



Dental contract reform programme

Proposals for stage 2 piloting

Dental contract reform programme: Proposals for stage 2 piloting

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Foreword

We are committed to introducing a new contract for primary care dentistry that will focus on improving oral health and increasing access to services. We intend such a contract to allow dentists to deliver continuing care focused on preventing as well as simply treating dental disease.


The new contract will have three key elements, registration, capitation and quality. Pilots testing elements needed to design such a contract have now been running in 70 dental practices for the last 12 months.

Today we are publishing proposals to extend piloting that will allow further testing and development of the contract elements.

Significant challenges remain, but both dental staff in pilots and patients have been overwhelmingly positive about the new approach to clinical care seen in the pilots. Further development is needed but we think a pathway approach should form a key part of any future contract.

We have developed the proposals for the next stage in our plan for contract reform working closely with the experts represented on the national steering group (NSG) for dental reform. These include representatives of the wider dental profession, dentists working in pilots, NHS commissioners and dental academics. We are grateful for their continued advice and support.

We believe these proposals are a further significant step on the road to creating a prevention focused NHS dental service that both delivers significant improvements in oral health and increases access to care.

A handwritten signature in black ink, appearing to read 'Lord Howe', is positioned above the printed name.

Lord Howe

Parliamentary Under-Secretary of State for Quality

Introduction

1. We are committed to improving oral health and increasing access to NHS dentistry. Our intention set out in the Coalition Agreement to introduce a new dental contract based on registration, capitation and quality is a key part of our programme to deliver on these goals.
2. Our aim as with other areas of NHS care is a service that provides access to high quality, clinically appropriate care for all those who choose to use its services. We intend the service to enable care of which dentists can be proud and in which patients can have confidence.
3. Critically, in setting out our aim for a contract based on registration, capitation and quality we want to promote an approach that recognises that the risk of dental disease is a long term, indeed lifetime, issue that requires a preventative approach focused on continuity of care.
4. Piloting to test elements needed to design a new contract began in mid 2011. This first stage of piloting has allowed us to test the principles on which any new contract will be based, including the patient pathway, dental quality and outcomes framework (DQOF) and simulations of capitation.
5. This first year has demonstrated the complexities of such a fundamental change and reinforced the need for careful testing and development before making national changes.
6. Building on the learning from this stage, we now intend to run a further stage of piloting from April 2013 with an expanded set of pilots. This second stage will test how the elements of the contract being tested work most effectively together to deliver the goals of improved oral health and increased access.
7. We also intend to expand piloting from high street practices to salaried primary dental care services. It will be important to understand how the pathway approach works with the typically high need groups seen in these services.

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8. All the second stage pilots will use a revised patient pathway as the core of their approach. The pathway approach, while needing significant further development to make it fit for national roll out, has proved both clinically credible and extremely popular with patients.
9. We can now say that we intend, based on the experience of the first 12 months of piloting, to put a pathway at the centre of any new contract we introduce. While the work on the DQOF is less advanced, we also expect (subject to successful piloting) that a DQOF will form the second key part of the quality element of any new contract.
10. These decisions on how quality will be delivered in a new contract are important steps forward in the wider programme of contract reform. The pathway supports dentists to do the right thing for patients while the DQOF allows the outcome of decisions taken on patients' oral health to be measured. Together, these are powerful tools to deliver the goal of high quality, clinically appropriate care.
11. The new stage of piloting will launch on 1 April 2013. All existing pilots will, if they continue to meet the eligibility criteria and have their commissioner's continued support, be offered the chance to join the next stage of the scheme.
12. Additionally, we will be selecting new pilots with the aim of bringing the total number of pilots in the second stage to around 90-95. There will be an open application process for would-be new pilot practices.
13. Guidance on how practices can apply to become pilots as well as next steps for existing pilots interested in continuing are available at <http://dentalpilots.pcc.nhs.uk>.
14. The NSG has been closely involved in the work to learn from the first 12 months and the proposals for the next stage of piloting that we are now setting out. The NSG membership is drawn from representatives of the profession, patients, dental pilots and commissioners. Sub groups have been set up to provide detailed oversight and external input into learning from the first 12 months of piloting, under the overall guidance of the NSG.
15. An evidence and learning sub group (ELG), led by Professor Jimmy Steele, has been drawing out the qualitative and quantitative learning. Alongside this a clinical review sub group (CRG) made up of dental experts and pilot practitioners and led by Eric Rooney

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(consultant in dental public health in Cumbria & Lancashire). The CRG has been reviewing the working of the pilot patient pathway and will be making recommendations for its development later this autumn.

16. The report of the ELG, prepared by Professor Jimmy Steele, is published today along with a report commissioned from a market research company on patient and practice staff perceptions of the piloting experience. These reports are available at www.dh.gov.uk/dentistry.

17. We are very grateful for the work of these groups. Their input to the pilot programme and wider work on the proposed new contract has been and continues to be invaluable. Annex 1 lists the current members of the NSG, ELG, and CRG.

Our approach and the learning so far

18. The intention to introduce a new contract based on registration, capitation and quality demonstrates our commitment to move to a prevention focused model that directly rewards dentists for improving patients' oral health and better promotes access.
19. The existing contract, introduced in 2006, does not explicitly reward quality or prevention. Dentists are paid largely on the basis of treatment delivered. This is not unique to the 2006 contract; historically dentistry has not focused on prevention but on treating existing disease. When the NHS was established over 60 years ago this made sense. Oral health was extremely poor and treatment needs were consequently overwhelming. Oral health has, over the decades, been transformed but NHS dentistry has remained largely treatment focused.
20. Treatment is still an extremely important part of dentistry and some groups still have high treatment needs. Many of those born before fluoride toothpaste became widely available in the 1970s have heavily restored mouths. Even if their disease is now stabilised, they will continue to need relatively intensive interventions to maintain their existing fillings, bridges and crowns over the coming decades. Similarly, while many younger people are caries free, this is less true of those in disadvantaged areas. These younger patients with heavily restored dentitions will also require lifetime care and maintenance. But the direction of travel is to a population with increasingly lower treatment needs.
21. Therefore, we intend to introduce a contract that both supports dentists to treat disease and provides a clear focus on prevention within an overall approach based on continuing care. The aim is to improve patients' oral health over the longer term rather than simply treating the immediate, presenting disease.
22. Our approach draws on the work of the Independent Review of NHS Dentistry carried out by Professor Jimmy Steele in 2009. This review set out many of the principles against which we are developing our overall approach, particularly in the key area of quality.

23. This was the context within which we announced in 2010 our intention to pilot elements needed to design a new contract and specifically to test:

- A pilot patient pathway
- A pilot DQOF
- Three remuneration models:
 - Type 1 (guaranteed income)
 - Type 2 (a simulation of capitation)
 - Type 3 (a simulation of capitation for routine treatment and guaranteed income identified for complex treatment)

24. The evidence and learning sub group of the NSG has been continuously reviewing the evidence that has started to emerge and their report on early findings is published today. Their report drew on early data from the pilot clinical systems and also on market research commissioned from ICM to survey patient and staff experience. The full ICM report is available at www.dh.gov.uk/dentistry.

25. Alongside the work of the ELG, the CRG has been reviewing the working of the patient pathway to see what changes if any should be recommended. The recommendations will be available in mid-autumn and will be key to the next iteration of the patient pathway that will be used in all pilots taking part in the next stage.

26. We have also engaged directly with all pilots, seeking their feedback over the last few months. We held a series of regional engagement meetings to which all local pilot participants were invited. These meetings were held to share the early learning from the first 12 months with pilots, as well as to get their feedback on the national learning and their local experiences. A summary of the issues and points made at the meetings is attached in Annex 2.

27. The detailed learning from the first year is set out in the ELG report and the other documents now published. It is still very early for definitive findings and there are significant challenges ahead before we can design a final system or move to national roll out. These challenges include:

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- Understanding and addressing the drop in access seen in the first year and the consequent pressure on appointment books as well as the impact on patients and practice staff
- Supporting practices to adjust to the new ways of working that the focus on prevention requires – which is often at odds with the ways that fit the units of dental activity (UDA) system.
- Managing inadvertent impacts of the new approach: for example the impact of the pathway approach on patient charges.
- Understanding how the new approach works in non high street settings.

Next Steps

28. Work remains to be done to refine the pathway to ensure it delivers maximum health gain while being commissionable and deliverable. However, the pathway concept is now well established and, based on the experience of the first stage of piloting, the government intends to introduce a pathway approach as a fundamental part of the quality element of any new contract.
29. Similarly, a quality and outcomes framework is something that must be sensible to have in any new system. The DQOF needs extensive further testing and development and could not be applied in stage 1 piloting (because the end of year came just six months in - this is discussed in more detail below). Subject to the live test that we hope further piloting can provide, we expect a DQOF to form an integral part of the quality element of the new contract. The pathway supports dentists to provide clinically appropriate care and the DQOF allows the outcome of those decisions to be measured.
30. The second stage of piloting will be used to refine these and other elements of any new contract and test how they can most effectively work together in the high street and other settings to deliver oral health gain and access.

Quality

Patient Pathway

31. The next stage pilots will use a more developed version of the existing pilot pathway based on the recommendations of the CRG. Their recommendations will go to the NSG shortly for consideration, along with feedback from practices on their operational experiences. We expect their final report to be published by mid autumn. Changes to the pathway will be implemented from 1 April 2013.

DQOF

32. The DQOF has not yet been applied in a pilot setting. The mid year start date for the first stage of pilots meant that there was insufficient clinical data at the end of 2011/12 to allow the clinical elements of the DQOF to be applied. Some patient experience data was available but pilot performance on the patient experience metrics was so high and relatively uniform that this could not be used on its own to fairly discriminate between

practices on performance. Because the concept of a DQOF breaks new ground in dentistry, the thresholds were set deliberately low, as each metric was largely untested.

33. We do not plan to alter the percentage of contract income dependent on the DQOF. This will remain at 10%. However, the thresholds and indicators may need adjustment for 2013/14. We intend to work with the NSG through the autumn on the learning from 2011/12 and the emerging learning from 2012/13 on whether individual indicators or thresholds require alteration. Any changes will be applied from 2013/14. The metrics and thresholds will remain unchanged for 2012/13.

Capitation

34. As set out above, we intend to use as a basis for stage 2 piloting the existing 3 models of remuneration. Numbers of pilots are not currently evenly divided between the three types. For stage 2, we intend to bring the numbers testing each type into a better balance. This is likely to mean that new high street pilots will be focused on the type 2 and 3 models, as two thirds of existing pilots are currently type 1s.
35. One restriction on numbers of type 2 and 3 pilots has been that the stage 1 capitation model could not manage growth fairly for practices and the NHS. This meant that the type 2 and 3 models, which use capitation, had to be restricted to practices that had had no growth in the last 3 years. During the first year of piloting an immediate work around was found that allowed future growth (growth awarded to a practice after it started as a pilot) to be managed.
36. We are now looking at whether we can find a more sustainable solution that also manages historic growth. This would allow practices that have had growth in the last 3 years to become type 2 or 3 pilots. However, while it does not affect the division into the existing three broad pilot types, any solution would require some changes to the pilot capitation approach used in type 2 and 3. We will be considering the merits of this further with the NSG this autumn. Any recommended changes would take effect from 1 April 2013.

Registration/Continuing care

37. Continuing care with a focus on prevention is key to the new approach. In any new contract there will be a formal system of patient registration. This will mean patients can be sure that, once registered with a practice, they will receive ongoing care as and when clinically needed.
38. While patient registration is not being formally piloted, existing pilots are expected for the duration of their contract variation to treat patients being seen under the patient pathway as 'registered'. In other words they provide on-going care to these patients as clinically indicated including any 'in hours' urgent care required.
39. For stage 2 piloting, we are exploring whether it is possible or desirable to take this from an expectation to a legal requirement for pilot providers to provide on-going care (as clinically indicated) to patients while that patient is under the care of the practice.
40. This duty would not change the pattern of care delivered, but it would formalise the fact that while providers are receiving pilot funding for a patient they are required to provide on-going care under the pathway to that patient (as long as both the patient and provider remain willing to provide and receive that care). We will be considering this further with the NSG and lawyers. Any recommended changes would take effect from 1 April 2013.

Pilot numbers/salaried services

41. We expect to have between 90-95 pilots overall in the second stage scheme. If all 70 existing pilots wish to continue this means there will be 20-25 new pilots starting in April 2013.
42. We expect up to three of these to be salaried primary dental care services. These will test how the pathway functions with their very distinct patient populations. Simple weighted capitation is unlikely to be the full answer and, working with the British Dental Association (BDA) community dental services group, we will be testing how the pathway and the existing case mix tool that they have developed interact.

Operational IT and other issues

43. The pilots have been testing new and complex data systems, with the added complication that the systems at pilot stage are necessarily ad hoc solutions that impact on ease of use and functionality. The pilots and suppliers have shown considerable resilience and determination in making the system work. We are working with suppliers to improve functionality. Key changes we intend to make include:

- Improved operational functionality in practices
- Incorporation of clinical changes identified through the clinical care pathway review
- Improvements to data structure to enhance learning from the pilots

44. These changes should make a step change in ease of use of chair side IT. However, this will still be a pilot system acting as an add on to existing systems and we would expect there will be some continuing issues, which will need to be addressed before moving to national roll out.

Commissioning arrangements

45. The next set of pilots will be recruited and contracts finalised during the period in which primary care trusts (PCTs) are still responsible for commissioning. However, on the day the pilots go live commissioning will move from PCTs to the NHS Commissioning Board (NHS CB). We will be working closely with NHS CB to ensure arrangements work as seamlessly as possible and that they are a full partner in the arrangements.

Patient charges/patient charge revenue

46. The interaction of the existing definition of what is a course of treatment (CoT) and when a CoT (and its associated FP17) may be closed with the pathway approach has resulted in very long CoTs that include not only oral health assessments (OHAs) or oral health reviews (OHRs) but all associated interim care management (ICM) appointments. Only one patient charge can be raised per CoT. Because care is bundled into fewer but longer CoTs, patients on average are paying more for like for like treatment in non pilot practices than in pilot practices. The resulting lower charges have raised a number of issues:

- They do not provide a realistic test of patient behaviour under any new system

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- They reduce the total funding from patient charge revenue (PCR) available to the NHS and critically;
- They create inequity for patients. Patients in non pilot practices pay more for the same care than patients in pilot practices.

47. We are therefore proposing to change the existing regulations in order to allow:

- CoTs to be closed when all treatment (except for any scheduled for delivery through a future ICM) is complete.
- ICM CoTs to be created, which (unless the patient is exempt) may be chargeable.

48. This will not change the approach to clinical care. It is an administrative change to ensure that patients in pilot practices and those in standard practices are treated equitably in terms of patient charges.

49. The three existing patient charge bands will still apply. During the pilot stage, we intend at least to use the existing band 1 charge for ICM CoTs rather than creating a new band. Given the small number of pilots compared to UDA practices and the simplicity of the existing charge system, we think it would cause patients and dental staff confusion if we created a new charge band.

50. If the patient charge changes are agreed, detailed guidance on how to apply the new CoT definition and consequent changes to charging will be made available to pilots well before the new arrangements come into effect. This will include information for practices to use with patients.

51. The changes, subject to parliamentary approval, will take effect from 1 April 2013. Care and charging arrangements in non pilot practices will be unaffected and no change can be made to the existing arrangements in pilots in advance of the required secondary legislation (regulation).

52. It is important to be clear that the modification being made is a solution being put in place specifically for the pilots because we cannot, ahead of wider contract changes,

design a new system or be clear what modifications will be needed to the current system. It does not predict those future changes.

53. The changes will reduce, but are not expected to necessarily close, the current pilot PCR shortfall. Total PCR has multiple drivers, including overall access and the proportion of patients seen who are charge payers. The aim of this change is simply to bring the total patient charge per patient closer to that which a patient might expect under the current system.

54. In summary, in the second stage of piloting we intend that:

- All pilots will use a refined version of the patient pathway (to be developed for 1 April 2013 drawing on the work of the CRG)
- The overall proportion of income for the DQOF remains the same
- The DQOF thresholds and some indicators within the overall DQOF envelope may be revised (if appropriate and in discussion with the NSG later in the autumn)
- The proportion of practices piloting the three remuneration models will be rebalanced (currently 50% are type 1, 25% are type 2, and 25% are type 3). We will aim for closer to a third in each type in stage 2 to maximise the learning from each type.
- The three remuneration models will be retained but each may be refined (if appropriate - proposals to be considered later in the autumn by the NSG)
- Pilot numbers will increase to 90-95 and salaried services as well as high street practices will be eligible to be pilots.
- Operational issues around IT should be reduced (within the constraints of being a pilot system)
- Pilot contracts will be held by NHS CB not PCTs
- Technical changes will bring pilot patient charges into closer alignment with non pilot patient charges

Application and eligibility

55. Running pilots beyond 31 March 2013 requires new regulations. The existing regulations have a sunset clause (a provision in the regulations that terminates them after a specific date, unless further legislative action is taken to extend them). The new pilots are therefore legally a different entity from, rather than a continuation of, the existing pilots.
56. However, existing pilots will have a place in the new scheme reserved for them subject to their continuing to meet the required eligibility criteria and the agreement of the provider, commissioner and programme.
57. New applicant pilots including salaried services will apply via an on line form and existing pilots will have a separate, offline process.
58. Existing and potential new pilots will have one month from the date of applications opening to make an initial expression of interest. Applications will open from Monday 8 October.
59. The existing criteria and associated requirements are retained for new and existing pilots where they apply (the requirements on UDAs will not apply to existing pilots and salaried pilots requirements will vary slightly).
60. Key criteria are along the following lines:
- The applicant must hold (an) NHS dental contract(s), either GDS or PDS, and deliver mandatory services.
 - The value of the NHS contract(s) held by the applicant must be above a threshold of £100,000 per annum.
 - At least one of the NHS contract must have been in place for at least three years (measured from 1 April 2010).
 - The contract holder must currently use an IT system, at the practice (in all locations in which services are delivered), for the transmission of data to NHS Business Services Authority Dental Services (NHS BSA DS).

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- The contract holder must confirm understanding of and commitment to the principles for the pilots.

61. Additional criteria only applicable for non-salaried service GDS or PDS contract holders (high street services) are along the following lines:

- The NHS contract(s) held by the applicant must account for over 60% of the total earnings at the dental practice based on fees (to be verified using analysis of the reimbursement of non-domestic rates abatement data held by PCTs).
- The NHS contract(s) held by the applicant must have at least 80% of the contract value attributed to delivery of the UDAs, except where the contract is being delivered under either PDS plus, Steele pilot, or other local pilot arrangements to deliver mandatory services.

62. The chair side requirements have been expanded based on learning from the first round experience. We intend to be very specific about what chair side IT means. This will also mean we can be clear with applicants (who will be responsible for funding their own IT systems) about the costs involved.

63. For a full list of criteria, associated requirements and underpinning principles, please see Supporting information for stage 2 dental contract pilots, available at <http://dentalpilots.pcc.nhs.uk> from Monday 8 October

64. We intend to complete the application and selection process by the end of December 2012. Pre pilot training will be delivered between January – March 2013. Training (for existing and new pilots) will be for all practice staff and include training on:

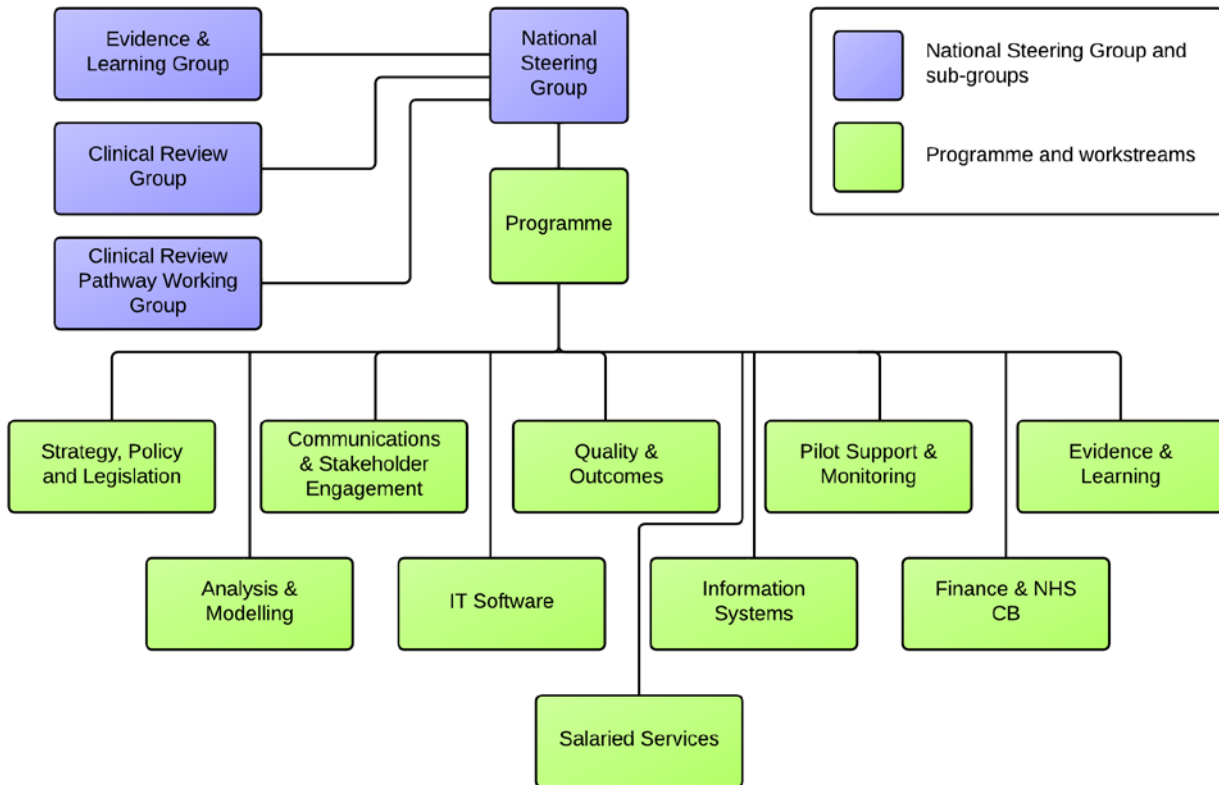
- A general pilot induction
- The clinical approach
- How the clinical approach interacts with the chair side IT
- Managing operationally

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65. The approach to training will be strongly informed by existing pilot feedback on their training experiences in the first round of piloting. As numbers increase we intend to increasingly include peer to peer training as part of the overall approach.
66. The aim - particularly for new pilots – is to ensure they learn from the existing pilots' start-up experience. This mentoring by existing pilots will be key part of new pilots' support.
67. Feedback from the current pilots indicates that training for any new pilots should include clear guidance on the care pathway with supporting information for patients, availability of software simulations, workshop style training for smaller groups of practice teams, easy to access question and answer guides and training on how to deliver the care pathway in a practice business environment. All practices selected to participate as pilots will be required to attend training.
68. As in the first round of piloting, pilots will contract separately with their software supplier for any necessary upgrades and/or detailed training on chair side IT provided.

Annex 1: Programme structure and lists of members

Programme structure overview



Programme team

Elizabeth Lynam	DCR programme director
Barry Cockcroft	Chief Dental Officer (DH)
Sue Gregory	Deputy Chief Dental Officer (DH)
Helen Miscampbell	Head of dental strategy (DH)
Elaine Maggs	DCR programme – Project support
Keith Ellis	DCR programme – Project support

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Daisy Wild Data analysis lead (DH)

Marianne Scholes Data analysis lead (DH)

Membership of the NSG

Elizabeth Lynam (Chair)

DCR programme director

Barry Cockcroft

Chief Dental officer (DH)

Sue Gregory

Deputy Chief Dental Officer (DH)

Serbjit Kaur

Head of dental quality & standards (DH)

Helen Miscampbell

Head of dental strategy (DH)

Prof Jimmy Steele

Dean (Newcastle Dental School)

Elaine Maggs

DCR programme – Project support

John Milne

Chair of GDPC (BDA)

Linda Wallace

Director of public policy & affairs (BDA)

Henrik Overgaard-Nielson

Vice chair of GDPC (BDA)

Keith Ellis

DCR programme – Project support

Fiona Erne

Assistant director of primary care dental, ophthalmic & pharmacy (NHS North West London)

Ruth Gasser

Head of Dental Policy (NHS BSA DS)

Sam Illingworth

Dental, Pharmacy & Eye Care Lead (NHS CB)

Paul Worskett

Dentist (Amblecote Dental Practice (Pilot site))

Daisy Wild

Data analysis lead (DH)

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Marianne Scholes	Data analysis lead (DH)
Andrew Powell-Chandler (Observer)	Head of dental policy (Welsh Assembly Government)

Membership of ELG

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Sue Gregory	Deputy Chief Dental Officer (DH)
Helen Miscampbell	Head of dental strategy (DH)
Daisy Wild	Data analysis lead (DH)
Marianne Scholes	Data analysis lead (DH)
Mark Shackell	Regional consultant (BDA)
Jane Moore	GDPC executive (BDA)
Philippa Risely Prichard	Dentist, (Market Place Dental Practice (Pilot site))
Andrew Jackson	Health economist (DH)
John Wildman	Professor of health economics (Newcastle University)
Cam Donaldson	Yunus Chair in Social Business & Health (Glasgow Caledonian University)
Ruth Gasser	Head of dental policy (NHS BSA DS)
Darren Williams	Statistician (NHS BSA DS)
Eric Rooney	Consultant in dental public health (Cumbria & Lancashire)

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Rebecca Harris	Senior lecturer in dental public health (University of Liverpool)
Fiona Erne	Assistant director of primary care dental, ophthalmic & pharmacy (NHS North West London)
Anna Ireland	Consultant in dental public health (NHS North Central London)
Keith Ellis	DCR programme – Project support

Membership of CRG

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Duncan Thomas	Dentist (Amble Dental Practice (Pilot site))
Helen Miscampbell	Head of dental strategy (DH)

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Angela Moon	DCR Programme - Project support
Natasha Dogmetchi	DCR Programme - Project support

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Steve Wright	Dentist (Thornhedge Dental Practice (Pilot site))
John Rayner	Dentist (Rayner Dental Practice (Pilot site))
Alison Rayner	Dentist (Rayner Dental Practice (Pilot site))
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Annex 2: Feedback from peer support group engagement events (summer 2012)

Introduction and Overview:

An important way of capturing the learning from the dental contract reform piloting process has been to seek feedback directly from our current pilots. Accordingly, during summer 2012, a series of engagement events were held for the 70 pilot practices across England (see Appendix below for dates). This was an open invitation to all practice staff. The events were well attended, with a good cross-section of staff, including:

- Dental care practitioners
- Dental nurses
- Practice managers and other administrative staff
- Providers and performers

Participants took the opportunity to feedback to members of the DH programme team on their experiences on the pilot, specifically responding to the following areas:

- Elements of the pilots that that were working well
- Elements that could be improved
- Their view on what those improvements could / should look like

Following a presentation of patient and practice staff survey results from an independent market research company, ICM Research, an open discussion was held with colleagues from DH and feedback captured on a number of issues. Feedback from attendees was positive with respect to the information presented and on the opportunity participants had been given to contribute their views. A summary of discussions was written up and circulated for participants' information and any final comments.

There were a large number of commonly expressed themes across each of the seven groups, with one or two region-specific issues also described. In brief:

- Practitioners felt that the care pathway approach and the focus on prevention was the right way forward. They appreciated the extra time for communication and prevention: “It feels like I’m doing what I was taught to do again”;
- The majority of patients liked the new approach and felt that they were receiving a good service;
- Many practices had been struggling to maintain access levels and had seen waiting times for non-urgent appointments increase. Practices had sought guidance from DH on managing their appointment books due to the increased time taken to perform the new assessments;
- Practitioners were finding it difficult to communicate the need for and benefits from the ICM appointments. Some patients opted not to book / attend ICMs and practitioners felt they were not applicable for lower risk patients.

A more detailed summary has been provided below on what is working well; what could be improved; and suggestions for making those improvements.

What’s working well?

- Patients and dentists like the care pathway approach
- Dentists like the time available for communication and prevention, which is helping improve attendance and patient compliance:
 - Starting to see improvements in patient attendance – more patients coming back, particularly around periodontics. This is directly related to the increased time with patients for communication and engagement
 - Positive impact for high risk children: the preventative messages are good and help with patient compliance;

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- Patients like the RAG colours, the self-care plan and the fact that they are getting good value (and a lot of treatment) for their money;
- Patients feel that they are being taken seriously and their care is personal to them;
- Patient information is good, however, a balance must be struck between the amount of detail and how accessible it is to patients.

What's not working so well?

- There are significant increases in waiting times across a number of practices and this has not improved much thus far. Some practices are unable to take new patients as there is no capacity
- There are still problems with the IT software. It hampers practice and could be made much smarter - frustrating for team members and time consuming for the whole practice
- Financial issues: patient charge revenue is not being deducted from schedules, which gives a false sense of financial security in the practice. This money sits with them until the FP17 is closed, which could be a year or longer, and can create business difficulties
- Self-care plans are very long and can be overwhelming for some patients. Also, consider how they are issued, eg one page document sent electronically instead of / as well as printed on the day

What improvements would you like to propose?

- Simplify the pathways. They are taking too long currently and are affecting access. More flexibility is needed around the length of the OHA, the need for ICMs and recall intervals;
- Training must be provided to all staff as they all must be able to articulate the care pathway, what ICM appointments are etc. Clinical and software training should be integrated. More supporting information for staff is required, such as FAQs, online resources, and software training;

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- More standardised patient literature is needed. This should be available within the practice from the outset, including explanation of what is and is not available on the NHS;
- Implement the outcomes from the software review. This would help streamline processes and reduce time;
- Training on data should be available to Type 1 pilots so they can see what the impact of capitation would be on their contract value.

How does the pilot work for practices operationally, in a business environment?

- Transition: The early months were very difficult and the impact on the whole team was not to be under-estimated. A phased roll-out will be required to ensure continuity of service;
- Management of Associates: From a practice perspective, understanding exactly what they have done is not always clear as the software is not easy to use. It creates difficulty in managing Associates' contracts and paying them; and makes it difficult for Associates to fully engage as they do not know their financial / activity position during the year;
- Access and efficiency:
 - Waiting times are still a concern and patients are being booked well ahead (up to 3 months in some cases). This impacts on ability to take on new patients and is also increasing the number of urgent appointments
 - It was noted that the patients spend more time at the reception desk than previously, going through the paperwork and booking appointments.
 - There has been an increase in the time spent on administration because of on-going contact with the software company dealing with queries and problems;
- PCR cash flow: needs to be managed appropriately, as practices are holding onto PCR for much longer than they previously would have.

Region-specific issues:

- Migrant seasonal workers accessing NHS dentistry. These patients are entitled to NHS care if they are EU nationals; however, the care pathway approach in the pilots is predicated on continuing care, which may be difficult or impossible for patients who will not be living in England for more than a few months. This issue highlights the need to consider regional and local issues in the development of a new contract for NHS dentistry. In addition, where seasonal employment patterns mean that fresh groups of EU nationals arrive for temporary work every year, it can mean that certain practices will find themselves doing disproportionate amounts of work to treat disease at the early stages of the pathway.
- Another regional variation is fluoridation (natural or otherwise) of the water supply, such as occurs in the West Midlands. The fluoride in fluoridated water improves the chemical structure of the enamel making it more resistant to acid attack, which reduces the rate of demineralization of tooth enamel and encourages faster remineralization in early caries. The link between the index of multiple deprivation and dental health may therefore be different in fluoridated areas than in non-fluoridated areas, and we should consider this in the development of the detailed capitation model.

Appendix: Dental Contract Reform Pilot Engagements – Summer 2012

North West	7 August 2012
North East and Yorkshire & Humber (combined group)	14 August 2012
East Midlands	16 August 2012
South West	29 August 2012
London & South East	4 September 2012
West Midlands	5 September 2012
East of England	6 September 2012