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Dental contract changes 2022/23 webinar

18:00 – 19:00, 27th July 2022

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Agenda

Topic	Speaker
Welcome	Ali Sparke, Director for Dentistry, Community Pharmacy and Optometry, NHS England
2021 reform process – engagement and issues raised	Sara Hurley, Chief Dental Officer for England
Learning from the prototype evaluation	Rachel Foskett-Tharby, Deputy Director for Dentistry, NHS England
Contract changes for 22/23	Ali Sparke
Next steps	Ali Sparke
Close	Ali and Sara

2021 reform process – engagement and issues raised

The current phase of contract reform started in 2021

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- Dental contract reform has been in discussion since the publication of a Health Select Committee Report in 2008 which led to the publication of the 2009 Independent Review of NHS Dentistry and a phase of piloting potential contract reform through the prototype programme.
- NHS England were invited by government to take the lead on the contract reform in March 2021. Six aims were identified:
  - Be designed with the support of the profession
  - Improve oral health outcomes
  - Increase incentives to undertake preventative dentistry, prioritise evidence-based care for patients with the most needs and reduce incentives to deliver care that is of low clinical value
  - Improve patient access to NHS care, with a specific focus on addressing inequalities, particularly deprivation and ethnicity
  - Demonstrate that patients are not having to pay privately for dental care that was previously commissioned NHS dental care
  - Be affordable within NHS resources made available by Government, including taking account of dental charge income.

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Process undertaken to understand current issues

- To support the development of reform options NHS England:
    - Ran an Advisory Group process from May-September 2021, supported by a technical working group
    - Undertook 10 engagement events with a wide range of stakeholders including dental contract holders, associates, dental therapists, hygienists, nurses and other practice staff, commissioners and patient representatives. These events were attended by 67 people randomly selected from 447 applicants to ensure a range of demographic characteristics.
    - Reviewed and reflected on the findings of the evaluation of the prototype practices with the support of these groups – we will now share a summary of these.

What was fed back through the engagement?

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- We identified the following areas which will require both short and medium term multi-factorial solutions to be addressed successfully. These were:
  - Access
  - Care for high needs patients
  - Addressing isolation and not feeling valued or part of the NHS
  - Urgent care
  - Affordability
  - Fairness
  - Skill mix/ teamwork
  - Reorientating the system towards prevention
  - Monitoring quality
- A range of potential solutions were discussed, many of which were taken forward for detailed development
- We also discussed the findings from the prototype programme, which experimented with a blended capitation / UDA payment mechanism. The findings from the evaluation were reviewed by the advisory and technical groups

Learning from the prototype evaluation

Prototype evaluation methodology and constraints

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- Three year evaluation of the data from the 21 ‘wave 3’ practices who entered the programme in 2016 was undertaken by NHS BSA.
- Where possible, comparisons were made with non-prototype practices. This was either all non-prototype contracts or a smaller, more comparable group of contracts (~4,000) depending upon availability of data.
- Comparisons were also made relative to the baseline year of 2014/15.
- Data sources were:
  - FP17 claims
  - Appointment transmissions (prototype practices only)
  - Monthly practice survey (prototype practices only)
  - Monthly patient survey of those receiving NHS care
- Significant differences are reported at a 1% threshold ($p<0.01$)
- Measures were agreed with the DCR evaluation group which included representation from DHSC, NHSE, BDA,CQC, BSA, PHE and a practising dentist.
- Main constraints: lack of a control group, some outcome measures not available or only available for prototype practices, carried out as an evaluation and implementation project where adjustments were made during the course of the programme and analytical datasets were not prescribed.

There was a fall in both the total numbers of patients able to access care and those who were charge exempt

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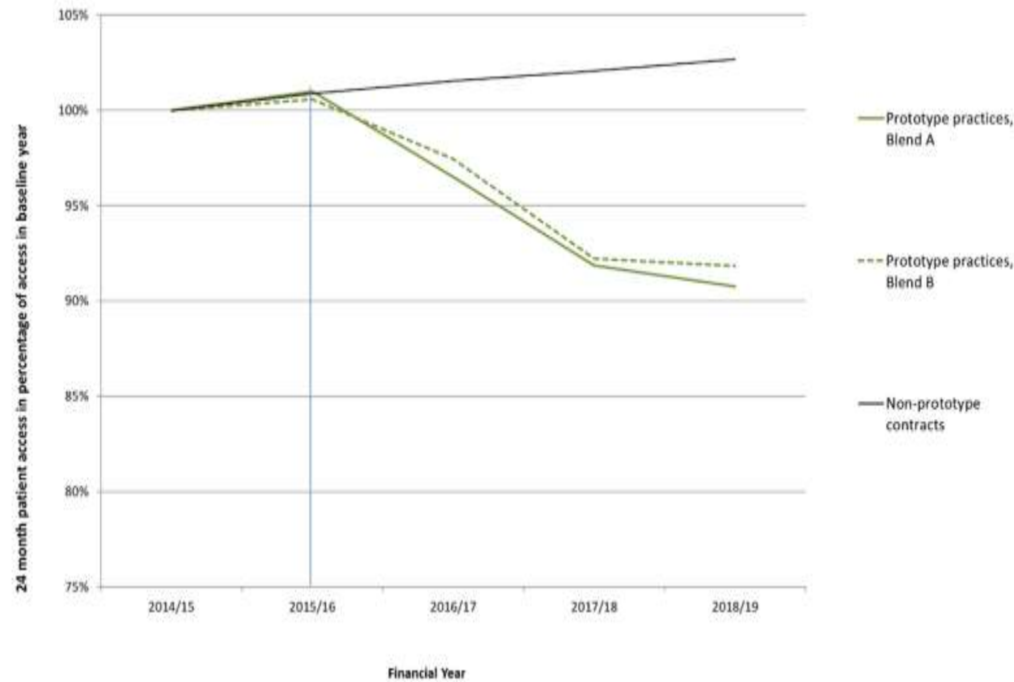
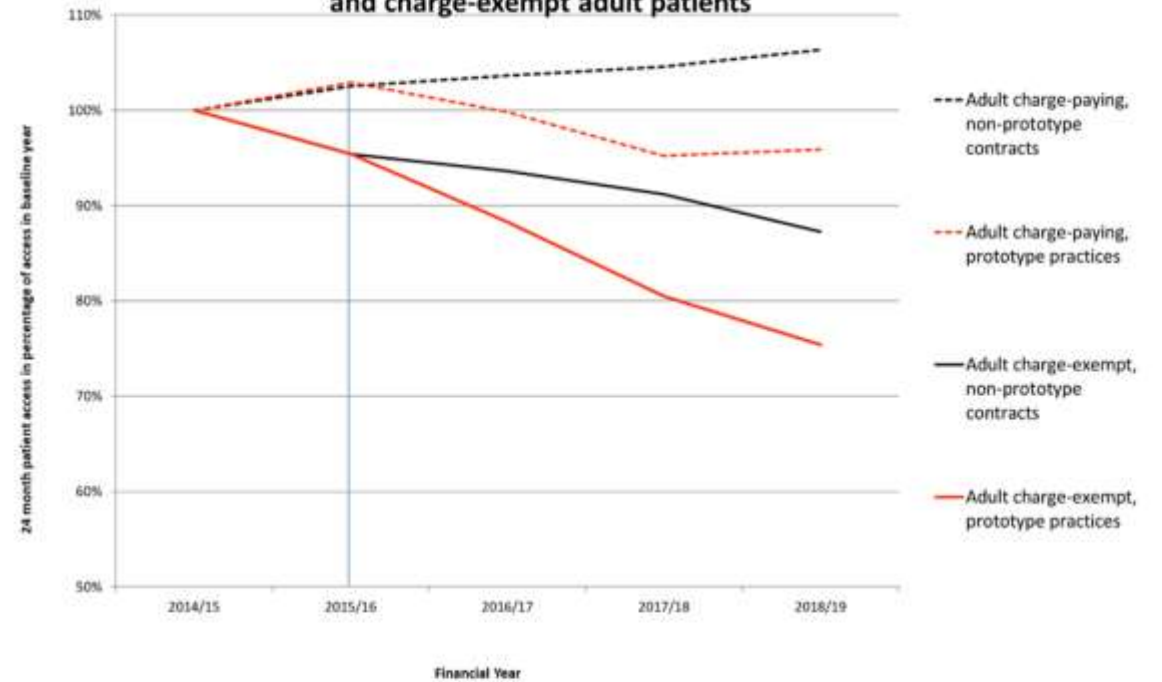
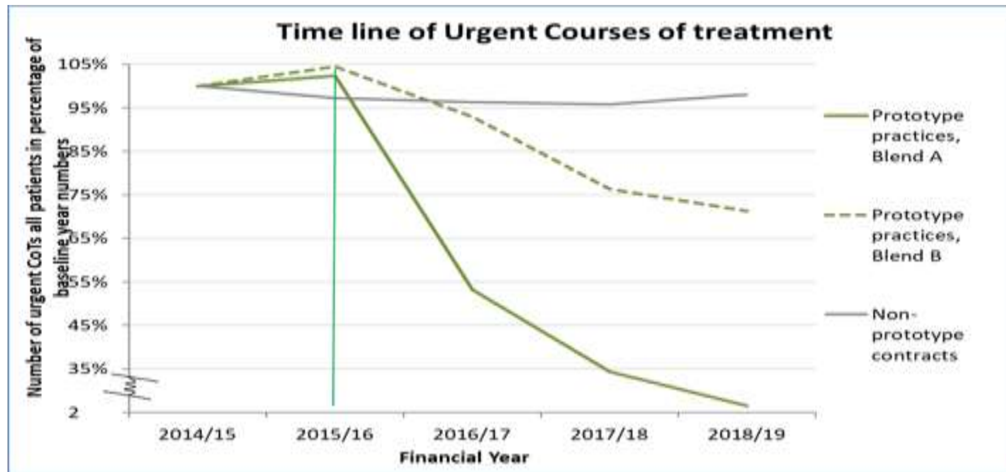
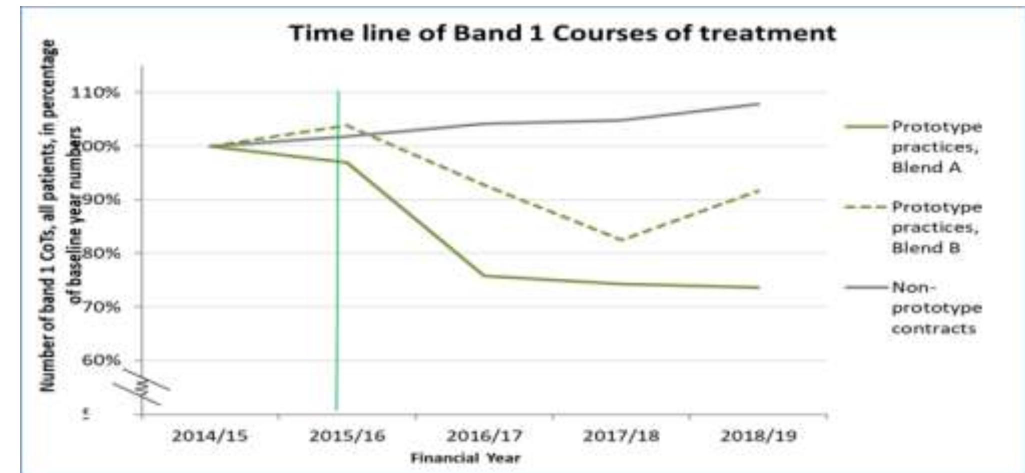
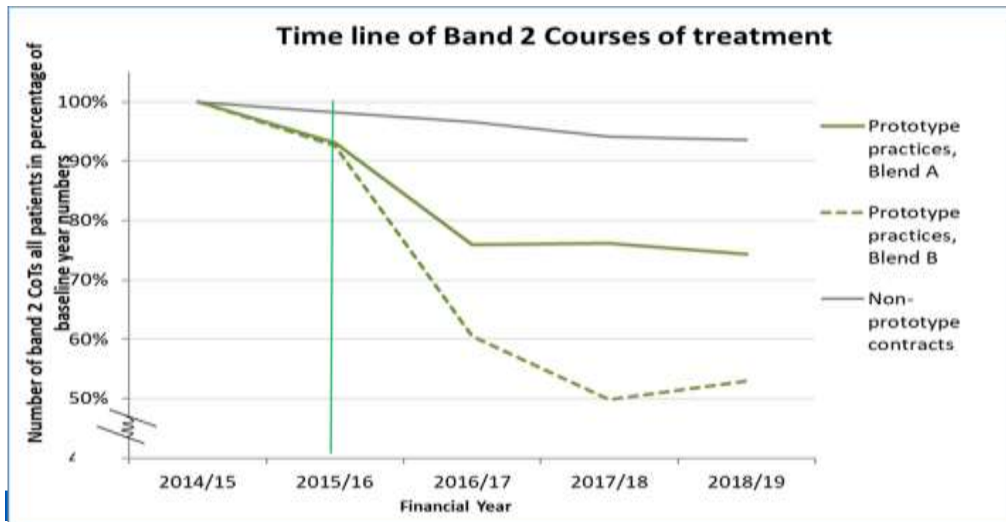


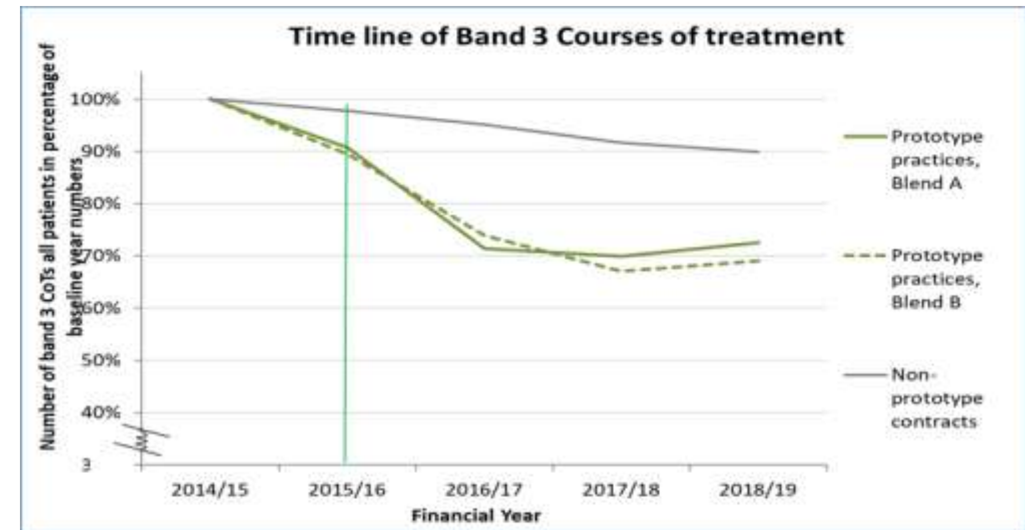


Numbers of courses of treatments reduced in all bands over the baseline year









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There was no increase in recording of prevention activities

	2016/17		2017/18		2018/19	
	Adults	Children	Adults	Children	Adults	Children
Prototype Practices	59.6%	62.2%	57.8%	59.5%	56.2%	57.1%
Non-Prototype Contracts	56.3%	58.2%	59.2%	61.0%	61.0%	62.8%

Nor in fluoride varnish application

	2016/17		2017/18		2018/19	
	Adults	Children	Adults	Children	Adults	Children
Prototype Practices	5.5%	42.2%	4.6%	46.1%	3.6%	48.2%
Non-Prototype Contracts	2.6%	41.4%	2.6%	48.1%	2.6%	52.6%

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Patient satisfaction with care was higher than non-prototype practices, but not with waiting times to appointments

	Patients satisfied* with NHS dental treatment received					
	2016/17			2017/18		
	N	%	CI	N	%	CI
Prototype Practices	3,141	97.1%	±0.76	3,865	96.9%	±0.71
Non-Prototype Contracts	53,175	95.7%	±0.23	33,295	95.7%	±0.29

	Patients responding that the length of time taken to get an appointment was 'as soon as necessary'					
	2016/17			2017/18		
	N	%	CI	N	%	CI
Prototype Practices	2,855	87.7%	±1.57	3,570	86.6%	±1.45
Non-Prototype Contracts	50,891	91.3%	±0.32	31,920	91.2%	±0.41

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Adherence to NICE recall guidelines

- Prototype practices showed closer adherence to NICE dental recall guidelines for both children and adults when compared to non-prototype contracts.
- Both children and adults had a longer interval between treatments in prototype practices compared with non-prototype contracts.
- However, approximately one-quarter of both adults and children did not return for a subsequent review of their oral health. This proportion is higher for those who were initially recorded as being high risk.

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Taking an incremental approach to reform

- The challenges facing the dental sector are complex and incorporate both contractual and wider issues.
- The learning from the prototype programme confirms the importance of careful analysis to fully understand the impact of major changes.
- The significant limitations of the alternative payment approach tested through these contracts mean that it cannot be taken forward for widespread implementation. However, the engagement was clear that there are important and urgent steps that must be taken. We are adopting an incremental approach:
  - Take short term action to introduce as many changes as possible which arose from the engagement in 2021, starting to address the identified challenges and ensure that care is focused upon those with the greatest clinical need
  - Work in parallel to develop longer term proposals, recognising some of the priorities will require more detailed analysis and evaluation

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Summary of the contract changes announced in July 2022

Refining UDA allocation to Band 2 care to account for complexity

- Band 2 CoTs were identified by the HSC in 2008 as ‘incorporating too wide a variety of treatment’. This was echoed in our engagement events with people highlighting the challenges and time consuming nature of providing care to people who require work to multiple teeth and root canal treatment.
- To start to address this we will be implementing the following changes:
  - To award 5 UDAs where a course of treatment includes the filling or extraction of three or more teeth and/or non-molar endodontic care to permanent teeth.
  - To award 7 UDAs for molar endodontic care to permanent teeth.
  - All other band 2 care will continue to attract 3 UDAs
- Implementation will require regulatory change.
- We are working with the NHSBSA and dental IT system suppliers to define the necessary amendments to the FP17 to support this change.

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Reducing the volume of low value clinical care

- The current NICE Guidance on recall intervals has had a limited impact on practice despite being a contractual requirement. For adults, there is little to no difference in oral health outcomes (caries, gingival bleeding and oral health related quality of life) when recalled on a personalised risk-assessed basis or a routine 6 month period.
- Fully implementing personalised risk based recall intervals could result in a 5% fall in unnecessary band 1 activity in adults.
- We will amend the FP17 to collect the following data:
    - Number of untreated decayed teeth at the outset of the course of treatment
    - BPE highest sextant score
    - Recommended recall period
- This information will be triangulated and shared back with practices to enable them to reflect on their approaches to personalising recall intervals.
- We will be working with the Personalised Care Institute and other stakeholders to develop shared decision making resources and patient facing communication materials to support clinicians with these conversations.

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Promoting the more effective use of skill mix

- We heard feedback from a wide range of organisations about the importance of recognising and supporting the appropriate use of the wider dental team in delivery of NHS care.
- We will be removing the administrative barriers which prevent dental therapists and others operating within their scope of practice and competence from opening courses of treatment.
- There will be an initial amendment to the FP17 to allow DCPs to submit a course of treatment under the contract holders personal identification number but we plan to move as rapidly as possible to DCPs having their own personal identification number on Compass.
- We will be working closely with clinicians already implementing skill mix and professional groups to develop case studies and guidance on how skill mix and direct access can be used in NHS practices, whilst working within the framework of the existing regulations.

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Minimum indicative UDA value

- A minimum indicative UDA value can be calculated by dividing the total contract value by the required activity. There are ~200 practices with an indicative UDA value of less than £23.
- Initial analysis suggests that practices with very low indicative UDA values may find it more difficult to fully and effectively deliver their contracted activity.
- Where a contract has an indicative UDA value of less than £23 we will reduce the required contract activity so that each UDA has an indicative value of £23. The contract total value will remain the same.
- This has no impact on practices where their indicative UDA value is already at or above this level.
- We will monitor the impact of this upon contract delivery and recruitment and retention to inform future discussions about pricing.

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Maximising access from dental budgets

- Where not all contracted activity is delivered this represents a loss of patient access to the NHS. Current rules prevent commissioners in most circumstances being able to release funding quickly from contracts where not all activity will be delivered, and so have limited ability to reinvest this money in year in practices which are able to deliver more.
- We are going to take a number of steps to allow more flexible use of dental budgets to ensure funding can be prioritised to practices best able to deliver NHS care.
- Firstly, the policy book will be revised to encourage proactive conversations between commissioners and practices, particularly where the contractor has delivered less than 30% of contracted activity by mid-year, to agree a voluntary reduction in their contracted activity for that single year.
- Secondly, following persistent under-delivery across 3 years, where voluntary reductions cannot be agreed, and no exceptional circumstances have been agreed, we will enable commissioners to unilaterally rebase contract value on a recurrent basis.
    - Persistent under-delivery is failing to deliver 96% of contracted activity in three consecutive financial years starting in 2019/20, 2022/23 and 2023/24 and then rolling forward on an annual basis.
    - The contract activity would be reduced to the highest level of performance in the preceding three years, designed to ensure the new activity levels are achievable

Enabling high performing practices to deliver more care

- In combination with the changes set out on the previous slide, we will amend the contract to enable practices who can, to deliver up to 110% contracted activity on a paid basis with commissioner agreement, subject to affordability.
- This will be supported by an open and transparent process whereby:
  - Commissioners identify there are resources not able to be committed due to under-delivery (or funding identified elsewhere)
  - Practices are approached and asked to put their names forward for potentially undertaking new activity under these powers
  - Commissioner discretion is applied to review need, inequalities, existing access issues, to award non-recurrent increases as necessary
- Contract tolerance will continue to be calculated at 96% of usual contracted activity, to avoid practices being penalised should all the extra activity not be delivered

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Improving communication with patients

- Practices will be required to update the NHS directory of services every 90 days as a matter of routine.
- They will also be required to update on an ad hoc basis to reflect any unexpected changes to opening times and delivery of services

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Questions arising from feedback to date

Common themes in the feedback to date

Skill mix

- Would dental therapists require performer numbers to be able to open courses of treatment?
  - No, the requirement to be on the Performers List is for dentists only. We are working with the BSA to introduce Personal Numbers for DCPs to enable them to open courses of treatment and submit the associated FP17. From October we anticipate that DCPs will be able to submit FP17s using their contract holders Personal Number as an interim solution.
- What are the practicalities of attending a dental therapist for treatment but a patient arrives with a problem/in pain - is the therapist able to take radiographs and diagnose the issue?
  - DCPs should work within both their scope of practice and their scope of competence. This is an individual determination and contractors should ensure that they have considered and assessed this when delegating contract activities to any other member of staff, irrespective of qualification or employment status.

IT implications

- When can we expect to see changes to the clinical system and Compass?
  - We are working with the BSA and clinical system suppliers to progress the required changes to the FP17 and to Compass. We will keep you updated as to when these will be implemented but we are working towards an Autumn 2022 implementation date.

Impact upon patient charges

- Will NHS England be introducing different/increased/reduced patient charges?
  - Dental patient charges are determined by the government rather than NHS England. However, there will continue to be a single patient charge for Band 2 care.

Next steps

Implementation and next steps

- The changes we have announced represent the first step in ongoing contract amendment and reform. There will be a number of important implementation steps which need to take place over the next few months, including updating the FP17 and working with the Department of Health and Social Care to support the regulatory changes necessary.
- We will in parallel start work on a new set of changes, tackling some of the longer term or systemic challenges which will remain.
- Our goal is to lead an ongoing conversation with you about the future of the sector, and we expect to undertake further stakeholder engagement in the late summer/ early autumn to consider other issues raised through the engagement, including building on the skill mix measures announced last week, workforce retention, children, health inequalities, evaluating options to support urgent dental care and payment reform.
- We will invite individuals and representatives to consider options as part of specific engagement across these areas, ensuring we hear from as many voices as possible.
- In addition, we are working with local teams across the country to support the delegation of dental commissioning to ICBs. We want to support the direction of travel outlined in the Fuller Stocktake, to ensure dental teams are embedded as part of a joined up approach to considering primary care, working closely with colleagues across general practice, community pharmacy and optometry.

Closing comments

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