Clinical audit and peer review scheme for the South West post-new 2006 dental contract: a report on progress so far

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IN BRIEF

- Understand the system of clinical audit and peer review in the South West.
- Appreciate how clinical audit can lead to improvements in patient care.
- Appreciate the role of clinical audit in a practitioner's clinical governance requirements.

GENERAL

With the introduction of personal dental services (PDS) into the South West the Local Assessment Panel (LAP) devised a new scheme consisting of 'cookbook' audits and piloted the scheme amongst the PDS dentists of South and West Devon, Somerset and Avon in 2005/2006. When the new contracting arrangements came into force, and in the absence of guidance from above, the LAP in consultation with the PCTs decided to consolidate the successful pilot audit scheme for PDS dentists and extend the new scheme to all the participating PCTs and their performers. The current scheme covers Devon, Somerset, Avon and Gloucester PCTs and is administrated by Mrs Jackie Derrick on behalf of Somerset PCT. All the audits showed improvement with the exception of the patient satisfaction survey where the first audit cycle showed an average patient satisfaction rating of 99% which cannot be improved on. We have redesigned this audit to try and make it more challenging and informative. The improvement in clinical record keeping was particularly marked. With the advent of new contractual arrangements in April 2009 it is essential that practitioners are able to demonstrate quality assurance in their practice and we believe that the South West scheme is a dentist friendly scheme, relevant to everyday dental practice.

INTRODUCTION

When the new contracting arrangements for general and personal dental services were introduced in April 2006 the obligation for clinical audit was included in the new standard contracts but was left up to the individual PCT to administer rather than the centralised system that had existed before.

The system of clinical audit and peer review had started as a pilot scheme in 1991 and had become a Terms of Service requirement in April 2001. All practitioners with a general dental services (GDS) contract had an obligation to participate in 15 hours of clinical audit and peer review activity in any three year period. This activity was monitored and administered by Local Assessment Panels (LAP) under the guidance of a Central Assessment Panel (CAP). Practitioners were remunerated separately for their audit activity and trained audit facilitators were available to help practitioners create and complete their audit activity. With the introduction of PDS into the South West the LAP devised a new scheme consisting of 'cookbook' audits and piloted the scheme amongst the PDS dentists of South and West Devon, Somerset and Avon in 2005/2006.

As usual the majority of the profession worked hard to produce thoughtful and informative audits which improved patient care and the small minority had to be dragged kicking and screaming into the twenty-first century.

The pilot scheme for PDS dentists met with overwhelming support from the participating dentists and the PCTs.

With the advent of the new contract the CAP and the central administrative arrangements ceased and PCTs were left to incorporate clinical audit and peer review into their own clinical governance arrangements. The obligation to participate in audit activity was still in the contract and the funding had, theoretically, been incorporated into the contract sums.

The Local Assessment Panel working in the South West had been organising clinical audit and peer review for dentists in Somerset, South and West Devon, Avon and Gloucester administered by Taunton Deane PCT. When the new contracting arrangements came into force, and in the absence of guidance from above the LAP in consultation with the PCTs decided to consolidate the successful pilot audit scheme for PDS dentists and extend the new scheme to all the participating PCTs and their performers. The current scheme covers Devon, Somerset, Avon and Gloucester PCTs and is administrated by Mrs Jackie Derrick on behalf of Somerset PCT.

SOUTH WEST CLINICAL AUDIT AND PEER REVIEW SCHEME

In the pilot scheme we devised a series of 'cookbook' audits for practitioners to complete. The first three were on:

- Infection control and decontamination
- Clinical record keeping
- Quality of radiographs.

With the advent of the new contract in April 2006 we added three more audits:

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- Patient satisfaction
- Recall intervals based on NICE guidelines
- Contractual obligations for nGDS and nPDS.

Each practitioner with an NHS contract for dental services with the participating PCTs was expected to complete an audit each year representing five hours of audit activity. No additional remuneration was available as the contracts notionally contained an amount to cover this activity and the PCTs administrative expenses came from their clinical governance budgets.

Each practitioner could choose one of the six audits and was given three months to complete the audit and return it to the LAP. The audits were designed as two stage audits with an initial set of results, an opportunity to examine the results and decide on any necessary changes to clinical practice, followed by a second cycle to see if any improvement had occurred. The audits were designed to easily demonstrate whether these gains had actually happened. We have included specific aims and objectives for each audit and practitioners must record whether they feel these have been met. We also have a section for feedback which is regularly used and are able to certificate five hours of CPD for each completed audit. The LAP read all the audits submitted and ensures that a satisfactory level of audit activity has been carried out by each dentist. We will return audits for further attention if they are deficient.

As with the original scheme the individual results were confidential to the participating dentist and the LAP. The panel felt that this would encourage the educational aspect of the audits and allow dentists to examine and improve their clinical practice without anxiety about PCTs monitoring their results. We are, however, aware of our responsibilities as registered dentists and to patient safety and if we see an audit which in our opinion highlights an issue of unsafe practice we will refer it to the relevant PCT. The results of all the audits are carefully recorded and presented to the participating PCTs in an anonymised form so that they can see any improvement in clinical practice by the dentists in their PCT area and compare it with the data from the South West as a whole. Each dentist is also sent the yearly results so they can compare their own results with that of their colleagues in the South West.

Each year the LAP runs a half day workshop for the participating PCTs and invites feedback from the PCT officers on how the scheme is operating and if any changes are necessary. This enables us to plan the following year's audits using the feedback from PCTs and participating dentists. The changes made for 2007/2008 following our workshop were:

- Introduced peer review
- Made modifications to the existing audits, especially the patient satisfaction audit
- Made an action plan a mandatory requirement for each audit which will be shared with the PCT
- Introduced a new audit on antibiotic prescribing
- Have included Devon PCT in the scheme.

RESULTS OF 2006/2007 SCHEME

The results of the audits will be given in some detail for the cross infection and radiographic quality subjects and a brief resume of the others will be given. If further details are required please email Mrs Derrick on Jackie.DERRICK@somerset.nhs.uk.

1. Cross infection control and decontamination structured audit

Aims and objectives

- To enable dental performers to evaluate their standard of cross infection control
- To use the results to promote discussion and necessary change
- To decide on and make any necessary improvements
- To review the changes made.

This audit consists of 100 statements concerning cross infection control and for each statement the participating dentist recorded:

A. Fully comply with the statement
B. Partial compliance but further work needed
C. Do not comply.

Sample statements

10. All clinicians and staff involved in invasive procedures are vaccinated against hepatitis B and have had a sero conversion test.
20. There is evidence that the appropriate PPE is available in the decontamination area, ie gloves, aprons and face protection.
30. Instruments are checked for cleanliness before sterilisation.
40. Have operators of the device (autoclave) received any training regarding its use?
50. Gloves are non powdered, hypoallergenic and low protein.

The results are recorded as a percentage for each of A, B and C. The practitioner is advised to examine their results and consider with their practice team if any improvements are required and how they could be implemented. The BDA Advice sheet 12 on infection control is recommended. Any changes to practice procedures and policies which are thought necessary should be implemented. Conclusions and any changes made are recorded in the box marked 'Conclusions and changes'

The audit is then repeated after any changes are implemented and the results of the second audit recorded as before. In a final box marked FEEDBACK the practitioner is asked to record their thoughts on the audit and how it could be improved. Also if they have a view on how the PCT could assist dental practices in maintaining a high standard of infection control they are requested to please let us know.

It should be noted that the audit contains some questions which mean that a finding of 'not applicable' needs to be recorded. (eg Q39 if you do not have a vacuum autoclave) or that some questions contradict each other. The purpose of the audit is not to register a 'perfect score' but to enable practitioners to evaluate cross infection control processes and hopefully improve them.

Results

Two hundred and forty-seven audits showed a 17% improvement in cross infection control standards (Fig. 1).

Some of the changes recorded

- Nurses to use heavy duty gloves for cleaning instruments and surfaces 37
- Cross infection control policy printed and available 57
- Immunisation records updated 31
- Ultrasonic cleaner to be drained and cleaned at the end of each day 30
- Face masks to be changed after each patient 19
- Disposable bibs to be used 9
- Improve disposal of extracted teeth 33

AND

- Practice owner does like us to wear uniforms
- Gloves to be changed between patients
- Changes not completed due to cost
- Below average score due to company policy to employ unqualified nurses
- The nurses do not get proper training before they start work.

Summary of the conclusions

- Cross infection procedures much better
- This procedure made me think more deeply about cross infection control
- Surgery uniforms now worn
- After the changes had been implemented, the second audit cycle assured us that the set standard had been achieved
- Improved our cross infection control considerably
- Basic infection control is of a high standard
- After 30 years in dentistry I'm not going to start using rubber dam now
- Increased staff awareness.

Examples of feedback

- Seemed to be doing quite well but must not be complacent
- I wasn't sure how much detail you wished to receive on 'changes/ conclusions after the first cycle'
- What does question 66 mean? Skin disinfection. Does this mean washing of hands, removing jewellery?
- Many thanks for this structured audit, very helpful. Where do we find a sample of a written cross infection policy?
- Some areas of audit not so clear ie Q44 & 45
- The PCT could assist dental practices in maintaining high standards of infection control by allocating funding specifically for washer/disinfector equipment and updated autoclaves
- Q5 – Feel this is not appropriate for non-clinical staff and could lead to incorrect information being given
- I am a single-handed practitioner, courses costing hundreds of pounds held by various companies are too expensive. Please run some.

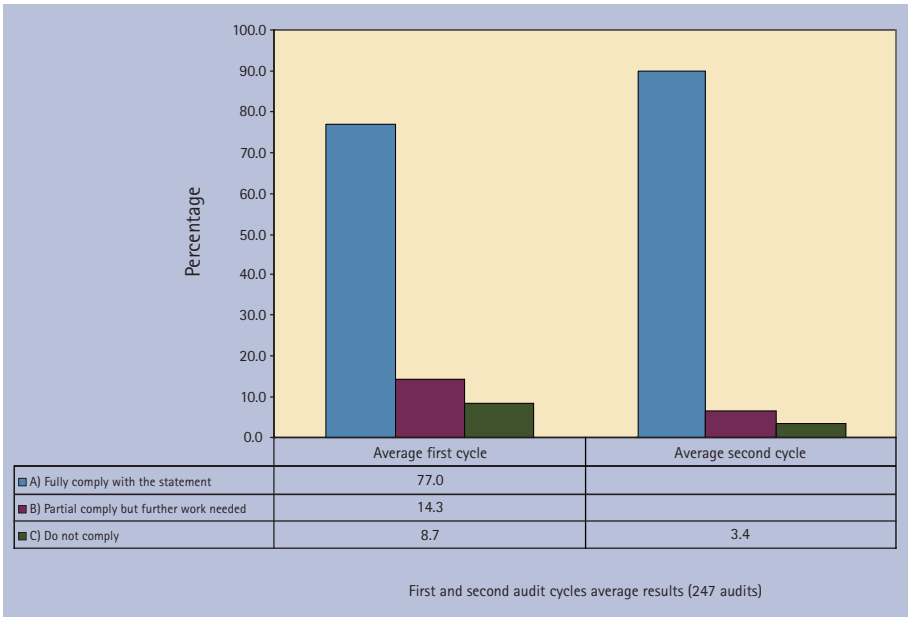

Fig. 1 South & West Local Assessment Panel area dental clinical audit – 1. Cross infection control and decontamination 2006/2007

Were the following AIMS and OBJECTIVES ACHIEVED?	Yes	No
To enable dental performers to evaluate their standard of cross infection control	150	
To use the results to promote discussion and necessary change	151	1
To decide on and make any necessary improvements	150	1
To review the changes made	149	1

Fig. 2 Cross infection control and decontamination clinical audit feedback

Assessment of aims and objectives

See Figure 2.

Conclusions

The audit satisfied the aims and objectives and contributed to a significant improvement in cross infection control in the South West.

2. Quality of radiographs

Aims

1. To set criteria and standards for good practice in the taking of radiographs
2. Compare current practice with the standard set
3. To collect data which will help decide what action is to be taken to

improve performance (eg improvement in technique, processing and performance of X-ray equipment)
4. To make changes where appropriate and to re-audit on a regular basis.

Objectives

1. To reduce radiation exposure to patients
2. To improve the diagnostic capabilities of radiographs.

Method

The audit consists of two cycles, a retrospective audit and a prospective audit. The retrospective audit involves the practitioner analysing a random selection of 50 recently taken radiographs. Each radiograph should be graded according to NRPB standards in quality, which are:

1. Excellent - no errors of exposure, positioning or processing
2. Diagnostically acceptable-some errors, but these errors do not detract from the diagnostic utility of the radiograph
3. Unacceptable-errors present, which render the radiograph diagnostically unusable.

With reference to the grading system, the practitioner analyses each film and put them into grades 1, 2 or 3. Radiographs from grades 2 and 3 are further examined in order to determine the causes of error and these are classified into faults due to:

a) Positioning
b) Exposure
c) Processing.

When the results of the first cycle have been collected the practitioner is able to see whether their technique for taking and processing radiographs requires any improvements. Analysis of the data from the grade 2 and 3 groups will highlight any changes that are required to improve on the results from the retrospective audit. Changes can then be implemented and assessed with the use of the prospective audit cycle, consisting of another sample size of 50 radiographs.

Results

There were 230 audits and there was an 18% improvement in quality (Fig. 3).

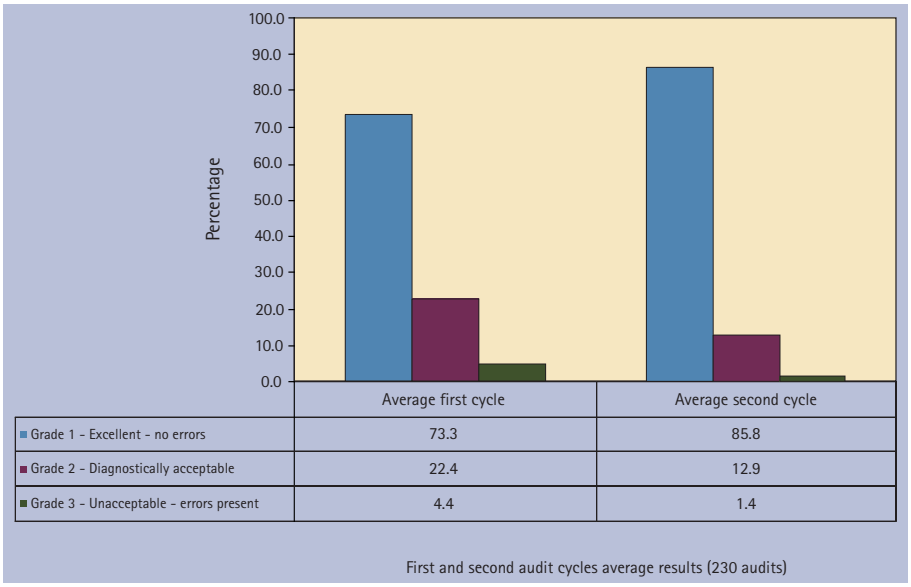

Fig. 3 South and West Local Assessment Panel area dental clinical audit. 2. Quality of radiographs 2006/2007

AIMS	Yes	No
1. To set criteria and standards for good practice in the taking of radiographs.	126	3
2. Compare current practice with the standard set.	127	1
3. To collect data which will help decide what action is to be taken to improve performance (eg improvement in technique, processing performance of X-ray equipment).	128	1
4. To make changes where appropriate and to re-audit on a regular basis.	125	4
OBJECTIVES		
1. To reduce radiation exposure to patients.	122	6
2. To improve the diagnostic capabilities of radiographs.	127	2

Fig. 4 Were the following aims and objectives achieved?

Some of the changes recorded

- Developing and fixing chemicals changed more frequently
- More careful positioning of film and X-ray head
- X-ray holders used more often
- Better staff training
- New equipment purchased.

Summary of conclusions

- High standards were achieved in first cycle but improvements were still recorded
- Care with alignment and processing produced better all round results
- Increasing use of digital systems will eliminate chemical processing problems, but not other common difficulties with positioning

Examples of feedback

- Easy to use and helped to improve techniques
- New equipment, especially film holders purchased
- Will do this audit every year to maintain standards
- Spent more time on staff training
- Very pleased with quality on first cycle.

Conclusion

The audit satisfied the aims and objectives and contributed to a significant improvement in the quality of radiographs (Fig. 4).

Summary results of remaining audits

Patient satisfaction survey

- Number of audits 185
- Percentage improvement 0.6

Audit of recall intervals in dental practice based on NICE guidelines

- Number of audits 38
- Improvement in factors considered and recorded at a dental examination 44%

Contractual obligations in the nGDS and nPDS

- Number of audits 39
- Percentage improvement 22.5%

Clinical record keeping

- Number of audits 183
- Improvement in clinical records with 0 items missing 150%

CONCLUSION

All the audits showed improvement with the exception of the patient satisfaction survey where the first audit cycle showed an average patient satisfaction rating of 99% which cannot be improved on. We have redesigned this audit to try and make it more challenging and informative. The improvement in clinical record keeping was particularly marked.

SUMMARY

The LAP feel that the South West clinical audit and peer review scheme has been a great success with both the PCTs involved and the vast majority of participating practitioners. The overwhelming feedback has been positive and the quality of many of the audits has been exceptional.

We are currently looking forward to 2008/2009 and have a workshop in February to discuss with the PCTs how they want the scheme to progress and integrate with their own clinical governance arrangements. Some of the issues we will be discussing will be confidentiality, poor performance, non compliance and the production of new relevant audits.

With the advent of new contractual arrangements in April 2009 it is essential that practitioners are able to demonstrate quality assurance in their practice and we believe that the South West scheme is a dentist friendly scheme, relevant to everyday dental practice. The underlying principle of the audits is to enable practitioners to examine their clinical practice in a non-threatening, structured and measurable way to give themselves the opportunity to examine their findings and make any necessary changes to improve their practice. It also gives practitioners an opportunity to compare their standards with that of their colleagues in the South West working under similar conditions. We encourage all participating practitioners to keep a copy of their completed audits as evidence to include in their personal or practice clinical governance portfolios.

My thanks go to Bernard and Stuart for their wise counsel, sense of humour and hard work. My biggest thank you, however, on behalf of myself, Bernard and Stuart, and all the dentists working in Devon, Somerset, Avon and Gloucester goes to Jackie Derrick without whose dedication, beyond the call of duty, the scheme could not operate.