

PRIMARY DENTAL CARE CONTRACT

DATA SET

On behalf of DHSSPSNI Dental Branch

By

Simon Reid
Dental Officer (Policy)
DHSSPSNI

PRIMARY DENTAL CARE CONTRACT DATA SET

To consider the development of Data Sets for the new PDCC we need to analyse what the function of the data set(s) will be.

1 INTRODUCTION

1.1 DATA SETS WILL BE AT TWO LEVELS

- (1) **Practice level** – within patients' records.
- (2) **Administrative level** – 'subset' reported from the practice (with access to patient record if required).

1.2 WHY DO WE NEED DATA SETS?

1.2.1 At Practice level?

- Quality Assurance of the patient record
- Patients have a right to access their records
- Supports patient risk assessment, oral health appraisal and treatment planning processes

1.2.2 At Administrator level?

- To enable remuneration
- To collect Public Health Information
- Assurance of
 - Professional Standards/Ethics
 - Compliance with regulations (general & contract)

- Probity checks
- Value for money

1.3 WHO NEEDS TO ACCESS THE DATA SETS – OR INFORMATION DERIVED FROM THE DATA SETS? (post RPA)

- Patient has right to access their records
- Practitioners will have contractual requirement to submit data sets to the Administrators
- RBSO – Effective administration of Family Practitioner Services
 - Finance (Remuneration)
 - Probity
- RHSCB – Family Practitioner Services
 - Commissioning
 - Performance Management
 - Service Delivery
- RAPHSW
 - Assessment of need
 - Public Health
 - Planning
- DHSSPSNI
 - Policy
 - Regulation and Legislation
 - Standards and targets

1.4 WHAT LEVEL OF INFORMATION WILL BE NECESSARY TO MEET OUR NEEDS?

GENERAL PRINCIPLES

- Data should enable analyses to ensure that public money is spent effectively and efficiently to provide primary dental care.
- We will have to balance ease of use (recording, reporting, collating, analysing, remunerating, assuring, surveying and storing) for both practitioners and administrators, with being 'fit for purpose, (efficiency, accuracy, consistency, reproducibility, sensitivity, specificity, validity, reliability, analysis-friendly, assurance friendly, public health capability).
- We should expect and respect professional standards for maintaining appropriate patient data, whilst ensuring public confidence that an acceptable level of data assurance is met.
- We should only require and store the minimum data necessary to fulfil our needs.
- We must consider ICT capability and capacity at practice and administrator level.
- We must consider Data Protection, Freedom of Information and Equality requirements.
- Information should integrate or be compatible with other patient databases

PDCC ADMINISTRATIVE CONSIDERATIONS

- Be consistent with GDC professional standards.
- Compatible with relevant Guidelines, EB practice, medico-legal standards.
- Review current HS45/EDI capabilities.

- Integration of dental notations with ICT.
- Easy to use web-enabled system.
- Integration with previously stored data.
- Consider type of Public Health data that can be extracted for formative and summative assessment of pilots/PDCC and to inform policy. (Especially in relation to preventive care).
- Enable registration and preventive care payments.
- Enable quality payments.
- Enable Item of Service payments for the Essential Services.
- Consider record-keeping, CRC, probity and practitioner performance issues previously encountered.

PRACTICE LEVEL DATA SET AND ADMINISTRATOR LEVEL DATA SET

The data set reported to the Administrator will not be as comprehensive as the data set held within the patient record at practice level. Often there will be a self-reporting process that certain requirements or procedures have been carried out by the practitioner. There will therefore be a high level trust reporting process. It is not proposed to be prescriptive with regard to the data set and what information should be held at a practice level, however the regulations will give an indication of the necessary level of information and compliance with the relevant guidelines will also be expected. Access to practice records would be possible if required to assure any reported claims and also for Quality Assurance purposes. The Administrator data set should be easily accessible from practice IT systems or manually and should be easily transferrable into the relevant electronic format for onward transmission.

2 DEVELOPING THE DATA SET

2.1 **HOW CAN THE DATA SET(S) BE DEVELOPED TO ENABLE THESE FUNCTIONS TO BE FULFILLED EFFECTIVELY AND EFFICIENTLY?**

STAGES IDENTIFIED:

1. Review relevant publications
2. Determine level of information required (section 1.3), to fulfil needs (section 1.1) and consider reporting process with regard to
 - (1) Registration
 - (2) PDCC Care Pathway
 - Oral health assessment
 - Risk Appraisal
 - Preventive care
 - Associated procedures
 - (3) Essential Services
 - (4) Occasional Services
3. Consider should one or more data sets be reported?

2.2 **RELEVANT PUBLICATIONS**

2.2.1 From **'GDC – STANDARDS FOR DENTAL PROFESSIONALS'**

THE PRINCIPLES OF PRACTICE IN DENTISTRY

- 1 - PUT PATIENTS' INTERESTS FIRST AND ACT TO PROTECT THEM

- 1.4 - Make and keep accurate and complete patient records, including a medical history, at the time you treat them. Make sure that patients have easy access to their records.
- 3 - PROTECT THE CONFIDENTIALITY OF PATIENTS' INFORMATION

2.2.2 From '**NICE GUIDELINES – DENTAL RECALL**'

- *“A new minimum dataset should be established, consistent with the new, more preventive philosophy inherent in the evolving arrangements for NHS Dentistry. Data should be recorded routinely in such a way to facilitate its use for service improvement at the patient, practice, primary care trusts, shadow Health Authority and national levels” [section 6.3]*
- **MINIMUM DATA REQUIREMENTS** - *“It will be important for the profession, the PCTs and the Shadow Special Health Authority (Dental Practice Board) to agree a coherent and workable dataset to allow efficient collection of data and the comparison of what happens in different localities over time. Continuity of existing longitudinal data sets is necessary” [section 6.3]*
- *Audit capability is recommended at Practice level, PCT level and National level. [section 6.3]*
- **IT IMPLICATIONS** - *“...routine information to be collected without additional administrative burdens. It is essential that these needs are reflected in the design, specification and development of new IT systems and that these requirements are met while satisfying contemporary data protection and privacy requirements.”*

“Confidentiality is a further consideration as appropriate information and agreement must be obtained from the patient, where necessary, to ensure that the legitimate use of patient information for improving the quality of patient care can continue.” [section 6.3]

2.2.3 **From ‘FGDP GUIDELINES – ‘CLINICAL EXAMINATION AND RECORD KEEPING’.**

- These guidelines relate to best practice for practitioner records.
- There is a difference in the minimum data set for the practitioner to record and the minimum data set for the practitioner to report to the administrator.
- It is useful to acknowledge this principle so that the administrator data set requirements are not unrealistic in comparison and should integrate where possible.
- These guidelines serve as a useful reference for best practice.

2.3 DETERMINE THE LEVEL OF INFORMATION REQUIRED AND INTEGRATION OF REPORTING

2.3.1 For REGISTRATION

DATA FIELDS REQUIRED

- Surname
- First Forename
- Date of Birth & CHI
- Health and Care number (IF DEVELOPED AND AVAILABLE)
- Address
- Registration date
- Registration category
 - There are currently six categories relating to the type of claim and seven categories of type of registration/occasional/referral.
 - These could potentially be rationalised to two, 'Accept for registration' (for set period e.g. two years) or, 'Not for registration' (covers occasional treatments).
 - As a 'rolling' registration mechanism, when a patient signs the acceptance form they are registering (or re-registering) to the practice/practitioner? This would eliminate some of the original categories if there is no 'legal' or other need. Also we would seek legal advice if children could be automatically moved into adult registration if they become eighteen during their two year registration?
 - Occasional claims will not attract a registration care payment and will be paid as IoS through Essential Services. It is proposed to incorporate the referral fee within the fees paid to recognised specialists.

- Declaration re patient charges or exemption.

The requirements would be similar to current ones but by simplification we could reduce the number of fields. This will require a legal opinion as some fields may be necessary for medico-legal or probity assurance purposes. It would also be an opportunity to consider previous issues raised by previous 'Claim to Record Checks' and Probity processes.

2.3.2 For PDCC CARE PATHWAY

DATA FIELDS REQUIRED

- History recorded Y/N
- EO Examination Y/N
- IO Examination Y/N
- Dental exam Y/N
- dmft/DMFT Score
- BPE recorded Y/N
- Simple Perio Treatment Y/N
(Proposed/carried out)
- Associated procedures
 - Panorol radiograph Y/N
 - I.O. radiograph Number
 - Other radiograph Number
- Risk Appraisal H M L

A sample Risk Appraisal Template, for internal practice use, is shown at appendix A. This will be used to inform the dentist and patient when planning care. An alternative version can be used by

practitioners but whatever format is used it should be retained with the patients' records, in the practice. This will provide a record of an appropriate risk assessment for assurance purposes.

The sample template includes the high, medium and low classification as used in some guidelines e.g. Selection Criteria in Dental Radiography FGDP.

- Special needs (exceptional risk) (enhanced payment)
- Recall interval 3, 6, 9, 12, 15, 18, 21, 24 months
- Preventive Services
 - BASCD Toolkit Y/N

If the practitioner reports the data at the 'registration' stage they should state in a declaration that they "agree to undertake preventive care as detailed in the BASCD toolkit" depending on the patients risk rating. This will allow prospective payments rather than payment retrospectively on the completion of the advices and interventions.

For the BASCD toolkit it is proposed to use a level of trust in reporting.

Records could be assured to check for compliance and that the relevant advices and interventions have been carried out.

The above fields should assure that the risk appraisal process is carried out and practitioner confirms this by high trust report. The regulations would detail what would be expected for the components of a generic appraisal and would allow follow up assurance of records if required.

These fields should permit an open and transparent process to check on prescribing patterns, trends and possible under-prescription. E.g. if a practitioner stopped taking radiographs, even if appropriate under the relevant guidelines, or,

if a practitioner was found to be an outlier for patients prescribed the maximum recall period.

A dmft/DMFT score has been incorporated to return data for Public Health purposes, for triangulation with other analyses and for data assurance. Advice was sought from a Dental Public Health Specialist and a range of measures and reports were considered.

However when the implications of using a wider range of Dental Public Health indicators were studied it became apparent that there would be an additional administrative burden to practitioners. Many practice IT systems for patient charting would be able to 'calculate' some of these indicators, but other indicators would require a more detailed examination charting than would be normally expected. There were other issues relating to the reliability, sensitivity and specificity of recording. The use of Socio-Dental Indicators was also considered.

On balance the dmft/DMFT is considered to be a useful indicator, is relatively simple to administer and with a clear protocol would be possible without calibration training.

2.3.3 For ESSENTIAL SERVICES

It would be expected that Essential Services would be claimed by IoS in a similar though simplified way as at present i.e. by item codes.

It will be necessary to incorporate a system for submission for consideration of 'Exceptional Treatments', under the principles discussed in the Essential Services paper.

2.3.4 For OCCASIONAL SERVICES

Reporting of claims for provision of Occasional Services would be similar to that described for Essential Services above, i.e. using item codes. The notable difference being that there would not be an associated registration report.

2.3.5 For 'QUALITY CARE PAYMENTS' REPORTING

Consideration needs to be given to the operationalisation of the 'Quality Care Payments' (QCP's) related to the quality indicator domains as proposed previously in the 'Care Payment & Quality Indicator Domains' paper.

DHSSPSNI have suggested as 'Practice Environment Indicators', using practice inspection, quality of patient care and charter marks. This would require some form of reporting and assurance process from the practice as a whole and would involve professional officers. Such a process would probably not require regularly reporting throughout the year but may be carried out within an annual process.

For 'Practitioner Indicators' DHSSPSNI have proposed the use of the practice profile, record card appraisals, peer review and possession of a higher qualification.

These will be reported differently in that they would have to be assured and will also involve professional officers to check and then authorise these payments. Such a process could also enable the assurance of the 'prospective' element of payments against care actually provided by means of the review of the practitioner profile and the assurance of a sample of patient records as part of the record card appraisal indicator process.

[PLEASE REFER TO CONCLUSIONS OF WORKING GROUP AT SECTION 3.2]

2.4 HOW MANY DATA SET SUBMISSIONS?

The reporting process has been considered in section 2.1 with regard to:

- (1) Registration
- (2) PDCC Care Pathway
 - Oral health assessment
 - Risk Appraisal
 - Preventive care
 - Associated procedures
- (3) Essential Services
- (4) Occasional Services

There is the option to have separate stages and submissions for these data sets or to combine them. We want to reduce the bureaucracy of reporting which although electronic will have data input implications for the practitioner and also consequences for administrators. Nevertheless we still require a certain level and type of data report.

A separate registration submission, following the appraisal process, would facilitate real time registration which can be operationally useful for the administrators and should be welcomed by practitioners. It allows practitioners to plan patient care from the outset and report on the proposed preventive care and other associated procedures. It would therefore be recommended to submit a combined data set for the registration and confirmation of the PDCC care Pathway.

The Essential Services element will be paid by a different system so the claim, with appropriate patient identifier, would go in separately. This separate report

will be submitted to claim for care provided as previously explained under section 2.3.3.

This will be at the completion of the Essential Services component of care and often this will be at a later date. If these separate data sets and report formats are used in this way, it won't delay the claim for registration.

It is considered that although there may be two submissions for patients (i.e. a Registration/PDCC Care Pathway claim and an Essential Services claim) when compared to the current system, the advantages outweigh the use of separate reports. The same data will still need to be reported, so the same effort of data input is necessary, but it will be two shorter reports rather than one longer one. Also a registration can potentially last up to two years until a new submission is required. There will be slight duplication of data with regard to the patient identifiers but as submission will be electronic this should be easily facilitated. Again this will enable real time registration and remuneration of the Patient Care Payment including the preventive care as required by the BASCD toolkit and other associated treatment within the PDCC Care Pathway. In this way remuneration occurs on trust in an ongoing manner for the registration of the patient, rather than claiming retrospectively on the completion of care during the registration period.

Those patients who are only accessing Occasional Services will not require a Registration/PDCC Care Pathway submission or an Essential Services submission. Occasional care will only be available to non-registered patients and registered patients will not require a claim for occasional items of care because all of their care will be covered by the Patient Care Payment or the Essential Services claim. The Occasional Services submission will report care provided as previously explained under section 2.3.4.

Separate reporting processes will be required for data relating to QCP's for 'Practice Environment Indicators' and 'Practitioner Indicators'. As these will be in a different format and parts may not be transmissible electronically, a separate mechanism will be required. These systems should however integrate as much as possible with the overall data sets and reporting processes described earlier.

3 SUMMARY OF FINDINGS

- **The Administrative level data sets should, where possible, be subsets of the Practice level data sets to reduce the administrative burden to practitioners.**
- **Where possible data should be easily extractable from the Practice data set to enable easy reporting of the Administrative level data sets.**
- **Electronic data reporting will be required and this should integrate with practice management systems and be 'IT-lite' and user-friendly for those practices who use manual patient records.**
- **The real time 'Registration/PDCC Care Pathway' data set as outlined should be considered.**
- **In a high-level trust environment prospective reporting of preventive care will be necessary to obviate having to claim for retrospective payment on completion.**
- **Separate 'Essential Services' [IoS] data set submissions will be reported on the completion of the restorative phase.**
- **Separate 'Occasional Services' data set submissions. These patients will not require the other types of data set submissions.**
- **Quality Care Payments at a practice and practitioner level will necessitate a different process involving Dental Officers and certification from external agencies. However whilst requiring such other reporting mechanisms these should integrate with the other data set reports described above and allow triangulation for data analyses.**

4 CONCLUSIONS AND RECOMMENDATIONS

The PDCC Data Set paper was released by DHSSPSNI to BDA on 4/9/08 in advance of the negotiation meeting of 24/9/08 when a presentation was given by Simon Reid. A 'Data Set Working Group' was formed, with representation from DHSSPSNI and BDA, which subsequently met on 13/11/08 and 24/11/08.

As a result of the discussions it has been agreed that information, similar to that currently used as a patient identifier, will still be required. This will enable identification of the patient for registration (for Patient Care Payment, PCP) and for claims for Essential Services treatment items and Occasional treatments. For registration purposes it would be proposed to rationalise the registration categories.

The Data fields for reporting the Patient Care Pathway to claim the Patient Care Payment were also considered. The initial high trust reporting system has been further simplified from the initial proposals, but certain data fields must be reported. This has now been minimised to 5 proposed fields

1. A Y/N report that a full patient assessment has been carried out (i.e. History recorded, Extra-oral exam, Intra-Oral exam, Dental Exam and BPE).
2. The dmft/DMFT score
3. That a risk appraisal has been carried out and a ranking of Low, Medium or High; the recall period and if an enhanced special needs payment is requested.
4. BASCD Toolkit preventive care, scoring 'Standard' or 'at Risk' and an undertaking to carry out the relevant preventive care.
5. Record of associated procedures i.e. number of large/small radiographs.

It was considered preferable to have the prescribed Risk Appraisal Template in place but practitioners would be free to use an equivalent model if they choose.

The Quality Care Payments, QCP's, have been discussed and because there was concern expressed about some of the planned indicators it is proposed to use the non-contentious ones. It is hoped to be possible to develop other appropriate indicators that could be considered for inclusion at a later date.

Those agreed are:

At the practice level

- Practice inspection where a standard must be reached to generate a payment. No payment can be made until this threshold is reached but pastoral advice would be offered in this respect to help achieve this standard.
- Possession of a recognised practice charter mark.

At the practitioner level

- Participation in Peer Review and Clinical Audit. This will be a prospective payment with retrospective checks in place. It would be hoped to simplify the process and reduce bureaucracy whilst still making it robust enough.
- Possession of a higher qualification

A report on the meetings of the 'Data Set Working Group' was presented at the subsequent negotiation meeting held on 3/12/08, explaining that agreement had been reached with the BDA on the matters detailed above.

5 FOR FUTURE DEVELOPMENT

Work is currently being carried out to develop a weighted capitation model that will be used to calculate the 'Patient Care Payment'. We will need to ensure that the PDCC Data Set proposed in this paper will enable those calculations to be carried out. Progress in this respect will be reported at a later stage.

The actual reporting format and fields for the PDCC Data Set will require future development and further work will also be carried out in relation to electronic data reporting and planning for the pilots.

APPENDIX A = RISK APPRAISAL TEMPLATE

RISK-BASED PATIENT APPRAISAL

IS THERE A RISK OF ORAL HEALTH AFFECTING GENERAL HEALTH?

Y N

IS THERE A MEDICAL CONDITION THAT RISKS DEVELOPING ORAL DISEASE?

Y N

IS THERE A RISK THAT LIFESTYLE CHOICES OR PREVIOUS DENTAL DISEASE COULD RESULT IN CARIES OR TOOTH SUBSTANCE LOSS?

- | | | |
|--|--------------------------|--------------------------|
| | Y | N |
| 1. Family history of increased caries risk? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Previous caries experience? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Poor oral hygiene? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. High and/or frequent sugar intake? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. High and/or frequent dietary acid intake? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is there exposure to Fluoride? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is there evidence of tooth surface loss? | <input type="checkbox"/> | <input type="checkbox"/> |

IS THERE A RISK THAT LIFESTYLE CHOICES OR PREVIOUS DENTAL DISEASE COULD RESULT IN PERIODONTAL DISEASE?

- | | | |
|--|--------------------------|--------------------------|
| | Y | N |
| 1. Family history of early onset/juvenile periodontitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Previous periodontal disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Signs of gingivitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Periodontal pockets BPE 3, 4, or *? | <input type="checkbox"/> | <input type="checkbox"/> |

IS THERE A RISK THAT LIFESTYLE CHOICES OR PREVIOUS DENTAL DISEASE COULD RESULT IN ORAL CANCER?

- | | | |
|------------------------------|--------------------------|--------------------------|
| | Y | N |
| 1. Tobacco use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Excessive alcohol use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Mucosal precursor lesion? | <input type="checkbox"/> | <input type="checkbox"/> |

ORAL HEALTH RISK APPRAISAL

Low **1** Med **2** High **3**

RECALL INTERVAL (MONTHS)

(CHILD 3-12) **3** **6** **9** **12** **15** **18** **21** **24** (ADULT 3-24)