



Modernising
NHS Dentistry –
Clinical Audit
and Peer
Review in the
GDS

Clinical Audit and Peer Review in The General Dental Services

April 2001

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Foreword

Clinical Governance in the GDS - The role of Clinical Audit and Peer Review

Guidance issued in March 1999 (HSC 1999/065 “Clinical Governance: Quality in the new NHS) is relevant to community and hospital dental services provided through NHS trusts. For the GDS, development has been driven centrally before handing on to Health Authorities (HAs) to manage as a Terms of Service requirement.

Clinical Governance is a Terms of Service requirement from April 2001. Every principal dentist will be required to have in place a practice based quality assurance system such as that described in the BDA publication “Quality Systems for Dental Practice” and ensure that all members of the practice participate in the programme.

Clinical Audit / Peer Review will be a central pillar of clinical governance so all dentists who provide general dental services will be required to participate in a rolling programme of Audit / Peer Review. Initially, the requirement will be to undertake a total of 15 hours in each successive period of three years. Because the NHS will require all dentists to participate, all dentists will be eligible to claim reimbursement of loss of earnings at the current rate for a total of 15 hours in each 3 year cycle. Claims will be submitted on completion of the whole project.

Demonstration of participation in Clinical Audit (or Peer Review) will be accepted by the General Dental Council as verifiable CPD within the GDC’s recertification scheme. This NHS requirement will therefore contribute 15 hours of verifiable CPD over a three year period for all dentists working in the GDS irrespective of their level of commitment.

Anything in addition to these requirements will be voluntary, but clinical governance will be developed over the 5-10 year programme and additional activities, such as risk management, for example, will be added as resources and the capacity of practices permit.

This document contains revised guidance on the new arrangements for Clinical Audit / Peer Review as part of clinical governance. The programme will be phased in over the next three years. Every effort has been made to ensure that dentists can participate when they feel ready to do so, but there may need to be some management of the process if take up differs from that profiled over the three year period. By year four the rolling programme will be fully established.

Introduction

1. This handbook sets out the conditions for the operation of the new Clinical Audit and Peer Review Scheme in the General Dental Services with effect from 1st April 2001. The new scheme builds on the best features of the previous “voluntary” Peer Review and Clinical Audit schemes in general dental practice. The new scheme will underpin Clinical Governance in the GDS. In the new scheme dentists may take part in either Clinical Audit or Peer Review.

Background

2. A Peer Review scheme for general dental practitioners (GDPs) was introduced as a pilot in August 1991. During the pilot, the scheme was evaluated by different outside consultants on two occasions. Both evaluations concluded that the scheme was a very valuable initiative and noted that the vast majority of dentists who had participated reported that they had found the experience useful. The consultants’ reports also commented on the scheme’s potential for improved service to patients.
3. A scheme for Clinical Audit in general dental practice was introduced in September 1995. The scheme was open to all GDPs in England and priority was given to those who had had experience of Peer Review. Arrangements for Clinical Audit were run in parallel with those for the Peer Review scheme. In 1999, an evaluation of the Clinical Audit scheme was commissioned. The evaluation investigated projects that were completed between April 1997 to March 2000. This evaluation recommended that more emphasis was placed in three areas. These were: methodology, Collaborative Clinical Audit and the evolution of clinical audit to make it more universal. A suggestion was made that pre-designed (cook-book) clinical audit methodologies should be developed.

Clinical Audit in the General Dental Services

4. Clinical Audit will be a central pillar of clinical governance, so all dentists who provide General Dental Services will be required to demonstrate that by the end of a three year period, they have participated in a minimum of 15 hours of Clinical Audit or Peer Review. The initial period will run from 1 April 2001. Activities do not necessarily need to be undertaken in any one year and can be split between years.

5. There are many different definitions of Clinical Audit. The one used in the Clinical Audit in General Dental Practice Scheme, which operated up to 31st March 2001 was “Clinical audit is the systematic, critical analysis of the quality of dental care, including the procedures and processes used for diagnosis, intervention and treatment, the use of resources and the resulting outcome and quality of life as assessed by both professionals and patients. The expected outcome is improved service and care for patients.
6. The aim of Clinical Audit is to encourage individual GDPs to self-examine different aspects of their practice, to implement improvements where the need is identified and to re-examine, from time to time, those areas which have been audited to ensure that a high quality of service is being maintained or further improved. Thus in a three year cycle an initial audit could take place in year one with follow ups in years two and three. The GDP, not an outside body, audits his/her own practice. Only an initial 15 hours will be funded in any three year period.
7. The scheme is overseen locally by the Local Assessment Panels (LAPs) and centrally by the Central Assessment Panel (CAP).
8. All dentists (Principals, Assistants and Vocational Dental Practitioners [VDPs]) with Health Authority numbers will be eligible for funding within the Clinical Audit and Peer Review scheme. Other dentists not on a Health Authority list may take part but will not qualify for funding.
9. Clinical Audit may be undertaken by individual GDPs or by a group of GDPs, who may not necessarily be in the same practice, working together in a Collaborative Clinical Audit. Some collaborative groups may include GDPs from HAs in adjacent LAP areas. However, it is for the LAPs to decide whether or not the distances between practices are reasonable and can refuse permission for dentists from other LAP areas to join in a collaborative audit if it would involve excessive travel. LAP permission must therefore be sought before starting any Collaborative Clinical Audit or Peer Review which involves dentists from more than one LAP area.
10. Dentists can receive help in structuring their Clinical Audits from an Audit Facilitator. Any dentist wishing to use a Facilitator or apply for funding should contact their Lead Health Authority (LHA) who can be identified from the list of Health Authorities in Annex 1.
11. It is necessary to contact the appropriate LAP before starting a Clinical Audit (see paragraph 22).

12. Guidance on how to obtain payment on completion of a Clinical Audit is given in paragraphs 44 – 53.

Peer Review in the General Dental Services

13. Peer Review is open to GPs as an alternative to Clinical Audit.
14. Peer Review provides an opportunity for groups of dentists to get together to review aspects of practice. The aim is to share experiences and identify areas in which changes can be made with the objective of improving the quality of service offered to patients. It is for dentists to take the initiative in contacting other dentists in other practices to form a Peer Review group. One dentist should act as the convenor (organiser) for the group.
15. It is entirely for the Peer Review group to decide on the frequency of meetings, the venues and other details of the group's proposed review. It is important that each participating dentist is willing to have some aspect of his/her own practice reviewed.
16. A Peer Review project must be completed within 6 months from the date that the convenor receives approval for the project. The first 15 hours of a project can be funded within the new scheme, subject to satisfactory approval (see paragraph 19). It is for the group to decide what aspects of their practices will be reviewed. The Peer Review may cover clinical, as well as administrative, aspects of practice.
17. Participating dentists can use a variety of source material for their review projects. The following are examples:
 - the Faculty of General Dental Practitioners (UK)'s Self-Assessment Manual and Standards (SAMS) which was funded by the Department of Health and other FGDP (UK) publications relevant to standards.
 - advice sheets and dental journals from professional organizations, such as the BDA, and specialist societies.
18. In preparing a proposal for a Peer Review project, dentists should bear the following points in mind :
 - (a) It must be well structured and include clearly defined goals.

- (b) It must have substance, but should not be too ambitious. It is better to concentrate on a few topics in some depth, rather than have a superficial look at a wide range of topics.
 - (c) There must be some potential benefit for GDS patients.
 - (d) It must not be purely research or be appropriate for Dental MADEL funding. A clear distinction must be made between Peer Review and other educational programmes. A Peer Review may highlight the need for dentists to pursue some educational activity in a particular area, but the educational activity, itself, cannot be part of the Peer Review.
 - (e) A Peer Review project must not consist solely of meetings at which a guest speaker gives a talk on a particular matter, although a presentation by a guest speaker might be part of a group discussion on the subject.
 - (f) It should not consist of dentists meeting to prepare for a postgraduate degree or diploma examination and be used as a vehicle to fund such meetings.
19. On completion of the Peer Review project the convenor must ensure that a typed resumé on a form END 3 (available from LHAs - see Annex 3) is submitted to the LAP via the nominated LHA together with an end of project report (available from LHAs – see Annex 3). Members of the group can only be authorised to receive payment for taking part once the LAP have checked the report. The LHA will submit all approved claims to the National Centre for Continuing Professional Education of Dentists (NCCPED) who will authorise the claim and arrange for payment to be made by the Dental Practice Board (DPB).

Conditions for undertaking Clinical Audit and Peer Review

20. In order to participate in the scheme and receive payments, a dentist must be on the list of a Health Authority. Dentists who do not meet this requirement may be invited to join in Peer Review Groups or take part in Collaborative Clinical Audits but will not receive any payment.
21. CAP approved and pre-designed methodologies for a variety of audits (off the peg or cook-book audits) are available from the LAPs.
22. A dentist should contact the Clinical Audit Adviser (CAA) via their LHA if he/she wishes to carry out an audit. The CAA may arrange for a facilitator to contact the GDP concerned to discuss the proposals for the audit. If the dentist has already undertaken Clinical Audit or wishes to carry out an audit with a pre-designed methodology and considers that assistance from a facilitator is not required, this should be stated on the application form BID 1 (available from LHAs - see Annex 3), which must be completed and submitted to the LHA. If the dentist is on the list of more than one LHA he/she may send it to whichever one he/she considers is most convenient in the case of a Clinical Audit and to the LHA from which the majority of group members come (if a Peer Review or Collaborative Clinical Audit).

Clinical Audit

23. If the LAP approves the application, the dentist must complete the Clinical Audit within four months from the date when he/she receives approval for the audit. Only 15 hours of Clinical Audit activity will be paid for in a three year period. GDPs may carry out more than these 15 hours if they wish but will not receive payment for these additional hours from GDS clinical audit funds. On completion of the audit the dentists should submit a claim for payment on form PAY 2 (available from LHAs - see Annex 3) together with form END 3 (available from LHAs – see Annex 3) which is part of the end of audit report, to the LHA.

Collaborative Clinical Audit

24. A dentist may consider that a proposed audit may best be undertaken in collaboration with other dentists. This should be discussed with the CAA before an application is submitted. However, it is for the LAP to decide whether or not Collaborative Clinical Audit is appropriate in a particular

case. When it does take place, Collaborative Clinical Audit should normally involve between 2 – 8 dentists. If, exceptionally, a group considers that it needs to be larger, an explanation should be given on form BID 1. Collaborative Clinical Audits must be completed within 6 months from the date when the group concerned receives approval for the audit.

25. Collaborative Clinical Audit may take place between single-handed practices or practice(s) with two or more dentists. In either case at least two dentists must be involved. It is essential for all the names of participating dentists to be included on the application form BID 1.

Peer Review

26. A dentist participating in Peer Review should normally join a group of between 4 – 8 dentists. The group must identify a convener and it will be his/her responsibility to submit the application for funding on behalf of the group. It is essential for all the names of participating dentists to be included on the application form BID 1.

Confidentiality and Anonymity

27. Dentists must ensure that patient anonymity is ensured in all projects (Clinical Audit, Collaborative Clinical Audit or Peer Review). As participation in Clinical Audit is a Terms of Service requirement, all dentists working in the General Dental Services are required to demonstrate that they have fulfilled Clinical Governance requirements by completing a minimum of 15 hours of Clinical Audit or Peer Review in a three year period. However, although participation must be demonstrated, it is unnecessary for the end of project report to be considered by any group other than the LAP or, if requested, the CAP and the nature of the Clinical Audit or Peer Review and its outcomes should remain confidential.

The Administrative Structures for the new Scheme

Introduction

28. Apart from the 13 LHAs (Annex 2), very few others have been involved in the administration of Clinical Audit and Peer Review for dentists and the majority of dentists have not taken part in the voluntary Clinical Audit and Peer Review schemes. As a transitional arrangement, during the first three year cycle of this mandatory requirement, it is proposed to make available to HAs the expertise of the existing LHAs and the Local Assessment Panels which they support acquired during the hitherto “voluntary” schemes for Clinical Audit and Peer Review.
29. The volume of administrative work in support of Clinical Audit and Peer Review will increase significantly where LHAs take responsibility for other HAs, and this will have staffing and financial implications. In such circumstances it would be unreasonable to ask LHAs to meet these costs solely from their own resources when much of the work they carry out is on behalf of other HAs. From 1 April 2001, HAs taking advantage of these arrangements should expect to contribute an annual per capita sum to the relevant LHA for each dentist in contract with the HA. LHAs should make early contact with HAs to confirm local arrangements. The existing LHAs will be asked to continue to carry out this function during the next three years, but every HA should prepare to take on this responsibility by April 2004 at the latest.
30. Each LHA should:
 - (a) Provide information to dentists who require it and issue forms as necessary.
 - (b) Acknowledge receipt of all applications.
 - (c) Scrutinise applications to ensure that all the information has been provided before applications are passed to LAPs. If there are any omissions or discrepancies, the Health Authority should take this up with the individual dentist or the convenor, as appropriate. If necessary the application form should be returned to the dentist or convenor.

- (d) Check that each dentist is on a Health Authority dental list. This may involve contacting other Health Authorities for confirmation. All dentists (Principals, Assistants and VDPs) with Health Authority numbers will be eligible for funding within the new scheme. Other dentists not on a Health Authority list may take part but will not qualify for funding.
- (e) Submit completed application forms BID 1 to LAPs.
- (f) Contact the NCCPED, either in writing, by fax or by email to confirm that the funding required is available.
- (g) Confirm with the NCCPED that individual dentists have not used up their allocation of 15 hours of Clinical Audit or Peer Review funding within the current three year cycle.
- (h) Contact the dentist or convenor concerned, as appropriate, should a LAP decide that a particular application cannot be approved for funding, to explain why.
- (i) Pass an explanation for non-approval to the facilitator concerned.
- (j) Advise the dentist or convenor, as appropriate, that although approval has been given for their project, payment cannot be made until the start of the next financial year, should the budget for the previous year have been exhausted.
- (k) Receive completed PAY 2 and END 3 forms.
- (l) Pass the END 3 to the LAP for approval and, when this approval is given, send the PAY 2 to the NCCPED for payment by the DPB. Instruct the NCCPED what payments should be made to facilitators and LAP members.
- (m) Agree the number of hours that LAP members should be paid for attendance at LAP meetings.

Role of a Local Assessment Panel (LAP)

- 31. The function of the LAP is to oversee Clinical Audit and Peer Review in its area. More specifically, it will:
 - (a) Consider the application forms BID 1 and pass comments and recommendations to the representative of the LHA.

- (b) Ask for additional information, if necessary, before deciding on an application.
- (c) Give an explanation for its decision when an application is turned down.
- (d) Aim to give its decision within two months of receipt of the application.
- (e) Re-consider applications which have earlier been turned down.
- (f) Consult with the CAP if there is an issue that cannot be resolved locally.
- (g) Receive reports END 3 on completion of projects and scrutinise these reports to see that all the information requested has been included.
- (h) Ensure that an explanation is given to the project Convenor / Facilitator should an end of project report be unsatisfactory.
- (i) Identify the number of Facilitators needed to serve their area and report this to CAP at regular intervals.
- (j) Direct and monitor the level of Facilitator support given to each project.
- (k) Ensure that all Facilitators are trained on a course approved by CAP and that they receive regular refresher training.
- (l) Manage Facilitators in a systematic way and on a regular basis.
- (m) Submit quarterly reports to the Chairman of the CAP.
- (n) Confirm approval for payments to the representative of the LHA and ensure that all claims to be sent to NCCPED are processed promptly by the LHA.
- (o) Liaise regularly with the Postgraduate Dental Deans and other providers to identify educational needs and opportunities.

32. LAPs should decide on the frequency of meetings, bearing in mind that decisions should normally be made within two months of receipt of applications. A LAP should not consider an application for project funding from a member of the same LAP. In these circumstances the application should be referred to a neighbouring LAP.

Membership of Local Assessment Panels (LAPs)

33. Each LAP should have a minimum of four members, including the chairman, of whom three must be GDPs as follows:
- (a) One must be a member of and appointed by the GDSC.
 - (b) One must be a dentist who is involved in the delivery of Postgraduate Education.
 - (c) One must be a dentist who serves as the Clinical Audit Adviser.
 - (d) One must be the LHA nominee (normally an Administrator).

Appointment of LAP members is a matter for the LHA in collaboration with the GDSC.

At any meeting of the LAP at least three members must be present.

The membership of a LAP should be reviewed every three years in collaboration with CAP.

Role of the Clinical Audit Adviser (CAA)

34. The Clinical Audit Adviser (CAA) is a member of the LAP with direct responsibility for:
- (a) Advising the LAP on all Clinical Audit matters.
 - (b) Overseeing the work of Clinical Audit Facilitators in the LAP area.
 - (c) Helping Convenors of Peer Review groups if required.

CAAs must have been trained as Facilitators but should not work as a Facilitator at the same time as holding the appointment of Clinical Audit Adviser. CAAs should serve initially for a 2 year period (and not more than 4 years). CAAs can return to the role of a Facilitator after serving as CAAs. A job description is available from NCCPED or BDA – see Annex 4.

Role of Clinical Audit Facilitators

35. A number of dentists have received appropriate training to undertake the role of Clinical Audit Facilitator. Their role is not to audit a practice but to be available to provide help, advice and support for dentists who wish to undertake audit. The Facilitator will generally assist dentists in the design and implementation of their audit or may suggest sources to select “cookbook” topics and methodologies. The Facilitator should liaise with both the Clinical Audit Adviser and/or the LHA before they undertake any facilitation and must receive prior instructions from the appropriate LAP. Under no circumstances should Facilitators facilitate outside their own LAP area unless they have a written request to do so for a specific project from a specific LAP.
36. Facilitators do not necessarily need to meet those who wish to be facilitated in person and may, if appropriate facilitate by telephone, videoconference, e-mail, etc. They must maintain a log book of their activity and submit claims regularly to the LHA which will scrutinize both the log book and the claims. The LHA will then forward claims to the NCCPED for authorisation on form CAF1 (available from LHAs – see Annex 5). The log book (and subsequent claims) should include time spent travelling to dentists’ practices, if this is appropriate and details of why it was necessary to facilitate an audit. Facilitators should agree the form of their log with the LHA and Clinical Audit Adviser. A suggested format for a log book is shown in Annex 5 (available from LHAs). Facilitators must claim hourly fees, together with reimbursement of any travelling expenses, via the LHA on form CAF1 (available from LHAs – see Annex 5). Claims should be submitted at least quarterly and cannot be backdated more than 6 months.
37. Facilitators may review a completed project before it is finally submitted to the LHA and provide the dentist with feedback and guidance on any educational requirements or opportunities that may have been highlighted. It is therefore essential that Facilitators have a broad knowledge of the educational opportunities available in their region and can direct dentists as appropriate. Facilitator’s comments and recommendations can be included with any END 3 when it is submitted.
38. CAP approved training will be provided to all Facilitators. Facilitators cannot undertake their role until they have been appropriately trained. Refresher training will be provided and all Facilitators should attend refresher training at least once every three years. A job description is provided (available from NCCPED or BDA – see Annex 6).

Role of the Central Assessment Panel (CAP)

39. The new steering group will be referred to as the CAP. The group's Chairperson is appointed after negotiation between the GDSC and the NHS Executive. The other members include three members appointed by the GDSC, one member from the Quality Assurance Forum, one representative from the Faculty of General Dental Practitioners (UK), one member representing COPDEND, one member representing the NHS Executive and a representative from the NCCPED. A representative from the National Assembly for Wales may also attend as an observer.
40. The main functions of the CAP are to:
- (a) Oversee the general conduct of the Clinical Audit and Peer Review scheme and review guidance in the light of experience.
 - (b) Advise LAPs on individual issues, when required.
 - (c) Consider quarterly reports from the LAPs.
 - (d) Respond to the quarterly reports.
 - (e) Select a range of end of project reports for in-depth analysis to ensure quality assurance.
 - (f) Review and re-define organizational roles and management functions of the LAPs.
 - (g) Approve and/or arrange suitable new Facilitator training and refresher training for Facilitators.
 - (h) Organize Workshops for LAPs and Facilitators.
 - (i) Help the LAPs establish and develop a method of feedback to help dentists improve their practice, giving examples of best practice.
 - (j) Assist in the development of strategic plans to implement and monitor the Clinical Audit and Peer Review schemes and review these plans annually in negotiation with the Department of Health and the NCCPED.
 - (k) Review all forms relating to Clinical Audit and Peer Review as necessary.

- (l) Review the contents of this publication as necessary and advise the NCCPED and the NHS Executive of the need for changes.
- 41. Fees for members of the CAP (excluding representatives in salaried employment) will be paid at the same hourly rate as those paid to dentists taking part in Clinical Audit and Peer Review and LAP members (see paragraphs 44 and 54 and Annex 7).
- 42. Administrative support for the CAP will be provided by the British Dental Association (BDA) for a fee to be negotiated annually with the NCCPED.

Role of the National Centre for Continuing Professional Education of Dentists (NCCPED)

- 43. The NCCPED is responsible for:
 - (a) Allocating notional (but not actual) funds from the Clinical Audit and Peer Review budget to the projects, in line with the requests of the LAPs and confirming bid allocation reference details to LAPs.
 - (b) Processing correctly authorized requests for payments via the DPB.
 - (c) Liaising with LAPs and the CAP as necessary.
 - (d) Managing the Clinical Audit and Peer Review budget for the NHS Executive.

Funding

For dentists undertaking Clinical Audit and Peer Review

- 44. All dentists with Health Authority contract numbers (irrespective of their annual earnings from the GDS) will be required to participate and be eligible to claim reimbursement of hours at the current rate (see Annex 7). In each three year cycle, reimbursement up to a maximum of 15 hours can be paid.
- 45. The Convenor of a Peer Review Group, or the leader of a Collaborative Clinical Audit, will also be entitled to claim an additional sum (see Annex 7) for the extra work that these tasks entail.

46. Additionally, a Peer Review group or Collaborative Audit can claim financial help towards the cost of secretarial support up to a maximum as shown in Annex 7 per completed Peer Review or Collaborative Audit. Claims for such expenses should be submitted on form PAY2 (available from LHAs - see Annex 3).
47. Dentists will also be entitled to claim travel expenses at Public Transport rate (see Annex 8) in line with their project submission which should not normally involve more than 6 return journeys. Approval of all travel will be subject to LAP consideration.
48. All claims should be submitted on completion of a project.
49. Payment for all claims will be authorized by the LAP and then submitted to the NCCPED for direct payment to the dentist concerned by the DPB. Once received by the NCCPED all claims will be paid within 28 working days as long as they have been correctly authorized by the appropriate LAP.
50. All claims must be submitted on the appropriate form PAY 2. All claims submitted for payment must include the relevant bidding reference number which will have been notified to the LHA by the NCCPED at the time that a bid was submitted (see paragraphs 30(f) and 43(a)).
51. If a Peer Review project is not completed, a report, with supporting papers, should be submitted to the LAP detailing how many sessions were completed and why it was not possible to complete the project. The LAP will then consider whether or not some payment should be made. Should it decide that payment should be made it will forward the papers and its recommendation to the CAP, who will either agree and pass the claim form PAY 2 to the NCCPED who will arrange payment, or reject the application and return it with reasons for its rejection to the LAP for onward transmission to the dentist(s) concerned.
52. The same procedure should be followed in the event that a Collaborative Clinical Audit is not completed.
53. Claims submitted before the end of February each year will normally be paid by 31st March that year, when funding has been given prior approval.

For CAP and LAP Members

54. Non-salaried members of the CAP and LAPs will be paid per hour for work both in committee and outside of committee, at the same hourly rate as that paid to dentists who take part in Clinical Audit and Peer Review (see Annex 7). If work takes place out of Committee, members of CAP or LAPs are expected to keep a log book (see Annex 5). Funding will be provided up to a maximum of 7 hours in any 24 hour period.

For Clinical Audit Facilitators

55. Facilitators will be paid per hour for their activities, validated by production of their log books, at a rate shown in Annex 7. The higher fee takes into account out-of-pocket expenses such as telephone calls, stationery etc. The claim must be approved by the LAP on the recommendation of the Clinical Audit Adviser.

General

56. All rates of pay will be subject to periodic review. Revisions to rates of pay and other allowances will be notified to LAPs at the earliest possible opportunity and can be found on the NCCPED website www.nccped.co.uk and in the Statement of Dental Remuneration. The hourly rate for peer review and clinical audit will be the same as the hourly rate for CPDA.
57. **This booklet replaces all guidance previously issued by the Department of Health regarding Peer Review and Clinical Audit in general dental practice. Dentists are advised to refer to the annexes to this document to identify their lead Health Authority and locate the appropriate forms necessary to make a submission of projects for approval and, if applicable, for funding.**

Enquiries

58. Enquiries about this guidance should be addressed to:

The National Centre for Continuing Professional Education of Dentists
(NCCPED)

4th Floor
123 Gray's Inn Road
London WC1X 8WD

Tele: 020 7905 1227

Fax: 020 7905 1224

Email: lsurry@nccped.co.uk

General enquiries should be addressed to:

Chairman, Central Assessment Panel (CAP)

British Dental Association (BDA)

Education and Science Department

64 Wimpole Street
London W1M 8AL

Tele: 020 7563 4131

Fax: 020 7563 4541

Email: cap@bda-dentistry.org.uk

Annex list

The following documents were referred to in this guidance document. This list indicates to whom the documents are relevant and from where they may be obtained. As all annexes may be subject to review and amendment the most up-to-date copies can be located on the NCCPED website:

www.nccped.co.uk

Annex	Subject	For	Available from
1	List of Health Authorities	Dentists	In this document
2	Lead Health Authorities (LHAs)	Dentists/HAs	In this document
3	Forms for bids, claims and end of project returns, to include: BID 1 – standard form for submissions PAY 2 – standard form for claims from dentists relating to projects END 3 – end of project questionnaire. Guidance on submission of Clinical Audit and Peer Review projects Guidance on content of end of project reports.	Dentists	LHAs
4	Clinical Audit Adviser’s Job Description	HAs	NCCPED or BDA
5	Facilitators/LAP/CAP claim form including the log book – CAF1	Facilitators/ LAP members CAP	LHAs NCCPED
6	Facilitator’s Job Description	Facilitators	NCCPED or BDA
7	Rates of payment	All	LHAs or NCCPED

Annex 1

Health Authority (HA)	Region	Lead Health Authority (LHA)
Avon	South West	Somerset Health Authority
Barking & Havering	North Thames (East)	Enfield & Haringey Health Authority
Barnet	North Thames (East)	Enfield & Haringey Health Authority
Barnsley	Trent	Southern Derbyshire Health Authority
Bedfordshire	Anglia	Suffolk Health Authority
Berkshire	Oxford	Berkshire Health Authority
Bexley & Greenwich	South Thames	Lambeth, Southwark & Lewisham Health Authority
Birmingham	West Midlands	North Staffordshire Health Authority
Bradford	Yorkshire	North Yorkshire Health Authority
Brent & Harrow	North Thames (West)	Brent & Harrow Health Authority
Bromley	South Thames	Lambeth, Southwark & Lewisham Health Authority
Buckinghamshire	Oxford	Berkshire Health Authority
Bury & Rochdale	North West	Bury & Rochdale Health Authority
Calderdale & Kirklees	Yorkshire	North Yorkshire Health Authority
Cambridgeshire	Anglia	Suffolk Health Authority
Camden & Islington	North Thames (East)	Enfield & Haringey Health Authority
Cornwall & Isles of Scilly	South West	Somerset Health Authority
County Durham	Northern	Gateshead & South Tyneside Health Authority
Coventry	West Midlands	North Staffordshire Health Authority
Croydon	South Thames	Lambeth, Southwark & Lewisham Health Authority
Doncaster	Trent	Southern Derbyshire Health Authority
Dorset	Wessex	Dorset Health Authority
Dudley	West Midlands	North Staffordshire Health Authority
Ealing, Hammersmith & Hounslow	North Thames (West)	Brent & Harrow Health Authority
East & North Hertfordshire	Anglia	Suffolk Health Authority
East Kent	South Thames	Lambeth, Southwark & Lewisham Health Authority
East Lancashire	North West	Bury & Rochdale Health Authority
East London & The City	North Thames (East)	Enfield & Haringey Health Authority
East Riding	Yorkshire	North Yorkshire Health Authority
East Surrey	South Thames	Lambeth, Southwark & Lewisham Health Authority
East Sussex, Brighton & Hove	South Thames	Lambeth, Southwark & Lewisham Health Authority

Enfield & Haringey	North Thames (East)	Enfield & Haringey Health Authority
Gateshead & South Tyneside	Northern	Gateshead & South Tyneside Health Authority
Gloucestershire	South West	Somerset Health Authority
Herefordshire	West Midlands	North Staffordshire Health Authority
Hillingdon	North Thames (West)	Brent & Harrow Health Authority
Isle of Wight	Wessex	Dorset Health Authority
Kensington, Chelsea & Westminster	North Thames (West)	Brent & Harrow Health Authority
Kingston & Richmond	South Thames	Lambeth, Southwark & Lewisham Health Authority
Lambeth, Southwark & Lewisham	South Thames	Lambeth, Southwark & Lewisham Health Authority
Leeds	Yorkshire	North Yorkshire Health Authority
Leicestershire	Trent	Southern Derbyshire Health Authority
Lincolnshire	Trent	Southern Derbyshire Health Authority
Liverpool	Cheshire	South Cheshire Health Authority
Manchester	North West	Bury & Rochdale Health Authority
Merton, Sutton & Wandsworth	South Thames	Lambeth, Southwark & Lewisham Health Authority
Morecambe Bay	North West	Bury & Rochdale Health Authority
Newcastle & North Tyneside	Northern	Gateshead & South Tyneside Health Authority
North & East Devon	South West	Somerset Health Authority
North & Mid Hampshire	Wessex	Dorset Health Authority
North Cheshire	Cheshire	South Cheshire Health Authority
North Cumbria	Northern	Gateshead & South Tyneside Health Authority
North Derbyshire	Trent	Southern Derbyshire Health Authority
North Essex	Anglia	Enfield & Haringey Health Authority
North Nottinghamshire	Trent	Southern Derbyshire Health Authority
North Staffordshire	West Midlands	North Staffordshire Health Authority
North West Lancashire	North West	Bury & Rochdale Health Authority
North Yorkshire	Yorkshire	North Yorkshire Health Authority
Northamptonshire	Oxford	Berkshire Health Authority
Northumberland	Northern	Gateshead & South Tyneside Health Authority
Nottingham	Trent	Southern Derbyshire Health Authority
Oxfordshire	Oxford	Berkshire Health Authority
Portsmouth & S E Hampshire	Wessex	Dorset Health Authority
Redbridge & Waltham Forest	North Thames (East)	Enfield & Haringey Health Authority
Rotherham	Trent	Southern Derbyshire Health Authority

Salford & Trafford	North West	Bury & Rochdale Health Authority
Sandwell	West Midlands	North Staffordshire Health Authority
Sefton	Cheshire	South Cheshire Health Authority
Sheffield	Trent	Southern Derbyshire Health Authority
Shropshire	West Midlands	North Staffordshire Health Authority
Solihull	West Midlands	North Staffordshire Health Authority
Somerset	South West	Somerset Health Authority
South & West Devon	South West	Somerset Health Authority
South Cheshire	Cheshire	South Cheshire Health Authority
South Derbyshire	Trent	Southern Derbyshire Health Authority
South Essex	Anglia	Enfield & Haringey Health Authority
South Humber	Trent	Southern Derbyshire Health Authority
South Lancashire	North West	Bury & Rochdale Health Authority
South Staffordshire	West Midlands	North Staffordshire Health Authority
Southampton & S W Hampshire	Wessex	Dorset Health Authority
St Helens & Knowsley	Cheshire	South Cheshire Health Authority
Stockport	North West	Bury & Rochdale Health Authority
Suffolk	Anglia	Suffolk Health Authority
Sunderland	Northern	Gateshead & South Tyneside Health Authority
Tees	Northern	Tees Health Authority
Wakefield	Yorkshire	North Yorkshire Health Authority
Walsall	West Midlands	North Staffordshire Health Authority
Warwickshire	West Midlands	North Staffordshire Health Authority
West Hertfordshire	Anglia	Suffolk Health Authority
West Kent	South Thames	Lambeth, Southwark & Lewisham Health Authority
West Pennine	North West	Bury & Rochdale Health Authority
West Surrey	South Thames	Lambeth, Southwark & Lewisham Health Authority
West Sussex	South Thames	Lambeth, Southwark & Lewisham Health Authority
Wigan & Bolton	North West	Bury & Rochdale Health Authority
Wiltshire	Wessex	Dorset Health Authority
Wirral	Cheshire	South Cheshire Health Authority
Wolverhampton	West Midlands	North Staffordshire Health Authority
Worcestershire	West Midlands	North Staffordshire Health Authority

Annex 2

Region	Lead Health Authority (LHA)	Contact	Telephone	email address
Anglia	Suffolk Health Authority, PO Box 55, Foxhall Road, Ipswich, Suffolk IP3 8NN	Caroline Thornberry	01473 323323	caroline.thornberry@hq.suffolk-ha.anglo.nhs.uk
Oxford	Berkshire Health Authority, 57-59 Bath Road, Reading, Berkshire RG30 2BA	Lorraine Roberts	0118 982 2864	Lorraine.Roberts@berks-ha.nhs.uk
North Thames	Brent & Harrow Health Authority, 21 Pinner Road, Harrow, Middlesex HA1 4BB	Julie Taylor	020 8537 3116	
North Thames	Enfield & Haringey Health Authority, Holbrook House, Cockfosters Road, Barnet, Herts EN4 0DR	Anne Atkinson	020 8272 5500	ann.atkinson@enhar-ha.nthames.nhs.uk
South Thames	Lambeth Southwark & Lewisham Health Authority, 1 Low Marsh, London	Ms Cheri Gibson	020 77167000 ext.7805	cheri.gibson@ob.lslha.sthames.nhs.uk
South West	Somerset Health Authority, Wellsprings Road, Taunton, Somerset TA2 7PQ	Mrs Jackie Derrick	01823 344319	jackie.derrick@staff.somerset-ha.swest.nhs.uk
South West	Dorset NHS Health Authority, Victoria House, Princes Road, Ferndown, Dorset BH22 9JR	Adrian Wright or Andrew Johnson	01202 851212	andrew.johnson@dorset-ha.swest.nhs.uk
North West	Bury & Rochdale Health Authority, Ground Floor, 21 Silver Street, Bury BL9 0EN	Phil Emmott or Lindsay Wetherall	01706 869 666	Lindsay.Wetherall2@bury-roch-ha.nwest.nhs.uk
North West	"South Cheshire Health Authority, Primary Care & Service Development Directorate, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester CH2 1UL	Miss Faye Sheane	01244 650489	Faye.Sheane@messa.scheshire-ha.nwest.nhs.uk
Northern	Tees Health Authority, Poole House, Stokesley Road, Nunthorpe, Middlesbrough TS7 0NJ	Malcolm Smith or Myles Bradley	01642 320000	
Northern	Gateshead & South Tyneside Health Authority (Correspondence to: 54 High Street, Easington Lane, Tyne and Wear, DH5 0JN - marked Peer Review & Clinical Audit)	Pat Kilker	0191 526 4905	p.g.kilker@ncl.ac.uk
Yorkshire	North Yorkshire Health Authority, Rydale Building, 4th Floor, 60 Piccadilly, N. Yorkshire YO1 9PE	Susan Johnson	01904 825189	Susan.Johnson@nyorks-ha.northy.nhs.uk
Trent	Southern Derbyshire Health Authority, contract Department, Derwent Court, Stuart Street, Derby DE1 2FZ	Catherine Ball	01332 626300 ext.6377	Catherine.ball@mail.sderby-ha.trent.nhs.uk
West Midlands	North Staffordshire Health Authority, 120 Grove Road, Fenton, Stoke-on-Trent ST14 4LX	Kate Taylor	01782 298123	Kate.Taylor@nsha.wmids.nhs.uk

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