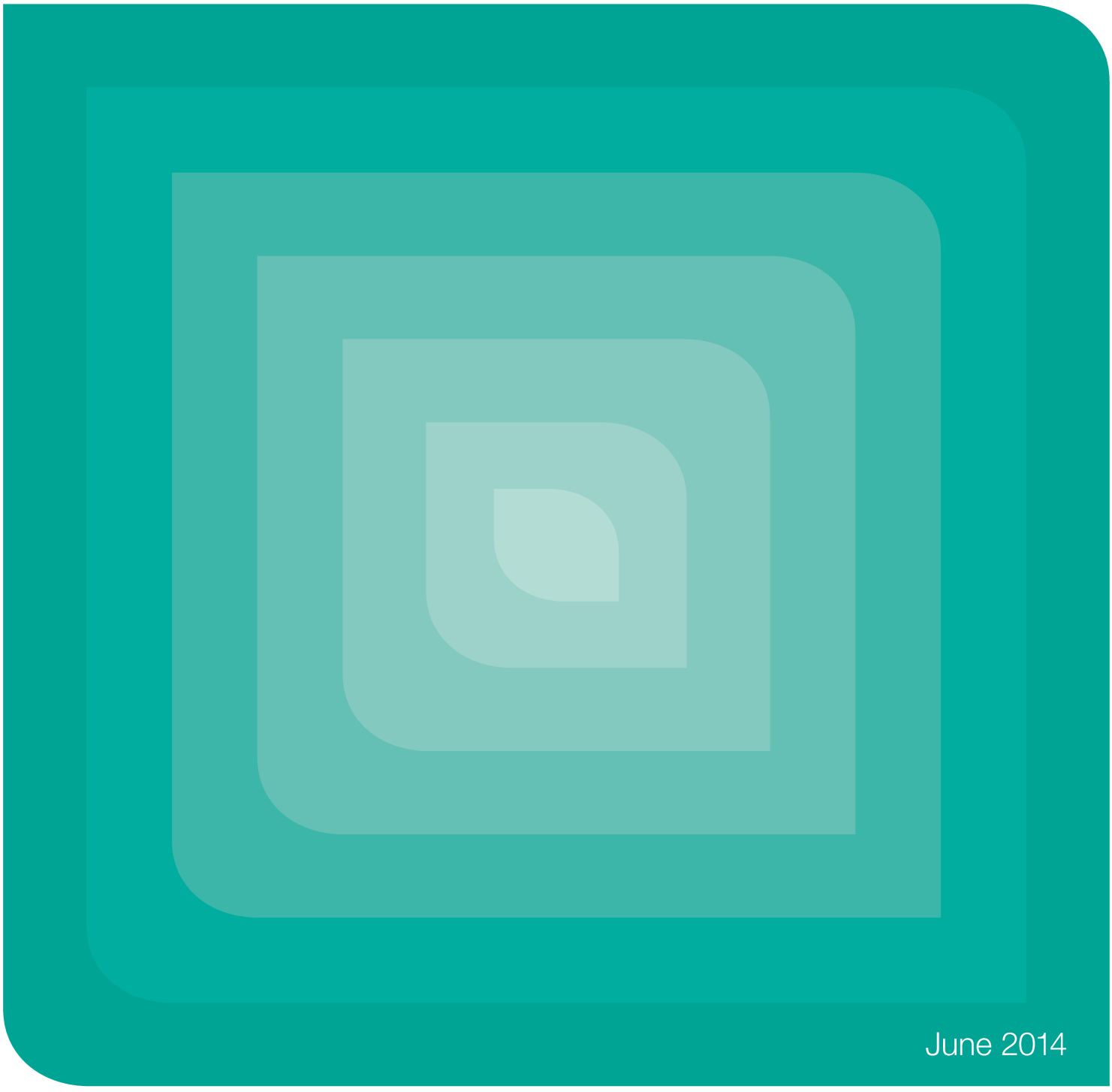
Department of Health

Dental Contract Reform: Engagement

Paper 1: Overview



June 2014

Purpose

This paper introduces an engagement exercise on the way forward for Dental Contract Reform. It is particularly aimed at the dental profession and wider dental community.

Your comments, as part of this engagement, will inform the next stage of reform. This next stage, which is expected to start during 2015/16, will see a limited number of prototype or pathfinder practices testing one or more variants of possible new systems.

The engagement runs until the end of July 2014.

This document considers:

1. The reasons for reform
2. The elements of NHS dentistry that are not expected to change
3. Progress and learning from the programme so far
4. Implications for on-going work
5. Evolution not revolution
6. Next steps

There are three additional papers associated with this paper, that explore the key elements and foundations of the Dental Contract Reform programme.

These associated papers are:

Paper 2: The clinical philosophy

Paper 3: The measurement of quality and outcomes

Paper 4: The remuneration approach

There is an opportunity in each to feedback your thoughts, comments and experiences.

Context

This engagement on Dental Contract Reform follows NHS England's recent "Call to Action" on dental care and oral health. The Call to Action exercise which ran from February – May 2014 aimed to stimulate the debate around dental services in the context of developing a 10 year strategic framework for primary care.

Whilst the two exercises are separate, the Department of Health and NHS England are working closely to ensure the approach is joined up. The development of dental reform engagement has been informed by the discussions on contract reform in the Call to Action. The wider outputs from the Call to Action and any decisions taken on the development of a strategic framework will also draw on this engagement which is focused specifically on contract reform. The work on contractual reform is led by the Department of Health with close engagement by NHS England and Public Health England.

1. The reasons for reform

The Government is committed to reforming the current dental contractual system in order to further increase access and improve oral health, particularly of children (Coalition – Our Programme for Government 2010).

An important driver for change is the changing patterns in oral health and patterns of disease we have seen over recent years. Historically dentistry has focused on treating active disease. The transformation in oral health over the last 40 years has brought an increased focus on the prevention of future disease. This has been highlighted in a number of reports and notably in the Steele Review, "NHS dental services in England: An independent review" [1] led by Professor Jimmy Steele, June 2009. Primary care dentistry needs to be able to deliver prevention based care as well as providing appropriate treatment, and retreatment of current disease, where necessary.

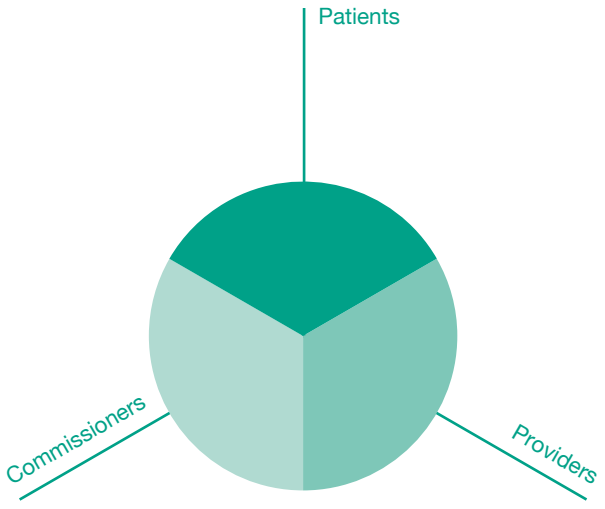
The principles underlying the approach to developing a reformed system are that it must:

- support dentists in offering appropriate prevention and active treatment, therefore supporting improvements in oral health
- allow the quality of care to be objectively measured
- promote a continuing relationship between practice and patient, providing patients with security of ongoing care
- ensure an appropriate number of patients are offered care
- support the goal of increasing access
- not disadvantage groups who find it more difficult to access services
- be capable of being commissioned both effectively and efficiently.

Reform is focused on two key areas:

- **Quality of care:** developing a philosophy of care that reflects the new preventive focus (the preventive pathway); and measurement of the quality of care delivered (currently being piloted through a Dental Quality and Outcomes Framework or DQOF approach)
- **Remuneration:** developing a remuneration system that supports both access and the approach to care described above including promoting continuing care (capitation/ registration).

As with any part of the NHS, the system must work for the three key interest groups shown below:



2. The elements of NHS dentistry that are not expected to change

- Overall expenditure by the NHS on dentistry is not expected to alter as a result of these system changes
- The scope of NHS care is expected to remain unchanged
- It will be a commissioned system where contract remuneration remains capped
- There will be metrics for measuring delivery and there will be financial recovery where there is under-performance
- The current ability to flex the levels of service a practice offers by an agreed variation (temporary or permanent) to the levels of service specified will be retained. Any new remuneration system will have to have this capacity
- Patient charges will be expected to continue to raise a similar proportion of costs and the collection of charges is expected to remain with practices
- The system is expected to continue to allow for appropriate mixing of private and NHS care.

3. Progress and learning from the programme so far

The testing of elements needed to design a new system began in 2011 across 70 high street practices. In 2013 these were joined by around 20 further practices including some community dental services (CDS). The CDS are testing the clinical approach only.

The practices have been:

- piloting the pathway approach to preventive care. Drawing on the pilot experiences and input, the clinicians advising the programme are developing and refining the way in which the pathway approach is used
- using a shadow DQOF to measure the quality of care delivered
- remunerated in one of three ways, two of which simulated in a limited form weighted capitation (so had some contract value at risk) and a third which offered guaranteed contract value (no contract value at risk). Since 2013 all pilots have also been testing a form of shadow patient registration.

All the pilots have been collecting detailed anonymised data on numbers of patients seen and care delivered to each patient. This data and wider work supports extensive modelling and analysis which enables options for possible new arrangements to be considered. The work to gather evidence and learning is being led by Professor Jimmy Steele. He chairs an independent Evidence and Learning group made up of dentists, commissioners and academics. The most recent report produced by this group was published February 2014.[2]

Evidence and Learning report

A key finding reflected in this report is that the clinical approach is showing benefits to the oral health of patients. It is still early days, especially when assessing significant and sustained clinical changes, but the initial signs are promising. Dentists and patients have generally reported a greater satisfaction with the pilot approach compared with the existing system of care delivery.

The pathway approach is liked and has already been refined based on learning from the pilots but it is clear that moving forward with a pathway approach for the system as a whole will present considerable challenges. One group of these is around the interaction between the use of clinical pathways and clinical autonomy / the use of clinical judgement. As the pilots have shown, those new to pathway working can find it restrictive at first but once they become familiar with it, the benefits become apparent. All of this indicates that embedding pathway working across the system as a whole will be a significant cultural challenge.

To move forward with the pathway approach we need to have greater confidence that we can develop a way of presenting the pathway that releases the clinical benefits without putting too much pressure on resources or alternatively damaging access (patient numbers have fallen in many pilots). In order for us to achieve this we need to continue our work around:

- Gaining a better understanding of the extent to which the various features of the pilot design have made following the pathway approach take longer than we would have expected in a 'live' system. So, for example our need to obtain a great deal of data from the pilots means that the specification for the computer support system is much more detailed than it would be in a 'live' system.

- Gaining a better understanding of what we should expect to see in terms of treatment levels. We had expected that the pathway approach would lead to a drop in treatment levels to some extent. However, we need to be sure that the presentation of the pathway does not put an excessive emphasis on prevention – to the extent that necessary and appropriate treatment does not then take place. We also need to find ways to make sure that if the pathway runs with a capitation approach to remuneration, we can ensure that treatment is not neglected for financial reasons. Please see Paper 4: The remuneration approach for further details of capitation and other approaches. All of this feeds into our understanding of how to develop a way forward.

There have been other impacts which are a consequence of the changed approach but are not a barrier to reform. Patient charge revenue (PCR) has fallen significantly in the pilots. Part of the fall has been the result of the impact on access (if fewer patients are seen there is a reduced pool of patients being treated and therefore charged). In addition there has been a change in the balance between prevention and treatment. This has also affected PCR levels. Minor modifications have already been made to allow for the pathway approach. The learning from this and later stages of testing will be carefully considered to see how much change will be required to the charge system going forward. Patient charge changes will follow any decisions made on the design of a new system.

4. Implications for on-going work

We have to find a presentation of the pathway approach that delivers the clinical benefits identified without being so time consuming or detailed, that it either reduces access levels or puts too much strain on the resources available.

This will require some further adjustment of the various elements, which is why work continues on the presentation of the pathway and developing deeper understanding of its effects on treatment. We then need to link the pathway approach with a remuneration model best aligned to its aims.

The existing pilots and the current contractual system show the challenges of any remuneration system. For a system to be capable of roll out the remuneration approach has to support patient access, appropriate levels of treatment and quality of care.

The current system can be seen as a pure activity based system. In addition there is no remuneration specifically for prevention, no contractual links between practice and patient beyond each course of treatment and no direct incentive to maintain patient numbers and therefore access (currently measured through the number of different patients seen over a period of time). This does not mean that patients are not offered prevention or continuing care under the current system; but the incentives in the current system are not well aligned with a prevention approach. The payment system is driven by courses of treatment delivered, regardless of how many or how few individual patients are receiving those treatments.

A system based purely on capitation may promote an increase in the number of patients seen, but it does not promote treatment. Activity alone promotes treatment but does not check over-treatment. And neither system on its own measures or rewards high quality care. Getting this balance of incentives right in any remuneration system is very challenging. The perverse incentives which result from an imbalance can have significant impacts on oral health and patient experience and are frustrating for clinicians keen to provide appropriate care.

This is why we are considering whether a combination of capitation and activity in a future payment system may be appropriate (a so-called `blended' system). Any new system will also include a measurement of quality and where appropriate, remuneration based on quality.

There are other challenges beyond the blended system. The current system of locally determined contract values is able to reflect the individual characteristics of a practice. A national system, even if weighted as is the intention, is by definition unable to reflect any factors beyond those used in the national weighting formula. Practice populations are not necessarily alike even when demographic profiles suggest they should be. Areas with influxes of seasonal workers entitled to NHS care are one example but there are many others where a national system alone may not appropriately remunerate. There may need to be a mechanism to allow for additional payments where there are specific local factors that a national system would not be likely to adjust for.

5. Evolution not revolution

The approach to this reform is deliberately very different from previous changes. A criticism of previous changes has been that there was insufficient testing before design and then implementation. The Government made a key commitment from the start of this reform process to use piloting to inform the design of the contract and to ensure that the impact of proposed changes is, as far as possible, understood before any new arrangements are implemented.

This approach is based on evolutionary not revolutionary change. The aim of this gradual approach rather than a single "big bang" is to minimise the risk of unforeseen impacts that might destabilise patient care, dental practices as businesses or the smooth running of managing contracts by commissioners. This approach to testing also allows other consequences and implications, for example on the patient charge system and performer remuneration, to be fully understood and addressed ahead of widespread change. Some of these issues, such as patient charge revenue are the direct responsibility of the Department of Health/NHS England. Others such as performer remuneration are the responsibility of the profession. Either way it is vital that the impact of both is fully understood.

6. Next steps

As set out in the introduction, 2015/16 will see a limited number of prototype or pathfinder practices testing one or more possible new systems. What is tested in 2015/16 will, we hope, provide the learning to build on and enable roll-out for a new system. This will be a foundation enabling further evolutionary change.

We are keen to work with the profession to align contractual incentives with the outcomes that clinicians want; and ensure an alignment with the needs and aspirations of the people who should be, at all times, at the heart of our NHS – the patients.

This exercise offers an opportunity to engage about the general issues of reform and we will use its output in the detailed design of what will be tested next year.

Please use the feedback links in each document to send in your comments as it is really important that you, the profession, input into the development of the service.

References

[1] NHS dental services in England – an independent review, June 2009
http://www.sigwales.org/wp-content/uploads/dh_101180.pdf

[2] NHS dental contract pilots – Learning after first two years of piloting
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/282760/Dental_contract_pilots_evidence_and_learning_report.pdf

This paper has been produced by the Dental Contract Reform programme

Any comments or queries on the papers should be made to the team via the online feedback mechanisms.

Feedback on the papers, sent via email, will not be considered as part of this engagement activity.

Department of Health
80 London Road
London
SE1 6LH
dentalengagement@pcc.nhs.uk