Department of Health

Dental Contract Reform: Prototypes

Overview document

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Dental contract reform: Prototypes

Overview document

Prepared by Dental Contract Reform Programme, Department of Health

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Foreword

Dental access and oral health are steadily improving. Since 2010 the number of patients seen by an NHS dentist has increased by 1.5 million[1]. This is encouraging progress. Yet there is still more to do on improving access further and in ensuring that even greater numbers of the population enjoy good oral health. This is why we committed in the Coalition Agreement to increasing access and improving oral heath further through reform of the current dental contract.

Significant reform is needed because the current unit of dental activity (UDA) system, like its predecessor, is a wholly activity based system with dentists remunerated for treatment and repair rather than preventing future disease. Systems focussed on treatment and repair met the widespread need at the start of the NHS, and for decades after, to address high disease levels. But the transformation in oral health seen from the 1970s onwards meant this approach became increasingly insufficient.

Any new approach has to meet the needs of, in oral health terms, an increasingly segmented population. Younger people have in many cases little or no dental decay, although where they do, reducing inequalities is an important part of our agenda. But older people, while often having little new or active disease, tend to have a legacy of heavily filled teeth that will need increasingly intensive levels of repair. Both groups need access to high quality preventative care and access to advice on how to maintain good oral health.

This is why we have been piloting a new approach that has three key elements. It provides guidance on care (the pathway), measures the quality of the care delivered (a quality and outcomes framework) and, in this next prototype stage, remunerates in a way that supports continuing care and prevention as well as activity.

The piloting of this approach started in 2011. I announced last April the move to a more advanced stage which would test a prototype of a possible new system. Today we are setting out that prototype approach, which blends together capitation, quality and activity payments. The development of this has been informed by a wide range of stakeholders. I am particularly grateful for the input of the pilots, without whose vital contribution there would be no dental reform, and members of the national steering group for dental reform, including the close involvement of the BDA leadership. Professor Steele's involvement and clinical input also continues to be invaluable.

The model we are setting out today is one which ensures that financial and clinical incentives are aligned and is therefore one which we believe will support clinicians to care for patients in the way I know, from my many discussions with dentists, they passionately want to do.

I know there has been frustration at the pace of reform. I understand this frustration but I hope there is understanding of why we have taken a measured approach. The reform we are proposing is ground breaking and, we believe, will enable primary dental services to best meet the changing oral health needs of the population.

Lord Howe Parliamentary Under-Secretary of State for Quality

1: Introduction

1. The Government is committed to further increasing dental access and improving oral health, particularly of children, through reform of the current dental contract (*Coalition – Our Programme for Government 2010*).

2. Primary care dentistry needs a remuneration system that supports dentists to deliver appropriate care to an appropriate number of patients. Crucially, recognising the transformed oral health landscape that has emerged in recent decades, it needs to support prevention based care as well as providing appropriate treatment, and retreatment where necessary, for current disease.

3. The principles of the reformed system have been set out in previous documents. The approach has three key elements:

    - a clinical approach focussed on thorough assessment and prevention as well as treatment, and which supports a pathway approach to care
    - measurement and remuneration for quality of care
    - remuneration that supports continuing care and a focus on prevention as well as treatment/activity

4. The principles align with the NHS Five Year Forward View, which emphasises the need to focus on prevention, to empower patients to take control of their own (oral in this case) health and to make the most efficient use of NHS resources.

5. The piloting of key elements needed to design a reformed system began in 2011 with the learning from this captured in a series of reports[2] [3].

6. Earlier this year we announced a more advanced stage of reform would start in 2015/16. In this new prototype stage dental practices will test whole versions of a possible new system, rather than, as in the pilots, key elements needed to design a new system.

7. Prototype development has been informed by an engagement exercise with the dental community. Carried out over the summer, the engagement exercise set out, and gave respondents the opportunity to comment on, the principles being considered for reform to clinical care, measurement of quality and outcomes and remuneration.

8. The responses to the engagement exercise have been analysed and are available, together with the original engagement documents[4].The early findings which were shared with a range of dental stakeholders were made available earlier this autumn[5]. The engagement exercise and the discussion of the early findings have been invaluable in refining thinking on the prototype approach.

9. The prototypes will continue to test and refine the pathway approach used in the pilots and, with some changes to individual metrics, the same broad set of quality measures. However, they will not test the same approach to remuneration.

10. As we set out when the pilots were first launched, the pilots were not using remuneration models ever intended for the final system. The prototypes in contrast will be using a remuneration system that, while it may still need significant refinement, is intended to form the basis of a new system.

11. The key change for the prototype remuneration model is that, while it will still include capitation and remuneration for quality, it will also include activity. The aim in creating a remuneration system that blends activity and capitation is to align as far as possible the financial and clinical drivers. Activity drives treatment and capitation drives continuing care and a focus on prevention. The aim in blending the two is to balance these incentives.

12. Any new system is expected to be based on standardised national values for capitation and activity. The capitation element will be weighted based on patient characteristics such as age and deprivation status using national capitation values. The challenge in moving from the current system of entirely local values is significant. Any new system will also have to be capable of flexing to meet local needs. There will need to be a careful balance between standardisation and local flexibility.

13. While recent decades have seen a transformation in oral health, inequalities remain. Any changes to the existing system need to support a further reduction in inequalities. But we also need to keep in mind that existing provision currently targets some of the most in need areas e.g. Clinical Commissioning Groups (CCGs) with income levels lower than the national average having more NHS patients seen per 100,000 population than the average for England as a whole[6].

Approach to change

14. The approach to this reform is deliberately very different from previous changes. The approach is evolutionary not revolutionary. Avoiding a “big bang” change minimises the risk of unforeseen impacts that might undermine patient care, destabilise dental practices as businesses or reduce commissioners’ abilities to meet their local needs.

15. This approach to testing also allows other consequences and implications, for example on the patient charge system (the responsibility of the Department of Health (DH)) and performer remuneration (the responsibility of the profession), to be fully understood and addressed ahead of widespread change. It is vital that the impact on both is fully understood.

16. The pace of change has, we know, seemed frustratingly slow at times but we are clear that it is essential to take the time to develop a robust system that will stand the test of time and which works for the three key groups: patients, dental practices and the NHS.

2: Background and scope of reform

17. Before the founding of the NHS in 1948, dental care was expensive and largely self-funded. Regular dental care was out of reach of much of the population. The NHS therefore inherited a heavy burden of untreated disease. The original remuneration system, fee per item of service, was well placed to meet this demand. The numbers of patients treated significantly exceeded the initial forecasts. By 1951 dental charges had been introduced to help with costs/control demand, but the model was effective in supporting dentists to treat the then high levels of decay.

18. Over the next 50 years the oral health picture changed radically. The initial decades of NHS care saw ever increasing numbers of patients retaining all or most of their teeth, albeit heavily restored. But while treatment was now widely available, disease levels continued to be high. The early 1970s saw the start of a step change in disease levels, almost certainly linked to the widespread introduction of fluoride toothpaste. Children born from the late 1960s onwards had progressively less disease culminating in the current position where 27.9% are disease free[7].

19. The 1948 remuneration system did not alter to meet this changing need. While patient charges were revised and expanded over the decades, the remuneration system remained essentially unchanged until 1990. The 1990 contract introduced a form of un-weighted capitation/registration where patients had a formal right of return to practice for a set period (up to 24 months). But the bulk of remuneration remained in fee per item of service and the relatively short registration periods brought their own issues of perceived or real insecurity around access to continuing care.

20. Through the late 1990s and early 2000s there were a number of schemes (so called old Personal Dental Service (PDS) pilots) where high street practices experimented with new forms of remuneration. These were sometimes solely based on un-weighted capitation (numbers of patients seen) and sometimes using a blend of patients seen and activity.

21. The 2006 reforms made a key break with the past. They introduced a commissioned system of annually agreed contract values. But the metric used for remuneration was based on pure activity (albeit compressed) without any element of capitation or registration.

22. With or without formal registration, there are strong drivers for practices to maintain a pool of patients who are seen regularly but the fact there is no contractual obligation in the 2006 system to offer care beyond a single course of treatment is a concern.

23. The particular concerns about the 2006 reforms were highlighted in the Health Select Committee report of 2008[8].These concerns and the deeper mismatch between remuneration based on activity and the developing focus on prevention were then drawn together and set out in Professor Jimmy Steele's Independent Review of NHS Dentistry.[9]

24. This was the immediate background to the Government commitment to reform the dental contract in order to improve oral health and increase access.

Scope of reform

25. The plans for reform and what will be prototyped are discussed in Chapter 4. However in considering the plans for reform it is important to be clear that not all elements of the existing arrangements are being considered for change, at least at this stage.

26. It is particularly important to be clear that nothing in the changes planned is intended to reduce or change the scope of NHS care available to patients. The changes are intended to ensure clinicians are supported to deliver the full range of care appropriate to a patient's need. As with medical care, the NHS role is to meet clinical needs.

27. There is also no intention to end a patient's ability to choose, if they wish, to have private treatment alongside their NHS care. As now patients will continue to be able to choose to have NHS care, private care or a mix of the two.

28. Primary care dentistry will remain a commissioned system with agreed annual levels of service delivery. As with any commissioned system there will be arrangements, as now, to measure delivery and for recovery of funding for services not delivered.

29. While the patient charge system may need redesign there will continue to be a patient charge system and it will be expected to raise the same proportion of the gross budget as now – around 25%.

30. Since 1951 patient charges have been collected from patients by dental practices on behalf of the NHS. This method of collection is expected to continue in any new system.

31. Dentists' expenses arrangements are also not expected to change. In particular laboratory fees for appliances. These are currently the responsibility of the dental provider (or performer) to fund from his or her gross remuneration. This arrangement is not expected to change as a result of the reforms.

3: Learning from pilots

Overview

32. The first steps to reform were taken in 2010 when we set out proposals for piloting[10]. 70 high street practices began testing the elements needed to design a new system in September 2011. In 2013 these were joined by around 20 further sites including some Community Dental Services (CDS). A list of the current pilots is available at[11].

33. Detailed anonymised data has been collected through the pilot sites on information including the numbers of patients seen and care delivered to each patient. This data, together with the operational experience of the pilots, has been the foundation of the learning from the piloting.

34. All the pilots tested a single clinical pathway approach to care, and a shadow Dental and Quality Outcomes Framework (DQOF). Remuneration prior to DQOF adjustments varied. Half the pilots had a guaranteed contract value for maintaining their level of NHS commitment. Half the pilots' remuneration varied depending on their capitated patient numbers within the limits of plus or minus 2% of their contract value.

35. The pilots also tested a form of patient registration. Pilots were contractually required to offer on-going care to all patients who had attended in the previous three years. This mirrored the capitation period used in the pilots. A practice's capitated patient numbers included all patients who had received NHS care at the practice in the previous 36 months and who had not subsequently been seen at another practice.

36. The table below summarises the pilot characteristics and how they differed from the standard units of dental activity (UDA) arrangements:

Content	**Pilots**	**Current Contract**
Pathway approach	Yes	No (as standard part of approach)
Clinical Indicators (DQOF)	Yes	No (as standard part of approach)
Remuneration for DQOF	Yes – up to 10% of contract value at risk	N/A
Remuneration for activity	No	Yes - 100%
Remuneration for capitation/patient seen	Yes – very limited form	No

Financial risk/gain prior to DQOF	Where any contract value at risk (50% of pilots have guaranteed contract value) this is usually a maximum of 2%. The pilots with contract values at this risk are also able to over deliver by 2% annually	100% of contract value at risk, 4% carry forward and 2% (with NHS England agreement) over delivery allowed
Registration	Yes – regulations require patients to be treated as registered	No
Patient Charges	3 patient charge bands as in UDA system + additional charge band for prevention only care (interim care)	Standard charges apply
Assurance (performance management)	Light touch reflecting fact this was pilot approach	Full performance management

The following sections consider the learning from each element of the pilot approach and the conclusions drawn for the development of the prototype models.

The clinical approach

37. One of the main challenges facing healthcare services is to ensure the provision of consistent, timely and evidence-based high quality care whilst making the best use of the available resources to meet demands. Over the last 20 years, the NHS has increasingly adopted a care pathway approach to address this challenge.

38. A care pathway embeds guidelines, protocols and evidence-based care into everyday use for the individual patient. A care pathway aims to have the right people:

    - doing the right things
    - in the right order
    - at the right time
    - in the right place

    This is in order to deliver the desired outcome of consistent, high quality, accessible and equitable patient-centred care. It also provides a means to compare planned care with the care actually provided to patients.

39. The pilot approach draws on the work of the Independent Review of NHS Dentistry carried out by Professor Jimmy Steele in 2009[12]. This review set out many of the principles against which we are developing our overall approach, particularly in the area of quality.

40. The review also recommended a preventive approach to care based on a pathway, taking account of widespread recognition that most clinical contact with patients, typically taking place in the primary care setting, would fit very well within a planned, pathway-based approach. It was also recognised that there are aspects of care that need to be provided on an urgent or unplanned basis. The review drew on evidence that included early local experimental preventive pathways.

41. The pilot approach builds on this, exploring how we can shift the focus of NHS dentistry towards prevention and oral health rather than focusing primarily on treatment and repair. The clinical approach can be summarised as:

- comprehensive standardised assessment of need (oral health assessment)
- regular reviews at intervals determined by oral health status (oral health review)
- preventive care and advice prompted by the pathway and tailored to the patient's need
- promotion of the need to stabilise patients' oral health before delivering some forms of restorative treatment (particularly advanced care)

42. The approach is showing benefits to the oral health of patients[13]. It is still early days, especially when assessing significant and sustained clinical changes, but the initial signs are promising. The approach has also been well received. Dentists and patients have generally reported satisfaction with the pilot approach.

43. But as set out in the engagement exercise and reflected in responses to the engagement, the approach still needs refining. Dentists struggled with some areas of the pathway approach. Common themes include:
    - the cultural change the preventative focus requires – from clinicians and patients
    - the tension between clinical judgement and use of a standardised approach (decision support versus decision replacement)
    - medico legal concerns – a fear that deviating from the recommended approach leaves the clinician vulnerable
    - the organisational change the approach requires – managing and organising the appointment book and the patient flows through the practice and patients coming on and off the practice 'list'
    - difficulties with the software

44. Recall intervals have not been applied in the pilots as originally envisaged. The pathway recommended shorter recall intervals for so called `red' patients and up to 24 month recalls (following National Institute for Health and Care Excellence (NICE) guidance) for the healthiest `green' patients. This differentiation in recall intervals for patients based on need is a key part of the new approach. Funding freed up by longer recall intervals for healthier patients has to fund the extra time less healthy patients require. However dentists found it difficult to extend recall intervals to the extent the guidance suggested. Individual clinical judgement and patient preference provided a strong driver to stick with shorter recalls.

45. Recall intervals are an example of the key relationship between clinical approach, organisational approach and remuneration. Capitation systems drive longer recall periods. But this did not apply in the pilots with the very limited impact on their remuneration of numbers of patients seen.

46. There has been a greater than expected fall in treatment volumes across the pilots. It was expected that treatment volumes would fall to some degree due to the pathway approach encouraging a greater focus on stabilisation before complex treatment is delivered and the removal of the inherent driver for treatment in an activity system. The falls in treatment volumes observed have, however, been greater than originally anticipated and there has been wide variation in the level of the falls between pilots.

47. The fall in treatment volumes across the pilots and the variation in the fall between pilots has highlighted the challenge we have in determining the appropriate treatment levels to expect in a new contractual system, where remuneration is based on a blend of capitation and activity. Further learning will be sought on this through the prototypes.

48. Conclusions on how the new approach to care, and particularly the way it was delivered through the pathway, operated in the pilots has to be tempered by their limited financial risk and, in the early years limited performance management. A key learning from the pilot stage which goes well beyond the pathway element has been the close link between perceived financial drivers and clinical and organisational arrangements in practices. Clearly it will be critical before any roll out to have tested the approach with a level of risk as close as practical to that in a national system.

Quality measures

49. Measuring quality and outcomes is important to the accountability of any system. It is also important to know the current level of outcomes within a system in order to drive quality improvement. There are three recognised principles or dimensions of health quality measurement: structure; process; and outcome[14].

50. These principles are now recognised internationally as the leading practice when considering this type of measurement and form the basis of the quality measures explored through the work on dental contract reform. Historically, the NHS has recorded structural information, for example the number of dentists providing NHS treatment.

51. The quality indicators used during the pilots were based on clinical effectiveness outcome measures of dental caries and periodontal health. They also included patient function and experience measured by a series of patient completed questions.

52. The scale on which this was done in the pilots was a new departure. And the pilot stage provided key learning on the challenge of not only designing viable indicators but ensuring reasonable data quality. As with any new data collection it was some months before viable data could be expected. But the sheer scale of data collected, the necessarily new software systems supporting the collection and the unfamiliarity of the process for participants created significant challenges. This is reflected in the fact that so far financial adjustments based on

DQOF have not been applied to the pilots. The intention is to apply these for 2014/15 but, as previously, decisions will be taken on whether the data is robust and complete enough to provide a fair result for participants. It is important that any system that measures and remunerates on quality is fair and robust.

53. NHS dental returns have historically been entirely payment driven. Under fee per item returns triggered payment. Under UDAs the returns provide assurance that the provider delivers their contracted levels of activity for the year. In the pilots only some returns were linked to remuneration. The late or non- returns that resulted, suggest that a link between returns and payment may be required in any new system.

Remuneration

54. In theory a capitation remuneration approach will result in treatment levels per patient falling (due to the removal of a financial incentive to provide treatment) and patient numbers increasing, assuming practices are rewarded or required to take on more patients. In the pilots, however, both treatment levels and patient numbers fell. Even allowing for increased time spent on prevention, we would have expected patient numbers to increase.

55. The reasons for the fall in patient numbers are complex. Factors such as the initial learning curve, significant culture change, the initial pathway approach, the issues with IT and not least the lack of tools available for providers to monitor the access position we believe were all involved. This is supported by the fact that the 2nd wave pilots saw smaller falls in access (see Figure 1 below). However the relative lack of risk compounded by in the early stages lack of tools or support to manage access seems likely to have played some part in these unexpected results on patients seen. Over the last 12 months work has focussed on ensuring pilots understand both the need to maintain access and have the tools to do so. Figure 2 shows the access trend for 1st wave pilots covering the period April 2011 – November 2014.

Figure 1: 2nd wave change in access

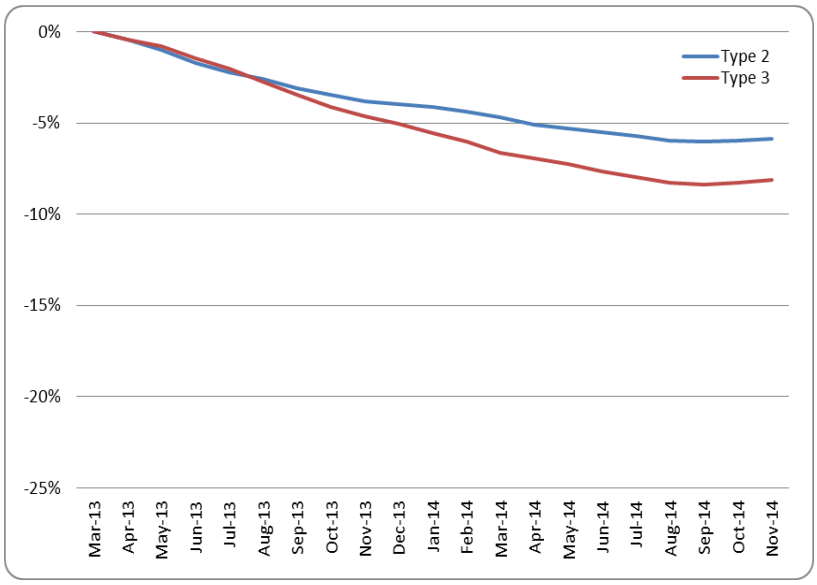
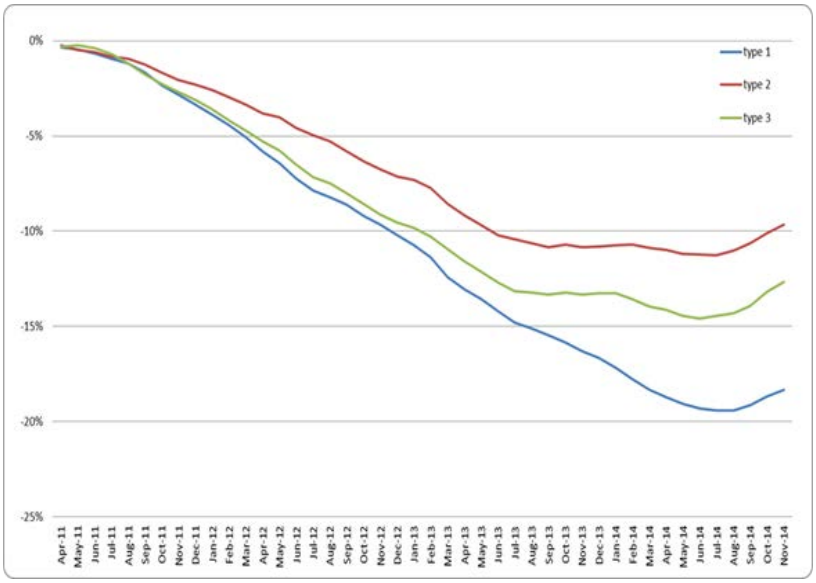


Figure 2: 1st wave pilots change in access



56. It would be simplistic to assume that the lack of financial risk in the pilots explains in total the fall in patients seen. Work is in hand to understand and address the clinical and administrative aspects of throughput in the pilots. This will involve members of the programme team undertaking a detailed practice review. Equally, the new approach needs to be tested against more realistic levels of financial risk if we are to understand how it would perform in roll out. The intention is to increase the level of risk in the prototypes to address this. Chapter 4 sets this out in more detail.

57. One of the issues with pilot remuneration was level of risk. However the piloting raised a more fundamental question about whether capitation and quality alone provided the best fit with the desired clinical approach – enabling a new focus on prevention while still supporting dentists to deliver all necessary treatment and retreatment. We were clear from the start that none of the capitation models tested in the pilots would form the basis of a new system. The piloting suggested that we needed to go further and consider an element of activity as well as capitation.

58. No remuneration system provides a neutral clinical or organisational environment. The metrics used will influence what kind of care is delivered and the level of financial risk/gain in the system will determine how strong an influence those metrics have on the care delivered. Full activity systems are known to carry the risk of over treatment. Similarly full capitation systems carry the risk of under treatment or neglect. There is no evidence that pilots under treated but equally there is no avoiding the reality that a system where the less treatment that is delivered the more profit the practice earns, carries inherent perverse incentives.

59. The more expensive the treatment and the less predictable the need for such treatment, the harder it is to refine capitation values to accurately predict such need. It also becomes hard psychologically for these relatively more expensive and unpredictable expenses to be seen as fair. The issues echo the problem seen in the UDA banded system where multiple treatments in the same band attract no more UDAs than a single treatment. Dentists have

consistently reported difficulties in accepting the swings and roundabouts inherent in the banded system and, particularly for more expensive treatment, this is exacerbated in a full capitation system.

60. Taking all these factors into account, our conclusion was that the level of safeguarding needed at least initially in a full capitation system which replaced a full activity system, would be both unrealistic financially and also operationally. Any system requiring heavy policing is by definition not one where financial and clinical drivers are aligned. We began to consider whether there was a way to balance the activity and capitation drivers which would support prevention and treatment needs.

61. This is why, in setting out the engagement exercise in the summer, the papers asked for views on whether we needed to consider including activity as well as capitation and quality in any new system – a blended approach.

Registration

62. The pilots have been testing a limited form of registration. In the 2006 system there is no contractual relationship between practice and patient once a course of treatment has ended. In the pilots practices remain responsible for patients until they cease to receive capitation/funding for that patient. This responsibility is for routine and urgent care. It is 'in hours' only. The existing NHS responsibilities for patients out of hours applied in the pilots.

63. While formal registration was ended in 2006, practices taking responsibility for ongoing care of regular patients continued. Patient surveys show around 97% of those seeking an NHS appointment at a practice they have used before are successful while only 73% are if the practice is new to them[15]. In other words practices identify and prioritise existing patients.

64. Like the pre-2006 system it was time limited and triggered by a capitation payment to the dentist. Under both systems it lapsed, at the latest at the end of the capitation period. So there is a theoretical 36 month maximum registration in the pilots and 24 months in the pre-2006 system.

65. The capitation and registration experience in the pilots suggests that formalising the duty of ongoing care carries no particular risks and is likely to be helpful for patients in giving them an awareness of their right of return. However issues that could not be tested in the pilots include the length of registration.

Patient charges

66. Pilots initially used the existing patient charge bands without modification. There were significant reductions in patient charges levied per patient and therefore patient charge revenue (PCR). In 2013 an additional band (band 1A) was introduced for the pilots to allow a charge for prevention only care. This has mitigated the drop but pilot patient charges remain well below the level of UDA practices.

67. Every patient charge system is designed for the wider system it supports. The fall in the pilots PCR reflects the fact that existing patient charges are not a good fit with a pure capitation system which has a preventive focus. The way the prototype blended remuneration system may affect patient charge levels is discussed in Chapter 4.

Conclusion

68. Before any roll out the overall reform model will need to demonstrate it is clinically sound whilst providing value for money and financial viability for the NHS and dental contractors.

69. The learning, summarised in the overview to the engagement exercise[16], found that measuring quality and, although untested, introducing an element of remuneration based on quality was seen to be a sensible approach. The clinical approach showed promise, was well liked by clinicians and patients but further work was needed to ensure it was fit for roll out.

70. Unsurprisingly, the pilots demonstrated that aligning financial drivers with clinical drivers and delivering value for money is complex. The necessary limitations of initial piloting particularly around levels of risk hampered the realism of the financial simulation. But despite this the simulation flagged up the learning that has enabled the prototype remuneration models to be developed.

71. The pilots were the test bed stage. The aim of the prototype stage is to develop a robust model fit for potential roll out. The next section on prototypes sets out how we intend the prototype approach to address these challenges.

4: Proposals for prototypes

72. The proposed prototype model is informed by the piloting, wider modelling and analysis and the testing of the developing thinking through the engagement exercise over the summer. The prototypes will consist of:

- a clinical pathway
- a set of clinical measures (DQOF)
- remuneration better aligned with access and clinical outcomes (a blend of quality, capitation and activity)

73. The table below summarises the key characteristics of prototypes compared to pilots:

Content	**Pilots**	**Prototypes**
Pathway approach	Yes	Yes (refined further)
Clinical Indicators (DQOF)	Yes	Yes (refined measures)
Remuneration for DQOF	Yes – up to 10% of contract value at risk	Yes – up to 10% of contract value at risk
Remuneration for activity	No	Yes – covering part care, band 2 and 3 (Blend A) or band 3 (Blend B)
Remuneration for capitation	Yes – covering all care	Yes – covering part care, band 1 (Blend A) or band 1 and 2 (Blend B)
Financial risk/gain prior to DQOF	50% of pilots had no financial risk beyond DQOF (which was not applied). 50% were able to over deliver by 2% but also had 2% of contract value at risk	Greater financial risk: All prototypes will be able to over deliver by 2% but will also have 10% of contract value at risk if there is under delivery.
Registration	Yes – regulations require patients to be treated as registered	Yes - as in pilots
Patient Charges	3 patient charge bands as in UDA system + additional charge band for prevention only care (interim care)	As in pilots.

Assurance (performance management)	Light touch reflecting fact this was pilot approach	Full performance management – to provide as real as possible test of the model
Legislative position	Regulations changed, no primary legislation required	Regulations changed, no primary legislation required

Pathway

74. The prototype pathway will be fundamentally the same as that used in the pilots and will use a further version (version 4) of the pilot software. The IT has been through a series of refinements during the piloting process. It has been substantially refined during 2014/15 with the development and roll out of version 3. Feedback is that these refinements have made the software significantly more user friendly.

75. For the prototypes updated guidance will reinforce further the message that the pathway provides decision support not decision replacement for clinicians. The pathway will continue to be refined during the life of the prototypes and beyond. As with any clinical guidance it will be a living document refined in the light of new clinical findings and in the light of on-going user experience. For clinical guidance to be effective it has to also be operationally robust.

76. The way practices use the pathway approach varies widely. Work is ongoing to explore how this variation impacts the delivery of clinical care and numbers of patients seen. We are planning a series of visits to pilots starting in early 2015 to explore differences in how practices are delivering clinical care and their approach to business management. The aim is to develop better guidance for prototypes on ways others have found to deliver efficiency without compromising clinical care.

Dental quality and outcomes framework (DQOF)

77. For prototyping, the quality indicators have been refined to take account of feedback from clinicians participating in the pilot and comments from respondents to the engagement exercise in summer 2014. Accordingly, the prototype DQOF retains its outcome focussed indicators and now includes a new set of best practice measures. The best practice measures are designed around the Delivering Better Oral Health (DBOH) document[17] and the NICE guidance on recall intervals[18].

78. DQOF remains a “living” set of indicators that will evolve in line with clinical practice and other developments. For example, NHS England is developing new Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs). As these work streams make progress and the new indicators pass their validity testing, we will look to incorporate them into DQOF where appropriate.

79. As planned for the pilots, in prototypes a financial adjustment will be applied based on a practice's performance against the DQOF framework for which up to 1000 points will be available. In theory up to 10% of remuneration will be at risk. However, based on the experience of the pilots, we expect the majority of practices to achieve the majority of the points available. Where a practice achieves less than 1000 points, any contract value deducted will be entered into a notional national pool to be redistributed amongst prototype practices based on their relative performance. Practices can be awarded up to 102% of their pre-DQOF remuneration level based on this additional payment. The mechanism means that practices can be remunerated based on their relative DQOF performance whilst the total expenditure for commissioners and total income for providers as a whole remains unchanged.

Remuneration

80. The prototypes will be based on a blended remuneration system where a practice's contract value and remuneration will be split between:

- a **capitation element** for which the practice would be expected to have a minimum number of capitated patients on their list and for which there would be an adjustment to remuneration on a pro-rata basis if their capitated patient number fell below this level

- an **activity element** for which the practice would be expected to deliver a minimum level of activity and for which there would be an adjustment to remuneration on a pro-rata basis if their activity fell below this level

81. Further to this there will be a **quality remuneration adjustment** based on relative performance against the DQOF.

82. There will be two blends of remuneration tested in the prototypes:

- **blend A -** Capitation is used as the basis of remuneration for oral health reviews and preventive care (current Band 1 type care) and activity payments are used for all treatment (current Band 2 and Band 3 type care)

- **blend B -** Capitation is used as the basis of remuneration for oral health reviews, preventive care and routine treatment (current Band 1 and Band 2 type care) and activity payments are used for more complex treatment (current Band 3 type care)

83. Testing two blends reflects the fact that a blended approach is a new departure. We need to be sure that we develop the most clinically and cost effective approach. Testing one blend and then, if that did not prove a success, the other blend would build in unnecessary delay. Testing both at the same time allows a direct comparison of the benefits and draw backs of each.

84. Further details of the remuneration mechanism that will be used in the prototypes is provided in Annex 3.

Registration

85. Registration will apply in the prototypes in the same form as the pilots. However wider work will continue, involving NHS England and colleagues across the system, to consider what, if any changes should apply in a rolled out system.

86. As with patient charge arrangements, the more significant the changes any introduction of registration introduced, the more challenging that would be to manage in a gradual roll out. For registration and patient charge changes, consideration will need to be given to whether these are changes that can only be made nationally.

Financial incentives

87. Practices will be able to over-deliver with respect to the capitation and activity elements of their remuneration by up to 2% of their contract value with commissioners deciding whether to pay for the over-delivery or allow it be carried forward to the following financial year. In contrast to the UDA system where providers have their entire contract value at risk if there is under-delivery, in the prototypes the financial risk associated with the capitation and activity elements of the remuneration mechanism will normally be limited to 10% of contract value.

88. Setting the appropriate level of financial risk in the prototypes is finely balanced. We need a reasonable level of realism to ensure findings are not simply the result of unrealistic financial arrangements. We do, however, have to be mindful of the fact that this is a prototype system. The testing is at a more advanced stage than in piloting but it is still testing and therefore participants take on a higher level of uncertainty than in a fully tested final system. We have been considering with stakeholders a reasonable balance between these two drivers and while a 10% risk associated with capitation and activity is still low in terms of testing the impact of any financial regime it is considered a reasonable starting point. Once the prototypes have proved the basic viability of the model we would expect the risk contractors take on to increase. Before any roll out the level of contract value at risk will need to be at its final level.

89. Further to any financial adjustments relating to capitation and activity, a financial adjustment will be applied based on performance in relation to the quality framework (DQOF). This adjustment will range from a 10% reduction in their remuneration level up to a 2% additional payment. Whilst in theory up to 10% of remuneration will be at risk, the DQOF will be designed so we expect the majority of practices to achieve the majority of the points available.

Patient charges

90. The prototypes will use the same patient charge system as the pilots - the current 3-band system as it stands with the addition of Band 1A for preventative only care. However a key difference will be the remuneration system. The blended activity/capitation system together with the greater financial risk should result in more treatment or, if this is not required, more patients seen. Either will increase patient charge levels in the prototypes compared to the pilots. But we are clear this may well not be to the levels seen in the current UDA system. The new preventative focus means the system is still likely to need later modification or

redesign to ensure a balance between charges for treatment and for prevention. Band 1A is a first step in this direction.

91. It is important to be clear that shortfalls in PCR in the pilot/prototype stage do not reflect on the viability of any new system. The information they give is on the level of redesign likely to be required to ensure a new system raises appropriate levels of revenue fairly. Any redesign of the charge system will be made based on the learning from the prototype stage and in partnership with patient groups.

Assurance approach

92. The prototypes will be managed through an assurance framework designed to test as closely as possible how the approach would work in a rolled out form. Central support to prototypes and commissioners will be available as in the pilots.

93. The pilots had light touch performance management in the initial years and an underpinning assumption that any serious performance issues would be dealt with outside the pilot programme. This aligned with the initial need to focus on establishing the pilot programme rather than managing a contract.

94. Prototypes and commissioners will, as in the pilot system have the right of exit/to exit practices from the scheme. As in the pilots, individual practices will be judged on DQOF, capitation and now activity performance.

Evaluation of the prototype scheme

95. The evaluation of the scheme as a whole will be key to judging its viability for roll out. The approach will need to demonstrate it:
    - improves oral health (building on the early evidence from the pilots)
    - increases or, as a minimum maintain the number of unique patients seen (patients under capitation)
    - demonstrates value for money
    - supports dentists and dental teams to address inequalities in oral health
    - supports dentists and dental teams to deliver the full range of NHS care clinically required
    - provides a stable business base for providers
    - is commissionable
    - ensures patients receive the full range of care clinically needed
    - enables a fair system of patient charges to be developed

96. The amended remuneration approach, the more realistic levels of contract value at risk and the tighter assurance framework will be key to testing whether the scheme can deliver value for money for the NHS and providers.

97. NHS England’s views on whether this proves to be commissionable will be important.

98. Most importantly, it must also work for patients. Patient charges must be fair and seen to be fair. Fundamentally, the drivers in the system must encourage and incentivise dentists to offer patients the full range of NHS care. Not to do so is already a breach of contract but patients continue to report being misled about the care that is available.

5: Prototype application and selection process

Eligibility and selection

99. All practices holding a General Dental Services (GDS) contract or PDS agreement to deliver mandatory services will be eligible to express interest in becoming an initial prototype, subject to meeting further basic eligibility criteria.

100. Those who meet the criteria will then form a pool of practices eligible for selection as prototypes. The intention in developing and applying criteria is to ensure:

- fairness to pilots and non-pilots
- lessons from piloting are built into the new criteria
- transparency in the approach

101. The eligibility criteria are set out at Annex 4. They are the same as those used for pilot selection with minor amendments. These amendments include specifying the number of days a week a practice must be open for NHS care (five or more) and barring restricted contracts such as contracts limited by either age or charge status. The goal in the eligibility criteria is to allow all types of practice to come forward except those that are either not full time (those open less than five days a week) or offering contracts which are restricted by age or charge status.

102. In the pilot stage PDS plus, Steele pilots, and other local contracts piloting a move away from full UDAs were excluded. When the pilots launched these local pilots were at an early stage and we did not want to bring them to a premature end. Three years on this restriction has been removed. All contracts delivering the legal minimum of contract value through UDAs (51%) will be eligible, if they meet the other requirements for consideration.

103. As with the pilots, selection as a first wave prototype is not a reflection of merit. The aim will be to select a range of practices with regard to characteristics including location, size, patient mix and whether they are a corporate or non- corporate.

104. Pilot and non- pilot practices are eligible to become prototypes and we expect to have both in the prototype group. The pilots are not guaranteed entry to prototyping. But the conditions set for entry for pilots and non-pilots will not be the same. We need to reflect the 3 years of piloting and the risks the pilots took in doing this. Specifically the pilots will not be required to meet the new eligibility criteria where these set a higher bar than the original criteria. And there will be some allowance made for the reduced access and activity seen in the pilots.

105. Expressions of interest will be made on line at www.pcc-cic.org.uk/contract-reform . All applications will be routed through the portal but once in pilots and non-pilots will follow different routes through the on line application process. As with the pilots, there will be no right of appeal.

106. As set out last spring when prototyping was announced, the intention is initially to test out the approach in a restricted number of practices. This will enable the first wave of prototypes to receive the same level of support the pilots have received. Once success has been demonstrated, we expect the numbers to increase. The first step is to demonstrate that this is a viable approach.

107. We value all applications and we will establish a community of interest for those applicants not selected to be prototypes at this stage. The aim is to create a group informed about prototyping and in a good place to become early adopters in any later roll out. This clearly illustrates our aspiration to scale up the approach if it proves successful.

108. NHS England colleagues are closely involved in the process of setting criteria and choosing practices. As in the pilots, Secretary of State will approve practices to become prototypes but contracts will be held by NHS England.

Community dental services (CDS)

109. The pathway and DQOF is currently being tested in three CDS. These services are working under the Pilot type 1 remuneration arrangements. The intention is to continue this through the initial prototype stage rather than expand numbers or move CDS services on to the prototype remuneration arrangements.

110. We need to test the pathway approach with vulnerable patients who are concentrated typically in the CDS but we are clear that the CDS and high street services may well need different forms of remuneration. This is why we intend for the initial prototype stage to stay with the existing numbers and approach.

6: Next steps: Beyond prototypes

111. The prototype stage is intended to be a forerunner of a reformed system, but it is not that system. Wider adoption of the approach depends first on the prototypes demonstrating this is a viable approach.

112. A wider roll out is not expected to need primary legislation. The pathway, because it is a clinical approach, does not need legislative change (and is not part of the pilot or prototype regulations). The changes to remuneration, including the DQOF arrangements, will need changes to regulations (as they do in the pilots/prototypes). Similarly we anticipate that any changes to patient charges would be made through secondary legislation.

113. Unlike previous reforms, the evolutionary approach means that scaling up does not depend on all practices converting to a new approach on a single day. NHS England will be able to scale up the numbers of practices once it is confident that the approach is viable.

114. The prototypes need to demonstrate they can deliver on the core success criteria: access, oral health and affordability. Once this has been achieved, there will be sufficient evidence to assess whether Blend A or Blend B is the most appropriate form of remuneration.

115. If success is demonstrated in the first 18 months of the prototype scheme then in 2017/18 the blend could be decided and numbers and level of risk could increase – this year could be used to fine tune implementation and stress test the approach. In 2018/19 numbers could increase further – this is the earliest date at which a reformed contract could become the prevalent approach. All participants by this stage would be using a system fit for national roll out. This would include realistic levels of contract risk.

116. Issues such as registration and national prices need further consideration prior to roll out. But, if the system shows itself to be viable these are all constraints that can be worked through and practices and commissioners will be keen to move as soon as practical to a system which we hope will support people to do the right thing, to the right patient, at the right time.

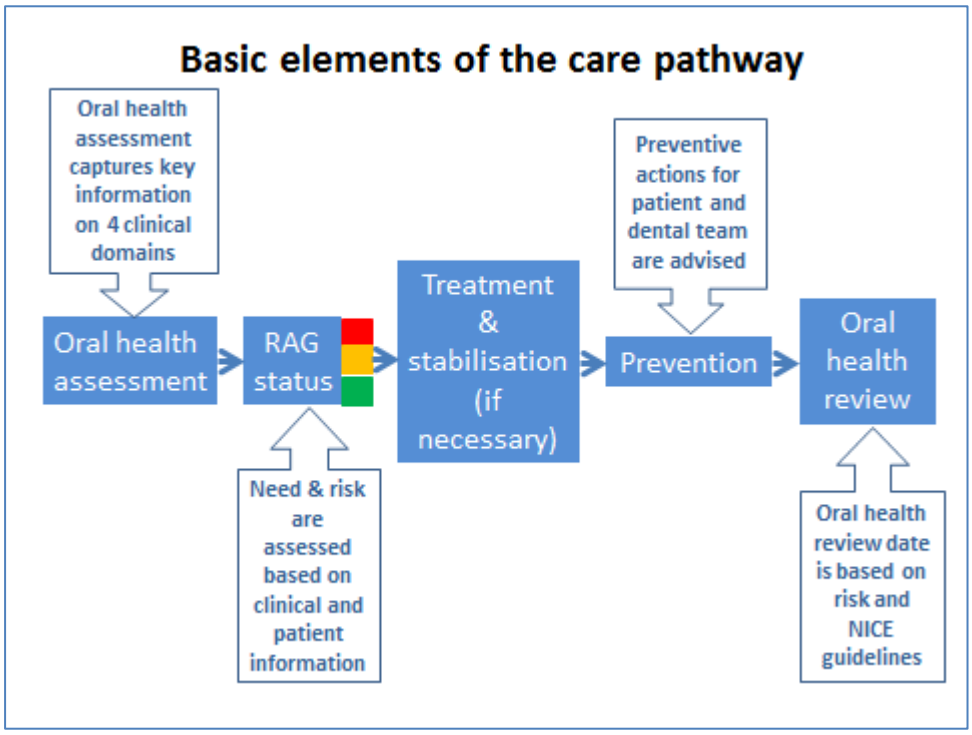
Annex 1: Pathway description

The preventive care pathway

The preventive pathway approach is about providing high quality clinical care, based on:

- a more holistic approach to planning care for patients
- promoting a long term preventive approach based on individual need and risk
- focussing on outcomes and effectiveness
- encouraging patients to take responsibility for protecting and maintaining their own oral health, with support from the practice dental team

The most common dental conditions- tooth decay and gum disease are largely preventable, hence the emphasis on prevention and patient self-care. There is much evidence to support specific preventive interventions, either by dentists /dental teams or by patients / carers. Also, there is NICE guidance regarding appropriate periods for routine recall of patients based on risk. The diagram below shows the basic elements of the care pathway.



Oral health assessment (OHA) and Red Amber Green (RAG) status

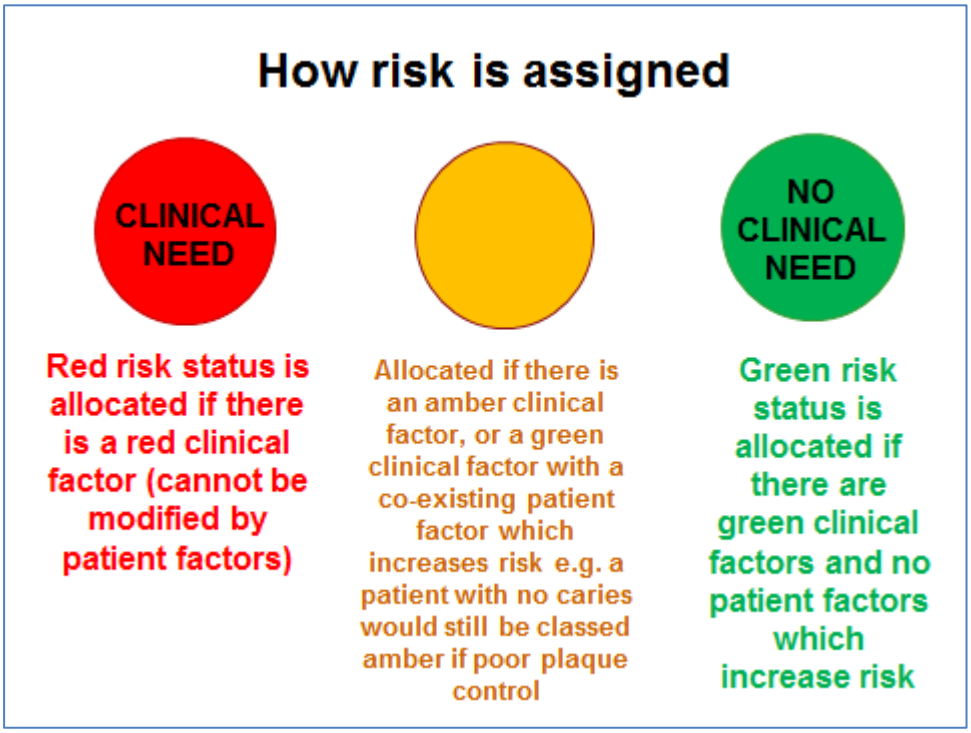
The pathway starts with a standardised assessment of a patient's oral health. Information collected is used to assign risk in four clinical areas:

- dental caries (tooth decay)
- periodontal disease (gum disease)
- tooth surface loss (worn down teeth)
- conditions affecting the soft tissues of the mouth, for example oral cancer

in order to diagnose any current disease and assess a patient's risk of developing disease in the future. This includes assessing any patient factors that could contribute to current or future problems.

For each clinical area (caries, perio, tooth surface loss, soft tissues):

Clinical factors + patient factors = RAG score



The RAG score informs the recall interval (ie date of oral health review – see below), and preventive appointments (if needed) for each patient.

Treatment and stabilisation

Any necessary treatment is provided – in some cases, it might be appropriate to stabilise the patient's oral health before undertaking treatment.

Self-care plan

Some modifying factors (e.g. diet, smoking) can be influenced and altered through changes in patient behaviour. The self-care plan provides patient specific information using a red/ amber/ green (RAG) traffic light system and is a useful platform for communication with patients, including awareness of their responsibility for self-care.

Oral health review (OHR)

The OHR is a refresh or updating of the original oral health assessment, and re-starts the pathway cycle.

The development of the pathway approach used in pilots and prototypes

An advisory group of clinicians developed the primary care pathway following a thorough examination of available evidence into national and international best practice and drawing conclusions that were supported by consensus. The group included:

- Chief Dental Officer (CDO) and Deputy CDO
- primary care dentists
- dental public health representatives
- dental academics

All pilots within the current programme have been using this preventive care pathway since 2011 as will the prototypes. The pathway has been subject to evaluation and revision and remains a ‘live’ framework, subject to ongoing refinement as we continue to learn from the pilots’ experiences of putting this preventive approach into operation.

The key elements of the preventive care pathway being used in the pilots, which are set out above, are intended to promote continuing care. An important feature of the preventive approach is to encourage patients, where able, to take shared responsibility for their own care. The preventive care pathway should be a jointly shared responsibility between clinician and patient to agree the approach to delivering improved oral health.

Annex 2: Quality indicators and scoring mechanism

Quality indicators for primary dental services

Introduction

Quality is a necessary part of future dental contracts and it will take time to get a quality system that is solely outcome based. Quality is defined as covering five domains:

- Clinical effectiveness
- Best Practice
- Patient experience
- Safety
- Data Quality

Work on quality indicators, and in particular outcome indicators, is relatively new in the NHS and even more so in dentistry. A Dental Clinical Effectiveness and Outcomes Group undertook the development of an initial wide range of potential quality indicators some of which were used in the pilot stage. Learning from the use of the initial DQOF has led to the development of the quality indicators for the prototypes. These indicators will continue to be developed over the coming years.

The Quality and Outcomes Framework is underpinned by the development of the clinical pathway used in the pilots and now in the prototypes. It is important that the framework, and its use, is based on available evidence, e.g. Delivering Better Oral Health (DBOH) and professional consensus.

The prototype quality and outcomes framework

For the framework

- Clinical Effectiveness outcome measures - the measures used in the pilots have been retained
- Best Practice process measures - following feedback from dentists during the engagement exercise in the summer of 2014, some process indicators have been introduced. These measure whether the care received by patients following an oral health assessment or review (OHA / OHR) follows best practice in terms of prevention, as evidenced by DBOH. They also measure compliance with NICE guidance on recall intervals. This means that dentists will be rewarded for doing the right thing.
- Patient Experience – the measures used in the pilots have been retained
- Patient Safety – the measures in the pilots have been retained
- Data Quality - during the pilot stage of contract reform, we found that measuring changes in quality was reliant on good data quality. Therefore, a domain that rewards dentists for submitting their data in a timely manner has been included

Payments for the Prototype Quality and Outcomes Framework

The payments to prototypes based on quality represent 10% of the contract value and will be comprised of 1000 points. The domains are weighted as follows:

- 30% (300 points) for Clinical Effectiveness (Outcomes)
- 30% (300 points) for Best Practice, of which;
  - 150 points for Best Practice (DBOH)
  - 150 points for Best Practice (NICE Guidance Compliance)
- 20% (200 points) for Patient Experience
- 10% (100 points) for Safety
- 10% (100 points) for Data Quality

As with the pilots in the dental contract prototypes, 10% of contract value is effectively based on performance against the DQOF for which up to 1000 points can be achieved. The DQOF is designed, however, so that we expect the large majority of pilots to achieve at least 800 points meaning in the large majority of cases only 2% of contract value would be at risk. Where a pilot achieves less than 1000 points, any contract value deducted is entered into a notional national pool to be redistributed amongst pilots based on their relative performance. Pilots can be remunerated up to 102% of their contract value based on this additional payment. The mechanism means that pilots can be remunerated based on their relative DQOF performance whilst the total expenditure for commissioners and total income for providers as a whole remains unchanged.

Clinical Effectiveness Indicators (Outcomes) (30%)

The information used to generate the indicators will be captured across consecutive oral health assessments and reviews and achievement of the indicator is described as either maintaining or improving a patient's condition.

The table below shows the outcomes indicators that will be used in the clinical effectiveness domain.

Outcomes		
Code	Description	Points
OI.01	Decayed teeth (dt) for patients aged under 6 years old	60
OI.02	Decayed teeth (DT) for patients aged 6 years old to 18 years old	60
OI.03	Decayed teeth (DT) for patients aged 19 years old and over	60
OI.04	Adults with BPE score improved or maintained at the next oral health review	60
OI.05	Adults with BPE score of 2 or more with sextant bleeding sites improved at the next oral health review	60

The threshold to achieve full points is 75% for indicators OI.01 – OI.04. The threshold for OI.05 is 50%.

Best Practice Indicators (Delivering Better Oral Health) (15%)

'Delivering better oral health' is an evidence based toolkit to support dental teams in improving their patient's oral and general health. An updated version was published in June 14 by Public Health England.

The practice software which supports the pathway approach in the prototypes captures information about advice and interventions given to patients following an oral health assessment or review.

The preventative action indictors are generated by matching those actions to the RAG status of the patient as shown in the following table.

Preventative Action Indicators		
Code	Description	Points
AI.01	For children assessed red: a) % of patients provided with at least two application of fluoride varnishes per year b) % of patients with at least one of the other recommended DBOH professional intervention actions	 15 10
AI.02	For green and amber children: a) % of patients provided with at least two application of fluoride varnishes per year b) % of patients with at least one of the other recommended DBOH advice actions	 15 10
AI.03	For adults assessed red caries: % of patients provided with at least one of the DBOH recommended professional intervention actions	25
AI.04	For adults assessed green or amber caries: % of patients provided with at least one of the DBOH recommended advice actions	25
AI.05	For adults assessed red perio: % of patients provided with at least one of the DBOH recommended actions	25
AI.06	For adults assessed amber or green perio: % of patients provided with at least one of the DBOH recommended actions	25

All the preventative action indicators have the same thresholds. Full points are awarded for achieving 75% and above. No points are awarded below 65%. Partial points are awarded for achieving between 65% and 75%.

Best Practice Indicators (Compliance with NICE Guidance) (15%)

One of the aims of the clinical pathway used in the prototypes is to ensure that resources are focussed on the patients that need it most. Guidance on recall intervals have been published by NICE and is used to recommend suitable intervals. The indicators in the following table match the appointment date of an oral health review with a previous review or assessment to calculate the actual interval. Flexibility is provided through a 12 week "window" around the recommended date and through threshold levels that allow clinicians to deviate from the recommended period when clinical circumstances warrant it.

Compliance with NICE Guidance		
Code	Description	Points
CI.01	For red children; % of patients with a recall interval for OHR a) For those aged under 3, of 3 months* b) For those aged 3 to 18, of 6 months*	25
CI.02	For amber children; % of patients with a recall interval for OHR a) For those aged under 3, of 3-6 months b) For those aged 3 to 18, of 12 months	25
CI.03	For green children; % of patients with a recall interval for OHR a) For those aged under 3, of 6 months b) For those aged 3 to 18, 12 months	25
CI.04	For red adults; % of patients with a recall interval for OHR a) For perio, of 9 months b) For caries, of 12 months***	25
CI.05	For amber adults; % of patients with a recall interval for OHR of 12 months	25
CI.06	For green adults; % of patients with a recall interval for OHR of 18 - 24 months**	25

Note: For each indicator, the recall intervals are in line with NICE guidance and with the information used by the supporting software to recommend recall intervals. The actual recall interval for a patient can lie within a window either side of the recommend date in order it to count as complied with the indicator. The window is 4 weeks before the recommended interval and 8 weeks after the recommended intervals

* except for children where the recommended interval is 6 months or less where the recommended period is 4 weeks either side of the recommended interval

** for green adults the interval is a fixed 6 months from 18 – 24 months after the previous OHA / R

*** where the patient is red for both caries and perio the shorter period applies

The NICE compliance indicators have similar thresholds to the preventive action indicators. Full points are awarded for achieving 75% and above. No points are awarded below 65%. Partial points are awarded for achieving between 65% and 75%.

Patient Experience Indicators (20%)

The NHS Business Services Authority sends out over 700 questionnaires to patients with six questions asking patients about function and their experience at the dental practice. The responses to the questions are used to generate the following indicators.

Patient Experience		
Code	Description	Points
PE.01	Patients reporting that they are able to speak & eat comfortably	**Max: 30** Level 1 45%-54% =15 Level 2 55%-100% =30
PE.02	Patients satisfied with the cleanliness of the dental practice	**Max: 30** Level 1 80%-89% = 15 Level 2 90%-100% = 30
PE.03	Patients satisfied with the helpfulness of practice staff	**Max: 30** Level 1 80%-89%= 15 Level 2 90%-100% = 30
PE.04	Patients reporting that they felt sufficiently involved in decisions about their care	**Max: 50** Level 1 70%-84% = 25 Level 2 85%-100% = 50
PE.05	Patients reporting satisfaction with NHS dentistry received	**Max: 50** Level 1 80%-84% = 20 Level 2 85%-89% = 40 Level 3 90%-100% =50
PE.06	Patients satisfied with the time to get an appointment	**Max: 10** Level 1 70%- 84% = 5 Level 2 85%-100% =10

Safety indicators for payment (10%)

Safety falls under the remit of the Care Quality Commission (CQC) and professional bodies such as the General Dental Council (GDC). The dental profession and commissioners are committed to ensuring that clinical practice remains safe and that safety is a fundamental part of the service that is delivered.

Consequently, patient safety is not something that should primarily be rewarded through a quality payment as all dentists should adhere to safe practices. However clinical aspects of patient safety can be monitored and rewarded through payment and payment will be made on the following indicator:

Safety Indicators		
Code	Description	Points
SA.01	90% of patients for whom an up-to-date medical history is recorded at each oral health review	100

Data quality indicators (10%)

The submission of timely and accurate data is an essential requirement of any quality and outcomes framework. The submission of timely and accurate data is also essential for the prototype programme in terms of capturing evidence and learning.

Data Quality Indicators		
DQ.01	Timeliness of appointment transmissions	50
DQ.02	Timeliness of FP17 submissions	50

In recognition that some issues may arise that legitimately lead to some late transmissions full points are awarded for achieving 95% and above. No points are awarded below 90%. Partial points are awarded for achieving between 90% and 95%.

Annex 3: The remuneration mechanism for prototypes

This annex provides an overview of the remuneration mechanism which will be used in the prototypes. It also provides an outline of the principles on which the remuneration mechanism will be based and our current thinking on how the mechanism will work – the full details of the remuneration mechanism will be provided to shortlisted prototype applicants prior to contracts being signed.

The remuneration mechanism will be based on a blend of capitation, activity and quality

The prototypes will be based on a blended remuneration system where a practice's contract value and remuneration will be split between:

- a **capitation element** for which the practice would be expected to have a minimum number of capitated patients on their list and for which there would be an adjustment to remuneration on a pro-rata basis if their capitated patient number fell below this level

- an **activity element** for which the practice would be expected to deliver a minimum level of activity and for which there would be an adjustment to remuneration on a pro-rata basis if their level of activity fell below this level

Further to this there will be a **quality remuneration adjustment** based on relative performance against the Dental Quality and Outcomes Framework (DQOF).

Unless there has been significant under-delivery of activity prior to a practice becoming a prototype, the financial risk associated with the capitation and activity elements of the remuneration mechanism will be limited to 10% of contract value. Practices will also be allowed to over-deliver with respect to the capitation and activity elements of the remuneration mechanism up to 2% of contract value (further details below).

Following the application of the capitation and activity remuneration adjustment the quality remuneration adjustment will be applied. The adjustment will range from a 10% reduction in their remuneration level up to a 2% additional payment. The 10% deduction would only apply if a practice achieved zero points on their DQOF indicators. Any deductions in remuneration as a result of DQOF performance will be re-distributed amongst prototypes based on their relative performance – this enables performance against quality indicators to be financially incentivised without any change in overall expenditure.

Two different blends of capitation and activity will be tested in the prototypes

There will be two blends of remuneration tested in the prototypes:

- **blend A -** Capitation is used as the basis of remuneration for oral health reviews and preventive care (current Band 1 type care) and activity payments are used for all treatment (current Band 2 and Band 3 type care)

- **blend B -** Capitation is used as the basis of remuneration for oral health reviews, preventive care and routine treatment (current Band 1 and Band 2 type care) and activity payments are used for more complex treatment (current Band 3 type care).

How will capitated patient numbers be measured?

A patient will count towards a practice's capitated patient numbers if they have had an oral health assessment or review with the practice in the previous three years and have not subsequently triggered capitation at another practice. For the purpose of any financial adjustments, a practice's capitated patient numbers for the year will be measured at year-end.

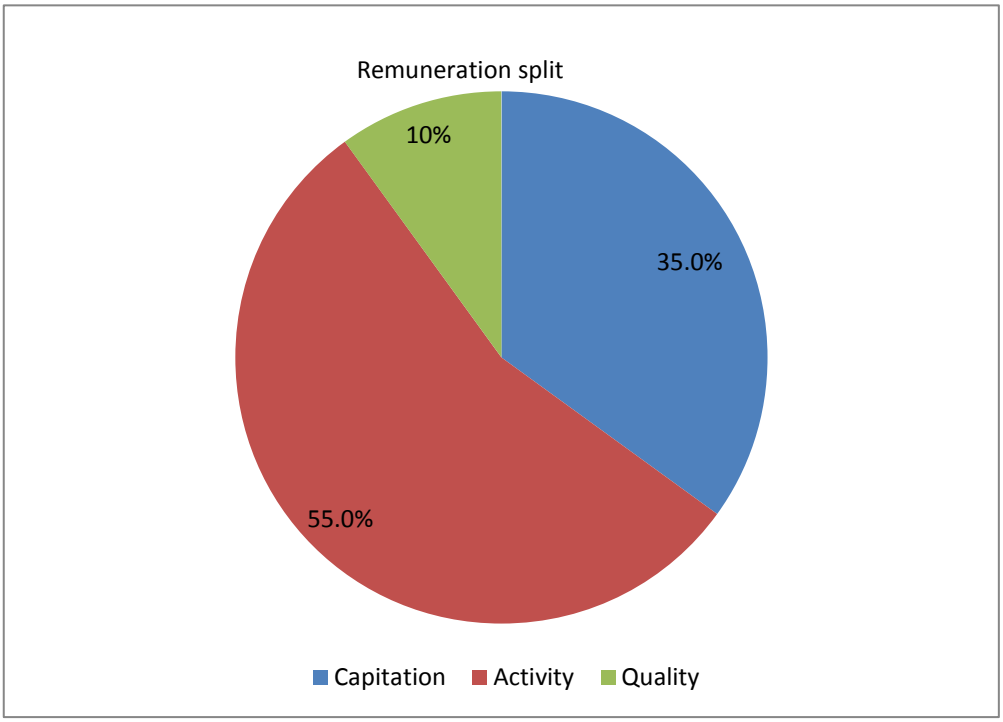
How will activity be measured?

Whilst in a future roll-out we may wish to move away from measuring activity in terms of Units of Dental Activity (UDAs) and the current banding system, for the prototypes we continue to measure activity in UDAs.

In remuneration Blend A:

- a Band 1 course of treatment will not count towards a practice's activity levels
- a Band 2 course of treatment will count as two UDAs towards a practice's activity levels
- a Band 3 course of treatment will count as eleven UDAs towards a practice's activity levels

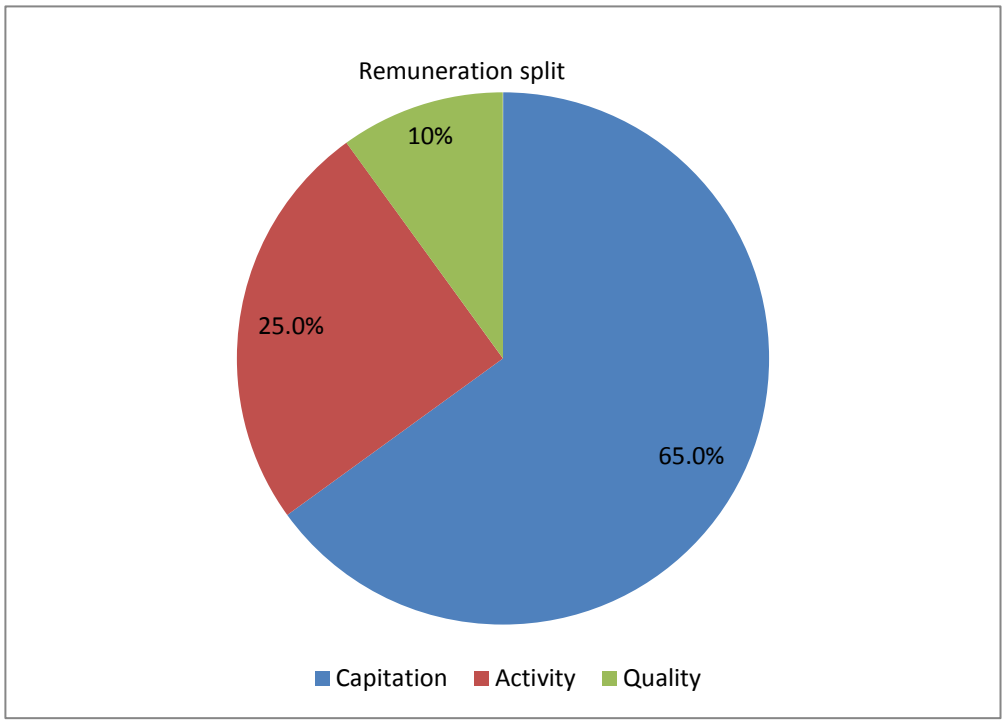
Figure 1: Blend A



In remuneration Blend B:

- a Band 1 course of treatment will not count towards a practice's activity levels
- a Band 2 course of treatment will not count towards a practice's activity levels
- a Band 3 course of treatment will count as eleven UDAs towards a practice's activity levels.

Figure 2: Blend B



Where a patient is a capitated patient with the practice, an urgent course of treatment will not count towards a practice's activity levels. Where a patient is **not** a capitated patient with the practice, an urgent course of treatment will count as 1.2 UDAs. This will allow for the scenario where a patient attends a practice for urgent care away from their usual practice.

Where a patient is treated on referral at a practice and does not trigger capitation at the practice through having an oral health assessment or review, the course of treatment will count towards a practice's activity levels.

Will it be possible to switch between the capitation and activity elements of the contract in terms of remuneration?

If a practice does not deliver their expected level of activity, they may with commissioner approval, be able to over-deliver on their expected patient numbers with corresponding changes to their remuneration. This will enable patient numbers to increase as oral health improves.

We would only expect in exceptional circumstances (and with commissioner approval) for a practice to be able to offset under-delivery with respect to capitated patient numbers with over-delivery on activity. This could occur though where the oral health needs of a practice's patient population change significantly, if for example another local practice closed

Will there be any tolerance on delivery of activity?

We plan to have a tolerance on activity levels delivered that is similar to the mechanism which currently exists in the UDA system where practices may carry forward under-delivery of up to 4% to the following financial year and may over-deliver by up to 2% with commissioners deciding whether to pay for the over-delivery or allow it be carried forward to the following financial year. This tolerance will allow for the fact that there will be some natural variation from year to year in the treatment needs even where a practice has a very stable patient population.

Annex 4: Eligibility criteria

Expressions of interest from existing pilot contractors will need to meet the same criteria as their original pilot application. They will also be asked to confirm their understanding and commitment to the prototype principles and requirements set out above.

Expressions of interest from non-pilot contractors must meet the eligibility criteria set out below:

- the applicant must hold an NHS dental contract(s) (GDS, PDS or PDS+) and deliver mandatory services
- the value of the NHS contract(s) must be above a threshold of £100,000 per annum
- NHS contract(s) held must have at least 51% contract value attributed to delivery of UDAs
- the NHS contract(s) must account for over 60% of the total earnings at the dental practice
- the contract(s) may not be restricted eg charge exempt and/or children only
- the practice must be open for NHS care for a minimum of 5 days a week in the main address for that contract
- at least one of the NHS contract(s) must have been in place for three years or more
- all contracts must have an end date no earlier than 31 March 2017 and preferably later than 31 March 2018. Contracts which end between 31 March 2017 and 31 March 2018 will not be automatically excluded from selection and will be considered on a case by case basis
- a chairside IT system must be in place at the practice(s) which is fully connected for the transmission of electronic data to the BSA
- the applicant needs to commit to self-funding any IT costs that are incurred as a result of participation as a prototype
- the applicant must commit to the prototype principles and requirements

Glossary

CDS	Community Dental Service
DBOH	Delivering Better Oral Health
DH	Department of Health
DQOF	Dental Quality and Outcomes Framework
GDS	General Dental Service
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OHA	Oral Health Examination
OHI	Oral Health Instruction
OHR	Oral Health Review
PCR	Patient Charge Revenue
PDS	Personal Dental Service
PREM	Patient Reported Experience Measure
PROM	Patient Reported Outcome Measure
RAG	Red Amber Green
UDA	Unit of Dental Activity

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