-month actual capitated patient numbers
This is the number of actual patients on the practice’s capitated list. The practice will be assessed on the number of patients on the list at year-end.

New joiners needed per remaining month
The estimated number of additional patients needed each remaining month of the financial year to achieve the Contractor’s Expected Capitated Population (CECP).

New joiners needed plus imminent lapsers
This column indicates the number of new joiners needed per remaining month in addition to the estimated number of patients due to lapse in the month following the reporting month.

Percentage of expected patient numbers currently delivering
This is the number of capitated patients the practice is currently delivering, expressed as a percentage of Contractor’s Expected Capitated Population (CECP).

For practices that did not participate in the pilot phase of contract reform, this percentage will be used to assess capitation performance at year-end.

Percentage of expected patient numbers currently delivering including transitional allowance
This is the number of capitated patients the practice is currently delivering, expressed as a percentage of required patients at March 2017 (minus transitional allowance).

For practices that participated in the pilot phase, this percentage will be used to assess capitation performance at year-end.

Section 3 – Activity - Prototype UDAs delivered

This section shows the number of Prototype UDAs the practice is currently achieving and the percentage of expected Prototype UDAs achieved, for the Financial Year to date.

Prototype UDAs carried out in month
This is the number of UDAs completed each month which count towards the Expected Minimum Activity (EMA) level. The method of counting the number of Prototype UDAs depends on whether the practice has been allocated to Blend A or Blend B. Details can be found in the annex below.

Prototype UDAs cumulative total
This is the cumulative total of Prototype UDAs carried out to date.

Expected Prototype UDAs
This is the expected activity for the relevant month. The calculation takes your
Expected Minimum Activity level and divides this by 12 and reports as a cumulative total. For example, in April this is 1/12th of the Expected Minimum Activity level, this will then add another 1/12th in May and so on until in March 2017, when the figure will match your annual Expected Minimum Activity level.

**Percentage of expected Prototype UDAs achieved**
This is the Prototype UDAs cumulative total expressed as a percentage of the Expected Prototype UDAs to date; we will use this percentage to assess performance at year-end.

**RAG Green 100% or more, Amber 90% to 100% and Red less than 90%**
This is a graphical indication of current performance for each month. Calculation uses prototype UDAs carried out in month as a percentage of expected prototype UDAs.
Green indicates on or above requirement,
Amber indicates between 90% and 100% of requirement.
Red indicates 10% or more below requirement

**Section 4 – Activity – scheduled activity vs. activity completed in month**

This section is included to illustrate the change from reporting activity *scheduled* in the reporting period to reporting activity *completed* within the reporting period. The purpose is to allow practices to monitor the overall volume of activity on the same basis as before and also as reported under Prototype rules, as Prototype UDAs will be based on activity *completed* in the reporting period.

**Total scheduled UDAs**
This is the *total* number of UDAs (regardless of Blend) reported on FP17s received by the BSA between the previous schedule cut-off date and the current schedule cut-off date, excluding those transmitted outside the two-month rule.

**Total UDAs completed in month**
This is the *total* number of UDAs (regardless of Blend) from FP17s received by the BSA to date where treatment was *completed* in the reporting month, excluding those transmitted outside the two-month rule. These UDAs will be used to count Prototype UDAs for the reporting month.

**UDAs for the reporting month**
As this reports the UDAs completed in a month *and scheduled* by the time of reporting, the most recent two months may be an underestimate of completed activity. This underestimation will also be reflected in the Prototype UDAs carried out in month in section 3. These figures will be refreshed in future versions of the report as more FP17 forms are processed.

See annex below for more information:
## Annex A

### Method of counting Prototype UDAs

#### Blend A

<table>
<thead>
<tr>
<th>Course of Treatment (CoT)</th>
<th>UDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1 CoT (excluding urgent treatment)</td>
<td>0</td>
</tr>
<tr>
<td>Band 1 – Urgent CoT for a capitated patient</td>
<td>0</td>
</tr>
<tr>
<td>Band 1 – Urgent CoT for a non-capitated patient</td>
<td>1.2</td>
</tr>
<tr>
<td>Band 2 – Non-Referral CoT</td>
<td>2</td>
</tr>
<tr>
<td>Band 2 – Referral CoT</td>
<td>3</td>
</tr>
<tr>
<td>Band 3 – Non-Referral CoT</td>
<td>11</td>
</tr>
<tr>
<td>Band 3 – Referral CoT</td>
<td>12</td>
</tr>
<tr>
<td>Issue of a prescription for a capitated patient</td>
<td>0</td>
</tr>
<tr>
<td>Issue of a prescription for a non-capitated patient</td>
<td>0</td>
</tr>
<tr>
<td>Repair of a dental appliance (denture) for a capitated patient</td>
<td>0</td>
</tr>
<tr>
<td>Repair of a dental appliance (denture) for a non-capitated patient</td>
<td>1</td>
</tr>
<tr>
<td>Repair of a dental appliance (bridge) for capitated patient</td>
<td>0</td>
</tr>
<tr>
<td>Repair of a dental appliance (bridge) for non-capitated patient</td>
<td>1.2</td>
</tr>
<tr>
<td>Removal of sutures for a capitated patient</td>
<td>0</td>
</tr>
<tr>
<td>Removal of sutures for a non-capitated patient</td>
<td>1</td>
</tr>
<tr>
<td>Arrest of bleeding for capitated patient</td>
<td>0</td>
</tr>
<tr>
<td>Arrest of bleeding for non-capitated patient</td>
<td>1.2</td>
</tr>
</tbody>
</table>

#### Blend B

<table>
<thead>
<tr>
<th>Course of Treatment (CoT)</th>
<th>UDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1 CoT (excluding urgent treatment)</td>
<td>0</td>
</tr>
<tr>
<td>Band 1 – Urgent CoT for a capitated patient</td>
<td>0</td>
</tr>
<tr>
<td>Band 1 – Urgent CoT for a non-capitated patient</td>
<td>1.2</td>
</tr>
<tr>
<td>Band 2 – Non-Referral CoT</td>
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</tr>
<tr>
<td>Band 2 – Referral CoT</td>
<td>3</td>
</tr>
<tr>
<td>Band 3 – Non-Referral CoT</td>
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</tr>
<tr>
<td>Band 3 – Referral CoT</td>
<td>12</td>
</tr>
<tr>
<td>Issue of a prescription for a capitated patient</td>
<td>0</td>
</tr>
<tr>
<td>Issue of a prescription for a non-capitated patient</td>
<td>0</td>
</tr>
<tr>
<td>Repair of a dental appliance (denture) for a capitated patient</td>
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<tr>
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<td>Removal of sutures for a capitated patient</td>
<td>0</td>
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<tr>
<td>Removal of sutures for a non-capitated patient</td>
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</tr>
<tr>
<td>Arrest of bleeding for capitated patient</td>
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<tr>
<td>Arrest of bleeding for non-capitated patient</td>
<td>1.2</td>
</tr>
</tbody>
</table>
Annex B

Method for calculating transitional allowance
For former pilot practices only.

The transitional allowance will be calculated in the following way:

At the end of March 2016, each pilot practices patient list will be constructed in two ways, using:

1) Old (pilot) rules, where all appointments/FP17 trigger capitation; and
2) Prototype rules, where prototype capitation triggers apply

The transitional allowance is calculated as the difference between these two capitated patient lists.

For example, if a practice had:
• 4500 patients under old rules; and
• 4200 patients under prototype rules

the net allowance measured at March 2016 would be 300 patients.

It is importance to note that the changes in the capitation rules means that there are circumstances where patients used to trigger capitation under old rules but no longer do under prototype rules, e.g. patients receiving band 1 urgent CoT. There are also circumstances where patients were not included in a practice’s capitated patient list under old rules but will now be included, e.g. under old rules patients referred to another practice for treatment were removed from the “home” practice’s list for the duration of that treatment but under prototype rules they remain on the “home” practice’s list.

Thus, the difference between old rules and prototype rules can be made up of patients in capitation under old rules only and also patients in capitation who only appear in prototype rules.

Continuing the example above, the net allowance of 300 may consist of:

• +400 old rules patients
  (for example, patients that triggered capitation for urgent treatment only)
• -100 prototype rules patients
  (for example, patients that now trigger capitation when they did not under old rules because they had been referred elsewhere for further treatment).

Resulting in a 300 patient net allowance at March 2016.

Once this calculation is complete the patient list constructed using old rules is checked to see how many patients would lapse and how many would remain at the next measurement points of 31st March 2017 & 31st March 2018.

Continuing the example, out of the 400 patients at 31st March 2016, if 200 of them would have lapsed then 200 of them will not have lapsed by March 17 and therefore would count towards the transitional allowance.
The calculation then deducts the 100 prototype rules only patients from this resulting in a transitional allowance at 31st March 2017 of 100 patients. This would be the provisional number included in the 2016-17 remuneration reports.

This process is repeated to calculate how many of the 200 old rules only patients left at March 2017 will still remain at 31st March 2018. For example say a further 50 patients would have lapsed by this date leaving 150 old rules patients. Then 100 prototype rules only patients is deducted meaning the transitional allowance will reduce to 50 patients for 31st March 2018.

This calculation will be undertaken individually for each former pilot practice.

Once the 2015-16 year end process has been completed, the transitional allowance will be finalised and practices will be able to view the patient list constructed using old rules and prototype rules to check the figures.