Exception Reports Guidance Notes

Gateway Reference: 06/NHSBSA/dental/06/14

1. Overview

The *quarterly contract exception report* and the *quarterly PCO exception summary report* present a set of contract risk measures for each individual contract. These measures may be associated with risks to the successful delivery of contracts, or to the quality of services and value for money associated with the contract. Commissioners should consider these indicators along with other evidence to determine whether there are clinical or service issues which explain the unusual levels of indicators, or if there are risks which need to be managed.

In the report, symbols have been used to draw attention to contracts where there appear to be exceptional levels associated with specific indicators.

Five consecutive quarters' rates are presented for each contract, including the most recently processed quarter's data. This is to provide some context to the current level for each indicator. Two symbols have been used; a solid, red circle which indicates what is considered an exceptional level of risk, and an amber diamond (lozenge) which is associated with what is described as 'high but not exceptional' risk levels.

The report also presents the components (numerator and denominator) of each measure which have been used to generate the exception indicators. In this report the data is presented for all contracts, whether or not they appear to demonstrate high risk levels. This will allow commissioners to observe reported risks in the context of all of their dental commissioning.

Indicators have been organised into four blocks, so that related groups of measures appear together. The first block of indicators shows issues relating to value for money and general contract management. The second group can help identify contracts with high levels of splitting or 'fragmentation' of courses of treatment. The third block of indicators can show issues relating to re-attendances and patient mix (that is the mix of exempt and non-exempt adults). Re-attendance frequency and patient mix both affect the level of access at the practice. The fourth group of indicators should help identify contracts with problems relating to unusual patient case mix. This includes the profile of different bands of treatment, and issues such as inlay rates compared to other restorations.

This report can only give a suggestion of how commissioners might start to form an overall picture of contract risk. Commissioners will develop their own profiles of risk based on local intelligence and circumstances which may include the information contained in this report.

The term *UDA* has been used throughout to indicate *Unit/s of Dental Activity*, both singular and plural. IQR stands for inter-quartile range, a measure of statistical spread. *FP17* refers to the individual dental claim records submitted by providers after a course of treatment, which includes the electronically submitted records (EDI) as well as the paper claims used by some providers. The word Form has also been used interchangeably with *FP17*. *Band 1 (2, 3, Urgent)* refer to the categories of treatments and therefore the number of UDA associated with the relevant claims submitted for those courses of treatment. *Adults* refers here to anyone aged 18 or over, who would therefore not qualify for free treatment available to under-18s. *Child* refers to those under 18 at the time of acceptance for a course of treatment. *NICE* refers to the *National Institute for Health and Clinical Excellence* who issue evidence based guidance for NHS healthcare providers, for example in the context of appropriate recall intervals.

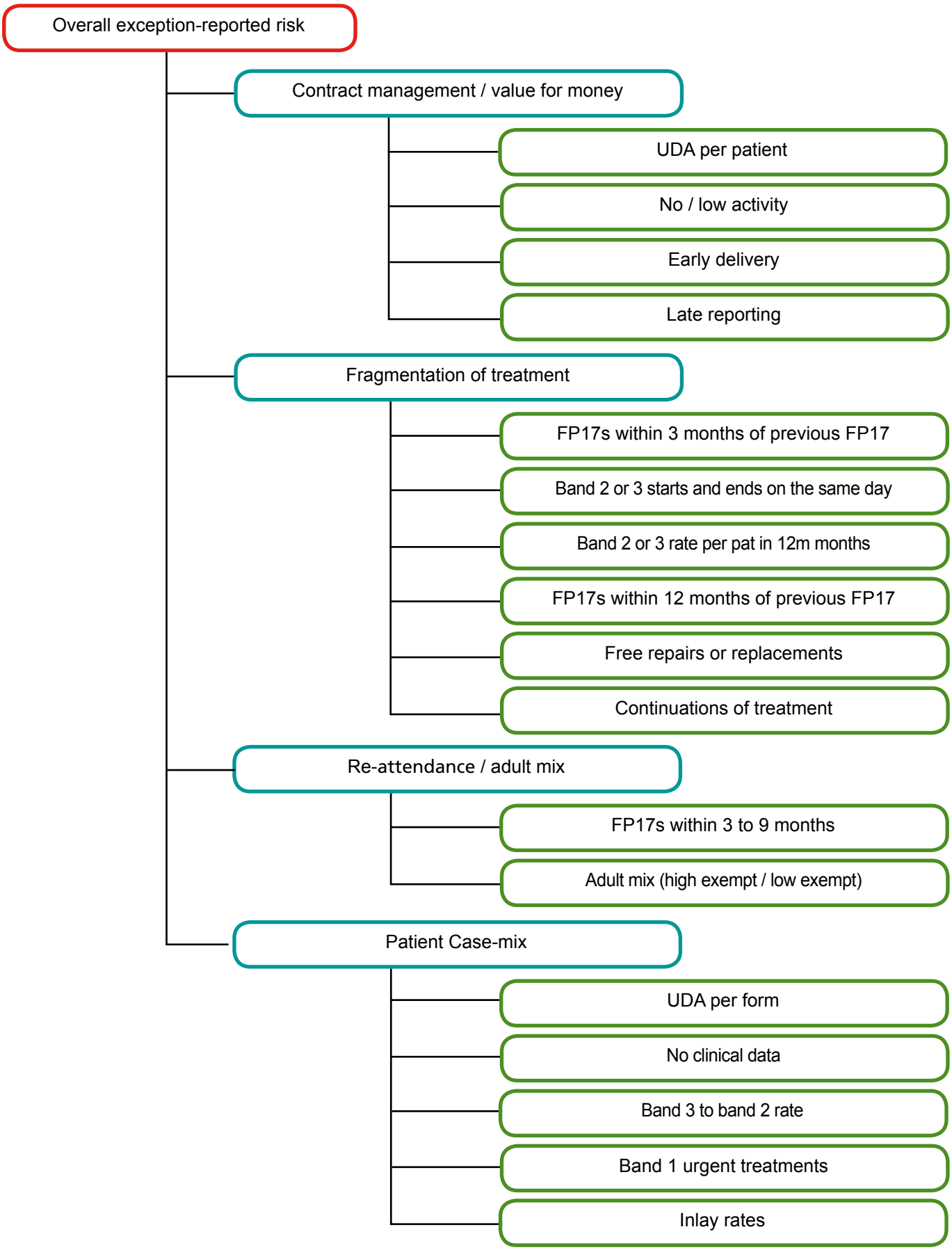
2. Identifying exceptions

For each indicator we have established an exception threshold. Where a rate for the contract is more extreme than the exception threshold, the contract is regarded as an exception for that specific indicator and quarter. The actual thresholds are calculated in a variety of different ways depending on the specific indicator. Generally they are based on 'order statistics' where all contracts are ranked or sorted by the indicator. From this distribution exception thresholds can be calculated, for example using the inter-quartile range (IQR) and adding a multiple of (usually one and a half times) this to the upper quartile.

A second threshold has been calculated to indicate an 'amber' status where the contract is regarded as high but not an exception. This is to allow commissioners to trace changes in status over time with a little more sensitivity. Details are given later in the guidance.

For most of the indicators, where a contract has delivered fewer than 10 units in the denominator value of the indicator (for example fewer than 10 FP17s have been scheduled in a quarter for the Free Repair and Replacement indicator), no exception status is given for that indicator. This is to avoid highlighting large numbers of very small or redundant contracts as exceptions, which would distract attention from contracts where there are significant levels of risk. Clearly for specific indicators of low or no activity, there is no lower limit on activity.

2.1 The Indicators



2.2. Exception Indicators of General Value for Money and Contract Management

Indicator	UDA per patient (adult, child, total), three separate indicators.
Description / Rationale:	The average number of UDA claimed for each patient in a quarter is a fundamental measure of the intensity of resource use. Particularly in the case of adults, if a contract has exceptionally high rates of UDA per patient it could indicate that resources are not being managed in the most cost effective way and that patient access is being compromised. High rates of UDA per patient can result from a combination of causes. For example, unusually high frequencies of treatments, and therefore, claims (FP17s) per patient would inflate the number of UDA per patient. Also an unusual mix of band 3 treatments compared to other bands would increase the rate. These two factors could have a range of underlying causes which need to be identified including an unusual case-mix at the practice. It may be that the practice has an abnormal policy on recall frequency of adults (NICE guidelines may be useful here for establishing acceptable frequencies with the practice) or it could be that the provider has misunderstood the rules relating to 'splitting' courses of treatment. Other factors which can influence the number of claims per patient include high failure rates (free replacements of guaranteed items or continuations of treatment).
Numerator:	Number of UDA associated with adult courses of treatment (eighteen and over) scheduled[1] (processed) during the period.
Denominator:	Number of adult patients who had at least one course of treatment processed during the period.
Thresholds:	The exception threshold for this indicator (and many of the others) is based on a well defined method for identifying statistical outliers without making too many assumptions about the nature of the distribution. The distribution of rates across GDS and PDS contracts for the whole of England and Wales is analysed by sorting the contracts for an indicator. The difference in rates between the contracts a quarter of the way along the distribution (lower quartile or Q1) and three-quarters of the way along (upper quartile or Q3), is found. This inter-quartile range (IQR) is then used by multiplying it by one and a half times and adding that range to the upper quartile. That point (Q3 + 1.5 x IQR) is then regarded as the outlier threshold. Contracts which are more extreme than this point for a specific indicator have been classified as 'exceptions' for that indicator. A second threshold has been calculated to indicate an 'amber' status where the contract is regarded as high but not an exception. This is to allow commissioners to trace changes in status over time with a little more sensitivity. Unless otherwise stated it is based on Q3 + IQR. It can be viewed as an early warning where there is a general upward trend in the rate.
Cross references:	It will be useful to look at forms per patient to see if the underlying cause is fragmentation of treatments (splitting). Free repairs and Continuations may provide further information about underlying causes as well an unusual proportion of Band 3 treatments. Inlay rates could be a causal factor.

1 The word 'scheduled' is used by NHS Dental Services in this report and elsewhere to refer to claims or records which are processed during a reporting period. The actual treatments may be associated with dates outside of the period.

Indicator	No activity / Low activity
Description / Rationale:	**No A Exception Reports Guidance Notes ctivity:** Contracts which are apparently open (having a contract status of 'active') appear as exceptions where no FP17s have been processed during the period. Possible causes may include problems with the way the contract has been set up on the Payments Online system (POL) or possibly the way the practice is attempting to transmit records. Sometimes contracts are left 'active' on POL after the contract has finished. Another reason may be that the contractor is transmitting data under an alternative contract, perhaps a redundant one or a new one. Another potential reason is that all of the records are being rejected because the transmitted contract details or treatment dates do not match those which are expected, because the details recorded on the POL system differ from those being transmitted. Further information about common reasons for FP17s rejections can be obtained from our website: *www.nhsbsa.nhs.uk/dentalservices.aspx* Where the commissioner suspects there are technical problem – they can contact either their Customer Liaison Manager, or the NHS BSA helpdesk on 0300 330 1348. **Low Activity**: Contracts are also classified as exceptions if their delivered UDA are much lower than expected, that is, compared with their contracted UDA. The threshold is calculated for each quarter based on the national distribution of contract delivery, and contracts with an exceptionally low proportion delivered are highlighted. Clearly the expected proportion changes with each quarter. Low activity may have technical causes, as with no activity above. It could result from problems with setting up or operating practice computer systems. Some contracts are misclassified as 'orthodontic' or 'general' preventing submitted claims from being counted. It may also be a reflection of a lack of control or adequate resources to meet the contract. The underlying cause will determine the action the commissioner needs to take to address the problem.
Numerator:	Numerator: Number of UDA delivered from the start of the current reporting year to the end of this quarter.
Denominator:	Denominator: Number of UDA contracted for the current reporting year.
Thresholds:	Outlier threshold: In the case of 'no activity' any open contract with no recorded activity is classified as an 'exception' for this indicator. In the case of low activity, contracts where fewer than 10 FP17s were received or where the processed UDA for the current year's activity scheduled since the beginning of the year is lower than the threshold are counted as exceptions. Please note that contracts where the contracted UDA is 400 or less are not counted as exceptions. The outlier threshold for this indicator is based on the distribution of rates across contracts for the whole of England and Wales and is calculated as the 5th percentile nationally.
Cross references:	The corresponding risk of excess delivery is highlighted under the Early Delivery indicator, below. An alternative cause for under delivery could be Late Reporting which is also reported in the exception report.

Indicator	Early Delivery
Description / Rationale:	The delivery of more activity than expected within a contract would result in the contracted UDA being delivered significantly early. This could indicate insufficient contracted activity; a poorly controlled contract or simply data quality issues, such as wrongly recorded contract UDA. The last problem might include where the commissioner has indicated zero or a small nominal quantity of UDA on POL, or where a part year change in contract has been inappropriately recorded. It is important for commissioners to record appropriate contracted levels on POL in order that appropriate performance monitoring and risk management of all contracts can be carried out. Help in recording contracts appropriately on POL is available by contacting the NHSBSA helpline.
Numerator:	Number of UDA delivered from the start of the current reporting year to the end of this quarter.
Denominator:	Number of UDA contracted for the year.
Thresholds:	The outlier threshold for this indicator is based on the distribution of rates across contracts for the whole of England and Wales and is calculated as the 95th percentile nationally. Please note that contracts where the contracted UDA is 400 or less are not counted as exceptions.
Cross references:	This indicator could contribute to high rates of UDA per patient; and Forms per patient.

Indicator	Late Reporting
Description / Rationale:	For each contract with activity, we have counted the number of FP17s scheduled, which were received more than 62 days after the latest date of treatment on the FP17. In most cases, the date of completion or date of last visit is used; if this figure was missing, the date of acceptance was used. The percentage of all claims received more than 62 days after the latest date of treatment was calculated for each contract. The contracts that submitted more of their FP17s after the 62 day limit, than the threshold, have been listed as exceptions. The threshold was set using the calculation for a statistical outlier, as with most of the indicators above. Incomplete courses of treatment are excluded from this calculation.
Numerator:	Numerator: Late FP17s scheduled during the quarter.
Denominator:	Denominator: Total FP17s scheduled during the quarter.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is based on the distribution of rates across contracts for the whole of England and Wales and is calculated as one and a half times the inter-quartile range above the upper quartile.
Cross references:	

2.3. Exception Indicators of Fragmentation (Splitting) of courses of treatment

Indicator	FP17s within 3 months of a previous course of treatment
Description / Rationale:	NICE guidelines recommend that the recall interval should be appropriate to the level of risk of dental disease for each patient . For adults the recommendations are that the shortest interval (exceptionally) should be 3 months. The longest should be 24 months, where there is no sign or risk of dental disease in the patient. If guidelines were being followed then a relatively small proportion of adult treatments would be expected to be within 3 months of a previous course of treatment. There is a theoretical risk dentists could split courses of treatment in order to maximise their UDA. The number of forms (EDI records or paper FP17s) submitted within three months of a previous course of treatment can be an indicator of the level of fragmentation of courses of treatment. NHS funded dentists are expected to identify all of the treatment needs during an assessment and, wherever practical, to provide all of the required interventions within a single course of treatment. This is true even when the individual components need to be spread over a number of months. Where dentists are submitting separate claims for assessment visits and individual treatments, the commissioner may want to understand why the provider believes this is appropriate. The vast majority of patients would be expected to have no more than one submitted course of treatment in a quarter. Relatively high rates of forms per patient within a quarter could be caused by high levels of continuations of treatment or free repairs and replacement. High rates of these may be a reflection of failure in the quality of treatments being provided. A common cause is the separate submission of assessment and treatment claims – which is not generally allowed under national regulations. Very high frequency recalling of patients would also have an upward pressure on this rate as would high levels of unplanned treatments, such as urgent or trauma treatments.
Numerator:	Numerator: Number of FP17s (adult, child, total) scheduled during the quarter where there was a previously recorded course of treatment ending less then three months previously anywhere in England or Wales. Where there is no recorded end date (incomplete treatments) then the date of acceptance is used.
Denominator:	Denominator: Number of FP17s (adult, child, total) scheduled during the quarter.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is based on the distribution of rates across contracts for the whole of England and Wales and is calculated as one and a half times the inter-quartile range above the upper quartile.
Cross references:	Indicators such as Free Repair and Replacement; Continuations; Late Reporting; Band 2 and 3 starting and ending on the same day; FP17s within 12 months; FP17s within 3 to 9 months; as well as other investigations will help to understand the underlying causes.

2 NICE Dental Recall Clinical Guidelines, CG19; October 2004, http://guidance/nice.org.uk

Indicator	Band 2 or 3 starts and ends on the same day
Description / Rationale:	Band 2 and 3 claims are submitted after a course involving dental treatment is completed. More often than not, these treatments will have an associated assessment or check-up which would have taken place at an earlier date and one or more treatment visits all of which would generally be regarded as part of a single course of treatment. If the course appears to start and end on the same day, this could indicate that a contractor is submitting separate claims for the assessment and treatment visits. The remuneration for assessment is included in the allocation of UDA for band 2 and 3 treatments so the dentist will be over-compensated for the treatments provided. Where the contract is flagged as an exception, further investigation should take place to establish if courses of treatment are being split or if dates are being improperly recorded on the returns.
Numerator:	Numerator: Number of Band 2 or 3 FP17s scheduled during the quarter where the date of completion is the same as the date of acceptance.
Denominator:	Denominator: Number of Band 2 or 3 FP17s scheduled during the quarter.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is based on the distribution of rates across contracts for the whole of England and Wales for 2010[3].
Cross references:	This indicator may be part of the explanation for a high number of forms per patient and high numbers of recalls within 3 to 9 months, as well as a high band 2 or 3 rate per patient within 12 months.

Indicator	Band 2 or 3 rate per 12 months
Description / Rationale:	Generally, the need for new courses of dental treatment will vary. Dentists will set recall intervals according to their perception of the dental risk in each instance. This might vary from 3 to 24 months. Where a provider appears to have a high proportion of treatments within 12 months of a previous treatment it is possible that there is a failure to provide adequate preventative advice or treatment during the earlier course of treatment. Alternatively it is possible that intended dental courses of treatment are being split across two claims, rather than being provided in a single course. Measuring Band 2 or 3 rates within 12 months of a previous band 2 or 3, in adults will give a slightly more subtle measure of splitting issues than shorter period recalls. For example dentists splitting treatments over 4 months or recalling for the next phase of treatment, will have higher rates here.
Numerator:	Adult band 2 or 3 treatments (FP17s) in the last 12 months.
Denominator:	Adult band 2 or 3 treatments (FP17s) in total.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is based on the distribution of rates across contracts for the whole of England and Wales in 2010.
Cross references:	FP17s within 12 months of a previous (below) includes checkups as well – and will detect splitting of checkups from treatments. This indicator can be used in conjunction *with FP17s within 3 months of a previous and FP17s within 3 to 9 months of a previous FP17.*

3 For some of the indicators where the distribution was highly skewed a transformed distribution was used to find the outlier threshold.

Indicator	FP17s within 12 months of previous
Description / Rationale:	Nice guidelines recommend that the recall interval should be appropriate to the level of risk of dental disease for each patient. For adults the recommendations are that the shortest interval (exceptionally) should be 3 months. The longest should be 24 months, where there is no sign or risk of dental disease in the patient. Evidence from the dental FP17s is that some dentists default to a 12 month recall interval. Where there are high proportions of patients without oral health problems this could represent a less than optimal use of resources. This indicator could result from a practice policy to maximise UDA within the contract. Exceptionally high rates are likely to be associated with practices with a recall policy not in line with NICE guidelines, for example a default maximum recall period of 12 months for adults.
Numerator:	Numerator: Number of FP17s scheduled during the quarter where there is a matching previous FP17 where the completion date on the earlier FP17 is within 12 months of the acceptance date of the later one.
Denominator:	Denominator: Number of FP17s scheduled during the quarter.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is based on the distribution of rates across contracts for the whole of England and Wales in 2010.[3]
Cross references:	This indicator may be associated with Free Repairs and Replacements; Continuations; Forms per patient etc.

Indicator	Free repair and replacement rates
Description / Rationale:	If an NHS dental treatment fails within twelve months the patient is entitled to have the treatment repeated or remedied free of extra charge. This most often applies to tooth restorations, such as a filling, root filling, inlay, porcelain veneer or a crown. If a filling fails within a few months of the treatment the patient can return to the practice to have the tooth refilled, with no patient charge. The dentist is entitled to the appropriate UDA for the treatment. Where there are high numbers of free repairs and replacements this will compromise the levels of access in the practice. In addition it could be an indicator of a failure to provide an adequate level of quality in treatments, and an unnecessary diversion of resources.
Numerator:	Numerator: Number of FP17s scheduled during the quarter where there is a free repair or replacement indicated.
Denominator:	Denominator: Number of Band 2 or 3 FP17s scheduled during the quarter.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is based on the distribution of rates across contracts for the whole of England and Wales and is calculated as one and a half times the inter-quartile range above the upper quartile.
Cross references:	Free repairs and replacements could be an underlying cause for exceptions in other indicators including UDA per patient and Forms per patient.

3 For some of the indicators where the distribution was highly skewed a transformed distribution was used to find the outlier threshold.

Indicator	Continuations of treatment
Description / Rationale:	The NHS Patient Charge Regulations provide that, where a course of treatment is completed but a patient then needs further treatment within two months, such further treatment is provided at no charge to the patient (although the dentist will receive the appropriate UDA). This was designed in response to concerns from patient groups to cover those few unusual situations where a dentist has completed all necessary care and treatment for a patient, but, for example, the patient unexpectedly returned within two months with a fracture in another tooth. Initial data, however, show much higher than expected numbers of claims for continuation of treatment, in many cases for patients whose initial course of treatment was only Band 1 (i.e. examination, scale and polish etc). This could indicate a misunderstanding by the provider, of the requirement to identify all the required treatment at the outset and to submit a single claim for all necessary interventions.
Numerator:	Numerator: Number of Band 2 or 3 FP17s scheduled during the quarter where there is a continuation of treatment indicated.
Denominator:	Denominator: Number of Band 2 or 3 FP17s scheduled during the quarter.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is recalculated each quarter and is based on the distribution of rates across contracts for the whole of England and Wales. It is calculated as one and a half times the inter-quartile range above the upper quartile.
Cross references:	High Continuations rates may explain other indicators such as Forms per Patient and UDA per Patient.

2.4. Exception Indicators of adult patient mix and re-attendances

Indicator	Adult FP17s within 3 to 9 months of a previous FP17
Description / Rationale:	Whilst splitting of treatment may be indicated by the number of claims submitted per patient within 3 months, multiple claims per patient between 3 and 9 months may be a better indicator of unnecessarily frequent re-attendances. NICE guidelines suggest that a range of re-attendance intervals would be appropriate for different levels of prevention and maintenance depending on the level of risk observed with the patients' management of dental health. Where there are exceptional rates of multiple claims per adult between 3 and 9 months the commissioner may want to understand the providers recall policy, to ensure it is not being used to maximise UDA and that it is consistent with agreed standards for oral health maintenance. A default recall policy with a relatively short interval, for example, would not be seen as an appropriate use of resources.
Numerator:	Number of FP17s for adults between 3 and 9 months of a previous claim.
Denominator:	Number of FP17s for adults.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is recalculated each quarter and is based on the distribution of rates across contracts for the whole of England and Wales in 2010. [3] above
Cross references:	Adult FP17s within 3 and 9 months may be associated with high UDA per patient and high rates of band 2 and 3 claims within 12 months.

Indicator	Adult exemption mix (high, low)
Description / Rationale:	The mix of exempt and non-exempt adults at a contract will vary quite widely across contracts for a number of reasons, not least the underlying socio-economic mix of the catchment population of the dental practice. However, an exceptional rate for this indicator could also be a sign of access problems, for example where a practice is not giving equal access to exempt and non-exempt patients, or where non-exempt patients are being diverted into private treatments. Commissioners may want to ensure that the access policies at the practice are not discriminatory and that the full range of treatments expected within the NHS are available to everyone who requires them.
Numerator:	UDA from non exempt adults scheduled during the quarter.
Denominator:	UDA scheduled from all adults during the quarter.
Thresholds:	There are two indicators and two exception thresholds. For high proportions of non-exempt patients the threshold is based on the national distribution in 2010 and has been set at two IQR above Q3. The low rate is set at 2 IQR below Q1 based on the same distribution.
Cross references:	

2.5. Exception Indicators of Patient Case-Mix

Indicator	UDA per Form
Description / Rationale:	A high UDA rate per form is a fundamental indicator of the profile of bands of treatment at the provider. Exceptional rates need to be investigated to ensure that the range of treatments being provided covers the full range of services expected of NHS contracts, and is not intended to maximise the UDA rate. For example, the proportion of inlays among tooth restorations can have a dramatic effect on the UDA rate per form in some contracts.
Numerator:	UDA scheduled during quarter
Denominator:	FP17s scheduled during quarter
Thresholds:	Outlier threshold: The outlier threshold for this indicator is recalculated each quarter and is based on the distribution of rates across contracts for the whole of England and Wales. It is calculated as one and a half times the inter-quartile range above the upper quartile.
Cross references:	High levels of Band 3 to Band 2 treatments might influence this indicator, more specific indicators such as high inlay rates compared with fillings will be of interest to commissioners.

Indicator	No clinical data
Description / Rationale:	All treatment FP17s would be expected to provide information about the treatment in the form of clinical data. The treatments are chosen from about 20 categories which includes an option for 'other treatment'. Band 2 and 3 FP17s should not be submitted without any clinical data.
Numerator:	Number of FP17s with no clinical data set.
Denominator:	Total FP17s scheduled during the quarter.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is recalculated each quarter and is based on the distribution of rates across contracts for the whole of England and Wales. It is calculated as one and a half times the inter-quartile range above the upper quartile.
Cross references:	

Indicator	Band 3 to 2 rate
Description / Rationale:	Attention tends to focus on fragmentation of treatments as a cause of excess UDA per patient. A completely different reason for high UDA rates is the mix of band 3 to band 2 treatments. Band 3 treatments carry four times the UDA of a band 2. Commissioners will want to understand the justification for exceptionally high ratios of band 3 to band 2 treatments. An example which has been found to be a significant factor in some contracts is high rates of inlays compared with fillings.
Numerator:	Band 3 adult FP17s scheduled in the quarter.
Denominator:	Band 2 adult FP17s scheduled in the quarter.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is recalculated each quarter and is based on the distribution of rates across contracts for the whole of England and Wales. It is calculated as one and a half times the inter-quartile range above the upper quartile.
Cross references:	A high band 3 to band 2 ratios may be associated with high rates of UDA per patient. This would suggest that case-mix is part of the explanation, at least. A recent study found high inlay rates to be an important cause in some contracts.

Indicator	Band 1 urgent treatments
Description / Rationale:	UDA from urgent treatments are claimed separately from planned treatments. A separate claim is allowed for the urgent treatment and the subsequent permanent intervention. Unusually high rates of urgent treatments would not be expected, except where the contract was for an emergency dental service. Commissioners will want to understand why a contract had an exceptionally high rate of urgent treatments. Urgent treatments might also be an indicator of failed treatments or a lack of preventative treatment.
Numerator:	Band 1 urgent UDA
Denominator:	Total UDA
Thresholds:	Outlier threshold: The outlier threshold for this indicator is recalculated each quarter and is based on the distribution of rates across contracts for the whole of England and Wales. It is calculated as one and a half times the inter-quartile range above the upper quartile.
Cross references:	Other indicators of failure such as free repair and replacement and continuations might be of interest here. High rates of urgent band 1 treatments might be associated with high number of Forms per Patient.

Indicator	Inlay Rates
Description / Rationale:	The inlay rate is based on the proportion of surface restorations (teeth with inlays and teeth with permanent fillings) done as inlays. This proportion should not be effected that much by the underlying level of caries in the catchment population, because one would expect both interventions to vary with the level of caries. Inlays are a form of indirect restoration of tooth loss, ranging from a small cavity to partial tooth loss. A clinical judgement is required to determine the appropriate restoration for each situation – but there is some evidence that inlays are being used for inappropriately small cavities where a direct restoration would be more appropriate. There is also evidence that the appropriate materials are not always used, sacrificing the permanence of the restoration, for cost. Inlays attract a Band 3 reimbursement, compared with band 2 for fillings. Where low cost materials are used inlays are the cheapest band 3 intervention available, which could present perverse incentives to dentists keen to maximise their UDA. It is also known that exempt adults are significantly more likely to be given inlays, than charge payers. Charge payers may be discouraged by the higher patient charge for band 3 treatments, opting for direct fillings instead. Where the inlay rates are exceptionally high, commissioners will want to understand the clinical justification from the dentist and also whether patients are being asked to choose between different restorations on cost grounds.
Numerator:	Adult FP17s – number of teeth with inlays on claim.
Denominator:	Adult FP17s – number of teeth with inlays or fillings on claim.
Thresholds:	Outlier threshold: The outlier threshold for this indicator is based on the results of an analysis and investigation in 2010. The outlier threshold is set at 0.20 and the amber threshold at 0.10.
Cross references:	Exceptional inlay rates may be one of the explanations for high UDA per form, and thus high UDA per patient.

3. Further Guidance and Support with using NHSBSA Dental Services information

For assistance with interpreting the information contained in reports and templates published by NHS DS please contact the Information Services team via the main help desk on 0300 330 1348 or by email on *nhsbsa.dentalservices@nhsbsa.nhs.uk*

If the AT/LHB has concerns about clinical behaviour and/or activity relating to the exceptions contained within its reports, you are invited to contact your local Clinical Adviser (CA) for further advice and clarification. A list of relevant Clinical Advisers is printed below:

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Contact details

Dental data can be contacted via the NHS Dental Services Helpdesk on **0300 330 1348** or email ***nhsbsa.dsdentaldata@nhs.net*** For general and Payments Online queries contact our helpdesk on **0300 330 1348** or email ***nhsbsa.dentalservices@nhsbsa.nhs.uk***
Website ***www.nhsbsa.nhs.uk/dentalservices.aspx***