

NHS Dental Contract: Proposals for Pilots

December 2010

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning/Performance Clinical	Estates Commissioning IM&T Finance Social Care/Partnership Working
Document purpose	For information
Gateway reference	15285
Title	NHS Dental Contract: Proposals for Pilots
Author	
Publication date	16 December 2010
Target audience	SHA CEs, PCT CEs, SHA Dental Leads, PCT dental Leads, dentists.
Circulation list	N/A
Description	NHS Dental Contract: Proposals for Pilots sets out proposals for pilots for a new dental contract based on registration, capitation and quality.
Cross ref	N/A
Superseded docs	N/A
Action required	N/A
Timing	N/A
Contact details	Dental and Eye Care Services Commissioning Directorate Department of Health New Kings Beam House 22 Upper Ground London SE1 9BW Tel: 020 7633 4251
For recipient's use	

Contents

	Foreword	3
Chapter 1	Introduction	4
Chapter 2	The need for a new approach	6
Chapter 3	Our policy proposals	9
Chapter 4	The pilots	11
Chapter 5	Next steps – selection and eligibility	18
Annex 1	Members of the National Steering Group on Reform of the Dental Contract	19
Annex 2	Quality and outcomes framework for dental pilots	20

Foreword

In the Coalition Agreement, we made a specific commitment to introduce a new National Health Service (NHS) dentistry contract that will focus on achieving good health and increasing access to NHS dentistry, with an additional focus on the oral health of schoolchildren.

When the NHS was founded in 1948, poor oral health was endemic, and the main work of NHS dentistry was the extraction of decayed teeth, and the creation of dentures.

Since then, the oral health of the population has changed. The latest surveys of the oral health of adults and children show that about two-thirds are free of visible tooth decay. People want a dental service that helps them to prevent oral health problems and maintain good oral health.

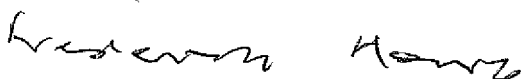
For the one-third who continue to suffer oral ill-health, treatment needs to be available, but the aim of that treatment should increasingly be to help people to achieve and then maintain improved oral health.

Until now, the NHS dentistry contract has remained focused on treatment; there has been little or no incentive for dentists to practise the sort of preventative dentistry that most people today want and need. It is time for this to change.

There have been false dawns in the past. Previous attempts to reform the NHS dental contract have failed to make the changes necessary. For this reason, we have worked closely with dentists' and patients' representatives, and NHS managers, to develop our proposals. And we have committed to pilot our changes before we implement them nationally.

Today we are publishing our proposals for pilots. We have developed them with the advice and support of a group of experts, including representatives of the British Dental Association, and Professor Jimmy Steele, author of an independent review of NHS dentistry. We are grateful to them for their advice and support.

We believe that our proposals offer the greatest opportunity to make NHS dentistry a service fit for the challenges of the 21st century.



Lord Howe
Parliamentary Under-Secretary of State for Quality

Chapter 1 Introduction

1. Our priorities for the NHS are:
 - putting patients and the public first
 - focusing on improvement in quality and healthcare outcomes
 - autonomy, accountability and democratic legitimacy
 - cutting bureaucracy and improving efficiency.
2. We are committed to applying these principles to the reform of NHS dentistry. We want the NHS to deliver dentistry that solves the problems of access that have bedevilled patients for many years, to help people to achieve and maintain good oral health throughout their lives.
3. People want to know that they can get access to NHS dentistry when they want to. They want to be able to register with a dentist, so they know they can go back to the same practice in the future. Two-thirds of adults and children are now free of visible tooth decay; people want a dental service that helps them maintain good oral health, not one that is focused on treatment only.
4. Dentists themselves need a new contract. We want to set dentists free from the burdens of targets and micro-management that have turned what should be a rewarding career into a “drill and fill treadmill”. Instead we want to enable them to exercise their professional judgement and encourage them to work with patients to prevent ill-health and promote good oral health, while being accountable for the quality of the services they provide.
5. Our aim is an NHS dental service that delivers high-quality, clinically appropriate preventative, routine and complex care for those who choose it. We want NHS dentists to feel proud of the service they provide to their patients, and for patients to have the confidence that they can get the services they need, when they need them.
6. To do this we need to change the way NHS dentistry is delivered. The Government set out in the Coalition Agreement its commitment to increasing access and improving oral health by introducing a new dental contract.

7. In paying dentists, we need to move away from the old “drill and fill treadmill”, which paid them only for activity, such as fillings, crowns and dentures. We need to change to a system whereby dentists are fairly rewarded through weighted capitation funding for the patients they take on, and motivated to provide the best clinical care through incentives to improve quality and clinical outcomes.
8. We are committed to delivering a better system for NHS dentistry and to piloting that system thoroughly before any wider implementation. Previous contract changes were not piloted, and consequences that might have been observed and addressed in the course of piloting were thus not foreseen. This paper sets out our proposals to run a series of contract pilots that will lead to a fundamental reform of the NHS dental contract. The pilots have been designed in consultation with a national steering group made up of representatives of the profession and patients, together with NHS managers. The members of the Steering Group are listed in Annex 1.
9. We intend to launch the pilots at the start of the next financial year (2011/12). We will select the pilot sites from among the dental practices that apply, with the support of their local primary care trust (PCT). Guidance on how to apply to take part in the pilots and detailed eligibility criteria are available at www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH_122660
10. We will assess the lessons of the pilots after a year, but if they are working well, we will consider allowing their extension until we implement the substantive new contract. We will then bring forward our proposals for this new contract, and for reforms to the patient charging system to fit in with the new contract. The changes will require legislation, and so we will then introduce them to Parliament in a Bill. Subject to the approval of Parliament, we would expect to implement the new contract in April 2014.

Chapter 2 The need for a new approach

11. We are committed to introduce a new contract for dentistry based on registration, capitation and quality. We have made this commitment against a background of widespread concern about the current system.
12. Introduced in 2006, the existing dental contract system is based on remuneration for activity – or units of dental activity (UDAs). The system does not reward quality. Dentists are paid largely on the basis of the volume of treatment delivered. In fact, the NHS has, until now, never recognised the importance of preventative care in dentistry, nor the value people place on achieving and maintaining good oral health.

Pre-2006

13. Some 60 years ago, when the NHS was founded, poor oral health was endemic. The first UK Adult Dental Health Survey, in 1968, found that 37% of adults had no natural teeth, and a major function of NHS dentistry was the extraction of decayed and damaged teeth, and the insertion of dentures. Thanks to the NHS, the “baby-boomer” generation have been able to retain their teeth, but often with a large number of fillings, and other restorations. The latest Adult Dental Health Survey, the first release of which was published this month, showed that the number of adults in England with no natural teeth has now fallen to just 6%. For those born from the 1970s onwards, the widespread use of fluoride toothpaste and greater awareness of oral health has seen a steady improvement in people’s oral health. Today two-thirds of adults and children are free of visible tooth decay, although tooth decay remains a problem for the minority, particularly but by no means exclusively in deprived communities.
14. Dentistry needs to change to reflect the changing needs of the people who use the service. When dentistry started to be delivered through the NHS, remuneration was based on a “fee per item”. Dentists were paid directly for the treatments they provided.
15. This fitted well with people’s needs in the early years of the NHS. As oral health improved over the years, dentists needed to bring preventative care into greater focus. However, the fee per item system meant that time spent on preventative care was, largely, unremunerated. There was a growing feeling within dentistry that the dental contract needed to be reformed to reflect the changing need for dentistry. The previous government introduced a new dental contract in 2006.

16. The 2006 contract was a missed opportunity to move away from the fee per item treadmill. It still remunerated dentists against activity (based on UDAs, rather than fee per item) and did not directly reward dentists for prevention or for the quality of services they provided. Dentists were incentivised to work towards their UDA targets, with financial clawback where these were not met.
17. While the contract gave PCTs the power to commission dental services to meet local health needs, the new contract also introduced unfairness into the system. Individual dentists have been given contracts, and different dentists have been paid widely differing sums for delivering the same treatments. Some dentists are paid half what others receive for the same treatments. The purpose behind this was to take account of the different needs of local populations, but because the contract value was derived from each dentists' treatment records, it further cemented dentists into a pattern of treatment rather than prevention. A significant number of dentists chose to stop working in the NHS rather than sign a contract, that they saw as unfair. Following the introduction of the contract, there was sharp fall in the numbers of people able to access NHS dentistry.
18. A key concern in the existing system for patients was its insecurity. While most dentists continue to see their regular patients, the 2006 contract removed registration from the NHS contract, and therefore any obligation to provide continuing care to regular patients. Under the current system, dentists commit to treat patients for no longer than a single course of treatment. This cannot be good for patient experience, nor for the promotion of good oral health over the longer term.
19. The House of Commons Health Select Committee was sharply critical of the new contract in its report in July 2008. It found that the contract had failed to solve problems of access, that the UDA-based system of remuneration was extremely unpopular with dentists, and that commissioning of dentistry by PCTs was often of poor quality. It called for registration to be reintroduced.

20. The Independent Review of NHS Dentistry carried out by Professor Jimmy Steele in 2009 found that the 2006 contract was in many dentists' eyes as much of a "drill and fill treadmill" as the old fee per item contract had been. The 2006 contract once again showed the need to pay dentists for providing high-quality, preventative care, not merely for giving treatment. The independent review called for dentists' contracts to encompass capitation and quality.
21. Experiments with capitation have been tried before. Under the pre-2006 contract, there were a number of pilots trialling capitation. But critically, these ran without a framework to ensure delivery of high-quality care, and there was a lack of detailed information about the treatment being provided. There was no ability for the NHS to assess the quality of care and, in consequence, value for money.
22. In moving to a capitation and quality model, we are therefore proposing a completely new way of remunerating dentists for the clinical care they deliver. We are building on the lessons of the past, and designing a system that will meet the needs of patients, and provide a more rewarding working life for dentists and their staff.
23. The next chapter sets out our policy aims.

Chapter 3 Our policy proposals

24. We propose to develop a contractual system based upon three elements – registration, capitation and quality.
25. This new approach reflects our belief that we should put patients and the public first, allowing them to receive personalised care to suit their needs, and setting dentists and their staff free to provide care in the way that is most suitable. Rather than paying dentists for providing individual treatments or courses of treatment, we will leave them free to determine how to care for their patients, and instead focus on the clinical outcomes they achieve over time.

Registration

26. Registration is essential in giving people assurance that they have a dentist to whom they can return when they need to, and who knows about the state of their oral health and their history. It helps to foster security and a spirit of partnership between the patient and the dental practice. A continuing relationship with registered patients helps the dentist to encourage them to take greater responsibility for maintaining good oral health, for example through diet and improved brushing regimes.
27. Registration is taken for granted in primary medical services. Many people still wrongly believe that they are registered with their dentist when in fact the 2006 dental contract ended formal registration in England, and no-one has the right to return to a dentist, no matter how long they have been treated by them in the past.
28. We intend to restore a right of registration. Because the contract pilots will be of short duration, we will not test this in them, but our formal proposals will include rights of registration for patients who want it.

Capitation

29. Instead of paying dentists according to the numbers of courses of treatment they provide, we propose to pay them according to the numbers of patients they provide care for.

30. In doing this, we recognise that not all patients are the same. For example, patients' needs change with age. Older people generally need more restorative dental treatment to maintain what may be already heavily restored teeth. Children may need frequent check-ups and preventative treatments such as fluoride varnishes, but mostly they do not need expensive restoration. As with other aspects of health, people from deprived communities tend on average to have poorer oral health and need more treatment. Women attend the dentist more frequently than men.
31. Therefore we will develop and test a weighted capitation formula, which will allow us to adjust the payments dentists receive to reflect the needs of the population for whom they provide care. For the pilots, we will base the capitation formula on the costs of delivering the current dental service. However, we recognise that those costs may be distorted by the perverse incentives that drive the current treatment-based contracts. And so the pilots themselves, which will not be based on payment for treatment, will help us to adjust the formula to reflect the actual costs of providing care.

Quality

32. Finally, it is essential that dentists continue to be accountable for the services they provide and for the money they receive from the NHS. And so we will introduce a system for monitoring and paying them for the quality of the care they provide.
33. We will use the pilots to develop systems that will allow dentists to record the oral health of their patients in detail, and monitor over time the progress they make in improving oral health. Recognising that to some extent people's oral health is outside the control of the dentist – because it is due to social and environmental factors such as diet, brushing regime, smoking, etc – we will derive from this quality indicators based on clinical outcomes.
34. In addition, it is essential that the patient experience is used to help determine the quality of services, and that there is compliance with quality and safety standards, and so we will develop a dental quality and outcomes framework (QOF), based on clinical outcomes and effectiveness, patient experience and safety.

Chapter 4 The pilots

Rationale

35. Changing the remuneration system has fundamental consequences for dentists, the NHS, and the people who use its services. The majority of dentistry is provided in general practice by dentists who are independent contractors. Although many dentists provide both NHS and private practice, for most, the NHS contract is their main source of income and thus essential to the quality and viability of the services they provide.
36. As such dentists tend to be quick to respond to incentives in the contract, any perverse incentives can lead to perverse effects in practice. The old fee per item contract paid dentists only for the treatment they provided, and so it gave them no incentive at all to take a preventative approach. The 2006 contract, while moving away from the fee per item approach, was still focused largely on treatment. The imposition on dentists of just three payment “bands” for courses of treatment meant that a dentist was paid the same for a single filling as they would be for carrying out multiple fillings, or treating a molar root canal.
37. These problems would have become evident had the 2006 contract been piloted. It is inevitable that dentists’ remuneration will affect the way in which they deliver clinical care, and we need to understand the drivers within any proposed new system before we consider implementing it throughout the NHS.
38. We intend to develop a new, national contract based on registration, capitation and quality. However, before doing so, we need to ensure that we have a weighted capitation formula that gives the right funding for different groups of patients, and a QOF that is robust, measurable, and creates the right incentives for dentists, without creating new perverse incentives as well. For these reasons, we consider it essential to carry out a set of contract pilots, which will help us to ensure that we get the final contract right for patients, for dentists and for the NHS.

What we are piloting

39. We intend to run three simultaneous sets of pilots. In all of the pilots, dentists will no longer have to carry out a given number of UDAs. All pilots will be required to adhere to a QOF. The three types of pilot are:
- type 1 – a simulation model
 - type 2 – a weighted capitation and quality model
 - type 3 – a weighted capitation and quality model, with a separately identified budget for higher cost treatments within the contract value.

Type 1 pilots

40. Under the type 1 model, dentists will receive the same contract sum as they currently do. They will be expected to adhere to evidence-based clinical pathways, and will be eligible for payment according to performance against the QOF. They will be expected to provide care for a specified number of people; but otherwise they will be free to provide clinical care as they judge appropriate.
41. If we seek to develop a weighted capitation model based on existing dental services, we would be assessing the cost of services on the basis of the current UDA-based system, which we know to be affected by historical activity and perverse incentives inherent in the contract. The same would apply if we went back to the data from the days of the fee per item contract.
42. By removing any financial lever to incentivise treatments of numbers of UDAs, and therefore courses of treatment, the type 1 pilots will help us to establish a fair baseline capitation value and a weighted capitation model reflecting the needs of different patients.

Type 2 pilots

43. Alongside the simulations, it is also important that we test dentists' responses to the proposed new system. The type 2 pilots will allow us to test this. These pilots will directly test the implications of applying a national weighted capitation model where capitation payments vary for different patients depending on factors such as age, gender and social deprivation.

44. In the type 2 pilots the practices will receive a capitation payment to cover all care (preventative, routine and complex), and will be eligible for payment according to performance against the QOF. The pilots will explore more realistically whether or not the factors used in the weighted capitation model reflect the needs of patients across different practices, and the response where the needs of individual patients differ from the average.

Type 3 pilots

45. The type 3 pilots will also receive a weighted capitation payment, but it will cover only routine care and treatment. The remaining contract value will be attributed to cover more expensive and complex care, particularly the types of treatments that require the services of a dental laboratory. Dentists will again be eligible for payment according to performance against the QOF.
46. Our aim is to implement a contract based on registration, capitation and quality, and these pilots will allow us to gauge whether the provision of a proportion of the funding explicitly for the dentist to use to provide some of the higher-cost, low-frequency care that is important to oral health makes any difference to clinical practice. It will thus help us to predict how the new contract will work, and to cost it.

Quality

47. Our new contract proposals will give dentists a great deal more freedom to make their own decisions, using their own clinical judgement about what is in the best interests of their patients. We believe that dentists will welcome this change, and welcome their liberation from the “drill and fill treadmill”. However, NHS dentistry accounts for nearly £3 billion of public expenditure (including the charges that patients pay), and it is right that dentists should be accountable for the service they provide. We believe that a QOF, which will measure the quality of their work and the clinical outcomes they achieve, is a better way of holding them to account than simply measuring the number of UDAs they carry out.
48. The pilots will help us to test a QOF in dental practice, and to develop and refine the systems that we can use to monitor quality and outcomes.

49. Quality covers three domains:
- safety
 - clinical outcomes and effectiveness
 - the patient experience.
50. Work on quality indicators, and in particular outcome indicators, is relatively new in the NHS and even more so in dentistry. The QOF itself will therefore need to continue to be developed over time. The pilots give us the opportunity to test and shape it in practice.
51. The QOF will be underpinned by the development of a comprehensive set of accredited clinical pathways. The importance of using clinical protocols using available evidence and professional consensus is a pillar of government policy, and in the context of dentistry has been highlighted by clinicians who are already pioneering quality frameworks.

Safety

52. Patient safety is of the utmost importance. Dentists and commissioners need to be committed to ensuring that clinical practice remains safe, and that safety is a fundamental part of the service.
53. Consequently patient safety is **not** something that should be rewarded within the QOF, as all dentists should adhere to safe practice at all times. In addition, safety in dentistry will be monitored through clinical regulation, working in partnership with the Care Quality Commission and the General Dental Council.
54. That said, one aspect of patient safety that should be measured as part of adherence to clinical pathways and the routine provision of oral health assessments is the taking of a patient's up-to-date medical history. This is something that the QOF will measure.

Clinical outcomes and effectiveness

55. The consensus within dentistry is that the ultimate clinical outcome is good oral health, and this should therefore be at the heart of the QOF. Working forward from first principles, for a patient to be in good oral health, fundamentally we mean that they:
- are free from pain

- have good functionality and aesthetic form to their teeth – essentially they can “eat, speak and socialise” to their own satisfaction
 - have clinically assessed good oral health now and can be confident that this will continue into the future.
56. The first two of the above outcomes are best judged by the patients themselves, and should be measured within the patient-related outcome measures (PROMs) domain (see below), rather than clinical effectiveness measures.
57. The third outcome is covered by the clinical outcomes and effectiveness domain, which focuses on both the improvement of oral health and the maintenance of good oral health. Essentially, the aim of a QOF should be to measure and incentivise movement of patients from a high-risk category to a lower-risk category.
58. The way in which this can best be measured involves a combination of overarching measures – for example the percentage of new patients undertaking a full primary dental care patient assessment or existing patients undertaking an oral health review, and the percentage of patients with an oral health and treatment plan. The outputs from the oral health assessment will provide the data to measure improvement and/or maintenance of oral health, and therefore outcomes that can be paid upon.
59. These assessments are fundamental to good dental practice, not only because they allow measurement of outcomes, but also because they determine the condition and level of risk for each patient, and therefore the recall interval for each patient.
60. The underpinning quality measures need to reflect the four main components of an oral health assessment or review, ie improvement or maintenance in the following areas:
- dental caries (tooth decay) – the number of teeth with carious lesions
 - periodontal health – evidence of bone loss, bleeding and basic periodontal examination (BPE) score
 - soft tissue health – evidence of soft tissue lesions
 - tooth surface loss – evidence of tooth surface loss causing wear of dentine in the teeth beyond that which is commensurate with age.

61. In each case, the dentist needs to assess and record the state of the patient's oral health, and so the QOF can be based on a set of "traffic light" indicators derived from each area, for example the percentage of patients moving from a high-risk category to a lower-risk one; the percentage of patients with new active carious lesions recorded at review; or the percentage of adults with an improving BPE score at review.
62. This approach – using clinical effectiveness measures as quality indicators – is in its infancy in NHS dentistry, but it is being piloted in a few practices. Initial feedback from those practices is that it does enable the dentists to measure oral health improvement, and that it motivates them to deliver clinical care appropriate to each patient's need and to perform a detailed assessment of each patient. They also believe that it is an aid to communication with patients, who find the traffic light rating easy to understand.
63. The system needs refinement. Some of the indicators of oral health are outside the influence of the dentist, for example social and environmental factors, and so the QOF needs to be able to focus on the clinical outcomes. Also, the IT systems for capturing and recording the oral health assessment are still at a developmental stage. However, adoption in the pilots will help us to refine the indicator set and work with the dental software suppliers to develop and improve the systems.
64. Because the pilots will be time limited, some areas of the assessment, in particular soft tissue and tooth surface loss, are unlikely to show much change, and so we will need to observe these indicators with no payment in the pilots, informing the utility or not of such assessment ratings in the eventual new contract.

Patient experience

65. Patient experience is critical in any assessment of quality. Indicators are needed to ensure that the service delivered is in line with patients' expectations, and that the outcomes are in line with what patients want and need. The measures should include:
 - experience of the appointment – engagement, being listened to
 - satisfaction with booking, facilities, etc
 - satisfaction with oral health and function.
66. The pilots will test the use of these measures. This will also provide an opportunity to test ways of capturing patient experience information – for example through text messaging following appointments.

Turning measures into payment

67. The contract pilots will allow us to test a payment system based on the above domains to gauge the best scoring system, the weighting that should be given to quality and to the components of the QOF, and the extent to which external factors, for example the size of the practice and number of patients seen, affect the quality scores.
68. For the pilots we have defined a framework of indicators, set out in the table at Annex 2. The quality element of the pilot contracts will be 10% overall; within that 10%, the weighting of the quality indicators will be 10% for safety, 60% for clinical effectiveness and outcomes, and 30% for patient experience.

Chapter 5 Next steps – selection and eligibility

69. We will be publishing an application form and supporting information for would-be pilots. The form will be available online at www.pcc.nhs.uk/dentalpilots. We ask applicants to submit their forms by 17 January 2011. Department of Health officials will then sift the applications to identify those that are most suitable for the piloting, and shortlist from these. This means that the applicants need to hold a substantial NHS contract, have a history of NHS work against which we can measure the pattern of care in the pilot phase, and be able to send data electronically.
70. Strategic health authorities and PCTs will be asked to comment on the shortlisted practices, and to confirm their willingness to support pilots. There will then be a selection of pilots, and induction workshops will take place in Leeds, Birmingham and London on 16, 17 and 18 February 2011. The expectation is that the pilots will launch in April 2011, or shortly thereafter.
71. We wish to draw from the widest possible range of practices to take part in the pilots. However, we also need to ensure that we can derive information from the pilots that will allow us to gauge the impact of the different pilot models, and thus help with the design of the contract proposals for national implementation.
72. The eligibility criteria will be set out in detail in the supporting information, but the main criteria will include the following:
 - The practice should hold a General Dental Services contract or Personal Dental Services agreement and provide mandatory services under the contract/agreement, and should have had a contract in place for at least three years.
 - The practice should have a significant NHS commitment, with a contract value of at least £100,000 per year.
 - The applicant should have in place an IT system that is fully connected for the electronic transmission of data to the NHS Business Services Authority.
 - The applicant should understand and commit to the principles of the pilots, including a commitment to the NHS and a willingness to share information on an “open book” basis to allow a full evaluation.
73. In the meantime work will continue to develop regulations under which the pilots will run, and to put in place the information systems at the NHS Business Services Authority to allow data capture and evaluation of the pilots to take place.

Annex 1

Members of the National Steering Group on Reform of the Dental Contract

- Ben Dyson, Director of Primary Care, Department of Health (Chair)*
- Professor Jimmy Steele, Head of School of Dental Sciences and Professor of Oral Health Services Research, University of Newcastle-upon-Tyne
- John Milne, general dental practitioner and Chair of the General Dental Practice Committee (GDPC), British Dental Association (BDA)
- Henrik Overgaard-Nielsen, general dental practitioner, Chair of the Federation of London Local Dental Committees and Vice-Chair of the General Dental Practice Committee BDA
- John South, Director of Primary Care and Provider Services, NHS Wirral, representing the NHS Confederation
- Marion Dinwoodie, Chief Executive, West Kent PCT
- Paula Pohja, Senior Public Affairs Officer, *Which?***
- Chris Edmonds, Head of Dental Services, NHS Business Services Authority

Department of Health officials

- Dr Barry Cockcroft, Chief Dental Officer for England
- David Lye, Head of Dental and Eye Care Services, Department of Health
- Dr Sue Gregory, Deputy Chief Dental Officer for England
- Helen Miscampbell, Head of Dental Policy and Strategy, Department of Health

Observer

- Andrew Powell-Chandler, Head of Dental Policy Branch, Welsh Assembly Government

* Succeeded as Chair of the Group by David Lye from October 2010

** Replaced by Miranda Watson from October 2010

Annex 2

Quality and outcomes framework for dental pilots

Patient experience 30% of quality payment	Clinical effectiveness 60% of quality payment	Safety 10% of quality payment
% of patients reporting that they are able to speak and eat comfortably	For children aged 5 years and under: reduction in number of carious teeth per child % under-5s improved or maintained at review	% of patients for whom an up-to-date medical history is recorded at each oral health review
% of patients satisfied with the cleanliness of the dental practice	For children aged 6 years and over: reduction in number of carious teeth per child % over-6s improved or maintained at review	
% of patients satisfied with the helpfulness of practice staff	For adults: reduction in number of carious teeth per dentate adult % improved or maintained at review	
% of patients reporting that they felt involved in decisions about their care	% of patients with basic periodontal examination (BPE)* improved or maintained at review	
% of patients who would recommend the dental practice to a friend	% of patients with BPE 2 or more with sextant** bleeding sites improved at review	
% of patients reporting satisfaction with NHS dentistry received		
% of patients satisfied with the length of wait for an appointment		

* Basic periodontal examination (BPE) is a standardised and graded examination of the supporting tissues to the teeth

** The mouth is divided into six sections known as sextants

