Department of Health

Dental Contract Reform Engagement Exercise:

Appendix

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Appendix 1

This appendix lists the redacted responses to the questions posed in each of the 3 engagement papers: clinical philosophy, quality and outcomes, and remuneration. Please note: Respondents who made no comment are not included, and grammar/ punctuation/ spelling is as submitted.

There is also a separate list of the various organisations that submitted responses at the end of this document. Individual respondents are not identified.

Paper 2: The Clinical Philosophy

Responses to Question 1

What are your views on the philosophy of a need and risk-based, preventive approach to care?

Respondent type	Response
Dentist	In total agreement that it is the best and only way forward
Local Dental Committee	We are interested in what is meant by right in your description of the right people, doing the right things, in the right order, at the right time, in the right place. We would like to see how you define right in each of the scenarios. Who will determine what right is? How can a system judge who is a right person to undertake a particular procedure? We know from the endless stream of tragic media stories that having the right piece of paper, does not necessarily make a person the best one for the job and this is something that concerns us. Experience must be made to count and provision for those with vast experience but without the relevant qualifications must be made in the design of any new system. Failing to do so would result in the loss of a great deal of clinical expertise, ultimately at the expense of the NHS. This would be nonsense. The pathway approach seems to be popular with the Department of Health, presumably because it can be easily monitored via practice reporting and it restricts/delays patient access to treatment (potentially saving money). The approach also makes sense to clinicians, at a purely clinical level, as it ensures that treatment is undertaken only when certain clinical criteria have been met. Despite this, we have concerns about the impact the pathway approach may have on patient care. Denying certain treatments to patients until they improve their oral health sufficiently to meet NHS criteria could undermine the NHS in attempting to reduce inequalities. Such an approach implies that all patients have an equivalent capacity to determine their own oral health improvement. Some, very often the most disadvantaged groups within society, may not have this capacity. In this way, the proposed changes threaten to marginalise those with the highest needs. If patients are able to opt-out of the pathway system, seeking episodic care whenever they wish, why would they not choose to opt-out? If such an opt-out were chosen by a higher number of patients within a practice than average, the opportunities to move patients from red to amber, or from amber to green, would also surely be less. This has the potential to disadvantage and destabilise practices in areas with the highest need, something that is a problem under the existing system and certainly must be guarded against in any reformed system. We have particularly serious concerns about the use of computers and/or algorithms to determine a patients eligibility for treatment. It is, frankly, insulting to highly trained professionals to suggest that their treatment planning and care decisions should be determined largely by a computer algorithm. We believe the default position of following the automatically generated care pathway needs to be radically

Respondent type	Response
	rethought. In terms of treatment being undertaken in the right place, we would question whether it is really possible to squeeze all patients and all types of clinical care into three simple tiers of complexity (as seems to be being done at the moment). We have very serious concerns that such an approach does not allow enough flexibility within the system for commissioners to fairly remunerate professionals in a way that reflects their skill level. Such an approach threatens to undermine, rather than support, the career pathways for dentists. In order to maximise the value for money to the NHS, any commissioning system must be able to match as accurately as possible the nuanced care needs of patients with the nuanced clinical skills and competencies of dentists. We believe that talking about the right place is something of a misnomer. Although it is a crucial factor in ensuring dentistry is provided in a safe environment for the patient, we believe sharing existing expertise across primary care to be the future for the NHS; more care, more locally. This relies on ensuring a workforce is available to meet as many of the patients needs in primary care settings as possible, rather than focusing exclusively on the setting.
National body	This approach is to be welcomed as it is important that patients are informed how to look after their oral and dental health to a high standard before having complex, expensive dental work provided. Consideration will have to be given to any patient groups that may be an exception e.g. Special Care, especially where the NHS is not supporting care home dental care adequately.
National Association	The principles of a preventive approach to care the right people; doing the right things; in the right order; at the right time; in the right place are wholly supported by the [redacted]. The delivery of consistent, high quality, accessible and equitable patient-centred care is something that we aspire to, and it is for this reason that the [redacted] continues to urge the Department to progress with reforms with all due speed. Dentists are currently hamstrung by a flawed and pernicious contractual system which is compounded by the inequities of rising expenses and below-inflation rises in contract values. We see considerable potential in the system currently being piloted, and we are keen to see further progress made through the introduction of a prototype model and the engagement of a significantly increased number of sites. A considerable amount has been learnt over the past three years, and it is our view that the Department must use this information to make a further step towards reform. Alongside its commitment to patients, it is our view the Department of Health must also commit to a consistent, high-quality and equitable approach to its contractual relationships with dentists. It is through such an approach, and with sufficient investment in the provision of care for the population, that the Department will achieve its aims.
Dentist	This is a good philosophy, however the principles that underpin this are already in practice in dental surgeries. The care pathway approach to treatment is already established and many GDPs are actively using this philosophy to treat patients. The RAG rating system is good and helps to determine risk of disease, however clinicians must be able to override the rating to tailor it to each individual patient.
Dentist	If as a profession we are serious about trying to improve the oral health of the populations we serve in a sustainable and cost-effective manner a shift to this approach is a must. Dental teams need to work with their patients to explain and inform them of their own dental risk and needs and tailor oral care pathways to match this.

Respondent type	Response
National Body	The [redacted] supports the overall philosophy of a need and risk-based preventive approach to care as it effectively advocates good dental practice. It should be noted that this type of approach is already used effectively within the Community Dental Service and Special Care Dentistry. More generally, we believe preventive oral hygiene and mouth care should be encouraged by carers and teachers in early years settings. The national Childsmile nursery, school and dental practice programme in Scotland has proved successful at reducing oral health inequalities and improving oral health among children, their families and the nursery/school staff delivering the project. We suggest a similar programme should be rolled out across England. In addition, other health care workers, for example pharmacists, should continue to participate in oral health care advice for patients. Although we support the preventive care pathway approach as it will support patients and encourage access to the highest quality of care, all the care provided by the NHS is an equally valuable part of that service. Intervention to tackle dental health problems must remain affordable to promote good oral health and tackle inequalities.
Dental Professional	As a profession who focus on the prevention approach to treat disease we are acutely aware of its necessity in the role of oral health. Every patient should be assessed on their individual needs and their risks. The difficulty is making the patient aware that prevention is key to their oral health and that their home care is more important for overall health than dental treatment alone. Patients have been used to attending dental surgeries for treatment and todays public demand immediacy. Prevention is a long term strategy and therefore needs to be sold as an investment in health.
Local professional network	We felt this the correct philosophy, the preventive approach, encouraging and supporting patients to take shared responsibility for their Dental Health is essential. All dentists need to follow NICE Guidelines; present contract drivers dont encourage this. May be this approach and a reformed contract would.
Dentist	The philosophy of the approach described is central and essential in the success of the sustainable delivery of dental care to any patient base. This ensures appropriate delivery of care to the correct patient at the correct time and maximises the likelihood of treatment success. Delivery where care is needed as opposed to demanded and also addressing risk factors as an integral part of a preventive approach will improve the quality of care delivered in the longer term. It will also produce a more definitive treatment pathway which will engage with patients
Dentist	This is correct
Dentist	The [redacted] believe that this is the correct approach to achieve the best utilisation of resources in order to provide the best treatment for patients, each specific to their individual oral health and risk factors. The Oral Health assessment process must be sufficiently robust to identify relevant risk factors to produce an accurate RAG score. The initial OHA takes substantially longer than a traditional examination and the contract must address this to ensure this is not perceived as a barrier by dentists. It is important to avoid a "one size fits all" approach as there is the potential to miss patients whose oral health needs dramatically change over a short period of time. Such patients may appear to have low risk and thus be prescribed preventative measures and recalls reflecting this low risk. Any change could potentially have severe negative effects unbeknown to both the patient and clinician in the intervening period between

Respondent type	Response
	recall visits.
National Body	[redacted] supports a need and risk-based, preventive approach to care but believes that there is still a need to investigate wider public health measures such as water fluoridation in order to address the existing widespread inequalities of oral health. A preventive care pathway will only support those who chose to access dental care with their General Dental Practitioner. Further efforts should be made to engage with parents who are not bringing their children to dental services, for example by working with nurseries and schools in a more collaborative manner, as demonstrated in the Childsmile programme. [redacted] continues to raise concerns that the pilot studies for risk assessment within the new contract does not include tooth surface loss (erosion) for children. The Child Dental Health Survey of 2003 found a prevalence of tooth surface loss into dentine of up to 50% of 5-year-olds and thus presents a serious concern, which should be formally assessed in all young patients and inform future preventive strategies.
National Body	The [redacted] are in support of the philosophy of a clinical pathway approach to care. They agree with the concept that care should be based on need after an assessment where the risk of current and future disease is taken in to consideration and care is based on a preventative approach.
National Association	We are supportive of adopting a need and risk-based, preventive approach to care. We also feel strongly that the new Contract should cover complex dental treatment where needed and that this provision should be adequately funded. In adopting this approach it will be important to give proper consideration to the changing requirements of dental practices as a result of this shift in philosophy. In particular, it will be vital to ensure that practices are given adequate time to transition in terms of the new dental equipment that will be necessitated. Changes to practice staffing requirements as a result of the new contract would also present challenges to dental practices adapting to the new care pathway, both in terms of the provision of operating space for staff such as Extended Duties Dental Nurses (EDDNs) and the associated space and equipment requirements. It will be important to ensure that practices are allowed sufficient time to prepare for these changes so as not to negatively impact patient care and access.
Dental Local Professional Network	The philosophy is wholly ethical, giving the patient the information about their dental health status, giving them more ownership so hopefully motivation. A tailored evidenced based pathway for the patient and dental team to follow can only be a good thing. We welcome an approach that shifts care approaches to a proactive and preventative rather than reactive. This will create better health outcomes for the population. This will also be useful in addressing health inequalities. In terms of broader Public Health interventions, dentists and the dental team are ideally placed to provide prevention and promotion messages to patients, such as smoking cessation advice, healthy eating advice or advice on sensible alcohol use. In this Area Team there is a drive to deliver the NHS Health Checks through dental teams Oral health prevention and education are not always part of general health promotion programmes. Dental teams certainly have a role to play in advising and shaping messages. For preventive dental care to be effective, the dental health practitioners need to be able to spend time with patients/individuals to counsel them about diet, drinking and smoking habits, to implement oral hygiene regimes and to discuss any areas of concern. This approach also makes it more likely for a greater skill mix to be used; the enhancement of the appropriately trained dental nurse is long

Respondent type	Response
	overdue. Enabler: Increasing an integrated approach to training for all in health and social care Properly embedding an integrate approach to health and social care into a contract reform Dentists should be given the ability to undertake the majority of work in primary care. There should be an appropriate rewarded skills escalator for enhanced skills or special interests training. Pathways need to have facilities for efficient and effective communication (e.g. IT systems) exchange, to allow training and enhanced clinical work to be undertaken in primary care. Having time within the working day to be able to do this. Efficient communication system in place Barriers: Publics perception of the Dentists role in looking after their overall general health Time to communicate health and social care messages between, dentists and patients and dentists with other health professionals e.g. GP or health visitor. Patients not taking ownership of their home oral care regime. Having too many or inappropriate targets.
National Body	In principle a reasonable idea, however its something that dentists should already be doing but dentists may not consider the current remuneration system is assisting them in achieving this. Provision of an easy to use framework to assist with this but not a framework that is too complex or prescriptive. In order for dentists to be confident in using care pathway software, dentists need to understand and be able to apply the principles underpinning the risk assessment and continue to apply appropriate clinical judgement. The potential to manipulate risk scores needs to be considered. There may be issues of calibration, for instance with regard to recording of BPE. Consideration needs to be given to how the system could work for those not using a DPMS system and how risk assessments may be applied. For example some dentists dont pay attention to NICE Recall Guidance and may fit any risk assessment to suit their own business profile. Does the patient actually understand the risk score they have been given? Communication and explanation of the risk by the dentist is vital. Some dentists may not be keen to do this if the patient is identified as a red risk but has already been a long standing attender at the practice.
Dentist	The philosophy is valid and relevant to current thinking
Dentist	Yes I agree that there should be a risk and need based preventive approach care but that the dentist should have the clinical decision in making this not necessarily a computer algorithim
Dentist	Government implementation of nationwide fluoridation would show its mettle in supporting a preventitive approach to care.
Dentist	The actual philosophy is sound and logical
Dentist	I think that this is an excellent way of working as it addresses the patient needs in an appropriate way.
Local professional network	Whilst this is an aspirational approach, in getting patients to take responsibility for their own teeth and avoids advanced care for patients who are unwilling or incapable of maintaining dental health. It is also a way of prioritising treatment for high needs patients away from low needs patientsIf as a profession we are serious about trying to improve the oral health of the populations we serve in a sustainable and cost-effective manner a shift to this approach is a must. Dental teams need to work with their patients to explain and inform them of their own dental risk and needs and tailor oral care pathways to match this.

Respondent type	Response
National organisation	We are supportive of this approach to contemporary dental care
Local professional network	The LDC is supportive of the main Call for Action objectives of improving oral health, improving access to dental care, and aligning financial incentives to the desired outcomes of increased access and better oral health. With over 1M patient contacts a week dentists are exceptionally well placed, skilled and equipped to contribute to the wider public health agenda. To promotion and prevention measures and to identifying health risks such as diabetes and oral cancer
National Body	It has long been the case that primary care dentists finish their training having with the motivation to provide preventative care based upon patient need and risk. This motivation is too often thwarted by a fee for item NHS system that make delivery of such care very difficult, if not impossible. Most dentists would agree that a risk-based, preventative approach is the best way forward, both clinically and financial, especially as the need to effectively control costs increase.
Dental software supplier	Good approach that reflects the changing future demands on the dental community.
Dentist	We agree with the philosophy of a needs and risk based preventive approach to care and the pathway approach . This does however present challenges for patients reliant on carers , hard to reach groups and those who do not have English language
Dentist	This is an excellent approach to managing care that we support. The important point is that the delivery of this kind of individualised care requires front loading in terms of time. This cannot be avoided if the approach is to be personal and robust. In addition the interim care appointments for high needs/ risk groups are vital to re-emphasis the importance of a preventive approach and reinforce advice .
Dentist	it is perfectly reasonable and in my experience it is what dentists have already been doing for years
Dentist	Great idea - we have seen the benefits of spending time on prevention
Dentist	good in principle however difficult to implement in practice without appropriate support from dedicated staff members and software support.
n/a	Yes appropriate approach as need to provide a preventative focus for treatment services to improve oral health but also need wider oral health improvement programmes and vast majority of dental budget spent on individual treatment and prevention vs community oral health improvement programmes. What about a national water fluoridation scheme or fluoride varnish scheme as in Scotland? Consideration should be given to support the engagement of dental practices in community oral health improvement programmes under the auspices of a specialist in dental public health.
Dentist	I agree with the philosophy however as always the devil is in the detail. I am now felling that the dental team seems to be the fall guy-ie if this approach is unsuccessful its due to the way it is delivered rather than the responsibility of the

Respondent type	Response
	patient. I work in an area where we see a lot of patients who attend only when in pain- i realise the procedures allow for these patients to be seen however I question whether in practice it will be successful there is also the necessary treatment to be carried out and I question whether it will be possible to do more for the same funding and improve standards. This doesn' t seem to fit
Dentist	The preventive approach to care matches my own philosophy of how to improve the oral health of my patients. I feel that past contracts have failed to reward the hard work that goes into a preventive approach and that good practitioners have been punished financially by doing good, ethical, preventive dentistry. I
Dentist	This philosophy works well with new comers as they are ready to absorb and easily learn the new system. The clinicians before hand were working on similar theory of dental care just the system is different and the way it is presented is different but essentially the same thing still the patients are on top priority. and educating them with different tools of health care. It is important to make the patients aware of their dental status to have the expectations to be realistic. It would be a good working guide to reach the goal of gold standards in dentistry.
Community dental service	It is essential to target limited resources to patients in highest need and to reduce the risk of further disease, there are many challenges. There will be patients who perceive a higher need than there actually is eg. regular scaling and polishing when they have good oral hygeine and are 'Green' RAG rated. There will be patients who dont think they are at risk or need intervention eg, 'nothing's hurting'. not pacifying these groups could be the group who thought pilot services were not as good as before.
Community dental service	Difficult to argue against the philosophy as it is based upon sound clinical approaches to providing dental care, i.e. identifying patients needs and their particular risk factors and then addressing both through effective interventions. There is an assumption that dental teams are well-practiced in providing effective oral health promotion to individuals, whereas there is not much evidence that individual-based chairside interventions are well-understood or practiced within dentistry. That is not to say that there are no effective one to one oral health education practices, but most dentists would not be familiar with how to provide effective oral health education. The basis underpinning the improvements in oral health over the past thirty to forty years have been largely whole population shifts in practices such as toothbrushing using fluoride toothpastes, which is largely due to shifts in the social norms with influences beyond the dental profession. It may be asking a lot to expect dental teams to be able to improve individual patients oral health behaviours prior to providing clinical interventions. For many patients their motivation to change their behaviour comes from seeing the initial results of treatment. Therefore to deny treatment until OH behaviours have improved may not work in the long run.
Dental Local Professional Network	A risk based approach to provision of dental care seems reasonable and is an approach that most practitioners have used for many years in an informal way.
Dentist	I feel that this is appropriate

Respondent type	Response
Dentist	I already practice such an approach as far as is possible within the current contract. If more time could be allocated to patient education, periodontal care, caries prevention and minimally invasive approaches with appropriate remuneration that would help support this approach.
Dentist	I think this is the way forward, but requires change of thinking among dentists
Dentist	An excellent way to reform the service
Dentist	Very beneficial for patients
Dentist	In theory a good idea
Community dental service	Good idea
Dentist	Well documented, easy to implement but ignored by a majority of older/non-uk trained and corporate dental bodies. Patients tend to accept preventative approaches as it results in less treatment, more advice and better education and communication from their dentist.
Dentist	It is just good practice.
Dentist	it is an appropriate and useful way of welcoming a new patient to the practice, and to know more about the patient and tailor prevention and care ccordingly
Dentist	Agree with a preventative approach to care
Dentist	It is the ideal approach
Community dental service	Favourable
Community dental service	A sensible, well founded approach but it must also allow for treatment of disease to be completed in a timely manner too.
Dentist	acceptable
Dentist	waste of time
Dentist	In principle this is a good idea. However, if you asked the patients association and other groups if this would have a good take up with their members I suspect you would not get universal support as you are removing flexible response. The point I am making is simpler systems run very well in other countries. Why not use those here and save money.
Dentist	I have always felt this is the best way to provide a dental service whether NHS or 'private'.
Community dental service	Great idea sand something we already try to follow in CDS
Dentist	The right way to proceed, putting the patient's oral health first.

Respondent type	Response
Dentist	In favour
Community dental service	In agreement so long as it works
Community dental service	In agreement
Dentist	This is precisely our role
Community dental service	There are a number of definitions of need. Which one does the paper refer to? Normative, felt, Expressed or comparative? As we are focusing on patient experience and equality, I believe this assessment needs to be clearly defined. Complaints from patients often arise because of this poorly defined aspect of the assessment of need. The preventive approach to healthcare is absolutely essential and despite efforts such as campaigning and lobbying for years, the successive governments support of preventing poor oral health has been one of neglect. Public health initiatives have not gone far enough and dentists alone will not resolve the high incidence of preventable oral disease.
Dentist	This is what all good dentist do already
Dentist	This is what I was trained to do 25 years ago and have only now got the opportunity to use this approach to care
Community dental service	This is the best way for an appropriate equitable service
Dentist	Prevention is good. Will the DoH fund it?
Dentist	It is good in theory, but some patients will not engage with the system. If a practice has a high proportion of a patient group that does not engage then this could disadvantage these practices.
Trainee Dentists	The philosophy currently working in the pilots works well. It is what is taught at undergraduate level. Seen by most as what good practise should be. Helpful to distinguish between need and want.
Dentist	The preventative approach is good but works only if the patient follows advice , In my experiance many patients do not follow the advice given
Dentist	Every patient should have a preventive approach to their dental care based ion their needs.
Dentist	I think the philosophy is fantastic. DBOH is a brilliant document- evidence based and the advice is straightforward to implement. The system easily identifies need and I like the fact that treatment is placed where need is greatest(i.e. patients with active disease are seen more frequently that those without). This is the best use of NHS resources in these current restrained times. I really like the preventive approach and feel I am performing 'good' dentistry and have good job satisfaction. It is now well established that most dental disease is preventable IF patients are given the knowledge and skill to self - care. I believe this to be excellent 21st Century dentistry, but worry that the potential savings in the cost of this type of care provision will take a long time to percolate and I am concerned whether this is really politically feasible.

Respondent type	Response
Dentist	Very good, but you are going against a commercial and human rights philosophy which says 'it is about what I want, not want I am told to do....my body , my choice'! So say people (the patients) these days.....Patients just want the best thing possible.....According to UK Law, that is what htey are told to expect
Dentist	My views were that the majority of GDP's were doing this anyway
Dentist	It's what we already do, though unrecognised.
Academic	Admirable. The main difficulty is patient compliance with attendance is poorest amongst those who need it most.
Dental Care Professional	It is a laudable aim but in a market economy where patients are more often driven by wants than needs it is not necessarily catering to the desires of the patient base
Dentist	Quite happy with this
Software supplier	there have been 3-4 years of pilots. what has happened to them?
Dentist	I agree with this philosophy
Dentist	All treatment carried out on the NHS in this country should all be requirement-based. All treatment should be that which is necessary; that which is needed by the patient. Preventive dentistry is a very laudable aim, but the majority of people in the UK that I meet just don't care enough about their teeth for that to be totally effective.
Dentist	Needs and risk are already assessed by many practitioners, who will be only too happy to move along a properly funded preventative approach. The interim care arrangements will undoubtedly raise more PCR from non exempt patients, but may easily result in a two or three tier system where exempt patients get the care, more affluent move along to more private treatment and those in the middle struggle with costs.
Dentist	I think this is a great place to start with the care of a patient, long term prevention is always best. I am fully aware though that there are a large number of people who resist, very strongly, any attempt at behaviour modification.
Academic	absolutely agree with this concept. this is what i practice now and also what we are teaching the under graduate students. it is highly effective method of treatment planning and providing patients with the information they need to improve their own health.
Dentist	prevention is the way forward.
Dentist	good philosphy. currently this is how we operate. however pt's needs vary both demographically and within a defined area. just because a practice is in a specific area of affluence, doesnt mean they treatment pt's who are affluent. we treat a whole range pf people. some of which travel from non affluent areas to get NHS treatment. thus the location of a practice is not as important as the historical dental need of that pt or group of pts that the practice treatment, as per on the NHS BSA profile.
Dentist	I feel this approach is a good one. It goes back to the principles learned at dental school and from evidence based research.
Dentist	Very much needed. I work in an area with high deprivation with very poor oral health, the worst performing area in the

Respondent type	Response
	2013 survey of oral health amongst 5 year olds. a new a approach to engage with and reduce the burden of poor oral health would be very welcome.
Dentist	The basis is sound but prevention can only be pushed to those that will listen
Dentist	Agree with the approach based on assessment and prevention
Dentist	i think it is very important to implement a risk assessed and patient need approach to dentistry. It will allow dentists to concentrate on specific disease processes and to create an individual pathway of improving oral health for that particular patient.
Dentist	I feel this is the way forward and do implement such a philosophy in my every day work in providing care for patients. the emphasis should have always been on prevention and patient education, and patients taking responsibility for their own oral and general health.
Dentist	I have always believed in a preventive approach to dental care and am frustrated that the current contract makes me do it for nothing.
Dentist	I think it's important to start with the fundamentals of dentistry (preventive care) with any new and ongoing patient. Without educating and demonstrating this to our patients we cannot expect them to help themselves, and also we cannot expect our treatment to be successful in the long term. I believe in risk based dentistry, I practice this.
Dentist	The philosophy is right but I think needs to be simplified.
Dentist	Sounds great on paper, can't really see it working in the real world!
Dentist	good idea..patients should take responsibility , good to get away from activity based system
Dentist	This is fundamentally sound and evidence supports this approach. The issue has always been the mechanism to deliver it and how to pay for it fairly recognising the time and effort
Dentist	In the real world, you must not penalise dentists by a lack of results. Many patients are resistant to preventative advice and it is not the dentists' fault.

Paper 2: The Clinical Philosophy

Responses to Question 2

What would be the challenges of applying this approach in your practice?

Respondent type	Response
Dentist	Time management and balancing the capitation
Community dental service	
Local Dental Committee	Assuming that most patients wish to enter the pathway-based approach to care (a considerable assumption), we believe the challenges of applying the approach within practices are considerable. One of the most significant challenges to practices will be the provision of suitable computing hardware and software, to assist in managing the reporting requirements efficiently. We are anxious to ensure that practices receive central help with the resources needed to computerise in a meaningful way. Although many practices use computers, this is very different from them being in a position to be able accommodate a pathway-based contractual mechanism reliant on the detailed reporting of patient data. The Department of Health must carefully consider how it can best support practices in this regard. It is not sufficient to comment blithely that there will be a paper-based reporting mechanism available to those without computers. This is not adequate. Crucially, a pathway approach to the provision of care would be completely different from the existing UDA arrangement, which necessarily deals in isolated episodes of care. Any newly implemented pathway-based system though, whether capitation-based or otherwise, would need to be conveyed clearly to patients. We believe that the Department of Health must take responsibility for conveying the planned changes clearly and effectively to patients. This will require considerable short and medium-term investment in national communication campaigns and locally-based information and support for the public. It must not be left to practices to convey information about system-wide changes to patients; this would constitute a dereliction of duty on the part of the Department of Health. Inevitably, practices will face dealing with a significant proportion of the messaging to patients. We believe there must be an enhanced payment associated with the oral health assessment (if not permanently, then at least for the first three years of any reformed system). This would support practices in providing patients with a proper explanation about the new system.
National Body	Managing patient expectations, especially those patients who feel they have paid their stamp and see access to a comprehensive range of dentals services as a right, as opposed to having to meet certain Oral and Dental health standards. This could see patients moving to other independent providers to seek care under private contract as opposed to subsidised NHS care.

Respondent type	Response
National Association	One of the most significant challenges for practitioners will be the shift required in the public perception of how they access and receive dental care and treatment. The proposed preventive approach to care will represent a considerable departure from patients established interaction with their dentist and the wider dental team, and the [redacted] is strongly of the view that the Department of Health, in conjunction with Public Health England, undertakes a significant public information campaign to ensure that patients are aware of the changes to be made in practice. This will assist in smoothing the transition to a reformed system, and will be of considerable benefit in practice. Whilst we agree that dentists and their teams will need to play a part in managing this transition for patients, it is our view that their role should be to reinforce messages communicated by the NHS and central government, rather than as primary educators. The early experiences of the first wave pilots was that the transition to a new way of working placed considerable strain on practice staff, and that communicating and reinforcing messages to patients only added to the complexity of working under new arrangements. At the [redacted] regular meetings with the Department of Health, we have raised concerns about the impact that the care pathway approach may have on single-dentist practices in particular. These practices represent 19 per cent of the provider population in England. Data from the second Evidence and Learning report showed that those pilot practices that employed a range of dental care professionals (or to use the Departments terminology, are skill mixed) and delegated effectively in the delivery of the pathway, saw the smallest changes to their list sizes. Whilst this is encouraging data for non-pilot practices that are skill mixed or in a position to develop their skill mix, it is concerning for those practices that do not have the capacity to accommodate such a change. Smaller practices are often situated in rural areas where there is otherwise little or no dental access, and their patient populations must not be disenfranchised by any future reform to the dental contract. The [redacted] is of the view that the inclusion of only three single handed practices in the pilot programme has been insufficient to develop a clear picture of how reform might impact this cohort. As prototypes are developed, we continue to call for the Department to increase the number of sites significantly, and within that, there must be a commitment to engage a representative proportion of single handed practices. If it is found that these practices will find the introduction of the new arrangements particularly costly or difficult, then the Department must put in place sufficient support for these practices. We believe that, alongside the need for central investment in I.T. systems, there is a need for consideration to be given for capital grants to support dentists to expand their practices to deliver this model of care. We are concerned about the impact of the pathway on the dental workforce. Evidence from the pilots seems to be that those that delegate care to DCPs find the process easier to manage. We are concerned about an increase in under-employment of associates or that we will see a growth in unemployment of general dental practitioners or a further reduction in their pay. This cannot be in the best interests of patients. Any changes to the shape of the workforce must be achieved over a number of years to ensure the present older population have ready access to dentists to provide the complex care they will need. The investment in I.T. hardware and software to support the pathway will be considerable for many practices, and although we understand that a paper-based version of the oral health assessment (OHA) has been developed, we are strongly of the view that Government must provide capital investment to support this upgrade. All pilot practices are currently operating the decision-support software as standard, and we

Respondent type	Response
	are not aware that the paper OHA is in regular use. If the Department is of the view that the paper OHA represents a real alternative to the software, we would welcome sight of evidence that this is manageable for both clinicians and patients. The concept of the care pathway is defined in this engagement document as developing and standardising best-practice care for all patients, regardless of who they are or who they see or the practice or service they attend. We are yet to be assured that the paper system presents a real alternative to the delivery of the pathway. To ensure a seamless implementation, there must also be significant training for dentists and their teams in the months prior to implementation. This training must be inside working hours and be fully funded by NHS England to the extent that practices are no worse off for engaging with the training. Although the community dental service (CDS) pilots are still in their infancy, they have already provided useful insight into how the programme will need to adapt to ensure that patients receive the most appropriate care, and that practitioners are supported to deliver this. A patients first visit to the service is generally focused on acclimatisation and thus charting and treatment are highly unlikely, and an oral health assessment may not be possible until a later appointment. For some patients, the completion of an oral health assessment may never be possible, and it is vital, therefore, that the software is sufficiently flexible to allow for this. It is our view that for the CDS, I.T. must play a supporting role to the delivery of the pathway, as the complexities and needs of patients accessing this service will be difficult to capture in an algorithm. It is essential that the care pathway is a clear, accessible tool for all patients, but this is particularly important for CDS patients who are reliant on carers. For the pathway to succeed in the CDS, carers will be an integral part of the pathway, and we welcome discussions with the Department as to how this will be facilitated.
Dentist	Time constraints Most dental practices are already working at maximum capacity to ensure that they are meeting current UDA requirements. If a new system is to be introduced, the effect this would have on patient numbers and time taken to assess each patient must be taken into consideration. Changes to the skill mix This would be difficult to apply to small practices. Also there is lack of funding for specifically hygienists in the NHS. It would be difficult to make them work effectively and remain financially viable. Consideration must also be given to patients that fail to follow advice despite the best efforts of the clinicians. Should they be denied treatment, especially advanced mandatory services? Patients expectations When patients attend a dental practice, they are expecting treatment and often will not understand or appreciate the long term clinical pathways that are now being proposed. There is a risk to GDPs that their treatment effectiveness will be measured by how well they improve a patients oral hygiene. This is inherently unfair as it is not in the control of the dentist. Some patients will be non-compliant.
Dentist	Clearly there will be challenges in making a shift to the preventive care pathway approach. Undoubtedly, having to complete an initial OHA for all patients would be very time consuming and impact on waiting times and access for patients. This would need to be managed carefully and practices would need reassurance that they would not be financially penalised for the apparent reduced activity. This pathway can only be successful with the widespread introduction of skills mix and a variety of dental care professionals within practices. It is not financially viable for dentists to be engaging in all aspects of the care pathway and the use of dental therapists and oral health educators

Respondent type	Response
	will need to increase. This presents challenges around workforce planning and education and training for existing teams.
Dental Care Professional	Patients realising the importance of assessments, monitoring of disease, and the role of prevention in obtaining oral health. The time factor would also be an initial problem but that would balance out over time.
Local professional network	Question 2: What would be the challenges of applying this approach in your practice? IT is one of the main issues there is a need for computerisation. Should this be part of the contract that the practices need to be computerised? It was felt a practice with out computers would find the pathway approach difficult to record and navigate. It shouldnt be too prescriptive, if it was it might reduce the clinicians likelihood to override computer led decisions, which they feel are incorrect. Training for systems must be available with minimum data sets. Would it be possible if a gradual introduction for pilot or experienced practice staff to assist in training or act as mentors as they have had on the ground experience and can give valuable tips? The time constraints of IT and associated assessments is a concern, although they have been streamlined (70 actions to 17) this will it was agreed increase the length of appointment needed at first, thus putting pressure on the appointment book and this would be a challenge to any busy practice. Every practice would need all staff buy in to ensure this approach was smoothly introduced.
Dentist	The most significant challenge centres around the change in approach from what the attending base has become accustomed to and what they will then experience. Change to a needs based service from what can currently be a demand led service will require careful communication pathways - centrally and locally and ultimately within a practice.
Dentist	remuneration
Dentist	The pilots have revealed a number of challenges in applying this approach: increased length of time to do initial assessments leading to increased treatment waiting times training of all staff in these changes changing the use of the whole dental team to contribute to delivery of treatment changing both patient and clinician's previous relationship from a more personal interaction in the prescription of treatment/preventative needs to an IT based prescriptive process creating IT systems which enable efficient data collection at OHA getting clinicians to adapt to the clinical pathways approach managing individual performer payments within a practice based capitation contract defining the distinction between NHS and private care to enable effective patient choice Possible solution Locally based training events prior to the introduction of any change would enable practices to plan for change. An information portal to allow accurate tracking of individual performer registration, activity measures and quality measures with the ability to transfer lists between performers. A defined list of treatment rules needs to be agreed to ensure clear distinction to be drawn between NHS and Private, ensuring clear and transparent effective treatment choice is offered to all patients. The definition of treatment items must avoid the complexity found in the previous fee for item system. This treatment definition is essential to remove the current uncertainties as to where the boundaries between NHS and private treatment lie.
National body	The document states that the OHA in the pathway is taking longer to operate per patient than the current system. If

Respondent type	Response
	the DH are fully supportive of a preventive approach to care then there must be time for GDPs to support their patients, but likewise the impact of this extra time must also be assessed in order to determine the effectiveness of the intervention and whether the time and resources are being given to the right people as described on page 3. There also must be adequate training and support (with appropriate remuneration) to facilitate the introduction of new IT systems as a result of the new contract.
National Body	The [redacted] as a provider of secondary dental care cannot comment on this question. However as a provider of primary dental care as part of the undergraduate education programme they can comment that this approach has already been adopted in principle within the undergraduate programme
National Association	We can only comment in general and believe that one of the biggest challenges will be changing patients attitudes and approaches to dental care, along with the ability of practices to prepare and equip for this new approach. Considerable investment in I.T. hardware and software will be required to support the pathway and although we understand that a paper-based version of the oral health assessment (OHA) has been developed, we believe that Government should provide capital investment to support this upgrade. The proposed risk based and preventive approach represents a considerable departure from current patient interaction with their dentist and dental team. Consequently we believe that there will be a need to support changes in the dental contract with an extensive Department of Health and Public Health England public information campaign to ensure that patients are aware of the changes to be made in practice. This should also promote patient buy in to the new contract and improved oral health. We also believe that the requirements of smaller/single dentist practices, especially those practices situated in rural or economically deprived areas where there is otherwise little or no dental access, should be carefully considered in terms of adapting to any new requirements. There must also be provision and funding for adequate training for dentists and their teams in the months prior to implementation.
Dental Local Professional Network	We have long worked under a system that encourages the quick fix without a long term plan for individual patients oral care, at present a patient is only technically registered while under a course of treatment. This will take some time for the change to be managed both of patient and practitioner. With a greater skill mix being employed we may see serious dentist unemployment. The number of undergraduates training will need to be sympathetically managed. Enablers: Dental registration offers continuity of care Improved referral system for difficult cases to get to the appropriate specialist service Home visits appropriately funded. Improved training opportunities. Barriers: Perverse incentives in contracts making the treatment of high caries rate patients unattractive i.e. narrow UDA bandings. Perceived high patient charges. Too much monitoring in a low trust environment. Patients embarrassed by their perceived oral condition Often specialist care required Admin /logistics e.g. the homeless do not have an address therefore completing NHS forms is difficult. No forms, no payment for dentist, no home address, no completed form! Lack of guidance of what services are available including costs The different bits of the health service are not joined up CDS/GDS/Social care hospital etc . Professional attitudes to the disadvantaged groups.
National Body	Depending on the practice profile and dentists perception of any remuneration model, they may start to select patients

Respondent type	Response
	to create a low maintenance green patient base, rather than encouraging a more mixed patient risk profile including higher needs (red) patients and seeking to gradually move patients from red to amber / green. Implementation of the preventive pathway approach must support the care and treatment of higher risk red patients, who may otherwise become caught in the stabilisation or urgent care cycle and are unable to access advanced care. Use of skill mix may be an issue. Some dentists want to use skill mix but their practice premises dont enable this to happen due to space constraints and lack of available surgeries. Dentists could become team leaders, delegating simple treatments and prevention to therapists, hygienists and extended duties DCPs. This would release dentists to undertake complex treatments. However if the skill mix isnt available then the dentist will still need to provide all treatments.. Some patients want to be seen by their dentist and dont want to see anyone else.
Dentist	time consuming in a busy nhs environment expensive on time as well as money losing clinical control /autonomy
Dentist	Space to have separate areas for dhe to operate to provide ohi etc
Dentist	Administrative difficulties which may be less challenging if the software was robust enough to work Expense patients' resistance to change
Dentist	The change for many patients and dentists is too fast and I spent far too long having to explain all the changes to patients - ironically I actually lose time when I could be discussing more oral hygiene measures. It is difficult to standardise risk due to the high level of questions and data that has to be entered into the pathway - there are far too many variables. I know from speaking to many dentists on the pilot that most the pathways are completed by the nurse without the dentist even looking at them due to the shear amount of information that needs to be gathered for the software. This means that the pathway data for many of the pilot practices are probably incorrect to start with. It would be better if dentists are able to have more say in what a patient's risk factors actually are rather than a computer programme. There are also many cases where certain treatments need to be provided to maintain oral health where the RAG scores may nort be ideal - an example is where simple fillings are provided in a nervous patient just to help acclimatise them to treatments or to help motivate them.
Dentist	We already do this as a pilot practice. The challenge is that not all patients fully understand what is being offered even after explantation although they are in the minority. They don't fully understand why NICE guidelines should be applied for example and feel money is taken off them unnecessarily if more frequent visits are needed or that they are being rationed appointments if on longer recall intervals.
Local professional network	Clearly there will be challenges in making a shift to the preventive care pathway approach. Undoubtedly, having to complete an initial OHA for all patients would be very time consuming and impact on waiting times and access for patients. This would need to be managed carefully and practices would need reaWhat would be the challenges of applying this approach in your practice? Currently we see large numbers of urgent appointments - how are they catered for in this system?Long waiting times - reduced access - in a high needs practice may be difficult to accommodate our current patient numbers for OHA and OHR - resulting in falling list size, loss of remuneration and practice viability ssurance that they would not be financially penalised for the apparent reduced activity.

Respondent type	Response
National organisation	(answered on behalf of typical mixed private/NHS practices). 1. The need to accurately identify risks of disease and the resources in terms of time, appropriate personnel and data; 2. The need for behavioural change in the practice team/organisation; 3. the adoption of cultural change in the patient population
Local professional network	At present a patient is only technically registered while undertaking a course of treatment. dental registration offers opportunities for continuity of care that the current contract does not
National body	There are very few in terms of delivery. First of all patients need to be willing to accept preventive care. It may take a generation to see major improvements as children move into adulthood but all patients would benefit to some degree early on. Additionally, more time and effort could be directed into preventive care for the expanding population of the dentate elderly in the management of, for example, root decay.
Dental software supplier	Its a paradigm change so time to gradually adapt coupled with good communication, training and tools will be key. Need to get staff and patients alike to understand the new paradigm and their responsibilities with in it.
Dentist	Time pressures are a challenge as is the provision of suitable software to support the pathway approach.
Dentist	Education of Practices so that they engage with the new approach and ensure that the prevention is delivered appropriately. Prevention becomes the central p[lank of the new approach. Using DCPs to deliver prevention will require some extra education and re-organisation.
Dentist	patients may object to the culture change and requirement to provide info they have already repeatedly given The repetitive nature and inflexibility of the computer program must be put in the context of the average NHS dentist who has to (because of targets) see dozens of patients a day. this is going to get very very boring as it doesn't allow for individual styles to be practiced
Dentist	Cost. I have added skill mix into the practice -at a cost of approximately ┬ú2000 per month. This is obviously having an effect on gross profits. Time - prevention is taking time. I have taken nine days away from the practice in the last 12 months - and my patient list size is still falling.
Dentist	The pre pathway questionnaire needs to be linked to the software so that patients can complete the pathway before their appointment and is automatically updated on the practice computer system. This is because a lot of time is wasted waiting for patients to fill in questionnaire at their appointment. It is not a lean approach for healthcare. Read Were not Japanese and we don't make cars (Fillingham, 2008a). A Also because of this wastage dental appointment often run late and therefore patients will become more dissatisfied for waiting. If this is not done the pathway questionnaire will be rushed or worse made up if the patient has not filled out a questionnaire which will lead to inaccuracies. This much be a priority.
Dentist	The challenge of 2 surgeries and a lack of space to expand to have more staff delivering the necessary assessment and treatment. Further it will require a huge sea change in patients expectations and responsibility. will it also be up to dentists to publicise this new working procedure
Dentist	Change in mentality of patients. They are used to the 'quick' examination and may not 'buy in' to the new approach.

Respondent type	Response
	They may get offended by more questions about personal lifestyle. Patients may question why we haven't always had this approach and ask why we are changing. Change in skill mix and personnel Time and remuneration. Waiting lists
Dentist	We are still working with R4 software so installation of new soft ware and staff training would be the initial issue. this philosophy has known to reduce the accessibility of dental care to patients as OHA take longer time so to manage the appointment books and patients expectation and keeping the list size stable would be the second major issue. Managing patient expectations to be seen every 6 months and educating them of the new standards are not just the results of CUTS but they are the new standards of care designed.
Community dental service	I see special needs patients, patients who are housebound and young children with management problems. Most of these patients will remain a RED RAG rating with little chance of improvement as they rely on carers to assist with care etc.
Community dental service	The main challenges will be working with the range of people involved in the care of for example someone with learning difficulties and challenging behaviour or someone with dementia or other mental health issues or someone who has a severe physical disability. Working in Special Care dentistry very often involves working with people who care for others and engaging with those carers to ensure that they work with patients to help provide their oral health care. Other challenges are working in prisons, where prisoners all too often do not have affordable access to suitable oral hygiene products. Clinicians within the salaried dental services currently have less (NB not zero) pressure to achieve UDA targets and are more likely used to extended team working, consequently there are likely to be less pressures in applying this philosophy than in the General Dental Services.
Dental Local Professional Network	Self ô the challenge of learning a new set of algorythms and embedding them in practice. The time taken to learn to work in the structured way that is required to gather the data Small surgeries of 1 or 2 practices will have difficulties due to lack of space to carry out confidential questionnaires. Contract values are unlikely to be high enough to enable employment of extra staff needed. This will result in a reduction in access and waiting time to see a dentist Patients ô adapting to new system, if they are comfortable with the old system, spending more time at the dentists to be assessed. They may be dissatisfied with the inevitable increased waiting times to see dentist. Staff ô learning the new approach Resources ô requires appropriate IT in the practice
Dentist	We are a busy practice and making appointments can already be difficult for patients. If a system is introduced that requires longer appointments initially this may cause irritation for many patients if they have to wait even longer before they can be booked in. I also think that patients who have been using NHS dental services at our practice for many years, or even decades, may think it quite unnecessary and cumbersome that we are all of a sudden having to gather all of this extra information from them - just to essentially have a check-up which used to take up 10-15mins of their time and, in their eyes, was perfectly adequate. It may be difficult getting them to understand the need for the sudden dramatic changes.
Dentist	Lack of appropriate remuneration and therefore lack of time.

Respondent type	Response
Dentist	Am no longer in practice, but I think the time is now to start re-educating dentists and their teams, something best done through CPD. Should not be confined to dentists participating in pilots/pritotypes
Dentist	Funding the additional time necessary
Dentist	Patients with high treatment needs
Dentist	finding the time to implement a complete new system. Also the pathhway seems to involve a lot of non clinical work
Community dental service	implementation and re-education of sections of the population
Dentist	The way we are remunerated for prevention is currently non-existent and unsupportive of a practice team approach. Patients who pay for their NHS treatment are suspicious whether they are getting value for money as they usually feel that dental charges cannot be justified for just giving advice.
Dentist	If new contract evolution not revolution then it could be difficult to restructure the practice staffing to provide the preventative aspects more cost effectively if the future is not certain.
Dentist	appropriate training of the dentist and the team. best way and stage to record the information leading to risk assessment utilising IT Time and remuneration
Dentist	As a practice owner with four associate dentists working for me the current UDA system works well for rewarding the associates. Some of the associates work harder than others and this is reflected in the amount of UDA's they complete and therefore in their pay. I feel that if UDA's are removed then the associates are likely to do the bare minimum amount of work that they can get away with and productivity will decrease.
Dentist	Simply the implications of needing to maintain the numbers of patients seen, when each visit takes longer, even after the initial stages, this simply will not work. Uncertain finance. Gradual implementation might result in patients moving practice to ones on different systems.
Community dental service	Clinical Director not aware that Special Care Dentistry for Children is the remit of Specialists in paediatric dentistry
Community dental service	Special care patients are often not responsible for thier own oral care. There is the additional challenge of sharing the onus for prevention with carers.
Dentist	my patients all lack mental capacity. Where would they fit in with your care pathways?
Dentist	it's not what the patients want
Dentist	Reduced patient throughput followed by slow computer systems struggling to process Terabytes of unnecessary data. If existing levels of patient satisfaction are in excess of 90% why risk losing that?
Dentist	The main challenge is persuading the patients to accept it; especially the 'red' status patients which is where the oral health improvement is needed. If we can shift the balance to more care for the reds so that the cost of looking after the green and high ambers decreases but that will not happen as the greens tend to want more care simply because

Respondent type	Response
	they care.
Community dental service	Many of our patients with learning disabilities an oral health problems would never move from a Red rating and this would affect our QOFF. Also may children are seen on referral and would not have continuing care. How would their quality of care be assessed?
Dentist	Organising the practice to use DCPs to best advantage, get patients used to this approach, less associates needed.
Dentist	Organisational, however I think we are a good way along with this already
Community dental service	Special needs patients and anxious patients have challenges which may not fit with the pathways as easily
Community dental service	I see many patients with some sort of special need and often with third party input eg carers. Getting third party support is difficult and needs to be taken into account. We have many emergency and "drop-in" patients who just want the dental treatment necessary without getting into any discussion of prevention.
Dentist	Financial
Community dental service	We have trained the majority of our DCP in oral health promotion. The would be very little change in current practice however the challenge for Special Care Dentistry is not supporting this philosophy but getting those who care for our patients on a day to support this philosophy. What are the results on achievable outcomes for SCD patients?
Dentist	A cumbersome and time consuming IT input can not replace the clinical judgement of the dentist and the need of the patient for treatment, Patient will also feel patronised, and will not attend for routine recalls and registration numbers will fall, they will also hate a computer program to decide what they can or can not have.
Dentist	The skill mix has to change. A therapist/hygienist is essential to any 2+ chair practice. Also it would be advantageous to train nurses with extra responsibilities regarding Fl varnish application and Oral Health education. The needs further investment and financial input.
Community dental service	'Looked after' patients for whom the risk would change depending on the quality of their care teams. They might be low risk with one group of carers and then change to high risk with another. Similarly other Special Care patients with complex medical needs whoose oral health may deterioirate as their condition or drugs change Vulnerable and socially excluded groups both children and adults may be difficult to access and will need additional support to get them on and keep them on any pathway.
Dentist	As there is no additional funding, it won't work
Dentist	What will be done with patients with low risks that still want to be seen every 6 months? How will patients that demand higher end treatment, but do not respond to preventative measures (eg poor oral hygiene), be dealt with? Refusing treatment to these people could lead to more complaints.
Trainee Dentists	Patient expectations need modifying. Changes in skill mix in practices. More preventative care delivered by DCPs. Increased time needed but no increase in funding

Respondent type	Response
Dentist	again prevention only works if the patient follows advice , will work not work in a high need area where many paints come only when they have pain \& need emergency it may work in an affluent area where people are more aware
Dentist	The current system does not remunerate for prevention in fact it penalises us for prevention as there is a financial and a time cost to provide prevention which is not realised in UDAs.
Dentist	Personally , I find I am more stressed than in the UDA contract.The reason is two fold: 1) The time required to communicate effectively with patients for the preventative approach and to get patients engaged with the concept is at least 20 minutes per patient for an OHA. Therefore I see less patients than I did previously and my waiting times for return for treatment have increased. This really worries me as I don't believe I am providing a good enough service if patients have to wait so long for treatment. It also means that access will be down. This is another worry as we know that the clarion call for the DoH is 'improving access'. If the system is nationally rolled out as we're piloting I think the Area Teams will be overwhelmed with patient complaints about the time they may have to wait for appointments. 2) My practice lost an associate and the associate wasn't replaced as the practice finances had been badly hit by the recession and the NHS pay freeze. We were told that the practice could not afford to replace the associate.The Principals gave all their remaining associates a 4% pay cut and we had to absorb the patients whose dentist had left. The consequence of this was we all had to work longer hours for no extra pay. This is a concern if practices believe they can change their skill mix with Contract Reform to make more money. Less associates and more therapists = cheaper but this will not lead to improved quality for patients.
Dentist	Motivate me by firstly establishing a good secure work environment, being protection from the unfair and corrupt suing for compensation and complaints system, and a secure salary which is not linked to performance (ie..i am not financially punished if the patient doesn't attend)...that is the first important thing. The rest comes next. There is no use to keep piling on workload and regulation and harsh working conditions and terms, and hoping that the health care providers will perform better...this is hypocracy...nursing staff are included in this
Dentist	If we go by the pilots, the OH assessments take up a lot of time, which means it is more difficult for patients to get appointment, which means they wait longer to be seen, which means access is affected
Dentist	Already been met and dealt with.
Academic	Already do it as best as possible within the present system. IT set-up costs need to be funded however, which is why we did not partake in a pilot scheme.
Dental Professional	If you treat every patient with their best interests at heart you would still see people who are low risk regularly to re-inforce their good habits and also catch them as close to the time that their disease processes change as some will always be bound to do due to life circumstances etc. Particularly with children there are so many life changing events go on as they grow I think it is completely ridiculous to leave any for a year before reassessing. So much damage could have been done.
Dentist	attitudes of patients and performers/staff the need to reorganise the workforce will performers be salaried? IT issues

Respondent type	Response
	training staff
Dental software supplier	if its the same as the latest pilot then it would put me out of business
Dentist	We have a high 'urgent' treatment through put with many in our patient base difficult to motivate regarding taking responsibility for their oral care, so improvements may be disappointing. Our business could suffer if remuneration were partly based on improvement in oral health but I await further data from the pilots.
Dentist	The patients don't care what we tell them, they wouldn't bother to clean their teeth at all if they thought they could get away with it.
Dentist	Staff balance will be a problem in practices. Associate dentists will undoubtedly be under pressure to become salaried (at much lower levels.) Hygienists and therapists are cheaper and will be in demand. Contract holders will be in more powerful positions.
Dentist	The number of patients to see and the amount of time involved in the initial change over despite the fact that large numbers of patients are already on 9 month or greater recall periods.
Academic	not aware of any. we aim to do this already. some dentists may require further training however.
Dentist	time limitations, however, having a skill mix within the practice helps deliver a prevetative approach more efficiently. i.e using hygienists and therapists.
Dentist	the practice is set up to provide treatment by dentists, not nurse/therapists, as they are not fully trained. i personally feel that the efficiency with which dentists work, far outweighs that of the nurses/therapists, so why make such a drastic change, when dentist performers are geared up at the practice to deliver dentistry ie exams/treatments/prevention etc
Dentist	There will be some patients who are quite happy with the status quo and who do not want to engage in shared responsibility but if the system is robust the majority will probably come round. Ensuring all members of staff understand the approach so pt questions can be met with accurate answers across the board. Managing patients who want complex treatment regardless of their risk factors...dental tourism may become a problem, with inappropriate complex work being provided abroad that then requires management here, in the UK
Dentist	Patient engagement and communication. The patient base is largely from minority ethnic communications without a tradition of attending the dentist except in an emergency situation, for many english is not the first language and whilst my staff are multi-lingual we cannot cover all the options. Engagement, communication and understanding may well be poor as a result. High treatment needs and particularly urgent treatment needs amongst the patient groups preclude being able to spend time on prevention; it is likely therefore that additional time spent on these areas whilst potentially beneficial in the longer term will reduce access in the shorter term.
Dentist	We have a 15/85% NHS/Private split so there are no isuues as the NHS punters get a good deal susidised to some degree by the private element

Respondent type	Response
Dentist	Limited clinical time. Patients needing or only wanting unscheduled care
Dentist	I think the challenges are going to be motivating the 'high need' patients, with multiple disease processes to get them to accept a preventative cae plan , that they have to implement themselves at home and for them to maintain an acceptible and imprved level of oral health
Dentist	TIME TIME TIME coupled with remuneration system that recognises the time and effort this requires tailoring advice to patients delivering it in a way each patient will understand. there is a lot of pressure under the current system to meet targets and therefore considerable restrictions on delivering ideal care to patients following this philosophy under the NHS.
Dentist	Only organisational, as with any change in a system. My staff are all well trained in prevention and I believe we would easily meet the new challenges of a preventive approach to care.
Dentist	The NHS. It is hard to keep standards high or to improve them when our performance is constantly compared against computer statistics and we get penalised very easily. For example - How can I recommend my high perio and caries risk patients to see me on recall / maintenance every 3 mos when in my area the average recall is expected to be between 12-24 months? If we don't meet this target we have to justify our actions. This is a barrier to good dentistry.
Dentist	The practice will need to be computerised.
Dentist	Time, patient co-operation, patient attendance, IT systems and the willingness of all concerned to adapt to changes.
Dentist	patient cooperation!!
Dentist	We currently have access to DCPs and hence the skill mix issue is one we addressed some time ago but I know of colleagues who will struggle with this due to lack of space and opportunity associated with smaller practices that currently provide an excellent service within their restricted opportunities
Dentist	Being paid for not doing interventional dentistry

Paper 2: The Clinical Philosophy

Responses to Question 3

Using this pathway approach, would there be any challenges associated with engaging with patients in your practice?

NB respondents answering “yes” were able to make free text comments.

Respondent type	Response	Additional comments
Dentist	No	
Local Dental Committee	Yes	Recall guidelines from NICE do not align with patient expectations for dental treatment. For many years, patients were advised to see the dentist every six months. The Department of Health must ensure that patients and the public understand the range of recall intervals recommended by NICE and ensure patients understand that dentists are not taking them for a ride by recommending they are seen at longer or shorter intervals than six months. Within the contract pilots, patient care plans have not always been well received by patients. Many have reported overflowing waste bins, as a result of the printouts offered to patients in pilot practices. It would be helpful to patients if the Department of Health would consider some alternatives to formulaic printouts for each patient. Instead, plans could be emailed and could be made available in different formats (such as video or audio) and languages. Perhaps an app might even be developed for patients to use. Many patients are episodic attenders, wishing only to seek care when they are in pain. A pathway approach may be able to encourage a small minority of these patients to become regular attenders, but we worry that it may, more significantly, act as a barrier to others when they learn about pathway-based NHS treatment. Sadly, this may put off some of those patients with the greatest need for care. Finally, the Department of Health must take account of the very different situations of practice premises. The variety of dental practice settings has helped to enable the incredibly efficient and wonderfully local provision of NHS dental services for patients. Nothing must be changed which could jeopardise the existing provision of services; patients would not tolerate the removal of local NHS services on which they rely.
National Body	Yes	See above however key is quality at every stage and that starts with quality home care and a diet low in refined carbohydrate. Additionally there is a disconnect presently in regard to remuneration and patient charges. If the GDP does and endodontic procedure it is rewarded with 3 UDAs, including the filling and any other care during that course of treatment. This is the same regardless of the number of root canal

Respondent type	Response	Additional comments
		procedures a patient requires. In the GDPs eyes (understandably) this is seen as inequitable, in fact patients are confused too, the rewarding of e.g. three endodontic procedures being the same as one endodontic procedures should be re-visited. There is also a further anomaly, some Area Teams have contracted Tier 2 and 3 level endodontic procedures to endodontic Tier 2 practitioners or specialists. In such instances the remuneration may be ú450 - ú750 for one tooth, double for two teeth, triple for three teeth etc. This is inequitable compared to a GDP who for Tir 1 (and in some cases Tier 2 or3) is receiving 3 UDAs credit which is exactly what they would have received for providing a filling with no endodontic procedure.
National Association	Yes	The fundamental principle of the pilot is to encourage a patients participation in the care pathway, and it is vital that the Department ensures that there are resources in place to enable practices to deliver this approach. Some of the concerns highlighted above the cost of software, and practices that are limited by size may result in barriers to patient engagement simply because practices do not have the resources to cope with this approach to treatment. Although observing NICE guidelines is a current contractual requirement, this can be difficult for patients to accept. Government information campaigns need to focus strongly on the guidelines to support the messages being delivered by dental teams. It is also important to recognise that prevention takes time. Patients need the time to speak to their dentist and then receive the help and support they need. It will be necessary for Care Plans to be available in different languages as well as formats suitable for those with learning and other disabilities. Alongside this, there must be clarification of the purpose of the RAG rating for patients, as in its current form, it has the potential to act as a de-motivator e.g. some patients with diabetes will never be rated Green. It might be that consistent Red and Amber risk factors may be counter-productive and de-motivating and might discourage attendance. It is our view that, when used in the CDS, the term patient engagement should be expanded to include the engagement of carers who will play a key role in the provision of oral care for many patients. For patients with challenging behaviour or a learning difficulty, engagement can mean anything from finally getting a patient to sit in a dental chair, or getting a smile or a hug at the end of an appointment. For this reason, the role of carers, family and other support becomes critical in achieving good results, and educating this network about the pathway is as important as patient education, and in some cases, more so.
Dentist	Yes	Dentists could be forced to engage with patients that are disinterested. This could be a good thing to ensure that the prevention message is communicated to all patients not just the ones you think may respond. This approach will create a conflict with the professional duty to treat patients who attend having problems especially with the time constraints of the NHS. It would be difficult to assess and treat at the same time. Practice that already follow a care pathway approach will find it easier to cope with the changes. Ideally this approach can work but only with additional nurses providing oral health education. This would increase clinical capacity
Dentist	Yes	Having spent time over recent months introducing this kind of approach with patients generally the feedback

Respondent type	Response	Additional comments
		is very good and, providing communication is high quality and effective, patients fully appreciate the need for investing in their oral health for the long term and taking positive steps to achieve this. Patients need to be given very clear and understandable messages regarding the team looking after their care and need to understand what is expected of them and the rationale behind this. Furthermore, if patients are to accept this style of care they need to have clear information about the consequences of not engaging with their preventive plan and any potential impact on their oral health and oral health care. Concessions need to be made for those patients who chose not to engage with routine care, but only seek urgent or unplanned interventions and practice diaries need to be flexible enough to manage this. Patients are likely to become frustrated is pressured on diaries from OHAs and OHRs lead to an increased wait for routine appointments and especially access to urgent care. Learning from pilot practices is vital in managing this and NHSE would need to support practices in achieving this balance in a non-punative way.
National Body	Yes	There are specific challenges to engaging with patients requiring Special Care Dentistry and specialist dentistry more generally. Often dentists have to engage with carers who may have different opinions or cultural expectations, which affect their views on what dental and oral care is needed. For example, some carers promote total independence and the freedom to choose to have, or not to have, treatment done and/or oral hygiene procedures. In such circumstances, dentists need to carefully balance oral health needs against a patients mental and physical wellbeing when treating patients with special care needs, and carefully discuss options with family and carers.
Dental Care Professional	Yes	Communication is key time is needed to communicate effectively and this approach will need time to explain and help patients work with us to work on their oral health. There will be a percentage of patients who will only attend when in pain and this approach will not be what they want to partake in. saying that, its in the patients best interests to follow their OHA.
Local professional network	Yes	Communication Publicity required supporting changes and messages so patients are expecting a chance in their visit and journey. National campaigns needed to explain the new philosophy and pathway so it is not a complete surprise and alien at their first visit. Patients may see themselves as beinghanded off to therapists rather than dentist and public and in practice education is needed to change this mindset. Patients should be able to opt out if they feel it is not what they want. Software improved to allow steps to be skipped if appropriate to smooth process
Dentist	Yes	It is our experience that an element of the patient base does not wish to participate in this approach and wish to continue with what they regard as a more "traditional approach". Clear, consistent communication of the benefits is key to the success of this approach.
Dentist	Yes	Time needed versus remuneration
Dentist	Yes	The pilots have demonstrated that patients have engaged with the pathway approach and have a greater understanding of their individual treatment needs. The RAG scoring system has provided patients with an

Respondent type	Response	Additional comments
		easy to understand insight into their oral health enabling them to contribute to their dental care. There are a number of patients who still perceive that they should be returning to the dentist on a 6 monthly basis and more work needs to be carried out to educate patients that this change is evidence based not financially motivated. Pathways must be flexible enough to enable those patients who do not wish to engage with a preventative programme to be offered an alternative pathway to enable them to access care without creating further barriers to care. Possible solution Patient education needs to be delivered by the NHS prior to the introduction of change to make them aware of the changes and the evidence based reasoning behind them.
National Body	Yes	Any information provided for children and young people should be written in an age-appropriate language. It is suggested that information should be provided for young people and not just their parents in order to practice the philosophy of shared responsibility outlined in this document.
National Body	Yes	The [redacted] as a provider of secondary dental care cannot comment on this question. However as a provider of primary dental care as part of the undergraduate education programme they can comment that the undergraduates are encouraged to engage in the approach outlined in paper two, as a fundamental part of their curriculum
National Association	Yes	Access is absolutely vital in the success of contract reform. The fundamental principle of the pilot is to encourage a patients participation in the care pathway, and it is vital that the Department of Health can ensure that there are resources available to enable practices to deliver this approach. Some of the points raised in Q2 could result in barriers to patient engagement simply because practices do not have the resources to cope with this approach to treatment.
Dental Local Professional Network	Yes	Patients are used to coming into practices and having a problem fixed in a short course of treatment. There will be a period of re-education of patients expectations regarding the speed of treatment delivery if extensive Oral Health Assessments need to be done first. Patients will need to be fully engaged with the new charging scheme. How this is going to reflect a capitation based structure will provide difficulties. In times of economic hardship experience has shown that private capitation based charging structures are readily dropped by patients to save money. A system needs to be in place that patients and practitioners are comfortable with without putting at risk the patient charge revenue. Patients are used to the skill mix of GMP so hopefully this will be less of a problem in GDP. Dental services should be fully integrated within primary care and social care to help develop local solutions for local needs, thus helping to tackle local oral health inequalities. There needs to be increased appreciation of cultural differences in relation to oral care, and cultural sensitivities ought to be respected, while possible issues recognised and not ignored. A key group that may be difficult to engage with will be older people in care homes (or their own homes), as a result of their being less mobile and unable to attend a dentist or their carers not recognising the continued importance of oral health. Older adults in nursing homes are often unable to address their own oral health

Respondent type	Response	Additional comments
		care and therefore have to depend on nurses, nurse assistants or care assistants to do this for them. However, these staff are often overworked, poorly informed about proper oral hygiene techniques, do not see oral health as a priority and fail to take responsibility for who should be providing oral health care assistance. Hopefully patients will embrace the prevention based approach.
National Body	Yes	The time it takes to implement the pathway correctly as some patients just want treatment completing as quickly as possible. Some patients not interested in pathway / preventive approach Skill mix, some patients want to only see their dentist. The cost of interim care visits may put patients off High risk red patients are likely to be more erratic attenders making a series of visits unmanageable Moving patients from red to amber to green may be more difficult than anticipated if the pathway is not sensitive enough to pick changes up. A course of treatment needs to be clearly defined as there needs to be a completion date for both patients and dentists Some patients dont recognise the preventive philosophy.
Dentist	Yes	patients wanting to go down a partial pathway route - how easy would it be to adjust pathway to pts wishes - if it disagrees with guidance they maybe unhappy with time taken
Dentist	Yes	Concerned that focus is heavily weighted to preventive pathway and that patients needing some restorative care will not be able to access it easily. There needs to be a balance
Dentist	Yes	Many mothers have found it difficult to keep track of differing recalls between siblings. R4 system did not allow for icm recall reminders
Dentist	Yes	The change is likely to be too fast for many patients (compared to what they are used to) and it has the potential to cause friction in the dentist/patient relationship. Slowly dripping in changes may be easier for a large number of patients (and dentists) to handle.
Dentist	Yes	See above
Local professional network	Yes	What would be the challenges of applying this approach in your practice? Currently we see large numbers of urgent appointments - how are they catered for in this system?Long waiting times - reduced access - in a high needs practice may be difficult to accommodate our current patient numbers for OHA and OHR - resulting in falling list size, loss of remuneration and practice viability What would be the challenges of applying this approach in your practice? Currently we see large numbers of urgent appointments - how are they catered for in this system?Long waiting times - reduced access - in a high needs practice may be difficult to accommodate our current patient numbers for OHA and OHR - resulting in falling list size, loss of remuneration and practice viability What would be the challenges of applying this approach in your practice? Currently we see large numbers of urgent appointments - how are they catered for in this system?Long waiting times - reduced access - in a high needs practice may be difficult to accommodate our current patient numbers for OHA and OHR - resulting in falling list size, loss of remuneration and practice viability
National	Yes	As described in 3. above, together with any time needed for explanation of the change in approach.

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organisation		However our experience is that with good communication, such change is accepted readily, on the whole.
Local professional network	Yes	Patient expectations - they are not used to other than short courses of treatment. And will promotion / prevention be subject to patient charges? This could be a big de-motivator for patients
National Body	Yes	Adult patients will often question the transition from a more traditional drill and fill philosophy. However, with a careful explanation and a well-advertised public launch from the Department of Health there could be a very smooth and motivated engagement. Our members believe the responsibility of explaining these changes should not fall entirely on GDPs. It is important that this work in accompanied by a public launch which emphasises shared responsibility, exploiting all opportunities offered by traditional and social media.
Dental software supplier	Yes	Patient acceptance and understanding of their responsibilities could be problematic.
Dentist	Yes	Difficulties with patients who do not speak English . Engagement of patients from deprived backgrounds especially the carers of young children .
Dentist	Yes	Just education. Patients are used to an interventionist approach where prevention is not seen as important. This has to change in Dentistry and the wider NHS
Dentist	Yes	many patients are already tired of being told what they already know and which they already have been told 100 times and have chosen every time to disregard. the obligation on the dentist to repeat messages will become very tiresome for patient and dentist
Dentist	Yes	many patients object to having their recall intervals extended. Although I personally think that the traffic light system works well, some complain that it is 'patronising and feel like they are back at school'
Dentist	Yes	The pre pathway questionnaire needs to be linked to the software so that patients can complete the pathway before their appointment and is automatically updated on the practice computer system. This is because a lot of time is wasted waiting for patients to fill in questionnaire at their appointment. It is not a lean approach for healthcare. Read Were not Japanese and we don’t make cars (Fillingham, 2008a). A Also because of this wastage dental appointment often run late and therefore patients will become more dissatisfied for waiting. If this is not done the pathway questionnaire will be rushed or worse made up if the patient has not filled out a questionnaire which will lead to inaccuracies. This much be a priority.
Dentist	Yes	As stated I feel they will need a huge change in their responsibility for improving their own oral health I realise it is our responsibility to educate patients however how well they will engage is debatable some people almost expect caries and issues as all their family are the same as its always someone else's fault
Dentist	Yes	see above. patients are not used to this approach and may wonder why we are changing our ways. Especially if treatment is denied because of their lifestyle. It will take time to engage them unless it is talked about honestly and openly nationally by politicians about why past contracts failed and why this may work.
Dentist	Yes	More time in appointment book for less patients many patients do not follow up many patients are transient

Respondent type	Response	Additional comments
		in the practice so continuity of care is affected Our practice in a high need area and the patients need more education for dental needs.
Community dental service	Yes	complex confounding variables regarding access, understanding , MCA legislation, communication with family, carers etc all make engagement challenging for certain individuals
Community dental service	Yes	See above. There will be challenges associated with special care groups, but we are finding ways of engaging staff within care homes as we already take a preventive approach. However, this does involve using an extended dental team approach, in particular dental nurses (oral health education teams) separately engaging with care home staff and providing dedicated training sessions within care homes etc. Within a dental practice setting, a major challenge is having enough space to engage with patients in an appropriate setting. The dental surgery is not the most conducive setting for oral health education for example and ideally separate less challenging rooms would be ideal, but a rare luxury in any dental clinic. Having the right balance of skill mix within a dental team is another challenge.
Dental Local Professional Network	Yes	The major challenge will be that of the time needed to explain the new system to the patient, and for delays as more time will be required when first assessing patients for the first time in the new system. The other challenges of the pathway approach will relate to whether a practitioner or practice can provide care at Level 2 or 3, which many have done in the past. If they are not contracted to do so the patient will have to travel to access Level 2 or 3, this may not be acceptable to patients. If practitioners are not allowed to deliver Level 2 care unless they have a contract this will remove skill development and professional development by practitioners. Separate contracting for Level 3 may be appropriate but encouraging practices to deliver Level 1 & 2 we believe is essential for appropriate patient care and professional development. Those that due to size or other reasons decline to deliver Level 2 should make appropriate arrangements for the delivery at this level. Patients will be confused as to why treatment previously carried out will now have to be referred elsewhere. Was the dentist practising negligently? Would retrospective claims be able to be made on this basis.
Dentist	Yes	My view is that the majority of patients really won't care. I know it sounds cynical, but as long as patients are not in pain, they really won't be interested in whether they are Red, Amber, or Green risk. I feel that the only aspects that they will care about with a new approach to dental care are a) is it going to cost more? and b) am I going to have to spend more time at the dentist to achieve pretty much the same thing. Therefore I feel that, unfortunately, you have to take a very tough line with patients to make them take an interest in their own health and realise that it partly their responsibility. You need to provide actual incentives for patients to change by having firm rules - for example that whilst a patient is categorised as either Amber or Red risk the NHS is not prepared to pay for them to have RCT on any premolar or molar teeth - this would need to be sought privately if the patient really wanted it. Or by saying that if a patient achieves Green risk status we can consider the provision of 'white' fillings for teeth (when required) instead of amalgam. It sounds very

Respondent type	Response	Additional comments
		harsh but, in my experience, a tough stance like this would be the only way to make patients really listen to anything that dentists have to say to them.
Dentist	Yes	Certain patients just do not want to hear it. In essence everybody knows that we shouldn't eat sweet snacks, we should brush our teeth thoroughly with fluoride toothpaste 2xday and floss 1xday and also that we shouldn't smoke or eat unhealthily and should exercise more. But people still do these things, I don't think a different way of delivering the same message will achieve much
Dentist	No	
Dentist	Yes	There will be a large initial (and smaller) ongoing need to help patients understand the changed service.
Dentist	No	
Dentist	No	
Community dental service	Yes	Time
Dentist	Yes	A lot of patient used to the old system who are very difficult to convert to new ways. Some patients just want to be seen by the same friendly face who they can trust with their long term dental care.
Dentist	No	
Dentist	No	
Dentist	Yes	Whilst I feel that the well motivated patients will like it there are others that aren't as motivated and won't be as interested
Dentist	Yes	Some patients will just simply not engage, the practice should not suffer as a result of this.
Community dental service	No	
Community dental service	Yes	Special care patients are often not responsible for thier own oral care. There is the additional challenge of sharing the onus for prevention with carers.
Dentist	Yes	see above
Dentist	Yes	prevention doesn't work
Dentist	Yes	No centrally directed system is going to be sufficiently flexible to meet the needs of the general public. I expect to be explaining why more advanced forms of NHS dental treatment will be unavailable because the patient is not suitable (according to the algorithm)
Dentist	Yes	Recalls are advised and agreed but rarely kept by our patients.
Community dental service	Yes	Many patients are not able to brush themselves and can be challenging when carers try to assist and provide care. They are not able to engage

Respondent type	Response	Additional comments
Dentist	Yes	2. Collecting patient charges, patients are inured to paying for "something done".
Dentist	No	
Community dental service	Yes	Need to engage with carers often rather than patient and this can lead to difficulties eg OH with a reluctant patient
Community dental service	Yes	As previous answer
Dentist	No	
Community dental service	Yes	Many patients are physical disabled which impacts on their ability to carry out routine OH. This problem is also applicable to patients with Learning disabilities, Autism and a variety of mental health disorders. Others patients may have such complex social or health issues that their priorities in life are a long way from OH care.
Dentist	Yes	Patients will not like or be happy with the system, we already perform all that is necessary to educate and improve patients oral health and provide the care that is necessary
Dentist	Yes	We have found that there was a greater than expected uptake in perio care especially. Where previously patients refused treatment this new pathway approach has changed some minds.
Community dental service	Yes	As above Difficulty in keeping appointments Full periodontal and radiographic assessment may not be possible for people with challenging behaviour or even strong gag reflexes.
Dentist	Yes	Lack of time due to DoH underfunding
Dentist	Yes	Some patients are not interested in preventative measures, they want a fix to their problem there and then- eg bridge placement in a patient with poor oral hygiene
Trainee Dentists	Yes	Changing patient expectations from more frequent visits for the healthy to risk based recall.
Dentist	Yes	In my practice many patients come only when they are in pain & many patients do not bother with prevention
Dentist	Yes	Prevention is more labour intensive and needs to have better uda values than the current zero udas when undertaken by practice staff. During the transition and early stages of the contract capitation numbers will decrease due to the extra time required to undertake the oral health assessment so protection of earnings needs to be in place.
Dentist	No	
Dentist	Yes	Most patients don't have good communicative ability and understanding.....They need basic good schooling, which they don't have
Dentist	Yes	I have a philosophy of not being more than 2 weeks booked up. Anything more than that adversely affects

Respondent type	Response	Additional comments
		patient care as it takes longer to treat disease.
Dentist	Yes	Yes, new patients to the Practice expect drill & fill.
Academic	No	
Dental Professional	Yes	Most regular patients like the contact and rapport that is built with the dental clinicians by seeing them on a regular basis. The pattern of regular attendance could end up being broken for some who we have struggled to get into that routine. Similarly sometimes although there is a logical pathway route for treatment. Patients life circumstances require that an alternative route needs to be taken and would demand such and may well end up with a good outcome for them by taking this different route.
Dentist	Yes	challenging patients expectations of care
Dental software supplier	Yes	you have no understanding of clinical dentistry
Dentist	Yes	As Q2 though some patients will be happy with the approach especially parents of our child patients
Dentist	Yes	We have such a large number of patients, taking the time to apply a purely preventive approach would take longer than there are hours in the day.
Dentist	Yes	Many patients are likely to give up on the preventative process, particularly if this is a prolonged phase as is very likely. Those who just want a simple filling or a new crown are likely to be frustrated.
Dentist	Yes	the time involved in explaining the changes to the NHS. (plus as above.)
Academic	Yes	on the whole no. some patients just dont want to hear it or engage with us. they simply want to come and stay registered as a just in case of a problem scenario. with the aid of a public campaign through press (DOH) then we would engage patients more i think.
Dentist		
Dentist	Yes	some people will not engage and turn up only when they wish to. they have spent 40 yrs getting used to a dental system, why make such a drastic change. pt's have other lives to lead
Dentist	Yes	There are always a few people who don't want to engage in self improvement or are unable to maintain motivation. However I think the RAG system should help more people engage than in the current system.
Dentist	Yes	As noted above engagement, communication and understanding is likely to be poor amongst the groups we treat. The patients are far more interested in accessing treatment for a specific problem usually pain or cosmetic. In particularly if they cannot access advanced forms of treatment,especially where cosmetics are concerned they will have this done aboard and when it fails expect the NHS to pick up the pieces, this already happens when we refuse to provide a form of treatment because we believe it is not in the patient's best interests and will get worse with the advanced care proposals.
Dentist	No	

Respondent type	Response	Additional comments
Dentist	Yes	Patients would regard with suspicion any attempt to curtail treatment because the system did not allow it due to poor prevention
Dentist	Yes	As said, motivation and high needs, in certain patients and a lack of priority to oral health
Dentist	No	
Dentist	Yes	The pathway approach is quite rigid. Many of my patients have oral health as a low priority. It has taken many years for me to raise the profile and importance of oral health to many of my patients. To suddenly restrict their access to care by a pathway would be discriminatory in my view.
Dentist	No	
Dentist	Yes	Explaining them the approach which will take 5-10 min at least. If the patient has no questions. Usually a dental check up appointment is for 15-20 min. That means the dentist will have less clinical time which is negative for quality and access. The public will need to be informed well in advance before the change takes place.
Dentist	Yes	Patient's understanding what/if any benefits of the change. Patients being willing to change their behaviors. Having the time to communicate the changes to patients and the basis for it. I've read the document and I'm not very clear!
Dentist	Yes	of course there would be!
Dentist	No	
Dentist	Yes	See the answer to Q1

Paper 2: The Clinical Philosophy

Responses to Question 4

From what you have seen of the pathway, do you think that the current pathway can be simplified whilst maintaining its clinical integrity? (please relate any response to your experience with or knowledge of the pathway).

Respondent type	Response	Additional comments
Dentist	No	
Local Dental Committee	Yes (If so, which elements could be simplified and how?)	We do not believe there to be sufficient information within the consultation papers to be able to comment usefully on this question. As noted above, we believe that the clinical integrity of the pathway relies on dentists being the ones making the decisions, not algorithms or computers.
National Body	Yes (If so, which elements could be simplified and how?)	Concern must be expressed in that the pilots report decreased access and lower patient charge recovery. Essentially this is decreased access which is relatively more expensive. Whilst applauding the aim of increased access it is presently difficult to understand how increased access can be delivered with no more funding either from Government or patient charges
National Association	Yes (If so, which elements could be simplified and how?)	It is difficult to suggest simplification of the pathway based on the diagrams provided in the document. Figures two and three (pages six and seven) are simplistic and do not, in our view, provide sufficient detail on the intricacies of the process. We are of the view that the OHA must be as straightforward as possible to ensure that it does not become burdensome to complete.
Dentist	Yes (If so, which elements could be simplified and how?)	There are too many questions in the oral health assessment. This needs to be simplified. The piloting has to be carried out and evaluated properly. More research and information is needed before a judgement can be made on its clinical integrity.
Dentist	Yes (If so, which elements could be simplified and how?)	Having read the information I believe the core preventive pathway is already fairly straightforward in its approach and philosophy. The complexity is around its scalability throughout England within all practices and their teams. The area where I believe there is still uncertainty is the interface between the basic preventive care pathway and treatment and specialist pathways and the 3 tier system. Further detail is required regarding the entry point to these pathways and the referral criteria which will be applied.

Respondent type	Response	Additional comments
National Body	No	
Dental Care Professional	Yes (If so, which elements could be simplified and how?)	It is unclear as to whether IC appointments are for patients with chronic periodontal disease. This should really be classed as necessary treatment as Chronic can have acute phases. Also, regular three monthly maintenance has been shown to be effective in reducing these episodes of acute periodontal disease resulting in less bone loss.
Local professional network	Yes (If so, which elements could be simplified and how?)	Pathways encourage adherence to NICE guidelines Software supporting pathways ensures steps/elements are not missed Cant condense too much without diluting effect, Gradual implementation incrementally allows practices to prioritise. Planned with agreed goals so that eventually all are on the pathway. Rather than a big bang a more gradual introduction. Could it say be introduced for under 18 first to allow this pathway approach to be introduced gradually. This would allow the group most likely to have the longest benefit to be prioritised and this would mean staff could get used to the approach and software/recording and applying. As less than 18 s are non-fee paying it would also mean no drop in Fee revenue. If the pathway were implemented gradually then there would be less dramatic pressure on the appointment book. Cant reduce number of patients drop will be an access problem-access must be maintained but the increased time to complete will and has as experienced by the pilot practices a increased wait for appointments.
Dentist	Yes (If so, which elements could be simplified and how?)	The current pathway whilst clinically desirable does not allow maintenance of patient list size due to availability of time. As such the oral health assessment itself is too long and also requires considerable communication time with patients. Much of the pathway requires duplication of information that is required as part of good clinical record keeping. A simplified process such as the one used by Oasis in the Cumbria practices would allow the engagement with the patients, allows RAG rating and can be measured to identify oral health improvements. It also engages patients very well.
Dentist	No	
Dentist	Yes (If so, which elements could be simplified and how?)	The [redacted] has direct experience of running a number of pilots representing the 3 different types and the following observations have been collected from member practices. The Oral Health Assessment (OHA) is a very powerful tool which helps to provide a consistent patient assessment. The OHA requires many questions to be answered and is very reliant on the PMS system for efficient data collection. In the current pilot, PMS systems implement the pathway in an over complicated way with a very rigid implementation of the pathway without sufficient attention being taken to individual patient needs. Initial exam takes substantially longer than a traditional examination, changes to the amount of data being recorded and the efficiency of the data capture needs to be simplified to ensure efficient use of surgery time. The way the current OHA deals with

Respondent type	Response	Additional comments
		advanced care and referrals is inconsistent with the limited service provision available for this type of treatment. The categorisation of complex care within the pathway is helpful in treatment planning but needs to be simplified in any future OHA. Clinical changes a. The medical history questionnaire within the pathway could be significantly simplified saving time whilst still ensuring relevant information is collected. Possible solution: A possible approach would be to simplify the required questions to include cardiac, diabetes, medication and allergy questions and to use the recommendations in the resuscitation council guidance to risk assess the patient using a scoring system. b. The social history questionnaire asks a number of important questions to assess patient risk but in its present form can cause confusion for patients. Possible solution: Allow the dentist to highlight relevant risk factors by direct patient questioning, simplifying the OHA and removing the need for patients having to complete a difficult and time consuming questionnaire. c. The question asking aboutdental sepsis is generally viewed as irrelevant Possible solution: It should be removed. d. The collection of periodontal indices can be very time consuming. Possible solution: A two phase periodontal assessment could be introduced using a BPE assessment only for the first phase to assess risk, and a second phase, including assessment of bleeding on probing and 6 point chart, carried out for patients who opt for further treatment. e. Advanced care and referrals is causing confusion. Possible solution: The OHA should flag treatment that is considered as advanced care to assist with treatment planning leaving the clinician to decide the most appropriate way to deliver the treatment locally. PMS / IT changes a. The age of the patient and the presence of natural teeth should automatically drive the OHA process eliminating the need to manually bypass irrelevant sections. Possible solution: Specify that the clinical charting is completed first enabling for example edentulous patients to be identified and caries, perio and TSL domains to be automatically removed from the OHA. b. The PMS user interface in its current form is too complicated and involves too many screen and mouse clicks. Possible solution: Allow the software houses sufficient flexibility in the OHA specification to enable them to design the most efficient data collection interface. The focus could change from a user interface that uses a fixed path to one which uses a fuzzy logic approach. This would enable a pathway to be presented which fits better with the circumstances of the patient being assessed. c. Some PMS systems collect data on the patients current complaint. Possible solution: This data can be recorded in the clinical notes and is of questionable value to the OHA. Future development: The prescription of dental radiographs could be included in the pathway which would help to eliminate the problem of inappropriate intervals being left between radiographic assessments.
National body	Yes (If so, which elements could be simplified and	As [redacted] has not been involved in the development or piloting of this pathway, we are unable to comment on this aspect.

Respondent type	Response	Additional comments
	how?)	
National body	Yes (If so, which elements could be simplified and how?)	The [redacted] as a provider of secondary dental care cannot comment on this question. However the undergraduate curriculum is designed around the needs of the learner and will naturally follow an oral health assessment with identification of need followed by a preventative programme in the first instance. The GSTT Dental Directorate Management Team as a provider of secondary dental care cannot comment on this question as the clinical pathway software has been specifically designed for use in primary care.
National Association	Yes (If so, which elements could be simplified and how?)	We think that that the OHA must be as straightforward as possible to ensure that it does not become burdensome to complete and we look to clinical colleagues to furnish detailed information. We believe that it will be important to simplify the feedback given to patients as much as possible. Feedback from the pilots indicated that some of the language being used in this feedback was overly clinical and difficult for patients to interpret. Poor communication in this regard will damage patients understanding of their care needs, which could in turn affect recall intervals, particularly amongst high-risk patients. This would ultimately impede the provision of treatment. Maintaining access levels is one of the most important objectives for the new contract and, as described in the two-year evidence and learning report, streamlining and simplification of the OHA procedure should be seen as a priority.
Dental Local Professional Network	Yes (If so, which elements could be simplified and how?)	The pathways seem reasonably straightforward but as ever getting it right with the IT and the Patient Charge Revenue system is a great challenge. Is there a need to ask the same questions every OHA or can it be streamlined for patients that are in the system.
National Body	Yes (If so, which elements could be simplified and how?)	There has been a lot of improvement from the original version to the current version 3 of the pathway which incorporates the factors required. There is limited room to simplify it further without impacting on the clinical integrity. The interim care visit could be reconsidered
Dentist	No	
Dentist	Yes (If so, which elements could be simplified and how?)	medical and social history.
Dentist	Yes (If so, which elements could be simplified and	The main problem is with the software and with the medical (and social) history forms rather than the simplicity of the pathway. I believe V3 will simplify the medical and social questions although I am still waiting for the update to see if this will be the case. As I mentioned in earlier questions, it

Respondent type	Response	Additional comments
	how?)	should be easier for dentists to determine risk factors as this is what we are trained to do. This will in turn make the pathway much more straight forward.
Dentist	No	
Local professional network	Yes (If so, which elements could be simplified and how?)	Having read the information I believe the core preventive pathway is already fairly straightforward in its approach and philosophy. The complexity is around its scalability throughout England within all practices and their teams. The area where I believe there is still uncertainty is the interface between the basic preventive care pathway and treatment and specialist pathways and the 3 tier system. Further detail is required regarding the entry point to these pathways and the referral criteria which will be applied.
National organisation	Yes (If so, which elements could be simplified and how?)	Our experience of the pathway is based on interaction with pilot practices. We understand that there has been simplification and reduction of repetition in the data entry required, however all aspects must be related to the established evidence-base for risk and permit data entry which is a simple and swift as possible.
Local professional network	Yes (If so, which elements could be simplified and how?)	they are relatively straightforward. But is the dnetists expected to ask the same questions at every recall visit
National Body	Yes (If so, which elements could be simplified and how?)	It is important that the pathway is not too prescriptive as a more tailored pathway based upon informed consent can improve outcomes for the patient. As a result simplification as a sole goal may be difficult to achieve.
Dental software supplier	Yes (If so, which elements could be simplified and how?)	Not sure whether its possible to simplify but it might be possible to gather more information in advance of the patient arriving in the chair (e.g. Medical and Social History) and hence reduce apparent assessment times.
Dentist	Yes (If so, which elements could be simplified and how?)	The software needs to be modified to make data collection simpler and less arduous .
Dentist	Yes (If so, which elements could be simplified and how?)	The feedback from the Pilots is that the OHA is too click heavy. I believe that this could be over come through close work between clinicians and software companies it rectify this. In any extent this will evolve. Setting up working parties of clinicians and software companies to continually improve the software is essential.

Respondent type	Response	Additional comments
Dentist	Yes (If so, which elements could be simplified and how?)	Idea for speeding up the whole process of the care pathway and therefore increasing access: This may sound obvious, but I thought I would let you know some thoughts: To save time and make paper version possible Navigation/clicking between screens and different domains takes time and is very IT heavy. Whole system would be better to run as a paper version as well as on the PC Ideally be able to run from one screen/one sheet of a4 paper which can be electronically Needs to limit data capture Objectives Set appropriate and sensible recall intervals according to presence/absence of active disease number/type of restorations within existing dentition tooth wear social factors - alcohol and smoking Idea of how to achieve on one screen/ sheet of paper Record only Patients name, address, date of birth BPE in 6 boxes (pocket depths can be recorded within notes but not transmitted) Modified bleeding recording - perhaps record presence/absence of bleeding on probing in any sextant in a format similar to BPE Number of new carious lesions Signs of toothwear Increased risk of oral cancer developing - patient smoker/drinking in excess of max recommended amounts Improving access Could this be self generated (after the clinical exam)via the IT software to self populate the relevant boxes and produce a suitable recall? If the whole thing is speeded up, then access may increase. That said, we still need time to teach prevention! Is this enough info to generate a pathway? KPI's and prevention If a blended contract is going to be the way forward, could key performance indicators be captured from the above? If these are set at sensible levels, then this would also encourage prevention FTA's Finally, if something can be done about late cancels/ FTA's, that would be great. I am sat here typing this now during a late 40 minute cancellation appointment! If something is done, this may help increase access. If I can be of any further help, please contact me: ----
Dentist	Yes (If so, which elements could be simplified and how?)	basic questions and less options. only 3 options per question otherwise patients will switch off and make the questionnaire up leading to false result.
Dentist	Yes (If so, which elements could be simplified and how?)	It all seems very time consuming and cumbersome Also if this has to be carried out for all patients this will mean alot of repetitive work feeding info in to a computer to almost justify the treatment you can provide again I realise the over ride possibilities however you will be 'caught' if done too often
Dentist	No	
Dentist	Yes (If so, which elements could be simplified and how?)	May be but I may not the right person to suggest on that yet.

Respondent type	Response	Additional comments
Community dental service	Yes (If so, which elements could be simplified and how?)	not familiar with current pathway, but believe that it is difficult to proceed without all the necessary information. This is not always possible for special needs patients eg. BPE
Community dental service	Yes (If so, which elements could be simplified and how?)	We do not have any direct experience of the pathway. Based on our understanding of the pathway, it appears quite cumbersome and time-consuming. It would be interesting to see if clinicians gut feeling would result in the same RAG scores and clinical pathway decisions for individual patients. An alternative is to use a very structured approach, but to use self-complete questionnaires and other members of the extended skill-mix team to undertake much of the initial assessment work, handing over a summary of the initial findings and the patient to a dentist (for completion/sign-off) only after that initial groundwork has been undertaken.
Dental Local Professional Network	Yes (If so, which elements could be simplified and how?)	The pathway is conceptually sensible, the dilemma is the time it takes to undertake the initial assessment. The use of appropriate IT to gather data from patients in advance of seeing a dentist, and perhaps the patient seeing a DCP for initial screening may assist but whether the patients wish to spend this extra time and pay an appropriate charge will be a challenge. Could the new pathways be introduced in stages so less time is required to input data on the initial sign up visit.
Dentist	No	
Dentist	Yes (If so, which elements could be simplified and how?)	I don't know, I'm not familiar enough with the pathway. This question is badly put so will give an inaccurate number of "No" responses implying that the pathway is perfect when a lot of respondents who click "No" will actually be "don't knows".
Dentist	No	
Dentist	No	
Dentist	Yes (If so, which elements could be simplified and how?)	Medical history , social history
Community dental service	Yes (If so, which elements could be simplified and how?)	within limits
Dentist	No	
Dentist	Yes (If so, which	Social history questions such as do you have high sugar or fizzy or acidic diet are a bit vague and

Respondent type	Response	Additional comments
	elements could be simplified and how?)	would be better as part of preventative advice depending on clinical findings. What is high? Pt are uncertain.
Dentist	No	
Dentist	Yes (If so, which elements could be simplified and how?)	I had a friend that was working under the new pilot system but had to leave the pilot scheme as it was so time consuming to use. I don't know how it could be simplified but feel that it needs to be.
Dentist	No	
Community dental service	Yes (If so, which elements could be simplified and how?)	seeking the opinion of specialist societies
Community dental service	No	
Dentist	Yes (If so, which elements could be simplified and how?)	do not fully understand what you are proposing so ' no comment' is what I really want to write
Dentist	Yes (If so, which elements could be simplified and how?)	all could be left out
Dentist	No	
Dentist	Yes (If so, which elements could be simplified and how?)	I'm not sure; would hope software will make all efficient.
Community dental service	No	
Dentist	No	
Dentist	Yes (If so, which	There is nothing wrong with the basic template. Just feed the detail back into the basic approach

Respondent type	Response	Additional comments
	elements could be simplified and how?)	then all can understand.
Community dental service	No	
Community dental service	Yes (If so, which elements could be simplified and how?)	Probably but I do not have direct experience of pathway
Dentist	Yes (If so, which elements could be simplified and how?)	The initial assessments are extremely lengthy
Community dental service	Yes (If so, which elements could be simplified and how?)	Things can always be simplified.
Dentist	Yes (If so, which elements could be simplified and how?)	the dentists as highly trained health care professionals already carry out all the elements of the pathway and they do not need a checklist, we treat patients as individual and tailor the care needed accordingly
Dentist	Yes (If so, which elements could be simplified and how?)	Version 3 of the pilot seems to go somewhere towards simplifying the system but due to software delays with Carestream we have no experience yet. This is frustrating and disheartening.
Community dental service		
Trainee Dentists	Yes (If so, which elements could be simplified and how?)	Only by streamlining some of the software systems in practice and utilising IT to capture the medical and social history details in an intelligent way that allows risk factors to be assessed.
Dentist	No	
Dentist	Yes (If so, which	The social history form and all it's questions promote good debate with the patient and it would

Respondent type	Response	Additional comments
	elements could be simplified and how?)	diminish the care pathway if this is too reduced. However, it is unecessary for 'urgent' patients and I know V3 (when it arrives!) addresses this issue. I'm worried that good elements of the system will be lost if the computer work is too reduced, but there is no doubt this is very onerous in the surgery. I believe that providing enough time is the key to delivering the care pathway successfully.
Dentist	Yes (If so, which elements could be simplified and how?)	There is always space for improvement.....but you try explaining it to a patient.....In other words..it should be simple enough for a dumb layman to understand!
Dentist	Yes (If so, which elements could be simplified and how?)	Why re-invent the wheel. The American Dental Association developed a caries risk profiler years ago. It is paper based, and so does not include the need to do mass computerisation for practices that run on paper records
Dentist	Yes (If so, which elements could be simplified and how?)	Remove the bureaucratic burden of giving Ministers data with which to congratulate themselves for working entirely to their own satisfaction.
Academic	Yes (If so, which elements could be simplified and how?)	Involvement of computers unnecessary! Competent clinicians will be doing it all already.
Dental Professional	No	
Dentist	Yes (If so, which elements could be simplified and how?)	ICM - just call it a recall appointmenmt based on patients risk status
Dental software supplier	Yes (If so, which elements could be simplified and how?)	we treat people on the basis of their complaint , then manage other issues such as prevention. We are very successful in the private sector. this should tell you something of the NHS!
Dentist	No	
Dentist	No	

Respondent type	Response	Additional comments
Dentist	Yes (If so, which elements could be simplified and how?)	I do not think we have seen enough detail I do not think we have seen enough detail of the pathway to answer this. The pictures look pretty but lack explanation.
Dentist	No	
Academic	Yes (If so, which elements could be simplified and how?)	a thorough examination (which is already listed) takes time to be done correctly! it could be faster perhaps with pre appointment questions (paper based or iPad based as technology advances) that the patient completes in the waiting room before their appointment. if this fed automatically into the system even better, saving time on data entry.
Dentist	Yes (If so, which elements could be simplified and how?)	software needs to be kept simple, and a dentist needs to be backed up by a nurse who is very good with computers. I my experience under the pilot, if a nurse is poor with IT, the time efficency of any appointment is severely compromised.
Dentist	Yes (If so, which elements could be simplified and how?)	if you make the assessment pathway so detailed, which is so time consuming, how on earth are dentists going to fulfil access problems.. the access problems will become worse! less questions doesnt mean less clinical integrity. the detailed questyions are more appropriate for advanced specialist treatments give the dentists the clinical freedom to do what they currently do and assess what they currently assess in the manner they are used. in the with the BDA guidelines
Dentist	Yes (If so, which elements could be simplified and how?)	I understand progress is already being made on simplifying the pathway e.g Removal of non relevant sections eg. peridontal status or tooth surface loss on an edentulous patient. This is to be welcomed. The ability to carry forwards entries from the initial OHA so only changes need to be noted on subsequent visits would shorten the work involved. I believe patients who fall into the amber grouping because of external factors they are unable to change e.g. diabetes, historic tooth surface loss have become demotivated because they can never progress to green. Suggestions have been made that the amber status should be abolished, that is probably a mistake as it seems to provide useful information; instead could we have two green categories (light green and dark green). Light green would be for those patients who have unmodifiable external factors, this would give them something achievable to aim for whilst still being informative for the clinician.
Dentist	No	
Dentist	No	
Dentist	No	
Dentist	Yes (If so, which elements could be	N/A

Respondent type	Response	Additional comments
	simplified and how?)	
Dentist	No	
Dentist	No	
Dentist	Yes (If so, which elements could be simplified and how?)	Patients questionnaires
Dentist	Yes (If so, which elements could be simplified and how?)	It needs to be idiot proof.
Dentist	Yes (If so, which elements could be simplified and how?)	It is rather complex and reliant on soft ware. I of course understand the need to capture the data. The alternative pathway for those who do not wish to engage is helpful but a significant percentage of the population will not have ready access to a dental practice such as the elderly "trapped" in their own homes or institutions/care homes. How is the pathway going to be tailored to them at a time in their lives when priorities of care and the opportunity to deliver them will have changed. The emphasis is rightly on the vulnerable as well as empowering those who can to take more responsibility for their own care when away from the practice, but I do not feel that the care of the growing elderly population has been given the emphasis needed.
Dentist	Yes (If so, which elements could be simplified and how?)	It is such a poor idea, I would not know where to start. It is a way of cheapening the supply of dentistry and removing clinical experience from the equation

Paper 2: The Clinical Philosophy

Responses to Question 5

How can dental professionals be encourages to follow NICE dental recall intervals?

Respondent type	Response
Dentist	In my experience the problem is more related to patients who have been conditioned over many years to suddenly not attend every 6 months dentists worry would be concerns medico legally if a pt suddenly developed problems in the interim that May have been avoided if seen sooner. In our litigious society assurances need to be given to the profession that the science behind the increased appointment interval would ofer sufficient protection should the need arise. On a more personal note I wonder if green pts only remain green due to the frequency of recall because I have noted regression into amber on a number of occasions following increased recall interval
Local Dental Committee	We have major concerns about the promotion of NICE recommendations for recall intervals. We do not believe that it is safe to see some patients only every two years. We remain convinced that an absolute maximum recall interval of 12 months should be applied to those with the lowest risk. Clinicians cannot be forced to provide treatment patterns which they regard as substandard. Experienced practitioners know that too much can happen within such a long timeframe. This can have unacceptable consequences for patients and the clinicians responsible for their care. The profession totally rejects current recall guidelines as they are designed purely to save money and are wholly detrimental to patient care.
Notional Body	Patient education is key here, perhaps once what is in the NHS offer is defined then patients who wish to be seen more frequently than the NICE guidelines can seek that care under private contract with their GDP. What is available for patients, and what GDPs are expected to provide under the contract should be defined more clearly than it is at present.
National Association	It is not clear from the document as to where exactly the Departments concerns lie with regards adherence to NICE recall guidance. As noted in paragraph 2.1, one of the most significant challenges to the success of the reforms will be to change the public perception of the need for six month recalls, and it is our view that the main responsibility for communicating this message prior to the introduction of a reformed contract lies with the Department of Health and the NHS, with the support of dentists. It is essential that this information is made available to reinforce the messages that dentists will provide to their patients, and indeed it is vital that dentists are supported by the NHS in circumstances where patients challenge the recall interval. Figure three of the document states that patients who forgo their right to continuing care will have treatment limited by what (they are) willing and able to accept/adhere to. Our understanding of the proposals for the provision of treatment is that this is not a matter of patient choice ô as it

Respondent type	Response
	appears from the above quote - but is contingent on a patients oral health and the their ability to maintain that treatment. It is on this issue that we anticipate the greatest number of challenges to a decision to delay treatment for a patient, and it is an area where the NHS, both locally and nationally, must commit to robust support for dentists. Having a high volume of patients on a three-month recall pattern is common in the CDS and perhaps the most significant barrier to adherence to NICE recalls is a lack of resource to deliver the necessary care. A lack of staff and the administrative burden faced by the CDS means that dentists time in clinic is often compromised. For the CDS, adequate resourcing and investment in the service is required to ensure that practitioners are able to follow NICE recall guidance in the best interests of their patients.
Dentist	This is or should be already being carried out. There are already indicators for this in the current NHSBSA submissions that are made for each patient. Recall interval already have to be tailored according to the needs of the patients. Recall intervals are also already monitored as part of Vital Signs data for all providers. There is a conflict in some of the guidance. NICE guidance suggests recall intervals of more than 12 months for some patients, however oral cancer screening guidance suggests that no one should have a longer recall interval than 12 months.
Dentist	If dentists are follow this pathway then the judgement around appropriate recall intervals ought to occur automatically. If patients have a true understanding of their individual risk and how that has been determined then the recall would follow accordingly. Furthermore if practices are working to a fixed budget there would be no incentive to see patients more frequently then they require as this would have a cost implication. Conversely if a proportion of contract value is assigned to quality and outcomes high risk patients will be seen more regularly to ensure compliance and oral health improvement or stability.
Dental Professional	BSDHT feel 24 months is particularly long period of time between dental visits, especially in light of the increase of mouth cancer (HPV related) in recent years. We would be happier assessing patients on a yearly basis and this will be a barrier to following NICE guidelines which state that a 24 month recall can be applied to those who have repeatedly demonstrated that they can maintain oral health and who are not considered to be at risk of or from oral disease.
Local professional network	Practices have done recall for along time, this pathway approach and the RAG system encourages NICE guidelines. Capitation part remuneration would also encourage dental professionals to follow NICE guidelines.
Dentist	The introduction of a capitation based product will encourage registration. Use of the NICE guidelines for recall examinations based on risk assessment and also through patient engagement to increase those intervals where appropriate increases access which grows a patient list size.
Dentist	Don't pay for the same group of patients being seen every 6 months. Pay per head seen over a 24 month period. This will increase access and will ensure the well maintained are only seen 18mth to 24 monthly. A practice should be rewarded for looking after more patients, the more patients a practice has is also an indicator of a practice that people want to attend. NHS money should follow the patients. The poorly performing practices that do not see new patients or retain them should lose funding.

Respondent type	Response
Dentist	There are a number of ways which will promote this and include: Continued presentation and emphasis on the scientific evidence that these guidelines are evidence based Increase patient awareness of the guidelines nationally by the NHS which will in time remove the dental professional's reluctance to implement the guidelines which is partially based on his/her avoidance of conflict with patients who have differing expectations regarding their care based on historical "norms". Ensure that the contract provides the correct incentives and measurements for following NICE guidelines.
National Body	If the evidence is that patients are exceeding their recommended interval, as seems to be suggested, could this be because GDPs are keeping too many patients on their books? Could part of the GDPs remuneration be reserved for those who see above a certain percentage of their patients on time? Furthermore, GDPs need to be prompted of the need to see children, not just because of caries, but to monitor any abnormalities in dental development. Delayed recall and thus referral of young patients with unerupted incisors (due to the presence of a supernumerary) or ectopic maxillary canines can result in excessive treatment and poorer long term consequences. Parents/children should be given information about the key stages of normal development by their dentist, to allow them to be proactive in their own recall arrangements.
National Body	The [redacted] as a provider of secondary dental care cannot comment on this question because a pathway within secondary care does not usually involve regular review appointments, other than in some specialist services were the review period is determined by the need of the patient and their response to treatment rather than a traditional 6 month review. The undergraduates are taught the current NICE guidance for dental recalls and are therefore not taught to follow the old style 6 month check up routine
National Association	We are unsure how dental professionals can be encouraged to follow NICE recall intervals and consider this to be an issue for patients themselves. There is a role for dental professionals in stressing the importance of recall periods to patients, but this should be seen as part of a wider communication effort by the Department of Health to generate greater understanding of the importance of oral health. An improved public perception of dentistry and oral health will do more to ensure that NICE recall intervals are adhered to than would any additional burden that could be placed on the profession.
Dental Local Professional Network	At present there is a lot of scepticism within the profession about the evidence base of the NICE recall guidelines. Show the profession the evidence that these guidelines are properly evidenced. There is significant pressure from patients to be seen at 6 monthly intervals, help with patient education would ease pressure on the practitioner. Many patients see it as a right to be seen 6 monthly and increasing this period as a way for the government to save money. UDAs encourage a more cautious approach to patient recall intervals.
National Body	Education for both dentists and patients. Where patients risk profiles do not seem to support identified recall intervals, appropriate monitoring and reporting needs to be able to identify and challenge this if necessary.
Dentist	guidance is clear but don't penalise payments or reduce payments for pts who need longer recalling intervals keep capitation payments valid for longer periods of time

Respondent type	Response
Dentist	
Dentist	Has Nice published a definitive report yet?
Dentist	It will happen over time - new dentists are all trained on NICE recall intervals and as a FD trainer, I see this as becoming much more of the normal practice in any case. Also NICE is only a guideline, there are always cases where we need to recall a patient at a different time interval to what is recommended - I don't think dentists should be penalised if they are recalling a patient at a different interval if they are doing this in the patient's best interest.
Dentist	Use of capitation in the equation
Local professional network	If dentists are follow this pathway then the judgement around appropriate recall intervals ought to occur automatically. If patients have a true understanding of their individual risk and how that has been determined then the recall would follow accordingly. Furthermore if practices are working to a fixed budget there would be no incentive to see patients more frequently then they require as this would have a cost implication. Conversely if a proportion of contract value is assigned to quality and outcomes high risk patients will be seen more regularly to ensure compliance and oral health improvement or stability.
National organisation	The NICE guidance is not mandatory but guidance and is predicated on the acceptance/agreement of the approrpaite interval by both clinician and patient. Many patients derive comfort from a recall frequency more than that recommended. We believe that given the continuing increase in cancer of the mouth, lip and pharynx an interval of more than one year is indicated only in established low risk patients. This approach is commended in current undergraduate texts.
Local professional network	Many patients see it as their right to be seen every 6 months. Is NHSE / DoH going to mount a media programme to inform them otherwise? Show dentists the evidence - there is a lot of professional sceptism about the evidence base for these NICE guidelines
National Body	By rewarding accurate prediction and adherence to recall intervals. Within a well-managed preventive scheme, it should be possible, in time to correctly gauge a patients recall needs. A small fee for this could be incorporated into the programme.
Dental software supplier	Embed into DQOF metrics that measure actual recall periods achieved or drive more indirectly by compensating for meeting access targets.
Dentist	Education and training is required for dentists and a public health initiative to educate patients. Additional recalls could be provided privately at the patients insistence .
Dentist	Dentists are already moving recalls out to longer periods. To a certain extent the new care pathway helps Dentists to assess need and risk factors in a more direct way. This will help with generating appropriate recall intervals. Currently approximately 70% of all recall intervals in the pilots are revised down by the pilot clinicians. The recall appointment part of the software is not sensitive enough to factors that may lead to a reduced recall interval. For example a heavily restored dentition is not factored in to the recall interval and so a caries and restoration free patient often has a similar

Respondent type	Response
	recall interval to a caries free heavily restored patient. We need to work on this element of the software to make improvements.
Dentist	by removing targets. dentists are under so much pressure to turn around courses of treatment so they can meet their targets means that asking dentists to see more patients with high needs to replace their existing stable patients puts the dentist at risk of contract size reduction and all the disadvantages that result from that.
Dentist	I have personally found this very diffcult. When I graduated in 1995, we were taught that heavily restored dentitions should be seen at least every six months. In the past I have extended recalls only to be proved incorrect and in one case a patient needed root canal treatment. The patient questioned if it would have been better to see him earlier and potentially avoid extensive treatment.
Dentist	make patients aware of the nice guidelines through posters/on the questionnaire for the pathway. Then its the "nhs" setting the recall not the dentist and then patients will be more accepting and not to blame the practice which could result in dissatisfied patients - again affecting contract values.
n/a	This is difficult as this is one of the dental health messages that patients have adopted. From the dental practice side it should be mandated and performance managed and clarified that if patient wishes to attend more frequently than required, this should be as a private vs NHS treatment. This is very important when you look at the number of band 1 treatments that are provided, the average recall interval between band 1 and band 1 courses of treatment and the cost to the NHS. This could also be addresses through undergraduate training on the use of the NICE guidance and the underlying evidence for the recommendations within it. Patient information clarifying recall periods and the NHS offer in this area as above.
Dentist	Again it is not just the onus of the dentist patients also need to follow the guidelines issue to them. Dentists will most have to follow the recall guidelines issue to them by the computer program Obviously there should be an improvement in Oral hygiene which should free up clinical time if recall periods are extended however it could also be swings and roundabouts where patients may also need to attend more frequently which will still impact on access
Dentist	I already try and feel the pathway will help this immensely. It will give us further evidence to explain to patients why they need to be seen 6/12/24 monthly.
Dentist	May be through Area team and local PCT leaflets and peer review
Community dental service	financial incentives
Community dental service	I dont know how much of a problem this is, but RAG scores and gut feelings should help dentists to determine recall intervals. I would think that the NICE guidelines are quite well-embedded now. A capitation system would encourage longer recall intervals as more patients could be on the books and managed appropriately.
Dental Local Professional	Many clinicians feel that the NIHCE guidelines are not evidence based and may not fit the needs of their patients. Having said that many patients who have not had much dental work other than examination, scale & polish in recent

Respondent type	Response
Network	years may benefit from going onto annual review. A review of NICE guidelines and agreement with the profession might increase compliance. Whilst one could build financial incentives into a new contract for compliance there is a risk of gaming by practitioners to get the results they wish.
Dentist	By making it so that the dental professional, or dental practice, will not be remunerated at all if they see a particular patient again before their determined recall interval. So, at the OHA a recall interval will be decided according to the information gathered - this would be a compulsory stage to enable the OHA to be completed using the IT software. Then, if the patient is seen again on the NHS before their determined recall interval, the dentist and practice will receive no remuneration for any work completed. Patients would also need to be informed that they would not be allowed to book a further assessment before a specificed date, unless they wished to have this privately.
Dentist	Difficult. I have always done this and all of my principals over the last 15 years of GDP associate work have been opposed to it as essentially you are turning away your responsible, motivated, regular attenders who are mostly a pleasure to treat to try to help new patients, however many people in this group are irresponsible, poorly motivated, poor attenders who show little interest in their dental health once they are out of pain and often are difficult to treat, fail to attend appointments and don't put enough value on their oral health and so moan even about low NHS dental costs. This is my direct experience over 15yrs as an nhs gdp. It is difficult to help those who are not motivated to help themselves.
Dentist	It needs to be done through the remuneration system
Dentist	The bigger problem is haveing patients follow their dentist's advice (and hence NICE recall intervals.
Dentist	
Dentist	I think in principal the dentist is the best person to decide on the recall interval for a patient.
Community dental service	given confidence that the NICE guidelines were determined using alot of data....not sure this was the case
Dentist	They can be encouraged by not being penalised for following them and a resultant loss in patient attendance. NICE dental recall intervals should become simpler:- 3 months (High Risk perio/smoker/poor oral hygiene/recurrent caries) 9 months (medium risk who proBably will attend in between for urgent care/lost fills etc) 12 months (low risk just require descaling and advice) 24 month should be removed for several reasons:- caries can develop beyond repair in this time frame even in people with good Oral Hygiene due to diet change/illness or lifestyle choice. after 2 years patients become disconnected from their dental practice and lose touch with the dental team. The key feature in getting people to attend is trust and if they only ever come to the practice every 2 years they lose that face to face communication and engagement essential in primary dental care. 6 month recalls should be scrapped as no-one tends to require this type of care from my experience but maybe extra hygiene care can be provided at a cost if the patient wishes so maybe making it an optional recall period, for which the patient pays extra to offset the cost funded by the NHS.

Respondent type	Response
Dentist	
Dentist	the only way is spread the Guidelines to the public too, so that inappropriate recalls, not linked to the care pathways will discourged
Dentist	
Dentist	We already do, but this has had massive financial implications of needing to take on more, generally high needs, patients in a practice, to maintain our UDA numbers. Remove the financial penalty of seeing new patients who might need an awful lot of work, and this would improve. In fact, incentivise seeing 'new' or high needs patients!
Community dental service	Popup of NICE guidelines in Computer system linked to a conditional field when noting recall
Community dental service	Record card audit to demonstrate justification or a requirement to justifiy on the software system.
Dentist	it's in our contracts
Dentist	by paying them to do it
Dentist	Perhaps you are asking the wrong questions. Ask first why other EC countries do not have NICE?
Dentist	Wrong question; most of us know . Problem is encouraging and changing patients. Those dentists who do not follow it are probably concerned regarding business viability
Community dental service	
Dentist	1.Educating them . 2.Some form of incentive/disencentive.
Dentist	Education
Community dental service	Making intervals easier to set eg by customised software (with possibility of override if necessary)
Community dental service	Incorporated into IT system
Dentist	Most already do
Community dental service	Make it a KPI
Dentist	some patients insist on six monthly recalls but those who do not are encouraged to attend for recalls at 9, 12 or 18 months intervals
Dentist	We have responsibility for our patients welfare. NICE don't appear in front of the GDC in cases of late diagnosed oral cancer on our behalf. Once we do not have to deal with UDAs dentists might rethink the recall intervals.

Respondent type	Response
Community dental service	Make them fully aware of the guidance. Synically linking the compliance to financial rewards or costs would probably work.
Dentist	Don't financially penalise us for following them, and also try to enforce guidelines which are to improve oral health not just save money
Dentist	National patient information- Quite often patients are the driver to seeing the dentist more often than they should.
Trainee Dentists	Through further education, and through appropriate incentives built in to the contract.
Dentist	Dental professionals do follow the guidelines a certain extent , many patients wants to come back 6 mthly /12 mthly
Dentist	At my practice we try to follow NICE, however patients also have a say which overrides our clinical judgement as our service is patient led.
Dentist	In my experience, it's not the dentists who have the problem following the Nice Guidelines-the evidence is compelling. It is the patients who find the 2 year (green RAG score) difficult to accept. Again,this takes time to explain. I think Contract Reform will have to be accepted as an evolutionary process for all stake holders. It is a different way of providing care and it will take time for everyone to get used to it.
Dentist	Make sure they don't financially suffer if they follow the intervals....simple
Dentist	They already are, because what everyone fails to mention is that the caveat with NICE guidelines was that, at the end of the day, the recall attendance should be based on what both the dentist and the patient agree on. The more you try, as a government, to eradicate clinical judgement, the more you risk eroding the skill set of the profession even further.
Dentist	NICE needs to tell Patients loudly and repeatedly. I can talk until I'm blue in the face, but they still want to come back every 6 months, and think that I am trying to cheat them, or make more money, if I suggest anything other than 6 months.
Academic	They already should. It needs to be instilled at the undergraduate level and as time goes by it will become the norm. Perhaps GDC mandatory CPD required in the interim?
Dental Professional	Only when these guidelines are seen to have patients benefits as a result of following them not just cost saving. for example the disaster of the assessment of Lower 8s leading to so many un restorable lower 7s
Dentist	give them a financial incentive to do so - capitation would work
Dental Software supplier	NICE is corrupt! Its in the news this week (12/6/2014) they are in the pay of pharmaceutical firms, and they are government 'yes' men. They will do what they are told to get on the annual honours list, most of the guide lines are not appropriate.
Dentist	A better question is how can we encourage patients to follow our advice on recall interval. Many of our patients agree to a specific interval but then book earlier.
Dentist	As far as I'm aware they already do?

Respondent type	Response
Dentist	This will not be relevant to the new process. The recall interval will or should fall out naturally from the pathway. In the interim how about a QOF payment for this? Could even be paid retrospectively for those who are working well already.
Dentist	it is important to encourage this while still allowing a degree of clinical judgement to prevail. If it is felt that there is no flexibility in allowing a dentist to still change the recall interval dentists will feel dictated to and possibly less likely to want to follow the guidelines. Many of my patients are already on longer recalls than the traditional 6 months anyway and a number are on shorter recalls.
Academic	better understanding and training, i often find with practitioners and students the document can be hard to understand and is open to interpretation significantly. the guidelines also permit the patient to decline our suggested recall and indeed they some times do, requesting to still be seen 6/12.
Dentist	Education. Pressure from comissioners.
Dentist	we already do.
Dentist	A robust computerised support system in deciding an appropriate recall should give more support....I suspect current reluctance lies in not wanting to risk a patient developing a serious problem which could have been treated at a much earlier stage with more regular reviews, regardless of a patients current risk factors a lot can change in two years and personally I worry that it is too long for most of my patients (I do work in the North, so perhaps there are higher decay rates than average). I want more reassurance that the guidelines are appropriate and that the computerised system will apply them with enough evidence to make its recommendations accurate.
Dentist	Provide a financial incentive.. Use a KPI to measure recall attendance with a small bonus payment for reducing levels of recall. A bonus rather than the normally applied penalties would create far more goodwill and encourage practitioners to co-operate rather than try to evade the NICE guidelines.
Dentist	Do you use a carrot or a stick. I have mentioned to many patients who attend 6 monthly that they need not attend so regularly but they want to. Many choose not to attend as often as they should. people make up their own mind and some cannot be influenced. There is then the issue of giving people what they want or managing a capped national budget. The professional is caught in the middle and has a business to run with all that that entails.
Dentist	Probably generational, when dentists trained in the NICE regulations become the majority the problem should gradually disappear.
Dentist	
Dentist	As a young dentist I can not see what the problem or barrier is to following the NICE recall intervals
Dentist	I recommend NICE recalls to all my patients. I have audited the recalls in my practice and found that patients pay little attention to it. They come when they want or if we remind them after their recall is overdue. Penalising dentists would be counterproductive. The only way to do it is to have a recall period printed on each patient treatment plan which they keep. This may stop dentists from encouraging inappropriate recalls.

Respondent type	Response
Dentist	By assessing our patients and treating them appropriately. But did you know that the prevalence of chronic perio is far higher than recorded? Dentists will treat accordingly but I think the system has to realise that treatment need in some cases is far higher than reported. The NICE guidelines shouldnt be used as a weapon to keep NHS spending down.the system has to be as honest to our patients as dentists are expected to be towards them
Dentist	By giving some extra points towards the DQOF.
Dentist	Make it appear relevant rather than a way for the NHS to save money.
Dentist	
Dentist	The NICE recall guidelines are unfortunately a contradictory document that leaves a cynical taste in the mouth of many practitioners. Suggestion of a 24 month recall has little or no scientific basis and all patients we have discussed this with suggest this is tantamount to being abandoned by the system. Given the doubling of incidence in oral cancer cases including a younger cohort (often those who have lower risk factors for caries and periodontal disease) a 12 month recall would be a maximum and this sits well with every colleague that this has been discussed with. As for a child recall of up to 12 months this conflicts with the evidence based (level 1) advice given in the current DBOH (2) which clearly impresses upon the dental team that the twice yearly application of topical fluoride is expected. Something that is also emphasised via PDS+ practice metrics. You will not be able to convince the profession that these extended recall intervals are anything other than a ploy to reduce access to a system that is over-stretched. The over health of the nation has in part been improved by regular access allied with the use of fluoride tooth paste and a limited input from water fluoridation (given its coverage). The 24 month recall would in my view be detrimental and given its unpopularity with the profession (which you claim you need to listen to) be unenforceable. Experience of PDS+ expected outcomes that pre-judge the treatment need and set unrealistic delivery targets place an impossible burden on the practitioner and the provider. This is an example of a government led health service aimed at controlling costs (understandable but don't blame the profession) rather than one that addresses the treatment need of the population
Dentist	Pay them for a lack of income by the implementation. No dentist is going to implenet these if it means a fall in income. PLUS I have seen many patients given the 'correct' interval who have suffered - gross caries etc.

Paper 2: The Clinical Philosophy

Responses to Question 6

How can clinicians be encouraged to exercise clinical judgement and change care pathway recommendations?

Respondent type	Response
Dentist	Needs to be made very clear from the outset but not likely to be a problem after working with the new systems for a short time
Local Dental Committee	This is an area we have very serious concerns about and it is ironic that it follows the question about NICE recall guidelines ô the very opposite of encouraging clinical judgement. As has been demonstrated by the various contract pilots, even where dentists are relatively protected from financial risk and have been instructed (on more than one occasion) to override the clinical pathways as necessary, there is an instinctive reluctance to do so. As is so often the case, setting a normal way of doing things undermines innovation and inhibits clinical freedom. The medico-legal implications of deviating from a Department of Health defined pathway give us serious cause for concern. Where a dentist decides to exercise their clinical judgement and deviate from the automated care pathway, they risk exposing themselves to litigation if anything goes wrong. Being risk-averse is the safest option for the clinician, but one that runs contrary to the above objective of ensuring the dentist exercises their clinical judgement appropriately. We believe the Department of Health must be in a position to provide robust assurances to clinicians that both the freedom to exercise their clinical judgement will be protected and that there are no risks to deviating from the standard care pathway, before any contractual reforms are introduced. The existing model being trialled within the contract pilots gives us great cause for concern in this regard. It must not be left to the courts to determine what appropriate dental care should look like.
National Body	Does this relate to over-riding the computer? As dental professionals we should all be working to the patients best interests. What would help here is a series of common examples outlining situations where clinical common sense has prevailed.
National Association	First and foremost, it is essential that the Department of Health produces clear guidance and training on the purpose of the decision support software, if indeed it is to be a core element of the reforms. The Evidence and Learning report highlighted that there was some confusion at the commencement of the pilots and that dentists followed the software too closely, and this was a consequence of insufficient clarity for practices on how the software should be used. Dentists are trained to diagnose disease and identify risk, and as the contract evolves and the philosophy becomes

Respondent type	Response
	embedded in practice, the software may become superfluous. There is, in our view, some tension between empowering clinicians to make the right choice for patients and providing an underpinning diagnosis software package which some have described as dentistry by numbers. It is within the Departments gift to empower clinicians to treat patients in what they believe to be the most appropriate way, and this will be done through clear guidance and training. In the [redacted] early discussions with the Department of Health, it was suggested that the introduction of a kitemark for the provision of Community Dental Services would be appropriate under a capitation system. Such accreditation would be provided to all services that had the appropriate equipment and facilities, and that had engaged a specialist in special care dentistry, and would be the only recognised services to provide care for those patients who may attract a higher capitation value.
Dentist	The current care pathway system is too IT focussed. If clinicians are to be encouraged to exercise their clinical judgment then this needs to be made much clearer in the software. It must be made easier to override the RAG system without incurring penalties. The converse to this argument also applies. What is the point of having clinical pathways if they are to be continually overridden? Surely there would have to be a very good reason to go against a prescribed care pathway.
Dentist	This would be a clinicians professional responsbility as a GDC registrant to ensure any care plan is provided in the best interest of their patient and not to simple follow an IT algorithm if it were not appropriate. However, any contractural framework needs to encourage clinicians and practices to do the right things and discourage them from doing the wrong things. This means that area teams need to take a considered and fair approach to managing cases where apparent deviations have occured where there is sound clinical evidence to support it.
National Body	Clinicians can be encouraged to exercise clinical judgement and change care pathway recommendations through mentoring, monitoring and regulation. This approach should also be emphasised in education and training programmes, and through professional standards.
Dental Professional	The computer programmes need to be easy to change. When implementing the OHA there could be a pop up to ask the clinician do you want to override this suggestion? this then gives the clinician autonomy.
Local professional network	Benchmarking would encourage this. Alerts on the computer to notify Dental professional after completing the assessment what recall is deemed appropriate may NICE guidelines to be adhered to. However the clinicians decision should always be allowed to override this as they can assess patients better than any computer system
Dentist	Clear concise communication of the expectations of the NHS system explaining boundaries will enhance the willingness of clinicians to exercise clinical judgement. The clinician must be confident that there will be no repercussions for taking this approach as long as there is clear recorded information relevant to this decision. This allows the dentist to apply the knowledge of their patients to their overall care. Clinicians also need to be supported to take partial ownership of the new processes and feel sufficiently engaged to allow them not to divert all blame for decisions to the system.

Respondent type	Response
Dentist	To be remunerated correctly.
Dentist	Identification of those factors which cause clinicians to remain loyal to "the system" or in this case the prescribed pathways needs to be fully understood and addressed in order to encourage deviating from such pathways. Such factors include: Clinicians are essentially risk averse. Fear of potential professional conduct and legal ramifications in the event of "not sticking to the book". Professionals fear the possibility of having to face such events and will avoid taking decisions which will need active justification. It is simpler, easier and perceived as less risky to stick to the system prescribed. Unfortunately without the tackling of the litigation culture we find ourselves in, this factor will continue to discourage decisions being taken for which the responsibility will be transferred from "the system" to the practitioner. Finding methods of reward, whether these are financial or other methods which encourage deviation from the prescribed pathway when relevant and in the patient's best interest. This is an area that could possibly be linked in to the "Quality" aspect of the remuneration. Potentially, areas of professional esteem, professional rewards and recognition (non-financial) should be devised to encourage relevant deviation of pathways where applicable in patient's best interests. Possible solution The DOH should engage with the indemnity organisations to agree on the medico-legal status of the care pathways. This is particularly relevant for the use of Interim care appointments which within the current pathways which are often delivered by extended duty nurses / therapists where a dentist led examination or review is not carried out.
National Body	Clinicians should feel supported to exercise their own clinical judgement but be able to justify their approach using an appropriate evidence-base. Clinicians need to feel that their opinion, expertise and experience is still valued. The pathway needs to be flexible enough to allow GDPs to use their clinical judgement whilst monitoring any outliers who may pose a risk to patient care.
National Body	Secondary care providers such as those within an academic centre have a role to play in the education of the clinical workforce to exercise their clinical judgement and not just follow a computer generated pathway recommendation. This applies to the qualified clinical workforce as well as the undergraduates.
National Association	The design of the software will be important here. The software should be seen as a tool for guidance rather than as a purely instructive measure. We believe that the provision of clear guidance from the Department of Health on the usage of the software will be vital to its utility at the heart of the care pathway.
Dental Local Professional Network	Having IT systems that are easy to override. Having education for practitioners showing when it is appropriate to change the pathway. The monitoring system needs to be sympathetic to the appropriate use of clinical judgement. If you are likely to be an outlier due to the demographics of your practice then there may be a discouragement to change a care pathway. We are working in a risk-averse culture and the consequences of making a poor choice and offering poor care/treatment to a patient is substantial deterrent to changing care pathway recommendations.
National Body	Dentists need to be educated regarding the pathway and how it works including the available guidance, best practice and evidence based dentistry that underpins the pathway Some have no confidence to override the pathway and others override on opinion and not sound reasoned judgement. Those dentists who are up-to-date with current

Respondent type	Response
	clinical teaching are more likely to have the confidence to come their own decision.
Dentist	make it easier on computer software ensure payment structure is still valid for the changes
Dentist	By making the pathway appropriate to the dentists patients needs and giving flexibility in the system for the dentist to provide appropriate treatment to cater for the patients individual needs not a rigid pathway were one size fits all
Dentist	Would help if I understand the algorithms behind the pathway recommendationd
Dentist	Make the software easier to use - as mentioned earlier most of the clinicians on the pilots that I have spoken to don't even look at the pathways as their nurses input all the data (whether it is correct or not) as the dentist does not physically have the time to check every minor detail on the pathway. It is also very difficult to adjust pathways once data is entered - details change between appointments (for example medical histories or even social habits) but the pathways are fixed once information is entered. It is currently easier to either accept (or ignore) the pathway as it is rather than having to go through the process of re-entering all the details all over again.
Dentist	Training to emphasise that pathways are a guide and they are the clinician
Local professional network	This would be a clinicians professional responsbility as a GDC registrant to ensure any care plan is provided in the best interest of their patient and not to simple follow an IT algorithm if it were not appropriate. However, any contractural framework needs to encourage clinicians and practices to do the right things and discourage them from doing the wrong things. This means that area teams need to take a considered and fair approach to managing cases where apparent deviations have occured where there is sound clinical evidence to support it.
National Organisation	Clinicians should be encouraged to understand that they will not be penalised disproportionately for departing - on jujstifiable grounds - for departing from pathway recommendations. They should also be encouraged to remain up to date with the current evidence base.
Local professional network	IT Systems that are easy to over-ride
National body	By allowing clinicians to work within a pathway that is tailored to the individual they are better placed to change recommendations if necessary. If joint decisions are made on the basis of informed consent, including explanation of all options risks and benefits, changes become more likely.
Dental software supplier	On the basis that exercising clinical judgement should lead to better outcomes then the logical conclusion is to better incentivise good outcomes which leads to the conclusion that you would need greater weighting applied to the DQOF and a gradual reduction of any financial safety net .
Dentist	There needs to be a period of training of practitioners and practice personnel before introduction of any reformed contract so that all involved in the care pathway understand the clinical philosophy which underpins it .
Dentist	This will happen and will not require encouragement. The main issue will be asking the Clinicians to trust the care pathway process and software. This is important because the pathway ensure more consistency of care based on an

Respondent type	Response
	evidence based approach.
Dentist	by making very clear what the consequence are of doing this. If dentists are going to be hounded by their AT to justify their clinical decisions and be threatened with breach or other sanctions they will have to do what the computer tells them to do. We are all practicing defensive dentistry because we are so over regulated and have no faith in the decision making powers of our regulators and this places an unfair pressure on every decision we make
Dentist	
Dentist	pathway should be organised in a way that the original treatment plan is decided by the clinician. The software can then recommend other treatment choices and the clinician can decide to accept them or not. This puts the dentist in the driving seat for producing a treatment plan but the software can suggest and nudge the dentist if it thinks something is missing.
n/a	By suggesting that this is what they are currently doing in applying the NICE recall interval guidance. Also by reminding GDC registrants of their requirements to put the patients best interests above their own or the practices needs. By practices keeping up to date with emerging evidence.
Dentist	with difficulty as if this is done too often I imagine algorithms will be tripped and dentists will need to justify why it is beng over written it all sounds very Big Brother
Dentist	If we are given the autonomy to override the IT system I feel this will be commonsense in most cases.
Dentist	I am still a novice but the IT personnel could help divert you through the clinical pathway and let a colleague put their clinical judgement to surpass the normal protocol if needed.
Community dental service	financial incentives/ penalties
Community dental service	Part of the algorithm must include an element of clinical judgement which may over-ride the algorithm. Not sure how that could be encouraged, but there could be a question and space for a clinician to explain why their judgement differs from the algorithm.
Dental Local Professional Network	Clinicians will exercise clinical judgement if the software allows it and the patient agrees.
Dentist	I don't necessarily think that they should be encouraged to do this, unless the care pathway software recommends for something to be done that is clearly unnecessary or inappropriate in a particular case. If clinicians are encouraged to challenge and change the care pathway, then what is the point in having a care pathway? As with other healthcare guidelines, I think clinicians should have to provide good justification for not following them. If the pathways are evidence-based and treated like other clinical guidelines, then patients should be receiving the best quality care if the pathway is followed. If all patients are treated according to these strict guidelines, then everybody receives fair and equal care (according to their needs), and there is less scope for legal challenges because all dentists are following a

Respondent type	Response
	nationally-set structure that is supposed to be in the best interests of the patients.
Dentist	Education and a system which will support this financially (i.e. with adequate remuneration and without the principal as a small business owner having to shoulder the risks of this approach - see above Q5 re human nature and the risks of turning away loyal patients).
Dentist	Through education
Dentist	Training and support
Dentist	
Dentist	I think this will happen naturally as they are used to altering patients treatment plan
Community dental service	given confidence in their own abilites, experience and judgement
Dentist	They should be guaranteed funding but be more transparent where it goes. For example do they pay for a hygienist, or how many nurses have been qualified for more than 2 years. Dentists can only exercise clinical judgment if engaged with LAT's or PCT's on a more frequent basis.
Dentist	Provide scenarios eg if you have supra calculus on upper 6's, lower incisors and good OH then you would need to override the RAG score.
Dentist	making it integral into the clincal softwares arranging regular training making it an element of CQC
Dentist	
Dentist	Train them well, including ethics! In the same way be ethical in dealing with the contracting arrangements! Don't be too prescriptive, clinicians have different ways of solving the same problem, leading to innovation. Ensure paid time is available for training and peer review. To encourage this.
Community dental service	The designers have credibility in their field
Community dental service	a tick box for agreement to the computer recommended pathway Yes/No. If No, the clinical decision can then be justified by the clinician.
Dentist	oversight and scrutiny to ensure they have acted in the best interests of their patients
Dentist	they do this anyway
Dentist	Are the two not mutually exclusive? If a clinician exercises his clinical judgement in a financially neutral system why does a care pathway become necessary? If you feel clinicians are not equipped to treat patients effectively what are you going to do about their training? This process appears to be transferring care from dental professionals (expensive to use) to clinical technicians (cheap to use). Turkeys & Thanksgiving?
Dentist	Education

Respondent type	Response
Community dental service	I don't know, it is a matter of ethics and wanting to provide the best care for your patients.
Dentist	Education, information and incentive.
Dentist	Education
Community dental service	By making the pathways meaningful and evidence based
Community dental service	Incorporated into IT system and not disadvantaged by exercising clinical judgement
Dentist	Engage a system that does not penalise spending time on prevention
Community dental service	Examples of good practice and a clear reward system supported by Dental Specialist networks and chat rooms for primary care dentistry.
Dentist	we allways exercise clinical judgment and do what is best for the patient
Dentist	If the skill mix within a practice is correct there should not be any issues. But single handed and smaller practices which cannot expand will find it particularly difficult to make the changes as the recommendations will be carried out by the same people doing the patient assessments.
Community dental service	Training and education of the whole team
Dentist	
Dentist	Education, and easy software to make and record the information
Trainee Dentists	Further education about how the algorithms work.
Dentist	they should be able to override the recommendation on their clinical knowledge as every patient is different & there is not one rule for everyone
Dentist	
Dentist	In my experience I find the pathways easy to follow and have not yet had a situation where I felt my clinical judgement was compromised.
Dentist	Pay them well
Dentist	That would depend on how flexible you make things. If you make the system too rigid, patient care will suffer because a one size fits all system doesn't work in health care
Dentist	Don't haul them up in front of the GDC when they do.
Academic	They are professionals and should already have the competence and responsibility to act in the best interests of their patients regardless of non-sentient 3rd party advice.

Respondent type	Response
Dental Professional	If the part of the payment relating to outcomes was removed dentists would be able to get on with using their skills in this more effectively rather than worrying about losing income for taking a detour.
Dentist	not sure
Dental Software Supplier	pay them the going rate for the work, there is plenty of money for bureaucrats, but none for the real people who run businesses and do the work.
Dentist	Training
Dentist	They already do this, every day, with every patient they see.
Dentist	The risk is that clinical judgement is suspended in the new pathway. “Computer says no”. We currently exercise our clinical judgement every day. Let us have the freedom to continue, with no compliance targets.
Dentist	
Academic	thorough training by NHS / DOH prior to roll out. understanding when to etc.
Dentist	Education. Experience of working under care pathways.
Dentist	instead of calling it pathway recommendations or guidelines, make it less restrictive. call it options
Dentist	Support, access to advice, assurances from the GDC / ombudsmen that not following the recommendations will not be seen as an automatic breach of best practice.
Dentist	They need cast iron guarantees that any overides will not subsequently be used to penalise them. The NHS and department track record is not good; existing KPIs, Vital signs etc are primarily used for sanctions. This creates mistrust. Reassurance on its own will not overcome this therefore any assurances need to be legally enforceable.
Dentist	Give them more time to CARE for their patients
Dentist	It will be very difficult. Litigation will mean dentists will not want to exercise clinical judgement if it does not agree with the computer software decision.
Dentist	
Dentist	knowing that there is no legal repercussion for not following the recommendations as long as the clinical judgement is safe and can be explained. I.e. there should be no underlying fear of being sued and left vulnerable if own clinical judgment is not the same as the recommendations. If anything are recommendations necessary, the very fact there are recommendations can dumb down the profession to following the computer, I personally do not look forward to the future prospect of a culture of 'the computer says.....'
Dentist	Older more experienced dentists would have no problem. Newly qualified dentists may beconditioned to rely on the pathway rather than excercise their own judgement. Emphasise that there will be no penalties to the practitioner if the pathway is overridden.
Dentist	More time needed between patients, extra staff to support the dentist and hence patient, for ever increasing

Respondent type	Response
	regulation, litigation and protocols that follow. Evidence based seminars free for every dentist to follow re risk based approach. Increased public knowledge.
Dentist	The clinician should not need any encouragement for that, but it will be good instead of green amber and red to have a point score system. 0-100, 0-35 green,36-70 amber,70-100 red. All the ambers or green cannot be the same!
Dentist	Don't regulate every decision that we make. Less 'Big Brother' is watching.
Dentist	If you recognise the considerable effort that the vast majority of practices currently provide within the restrictive confines of the current system then you would know that clinicians will readily engage with a system that recognises them fairly for doing what is needed and what they were taught at dental school. The bottom line is pay dentists fairly and be honest about what you expect. In addition you need to be honest with the public about what you can afford and also drive the issue of patients taking ownership of their own health which whilst it is mentioned receives scant recognition in reality.
Dentist	Indemnify them against legal action.

Paper 2: The Clinical Philosophy

Responses to Question 7

Can you see any reasons why the preventive pathway approach described in this paper would pose difficulties in meeting the needs of any particular patient group?

NB Respondents answering yes were able to identify what they felt to be issues for particular patients groups, and to suggest solutions

Respondent type	Response	Patient Group	Issue	Solution
Dentist	Yes	Lower socio economic groups and those with 'difficult' lives	They have better things to worry about.	Leave them alone to get along with their lives
Dentist	Yes	The elderly with restricted access to primary care	access and appropriate care	Greater engagement with the care providers and also encouragement of domiciliary contracts that are fit for purpose
Dentist	Yes	Patients in lower socio-economic groups	Money/time/willingness to change	?
Dentist	Yes	Immigrants who cannot read or speak good English	Understanding	Translation options
Dentist	Yes	Patients with complex social background	Not nitrated for their oral health	Specialist centres for referrals, not only hospitals
Dentist	Yes			
Dentist	Yes	I treat patients who have high treatment needs due to oral health being a low priority in their lives.	They are unlikely to change their habits in the short term	Allow years of gentle persuasion for change, improve their socio-economic status.
Dentist	Yes	irregular attenders	possibility maybe refused complex treatment i.e. endo/crown	override the pathway system?
Dentist	No			
Dentist	Yes	Irregular attenders who only	No interest in prevention	None

Respondent type	Response	Patient Group	Issue	Solution
		want urgent care		
Dentist	Yes	Elderly	Used to having 6 month recalls since 1948	Education
Dentist	Yes	People with high levels of existing disease	They want their fillings done even if their smoking related periodontal disease is active	Refer them to the department of health
Dentist	Yes	Those that demand/expect a "right" to all the NHS offers but fail to take personal responsibility.	Will demand treatment and blame the professional.	Spell it out "DoH" will not pay for treatment if responsibilities not met (Computer Says No????)
Dentist	Yes	Patients who wish to be seen more regularly than NICE suggests.	Feel they are being neglected by profession	Allow 6 monthly checks but maybe pay at enhanced rate or accept private alternative
Dentist	Yes	Minority ethic groups	Language and communication	Muti-lingual clinical staff, Translation services Free of charge to pt and practice or they wont be used.
Dentist	Yes	Minority ethnic groups	cultural barriers to accessing routine dental treatment	Education
Dentist	Yes	Hard working families/School children	Time. The pathway and preventive approach requires additional time and appointments which employers and schools are not willing to provide	Extended hours. Stop school penalising school children attending health care appointment speak to Michael Gove about this.
Dentist	Yes	Learning impaired/ special needs	Access, understanding abilty to comply and reliance on carers	Educating carers, out reach to care homes, training of carers
Dentist	No			
Dentist	Yes	any patient	any person can be demanding or expecting a certain type of dental care, hence places the dentist in a difficulty of meeting pt's demands versus clinical need versus minimizing risks.	more clinical freedom for the dentist

Respondent type	Response	Patient Group	Issue	Solution
Dentist	Yes			
Dentist	Yes	limited english	patients unable to fully appreciate a preventative message.	
Dentist	Yes	Individuals unwilling to make the extra effort	lack of patient motivation	limiting treatment options.
Dentist	Yes	irregular attenders	only attend with problems	
Dentist	Yes			
Academic	No			
Dentist	Yes	patients requiring care givers to come to appointments	the increased initial appointment times may make it difficult for the carer to come too. e.g. care homes don't have unlimited staff to take clients to long appointments	good information explaining why this is beneficial will help but not solve the problem
Dentist	Yes	patients who don't wish to change behaviour.	a prevention based approach requires patients to modify their behaviour and some are very anti that idea and occasionally even cease to engage with dentistry due to efforts to modify behaviour.	having clear information for patients available to reduce the dentists fear of being sued when the patient doesn't receive the treatment they want on the basis of the fact that they haven't changed their behaviour.
Dentist	Yes	patients who have aggressive forms of a disease	patients who have followed all the preventative advice and yet still get disease need to be rewarded and not penalised	make sure this is built into the system
Dentist	Yes			
Dentist	No			
Dentist	Yes	All of them	Everything	Don't implement this system
Dentist	Yes	High needs; poor understanding of self care despite attempts by dental practice.	Often low income families unable or not prioritising income to what is necessary for health	Community care and free brushes toothpaste?
Dentist	Yes	Child neglect cases	Lack social care support	Oversight by community service

Respondent type	Response	Patient Group	Issue	Solution
Dentist	Yes	Disabled/in care	Ignorance of carers	More education in that sector or goverment advertising to bring patients to surgeries or increased domicillary service
Dentist	Yes			
Dental Software supplier	Yes	poorly educated	motivation and understanding	not enough space here but may be a proper education!
Dentist	Yes	elderly	patient expectations not aligned with preventive philosophy	focus preventive advice on carers
Dentist	Yes	anxious patients	care not possible without sedation	contract sedation services
Dentist	Yes			
Dental Professional	Yes	Anxious Healthy Children	Anxious children need regular visits even if they are clinically healthy to build up their confidence and familiarisation	Assess for comfort level in having assessment
Dental Professional	Yes	Children generally	Time passes very slowly for healthy mouths a gap of a year could mean a completely different family circumstance and horrendous deterioration due to changed habits	
Dental Professional	Yes	Neglected children	If a childs parent was told that a year was fine in between visits this may then easily slip to more than a suitable time	Maximum of 6 months between visits for children.
Dental Professional	Yes	Teenagers	Often very varied intake of foods through this period with dietary fads which need to be caught early.	Maximum 6 months between visits for children
Dental Professional	Yes	Elderly	Onset of physical disabilities and or loss of mental capacity at the start of 2 year period before next check	Make 6 months the minimum time between visits

Respondent type	Response	Patient Group	Issue	Solution
			up could be disastrous	
Academic	Yes	Irregular attenders with high disease levels.	As above. Simply uninterested or decline assistance.	Non-capitation-based remuneration for those who decline to participate in prevention.
Dentist	Yes	They don't have a name	They don't want health, they just want treatment	Education
Dentist	Yes	Methadone addicts	Massive caries rate that will not be defeated by OHI	Allowing conservative intervention when needed
Dentist	Yes	Elderly	Poor OH due to lack of vision/manual dexterity	A NATIONAL campaign on the dangers of sugar and the benefits of effective OH
Dentist	Yes	Children	More dentists will leave the NHS if you cut the money, most likely the more competent ones that are left.	Children should have their care prioritised over non so vulnerable groups
Dentist	Yes			
Dentist	Yes	new foreign arrivals who can't understand or speak English	impossible task	spend too much money on arranging translators to accompany them to dental visits
Dentist	Yes			
Dentist	No			
Dentist	No			
Dentist	No			
Trainee Dentists	Yes	Care home residents / Those cared for by others	Getting preventative messages to be consistently heard and understood by varying care teams.	Broader based approach. Contracts with care homes rather than individual patients, changing responsibility to the care homes themselves.
Trainee Dentists	Yes			
Dentist	Yes	Lower socio-economic groups	In my experience these groups engage less with preventative approaches, they attend with a problem and want it fixing. Even when attending regularly they often	National education

Respondent type	Response	Patient Group	Issue	Solution
			show little interest in changing lifestyle	
Dentist	Yes	Those with access (mobility) issues	These people who may be at high risk of caries/perio could have issues being seen more regularly. If there is no provision of dentures (for example) until risk reduces then they may never manage this when functionally it is necessary.	Remuneration must be flexible to the needs of high risk groups
Dentist	Yes			
Community dental service	No			
Dentist	Yes	Patients who don't wish to engage at any level	Not willing to communicate	Get rid
Dentist	Yes	lower socioeconomic groups, older people,	due to lack of understanding and refusal to accept constructive advice and regarding sweets as a treat for their children after they had a tooth extracted due to caries	more media, public posters and public education and compulsory oral health education in the schools
Dentist	Yes	people with physical or mental difficulties		better education and training of the carers
Dentist	Yes			
Community dental service	Yes			
Community dental service	Yes			
Dentist	No			
Community dental service	Yes			
Community dental service	Yes			

Respondent type	Response	Patient Group	Issue	Solution
Dentist	Yes	Teenagers	Bad Habits, lack of knowledge, awareness	Changing habits/behaviour
Dentist	Yes	Poor perio	advising them why treatment would be witheld	????
Dentist	Yes			
Community dental service	Yes			
Dentist	Yes	High caries	Refusing to return for regular recalls to motivate regarding diet and fluoride care. Lack of income of patient.	Good balance patient charging. Advertising in practice and national media.
Dentist	Yes	High perio needs	Similar to above	
Dentist	Yes	Low needs	Older age groups who want crowns etc who do not need them but expect social health service to provide as a right	Standardise NHS service as currently if I refuse a crown on basis of not necessary the patient either complains and/or goes elsewhere.
Dentist	Yes			
Dentist	Yes	The elderly	Understanding the new arrangements, Failing to conform to algorithm requirements	Sympathy and support where possible
Dentist	Yes	Young families in lower socio-economic groups	cost of healthy eating as advised by healthcare professionals	Sympathy and support where possible
Dentist	Yes	Middle aged patients with significant dental breakdown	Insufficient resources made available to restore full function	Sympathy and support where possible
Dentist	Yes	irregular attenders	attend irregularly	core service only
Dentist	Yes	drug users	see above	
Dentist	Yes	elderly	see above	
Dentist	Yes	children	see above	
Dentist	Yes	special needs	see above	
Dentist	Yes	adults with reduced mental	unable to attend regularly and	allow a treatment based approach for these

Respondent type	Response	Patient Group	Issue	Solution
		capacity	exercise good preventive care	groups?
Community dental service	Yes	Special care atients	Often not responsible for own oral care	Formatted oral care plan for inclusion in patients overall care plan if in residential care etc.
Community dental service	Yes			
Community dental service	Yes	Children	Primary Care Clinicians in CDS have input into DGHs	Need to employ Paediatric dentists in DGHs like orthodontists
Dentist	Yes	Travellers	Not being around for long enough	Fire fighting is all we can hope to do!
Dentist	Yes	The un engaged	Just not interested	More firefighting, it is all they want.
Dentist	No			
Dentist	No			
Community dental service	Yes	patients that rely on a third party for prevention e,g, residential units, elderly , learning difficulties	changing views attitudes of carers etc	education...this has been a longstanding problem
Community dental service	Yes	young children	presenting late with advnced decay wherby active comprehensive care is needed, can be very difficulkt to change the attitudes of family etc	education, ative engagement withe the community and joint-up care with other healthcare workers e.g. health visitors
Community dental service	Yes	looked after children	accessing care, especially if in temp placements and moved alot	prioritizing their care
Community dental service	Yes	early onset Dementia	families already coping with alot, suddenly having to provide oral care and patients can be very challenging	support?
Community dental service	Yes	patients adlut and children with complex medical conditions	providing care is complex and often needs a multidiciplinary approach, difficulty accessing this care e.g. actual location of where to travel to	to conside the expansion fo specialist services to meet the needs of this and all the above groups whereby access to conventional dental care is difficult.

Respondent type	Response	Patient Group	Issue	Solution
Dentist	Yes	irregular attenders.	These patients have never engaged with dentists and whether you operate a patient pathway or not this will continue to be the case.	I have no idea
Dentist	No			
Dentist	Yes	Those unwilling or unable to accept the pathway approach	The pathways require the actice aceptance and participation of patients and/ot carers.	Training of professional carers, other groups may be intractable
Dentist	Yes	Thise who have high treatments needs but are resistent to the preventive message		
Dentist	Yes			
Dentist	Yes	The poorly motivated	See Q5	Difficult, maybe GDP's could be salaried like GP's so they get paid even if people FTA or if some treatments/patients needs are more complex/time consuming than others. Then adequate times can be set for each scenario with no chance of treatment choices being compromised due to remuneration issues.
Dentist	Yes			
Dentist	No			
Dental Local Professional Network	Yes	In theory the Special Needs patients should benefit from this approach, but may be denied some treatments due to having Amber RAG ratings which might actually assist them maintaining oral function in the future. Eg crowns. Some patients only		

Respondent type	Response	Patient Group	Issue	Solution
		attend when they have a problem or are in pain and are not interested in engaging in long-term treatment plans. Allowance needs to be made for this group.		
Dental Local Professional Network	Yes			
Community dental service	Yes	People with learning difficulties	Much more challenging. Frequently require work with carers and care organisaitons. Multiple agencies frequently involved	Require additional time and much work outside of clinical environment if to be done properly. Weighted system. Salaried dental services
Community dental service	Yes	People in Nursing Homes	Require domiciliary care, need to work with carers and care organisations. Need systems in place to work with homes effectively	Use of care plans, carers and care organisaitons required to have training of staff in oral health care. Domiciliary visits. Weighted system and Salaried dental services
Community dental service	Yes	People with dental phobias and pre-co-operative children	Access sporadic and require a lot of additional resources and range of approaches including behavioural approaches, hypnosis, CBT, sedation etc etc.	require a lot of additional resources and range of approaches including behavioural approaches, hypnosis, CBT, sedation etc etc.
Community dental service	Yes	Peoplewith high levels of oral health needs and with high levels of social and material deprivation. At an extreme this would include homeless people	Inadequate resources to focus and prioritise oral health whilst coping with other needs	Multi-agency approach. Weighted system and salaraied dental services
Community dental service	Yes	People with physical or mental health difficulties	Difficult access. Difficult compliance. Support required for general and oral health needs	Weighted system and salaried dental services

Respondent type	Response	Patient Group	Issue	Solution
Community dental service	Yes	learning disability patients	communication, financial information, medical history, poor carer support. access.	
Community dental service	Yes	Housebound	access to comprehensive care/diagnostics. inability to maintain an oral health regimen, limited dietary choices	increase or redirect resources.
Community dental service	Yes	pre-co-opertive children	rampant caries at first assessment, having a GA for extractions, not returning for education/prevention	promote outreach schemes eg childsmile fluoridation
Dentist	Yes	low socio- econmic	absences, irregular attendance	education, needs and understanding
Dentist	Yes	multiple teeth loss due to perio and caries	managing demands of the patients by their priorities or clinical priorities	educating and giving options available
Dentist	Yes			
Dentist	No			
Dentist	Yes	patients who don t comply	poor complying	to try harder however perhaps resources can be directed more resposbly
Dentist	Yes	smokers	detioration in oral health	referal for cessation however even though children have been taught the heath impacts still people chose to commence shoking
Dentist	Yes	Special needs	capability to part take in oral health responsility	
Dentist	Yes			
Dentist	Yes			
n/a	Yes	It would not meet the needs of the population not attending on a regular basis or not attending at all.		Fluoride vanish application in line with Delivering Better Oral Health should be mandated for all patients. Innovative contracting with hard to reach groups where there is evidence from local health equity audits showing these groups access

Respondent type	Response	Patient Group	Issue	Solution
				services less in partnership with PHE.
n/a	Yes	Studies have suggested that health education widens the health inequalities gap so people with the greatest need would be less likely to benefit.		Fluoride vanish application in line with Delivering Better Oral Health should be mandated for all patients. Innovative contracting with hard to reach groups where there is evidence from local health equity audits showing these groups access services less in partnership with PHE.
n/a	Yes			
Dentist	Yes	high risk	patients may not carry out the preventative advice given	unsure
Dentist	Yes			
Dentist	Yes	heavily restored dentitions	patients in this group do need examining more frequently	Reduce suggested recall interval
Dentist	Yes	Young adults	At OHA may be caries free. However, this age group ar`e prone to 'sugary' diets - coke/energy drinks etc.	Reduce suggested recall interval
Dentist	Yes	Families	Families do not like being split up with respect to different recall intervals	
Dentist	Yes	people with need of high complexity treatment	we have no provision locally to refer for specialist treatment	by clearly defining what complexities of treatment are available to patients and providing only that which is realistically affordable in the current budget.see proposal below which outlines one way of doing this ;A proposal to define the scope of care provided by NHS dentistry Introduction The Department of Health (DoH) has never produced meaningful guidance to detail what treatments should be provided to NHS dental patients. NHS dentists are told they

Respondent type	Response	Patient Group	Issue	Solution
				should provide all that is clinically necessary but this expression is open to hugely varying interpretations, which constantly change with time, rendering it of little use to dentists as a guide. NHS dentists work with the uncertainty of no consensus within the profession as to what complexity of care the NHS should provide whilst patients have ever increasing treatment expectations. To err on the side of caution and to avoid conflict with patients and regulators, dentists are driven to perform treatment above and beyond that for which they are being paid. This pressure on dentists significantly increases their stress and as a consequence compromises the quality of patient care. The burden on NHS dentists perform more than they fairly should is made worse by the NHS Choices web site, which misleads the public to believe they are entitled to more than dentists can properly provide within the GDS budget. By declaring on the site if your dentist says you need a particular type of treatment, you should not be asked to pay for it privately. Your dentist is not allowed to refuse you any treatment available on the NHS, but then offer the same treatment privately. Also, any treatment provided on the NHS has to be of the same high quality as treatments provided privately. The failure of the DoH to be open about what NHS dentistry can realistically provide will be perpetuated in the reformed contract unless the profession acts now. This document is a

Respondent type	Response	Patient Group	Issue	Solution
				proposal to resolve the ambiguity around what exactly NHS dentists are contracted to provide. It outlines a solution using resources produced by the DoH. It clearly defines what a patient should expect from NHS dentistry and spells out what it is fair to ask a dentist to provide within the GDS contract. Furthermore it fully supports the call to action from the DoH to secure and improve high quality services in the face of demographic pressures and rising public expectations against a backdrop of financial constraint. The Standard Dental Services Contract The lack of transparency around what should be provided by the NHS is not made any clearer by the Standard Dental Services Contract which tells dentists they are contracted to provide mandatory services. The contract also tells dentists they are not contracted to provide advanced mandatory services which by virtue of the high level of facilities, experience or expertise required in respect of a particular patient, the service is provided as a referral service;. The line between mandatory and advanced mandatory is ill-defined and relies on the variable definition of a high level. Dentists abilities contrast widely between individuals and throughout their careers, a high level for one dentist will not be the same as another and the point at which treatment becomes advanced is indistinct. Another cause for dentists to feel pressurised to provide treatment theyre not

Respondent type	Response	Patient Group	Issue	Solution
				contracted to carry out is the inadequacy of provision of referral services for advanced mandatory services. In Northamptonshire for example dentists have access to a restorative consultant for only one day per month and this service is for clinical opinion only, not to carry out the treatment. Rising patient expectations. Patients are told by NHS Choices web site; You're entitled to have all clinically necessary treatment on the NHS. This means that the NHS will provide any treatment that you need to keep your mouth, teeth and gums healthy and free of pain. This includes: dentures root canal treatment crowns and bridges any preventive treatment needed, such as a scale and polish, an appointment with the dental hygienist, fluoride varnish or fissure sealants white fillings orthodontics for under-18s NHS Choices is wrongly interpreted by many patients as them being entitled to anything they choose because the DoH does not define clinically necessary. NHS Choices creates a mismatch between what patients expect and what NHS dentists are able to provide. Patients who have been lead to believe they should be able to have any treatment will logically feel aggrieved if this is not offered to them. If a dentist has a different view to the patient of what is clinically necessary there is no clear guidance to justify their decision. Patients increasingly demand written explanations, which frequently disrupt the working day of a

Respondent type	Response	Patient Group	Issue	Solution
				NHS dentist and create disputes that are unpleasant and stressful for all concerned. This unremitting pressure on dentists significantly affects their well being and it has been cited as the reason for many dentists leaving the NHS. Contrary to accusations that NHS Dentists take advantage of the lack of clarity in the current contract to underperform, most dentists strive to provide the best possible service they can to meet their patients expectations. Frustratingly however, it is not possible within NHS budgets to provide the level of treatment that patients increasingly request. Dentists who attempt to do so risk failing to meet their UDA targets and the reward they would get for their efforts would be a cut in their funding. As well as having higher expectations, patients are more willing than ever to complain and this is set to continue. In 2014 Bill Moyes, chair of General Dental Council (GDC) said; The volume of patients complaints about poor dentistry is likely to increase. Service users will become increasingly consumerist in their outlook many already are - and so the pressure will not lessen for services to be designed around the needs of patients and for care to be delivered in ways that patients are happy with. For patients to be happy with the service they receive they need to know from the outset what that service (the NHS) is prepared to provide. This proposal is a way forward for Dental Contract Reform In the

Respondent type	Response	Patient Group	Issue	Solution
				Dental Contract Reform Engagement Papers dentists are told that the aim is to standardise best practice for all patients and; 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. For provision to be consistent a NHS-wide definition of what NHS dentistry will provide is essential. Without this, contract reform will worsen the position of NHS dentists because the DoH envisage that as in the pilots, practices will in the future be remunerated based on their relative performance against the DQOF. NHS dentists will be measured against outcome indicators including; 1. Patient experience - assessing the views of patients on their experience of care provided. 2. A patient being in good oral health by which it is meant; they are free from pain they have a good functionality and aesthetic form to their teeth- they can eat speak and socialise they have clinically assessed good oral health and we are confident that this will continue in the future For dentists to perform well against measures of patient experience, it is essential that from the outset of their treatment patients have realistic expectations of what is available. If dentists are to standardize best practice and produce clinically assessed good oral health these terms have to be transparently defined in a

Respondent type	Response	Patient Group	Issue	Solution
				way that dentists and regulators can refer to. Resources already exist to clearly define what NHS Dentistry should provide The Department of Health in the report by the Information Centre for Health and Social Care entitled Oral health and function- a report from the Adult Dental Health Survey 20091 provides us with a clear and evidence based definition of excellent oral health prospects. It states; ..it is possible to combine several clinical measures to identify those adults with the best current health. As a minimum these are dentate adults with enough teeth to function, a large majority of these teeth sound and untreated, and with no active decay or periodontal disease. This measure of excellent oral health prospects comprised people who met all of the following criteria: 21 or more natural teeth; 18 or more sound and untreated teeth and roots; no decay detected at any site; no periodontal pocketing of 4mm or more and no loss of attachment of 4mm or more; no calculus or bleeding. The retention of 21 or more natural teeth is widely used to define the minimum number of teeth consistent with a functional dentition for most people While this figure may be viewed as arbitrary, there is evidence to indicate that 21 or more natural teeth enable most dentate individuals to eat what they want in comfort without the need for a removable partial denture In addition to the definition of excellent oral health another document exists, the

Respondent type	Response	Patient Group	Issue	Solution
				production of which was funded by the Department of Health and administered through the Clinical Effectiveness Committee of the Royal College of Surgeons of England. The document is the Restorative Dentistry Index of Treatment Need and it can be found by pasting the following address into your web browser; http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/complexityassessment.pdf; The Restorative Dentistry Index of Treatment Need is a complexity assessment for the four aspects of restorative treatment; periodontal treatment, root canal treatment, fixed prosthodontics and removable prosthodontics. It provides a simple way of categorising the complexity of a patients restorative treatment need and provides a measure comprising 3 levels of complexity i.e. complexities 1,2 and 3 with complexity 1 being the least complex. The proposal This paper proposes that the DoH state what treatments NHS dentists are contracted to provide using the process described below. When a treatment plan for a NHS patient potentially involves periodontal treatment, root canal treatment, fixed prosthodontics or removable prosthodontics the dentist can use as references the Restorative Dentistry Index of Treatment Need in conjunction with the measure of excellent oral health prospects in their decision making process.

Respondent type	Response	Patient Group	Issue	Solution
				Deciding whether a treatment is available on the NHS will be very simple and is explained here and also illustrated in an algorithm; How to determine if a dental treatment is available on NHS 1. The NHS will continue to provide all patients with guidance and support to achieve and maintain excellent oral health. All patients should be free of pain, have good functionality and aesthetic form to their teeth and be able to eat speak and socialise. 2. If, to reach oral health as described above a patient requires any periodontal treatment, root canal treatment, fixed prosthodontics or removable prosthodontics and that treatment is at complexity level 1 it is available to the patient under the NHS and in General Dental Practice. (Irrespective of the number of teeth the patient already has). 3. If treatment is at complexity level 2 or 3 and that treatment is required for the patient to achieve excellent oral health it should be offered on the NHS as advanced mandatory treatment and a referral service should be provided for this. 4. If treatment is at complexity level 2 or 3 and is not required for the patient to achieve excellent oral health, that treatment is not available on the NHS and an alternative treatment plan has to be offered. In this case the patient can elect to have the treatment carried out privately in General Dental Practice by the same dentist if that dentist has the appropriate skills to do it. The algorithm

Respondent type	Response	Patient Group	Issue	Solution
				illustrating the decision making process is shown below; How this is different from what currently exists and how it will secure and improve high quality services in the face of demographic pressures and rising public expectations against a backdrop of financial constraint? It will provide NHS dentists with a clear guidance on the level of care they are contracted to provide It will explain to dental patients the evidence for the level of treatment the NHS will provide for them It will focus resources on treatment required to achieve excellent oral health by eliminating treatment that is not necessary to achieve this aim General Dental Practice and Restorative Referral Services will be freed from spending time and resources on the treatment of diseased teeth that are not necessary to achieve excellent oral health. It will free up time and finance to increase dental access to those most in need It will not require any additional investment in NHS dental services. References 1. http://www.dhsspsni.gov.uk/theme1_oralhealthandfunction.pdf 2. http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/complexityassessment.pdf (These are not hyperlinks you need to cut and paste them into your browser)
Dentist	Yes			
Dentist	No			

Respondent type	Response	Patient Group	Issue	Solution
Dentist	Yes	Special needs	Reliant on carers . Complex medical history .More difficult to communicate and motivate	Different ways of communicating care pathway eg pictorial . Use of visual aids
Dentist	Yes	Patients who have no English	Communication engagement and consent	Interpreters needed
Dentist	Yes	Patients in areas of high deprivation	Motivating attendance except as emergencies	Public health campaign via other health care professionals .
Dentist	Yes			
Dental software supplier	Yes	Children	Getting kids to follow a simple teeth cleaning regime is hard enough as it is.	A more child friendly CarePlan might help (could be linked to online interactive teaching aids etc)
Dental software supplier	Yes	Elderly	Not sure where this age group, with a life time of remedial treatment, would embrace the pathway.	Make sure connections are clearly made between oral health and more general health issues - so again eduvation products would help.
National Body	Yes	This pathway is ideal for dealing with caries free children but becomes more complex with more clinically challenging oral disease experience. Patients with specific medical conditions may be more difficult to manage, for example, non-quitting smokers, some diabetics, some learning difficulty patients will require more prolonged periodontal care than healthier ones to achieve similar health results. This may also be true of the restorative needs of those with eating disorders such as		

Respondent type	Response	Patient Group	Issue	Solution
		bulimia and anorexia nervosa.		
Local professional network	Yes	Learning difficulties	May have difficulty achieving sufficient level of oral health to enabkle them to progress with treatment	
Local professional network	Yes	Seldom Heard	No address = no treatment as cannot register for treatment without an address	Outreach Teams
Local professional network	Yes	Physically disabled	May have difficulty achieving sufficient level of oral health to progress with treatment	
National organisation	Yes	Those with cognitive or communication issues	Ability to understand questions relating to medical and social history	Availability of questions in different languages/different cognitive levels
National organisation	Yes	Those with particular religious beliefs	Relucatnce to accept application of fluordie varnishes containing alcohol	Research into the development of varnishes which do not contain alcohol
National organisation	Yes	Patients receiving care at home or in residential accommodation	Compliance issues with equipment and materials	Introduction of 3G compliant devices enabling remote working
Local professional network	Yes			
Dentist	No			
Dentist	Yes	Under 6 year olds	We don't always have enough cooperation to enter all the details and then check the teeth (as it can become very time consuming to do both).	Pathways need to be as quick as possible for these groups - and possibly focused more on those with active/history of disease
Dentist	Yes	Edentulous or less than 3 teeth in arch	Pathways are usually irrelevant for most of these groups	Remove pathways for these groups

Respondent type	Response	Patient Group	Issue	Solution
Dentist	No			
Dentist	Yes	over40s heavily restored mouths with good oh + diet now	does the system allow sufficient funding to provide them with ongoing restorative care	not just a capitationbased preventive system maybe fee per item for restorative work done
Dentist	Yes	eldery in care home house bound	need restorative care difficulty in improving oh etc due to medical conditions so ? if they would be eligible for restorative care because not improved on rag rating system	
Dentist	Yes			
Dentist	Yes	irregular attenders / high needs /	dont come back / it takes too long for them	allow pathway to be re entered at any time with interim payments
National Body	Yes	Patients who rely on others to attend dental practice	Difficulty in compliance if they require support to attend appointments	
Dental Local Professional Network	Yes	Patients with learning disabilities, a physical disability or have a language barrier	May have problems achieving a sufficient level of oral health to enable them to progress with treatment.	
Dental Local Professional Network	Yes	The seldom seen groups such as the homeless, drug users or sex workers	May find the system disenfranchises them.	Having an outreach system run by dental nurses, integrating into the Harm Reduction Teams run by NHS England and Local Authorities have been attempted in some small scale pilots.
Dental Local Professional Network	Yes	Older people in care homes (or their own homes)	as a result of their being less mobile and unable to attend a dentist or their carers not recognising the continued importance of oral health. Older adults in nursing homes are often unable to address their own oral	

Respondent type	Response	Patient Group	Issue	Solution
			health care and therefore have to depend on nurses, nurse assistants or care assistants to do this for them.	
National Association	Yes	Elderly, infirm, isolated and those in residential and other special care environments and care home environments.	Patients accessing community dental services, some of whom have very complex needs, may be unable to participate in the pathway but should still benefit from the clinical philosophy.	Ensure provision of adequate funding and ensure that enough flexibility is afforded to accommodate disparate care needs.
National Association	Yes	Patients with existing health conditions that could impact on their oral health.	Health complications impeding self-care and access to dental services.	Ensure provision of adequate funding and ensure that enough flexibility is afforded to accommodate disparate care needs.
National Body	Yes	The [redacted] as a provider of secondary dental care cannot comment on this question as the contract under discussion is within primary care. However the team can envisage that several vulnerable groups of patients might not have their needs met through the clinical pathway as outlined in the paper. The undergraduates have limited exposure to patients with high dental needs and little exposure to patients with dementia or other special needs however the basic principles of care for all groups of patients is taught within the curriculum and how		The secondary care sector with an academic environment are well placed to cater for the educational needs of a primary care dentist who may lack experience in adapting care plans for patients with special needs.

Respondent type	Response	Patient Group	Issue	Solution
		care plans need to be adapted for those with special needs.		
National Body	Yes	We know very little about the involvement of children and young people in the national pilots, indeed there is no mention of the Paediatric Dental Care Pathway in Figure 1. It is important to establish how this preventive pathway will interact with the Paediatric Dental Care Pathway to ensure all children and young people, but especially those with additional needs such as patients with clefts, significant medical histories or learning delay, are well supported and cared for.		[redacted] would be delighted if the DH would share the data from the national pilots concerning children and young people with us so that we can lend our expertise as to how the preventive pathway should be tailored to meet the additional needs of children and young people.
Dentist	Yes	Patients whose oral health needs dramatically change over a short period of time.	Such patients can be missed as they previously appeared to have low risk and thus were prescribed preventative measures and recalls reflecting this low risk. Any change which could lead to rapid deterioration and increased risk could potentially have severe negative effects unbeknown to both the patient and clinician in the intervening period between recall visits, since these were previously	Possible solution possibly identify all low risk patients with recalls of over 1 year to have a more basic recall with either dentist or hygienist/therapist for a "basic" recall where a full examination is not carried out, rather a pointed examination to simply check for those areas which could deteriorate rapidly with severe consequences e.g. oral cancer, onset of aggressive periodontal disease in younger patients, identification of general health issues which could alter the risk profile.

Respondent type	Response	Patient Group	Issue	Solution
			based on a low risk situation. A mechanism which ensures identification of such cases should be incorporated into the pathways approach.	
Dentist	Yes	Infrequent attendees who do not wish to engage with a preventative approach	Ensuring that effective treatment is offered to this group without providing artificial barriers for accessing care	Possible solution incorporation of the urgent and occasional pathways being used in the pilots to ensure that easy access is offered to infrequent attenders whilst encouraging future participation in a preventative approach. Care will need to be taken to ensure that this does not lead to perverse incentives by not offering these options to patients if the use of these pathways is measured for DQOF.
Dentist	Yes	New patients with high treatment needs	a capitation model potentially rewards under-treatment this is evidenced in some private capitation schemes. It also has the danger that high risk patients with most need could be excluded from treatment. Current DQOF may also discriminate against high risk patients who at OHR require further extensive treatment	An output measure of treatment activity combined with quality measures sensitive to the needs of high risk patients could help to combat these problems.
Dentist	Yes	Advanced wear cases	Requiring multiple restorations and maintenance.	Have these patients independently assessed an give them a higher tariff or one off payment to treat.
Dentist	Yes	Elderly patients	resistant to change, attendance difficulties, accessibility, ability to implement required actions -e.g. home care hygien	Communication, skill mix, outreach to care homes, education of care home staff
Dentist	Yes	Groups with Learning/	comprehension, ability to take	Education of carers/responsible individuals,

Respondent type	Response	Patient Group	Issue	Solution
		communication difficulties	ownership of care,	skill mix and dental resource, intepreters
Dentist	Yes	socially deprived groups, especially children	affordability of homecare products, ability to change diet habits through potential expense	support with educational aids and also provision of toothpastes etc
Local professional network	Yes	Pt s who relie on carers	getting advice to carers	Training
Local professional network	Yes	Elderly	not wanting to accept change	
Dental Professional	Yes	elderly, sick, specila needs	This pathway still requires the patient to come to the surgery. There should huge portions of our society being dentally neglected through no fault of their own. The pathway must access these people too.	utilise the skill mix, allow for Hygienists and therapists to open and close treatment
Dental Professional	Yes			Encourage dental practices to attend local care homes even 1 day a month. Make it part of the DQOF.
National Body				
Dentist	Yes	Patients requiring simple, but extensive dental treatment under guidance from a specialist/consultant	Patients under the care of specialist teams may only need a small proportion of their care provided directly by specialist teams and can have the remainder of their care provided by a local dental practice just as effectively. However if the contract does not make this finically viable, then such patients will be forced to have all their care carried out by specialist	The new contracts should allow for effective shared care arrangements to be contracted for so that where appropriate, a proportion of specialist treatment plans can be delivered by practices working to the prescription of specialist services.

Respondent type	Response	Patient Group	Issue	Solution
			teams at greater cost to the NHS and with the added costs of having to attend specialist units which may be at considerable distance to where the patients live.	
Dentist	Yes	Vulnerable groups	Vulnerable communities such as the homeless, substance misusers, children in the social care system often have straightforward clinical treatment needs but their particular social circumstances mean they are not cost effective to provide care for under a standard dental contract.	Commissioners must have the flexibility to fund practices to care for vulnerable communities. The alternative is that entirely separate services have to be established for vulnerable client groups. These are less cost effective than using existing resources in general dental practice to provide services, where the physical infrastructure already exists as well as the work force.
Dentist	Yes	Irregular attenders travelling communities.		Payment weightings based on the demographic of the areas that the dentists are working in.
Dentist	Yes	Demanding patients.		3 strikes rule Relating to attempts to educate and modify patient behaviour.
Dentist	Yes	Parents of patients with poor oral hygiene.		Payment weightings based on the demographic of the areas that the dentists are working in.
Dentist	Yes	Patients in care homes or prisons.		Payment weightings based on the demographic of the areas that the dentists are working in.
Dentist	Yes	Patients that need orthodontic treatment.		
National Association	Yes	Although not covered in detail in the document, we are of the view that the pathway approach has the potential to impact on the provision of	As discussed above, we are extremely concerned about the need for suitable testing of the pathway approach across a range of single handed practices,	We have concerns that the pathway approach may have the unintended consequence of widening inequalities in oral health for a number of reasons. Patients who access dental treatment only when they

Respondent type	Response	Patient Group	Issue	Solution
		treatment for some patients. The data at Annex A shows that there is positive movement towards an improvement in RAG status, but the [redacted] is concerned that individuals with a condition which can impact their oral health, such as diabetes, will be unable to access necessary treatment. It is essential, therefore, that guidance on the override function covers the provision of care that is in the patients best interests, despite what is prescribed by the software.	particularly those that serve rural communities and areas of high need. The development of standardised, best practice care may not be sufficiently flexible to accommodate the differing needs and wants of those accessing services, and it is vital that the programme has an understanding of how different communities adapt to this approach to provision.	are in pain and those who decide to opt out of the pathway may generate an increased inequalities gap as those who engage in the pathway see an improvement in their oral health. We are of the view that clinicians must be financially supported to deliver care to low-access, high-needs groups. Alongside this, domiciliary, prison and outreach services must be supported to deliver the pathway (even in a modified form) to ensure that we can be ambitious about the prospect of an overall improvement in oral health. The commencement of a prison-based pilot is, in our view, an essential step in the reform process. Such a pilot must take into account the inherent I.T. problems as it is vital that this patient group is not left behind in the reform.
National Association	Yes	Patients accessing Community Dental Services, some of whom have very complex needs, may be unable to participate in the pathway but should still benefit from the clinical philosophy. Similarly, an approach that is based on continuity of care with a degree of patient responsibility will be challenging for patients with a chaotic lifestyle e.g. homeless people, drug users and those with mental illness. With	We are hopeful that a move to prototype models in 2015 will facilitate the development of a clearer understanding of patient behaviour in a more live environment than is currently available in the pilots. Much of the success of the reforms will hinge on patient perception of the affordability of treatment, and we seek urgent clarification from the Department of Health on how patient charging will develop.	

Respondent type	Response	Patient Group	Issue	Solution
		regards to patients in care homes, we are of the view that every resident should have a written oral health plan that is communicated to all carers and forms a core part of the residents care. The [redacted] is part of the community dental services evaluation group and we hope to participate in further work on how the pathway should be modified for community dental service patients.		
National Body	No			
Local Dental Committee	Yes			Prevention of dental disease does not happen in dental practices. Whilst the promotion of good oral health may be imparted by the clinician and their team (even if it is not absorbed by the patient), patients do not prevent dental disease by turning up at a practice and, similarly, neither are dentists able to prevent dental disease by seeing patients for a few minutes in their surgeries. Prevention of patients dental disease happens each day, each month and each year, occurring as a result of the food they eat, the drinks they drink, the frequency with which they brush with fluoride toothpaste, and a host of other lifestyle factors, which are unique to each individual. We are concerned that a focus on

Respondent type	Response	Patient Group	Issue	Solution
				prevention, although highly laudable, is not an appropriate contractual metric to ensure the provision of good NHS dental treatment. Prevention and treatment must not be confused. We believe it is crucial that patients with long-term and chronic conditions are provided for under a system that focuses on the movement of patients through the red-amber-green (RAG) progression. Those patients with conditions likely to inhibit their progression to improved oral health must be provided for within a robust remuneration system.
Community dental service	Yes			
Dentist	Yes	Disabled	Access, poss dexterity, reliance on caters	Difficult to deal with within existing resources framework, may require more specialised approach poss within community
Dentist	Yes	Elderly	Learning new skills, dexterity, reliance on careers costs	Difficult to deal with within existing resources framework, may require more specialised approach poss within community
Dentist	Yes	Language and learning difficulties	Getting the message across, reliance on careers	Difficult to deal with within existing resources framework, may require more specialised approach poss within community
Dentist	Yes	Non motivated	Not motivated to buy into care pathway	Treat only as urgent while trying to convert

Paper 2: The Clinical Philosophy

Responses to Question 8

Are there better ways than those described of demonstrating oral health changes for community dental services patients?

NB Respondents answering “yes” were asked to describe their ideas and suggest any other need, outcome and/or risk factors that would be useful to incorporate.

Respondent type	Response	Additional comments
Dentist	No	
Community dental service	No	
National Body	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	CCDS dentists are a dedicated and often maligned group. They have specific skills and expertise in particular regarding Paediatric and Special Care Dentistry. The way should be trusting the CCDS to make sensible patient cantered judgements.
National Association	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	The ---- is working closely with the Department of Health to assess the progress of the pilots in the Community Dental Service. We are encouraged to hear that the three CDS pilot sites support the clinical philosophy of the pilots, but it is already clear that the approach which has been developed for general practice needs some considerable modification to be successful in the community dental service. It will also need to incorporate a degree of flexibility to reflect the range of medical needs and disabilities that some CDS patients have. The use of the RAG rating is perhaps the most challenging element of the pathway as, for many CDS patients, the priority is to prevent or delay deterioration, rather than to achieve improvement. Measures of success in the service might include overcoming patient fear and lack of cooperation, achieving a measure of compliance, and supporting patient lifestyle improvements including an improvement in sleeping and eating, and would represent much more robust indicators

Respondent type	Response	Additional comments
		than a focus on improvement in RAG score. We are of the view that the Casemix model should form a cornerstone of contractual reform for the community dental service, and we would be keen to explore an additional quality of life index.
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	The RAG approach is a good start, but it needs to be more flexible. It has been the experience of our local community dental services that they struggle to maintain many of their patients at Amber with little or no chance of moving them to £Green. In the opinion of our lead for community dental services that it is their job to keep them out of Red rather than get them to Green. It is very difficult to motivate patients who are disinterested or not willing to engage. There still needs to be some fine tuning of the RAG system that needs to be done to better reflect the oral health of the patient.
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	As per question 7, special care patients are no different in terms of adopting a risk based preventive approach and therefore should be managed within the same system. The only difference might be around managing expectations around what progress is likely to be achieved within this patient group. It is likely to the best outcome would be to manage risk and try to avoid deterioration instead of seeking dramatic improvements in oral health.
National Body	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	In order to demonstrate oral health changes for community dental services patients, validated disease specific quality of life tools should be used. Furthermore the World Health Organisation International Classification of Functioning, Disability and Oral Health, which is currently being developed, could help to measure functioning and disability, thereby helping to identify oral health changes.
Dental Professional	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	Each patient is assessed on their risk and needs and this will put many community patients in a higher needs category therefore they will need more time. Also it will depend on whether the patient will be rewarded by a goal oriented RAG score.
Local professional network	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	Monitor on service provided rather than changes. Monitor only those that should be monitored, it should be remembered that a lot of patients are referred to the community for one off courses of specialised treatment and not for continuing care that would allow a pathway approach to be applied. Deterioration rather than improvement may need to be monitored for special need groups. Clear identification under capitation system would be needed as these patients need more time and support.

Respondent type	Response	Additional comments
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	The system should allow community dental practices to work on a level playing field with and in some cases replace the community dental service in supporting high need/domiciliary based patients
Dentist		
Dentist		
National Body	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	Clearly, the needs of patients seen in the CDS are different from those seen in general dental practice, by virtue of their more challenging medical, dental or social needs. Clinical outcomes for these patients will broadly be the same as those in practice (in terms of reducing caries risk and improving gingival health) but there are other key indicators to demonstrate oral health change that may be specific to this group, such as reduction in prevalence/intervals of repeat general anaesthetics for dental treatment.
National Body	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	The [redacted] has no comment to make on this question as they do not manage community based services
National Association	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	We feel that the general practice approach will not be entirely suitable for the oral health needs of community dental services patients. A successful approach would incorporate a greater degree of flexibility in order to accommodate the range of medical needs and disabilities experienced in this sector.
Dental Local Professional Network	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	CDS patients are often only involved with the service for one course of treatment therefore measuring change in clinical indicators would be problematic. Patients with special needs may be a problem to measure change. CDS patients are often referred because of high disease levels therefore indicators based on e.g. dmft would need to be appropriate. Examining rates of decayed/missing or filled teeth would be a population level indicator ô this is already monitored for five year olds as part of the Public Health Outcomes Framework. It would be worth exploring extending this indicator to other particular age groups ô particularly older people. Any clinical indicators applied to CDS

Respondent type	Response	Additional comments
		patients need to take in to account the larger barriers to improving health present in many of these patients. This means that clinical improvements might be smaller than those seen in general practice patients following an equivalent preventive care pathway.
National Body	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	While the same overall approach to risk assessment should be adopted there may be some issues with regard to patient compliance for some patient groups treated and planning of the care pathway may need to be modified in some cases. For example there may be the need for acclimatisation appointments for anxious patients. There may be no consistent carer for the patient resulting in a lack of understanding of the patient needs. If the carer constantly changes which is often the case key information may be missing for dental appointments.
Dentist	No	
Dentist		
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	So me indication of disability data should be captured
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	I don't work in community clinics however in general practice we tend to look at plaque scores as a good indicator of oral health.
Dentist	No	
Local professional network	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	As per question 7, special care patients are no different in terms of adopting a risk based preventive approach and therefore should be managed within the same system. The only difference might be around managing expectations around what progress is likely to be achieved within this patient group. It is likely to the best outcome would be to manage risk and try to avoid deterioration instead of seeking dramatic improvements in oral health.
National organisation	If "Yes" (please describe below) and consider if there	For patients in residential accommodation or those with cognitive impairment or dementia: weight loss is frequently a function of masticatory ability/discomfort and

Respondent type	Response	Additional comments
	are any other need, outcome and/or risk factors that would be useful to incorporate?	information and advice to care workers is essential in this group
Local professional network	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	Any clinical indicators applied to CDS clients need to take into account the barriers to improving health many of these patients experience. Therefore clinical improvement may be smaller than in general population despite following a simlar preventive care pathway
National Body	No	
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	More process measures may be appropriate for patients reliant on others and unable to influence their own oral health. Patients with severe phobias may require cognitive behaviour therapy and behaviour shaping before being able to access care pathways .
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	The indicators used are sensible and to a degree measurable. The improvements generally were realistic and positive. The use of BPE is correct in terms of speed of data capture however it is well known that BPE is vulnerable to operator error. The statistics in the summary of improvements in periodontal health may support this view. This does not mean we should not use BPE it probably means we should pay more attention to sextant bleeding in conjunction with BPE.
Dentist		
Dentist	No	
Dentist	No	
n/a	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	Measure disease levels and impacts of oral conditions as current indicators are disease rather than health focused.
Dentist	If "Yes" (please describe	yes the services are different and should complement each other so although I am

Respondent type	Response	Additional comments
	below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	unsure as to how there should be differing ways of demonstrating changes
Dentist	No	
Dentist	No	
Community dental service	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	episodes of pain/emergency visits. Episodes of general anaesthetic/ sedation
Community dental service	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	Firstly it is important to have an additional weighting system to recognise the additional time and resources required to work with community dental service patients. The BDA weighting system widely adopted and currently used by the salaried Primary Care Dental Services is an example of such a weighting system. There is scope for it to be modified. However, that system does recognise the additional challenges faced in all areas of care and prevention and would need to be incorporated within contracts for the salaried community dental services. In addition as a salaried dental service, we work both with individuals and their carers and frequently with care organisations. Areas that we are working on to try to improve the oral health of these groups are to work with carers, care organisations and other health workers so that: 1) There are oral health care policies within care organisations 2) formal and informal carers are trained in oral health care of others 3) care organisations are encouraged to adopt healthier diet choices for their residents 4) Individuals have oral health care plans which carers, dentists, individuals and those with Lasting Power of Attorney are signed up to It may be feasible to use these as proxy measures of oral health (environments). E.g. proportion of residents with oral health care plans; proportions of carers trained in oral health; evidence of healthier diet choices within care homes, proportions of homes who have accepted training programmes in oral health care, etc. These would be in addition to individual based measures. At individual level, it may be necessary to accept that some oral health measures are not achievable to the highest levesl in many individuals within some groups. Many of these approaches could be greatly supported by taking a stick

Respondent type	Response	Additional comments
		approach rather than a carrot approach. E.gs. 1) making it mandatory for all residents in a care organisation to have an oral health care plan as part of their personal care plans 2) making it mandatory for carers to have training in oral health care of others 3) making it mandatory for care organisation to provide healthier food choices, low in sugars and reducing the frequency of sugar exposure
Dental Local Professional Network	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	We are not aware of any.
Dentist	No	
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	I don't know.
Dentist	No	
Dentist	No	
Dentist	No	
Community dental service	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	A more realistic approach
Dentist	No	
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to	No of patients requiring a longer recall intervals

Respondent type	Response	Additional comments
	incorporate?	
Dentist	No	
Community dental service	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	repeat GA statistics and urgent inter service audit needs introducing
Community dental service	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	Oral care plan in use by carers Regular dental checks attended
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	some cds clinics are for secondary care and entirely treatment based. eg sedation clinics
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	dmf scores
Dentist	No	
Dentist	No	
Community dental service	No	
Dentist		
Dentist	No	
Community dental		

Respondent type	Response	Additional comments
service		
Community dental service		
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	Ask the community dental services n/a to me
Community dental service		
Dentist		
Dentist	No	
Community dental service	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	I am not sure I think one approach would be good but reasonable adjustments would need to be made for particular vulnerable or complex groups
Dentist	No	
Trainee Dentists	No	
Dentist	No	
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	I believe we need to engage with the training of carers and care home providers to show how to brush teeth, the need for extra strength fluoride toothpaste and how to look after dentures. I believe we need to get into schools more to give oral health education to children. Not enough of this is being done.
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to	Yes

Respondent type	Response	Additional comments
	incorporate?	
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	A concerted national campaign, as seen in American States, combined with a national campaign based on the dangers of refined sugars. A 20% health tax on all products containing Fructose or High Fructose Corn Syrup, which could be SOLELY directed directly to an increase in peadiatric dental care
Academic	No	
Dental Software Supplier	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	pay general practice the proper rate
Dentist	No	
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	Have an awful lot more community dental clinics, with an awful lot more dentists in them.
Academic	No	
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	the original DMFT and perio indices are the most effective at demonstrating an imrpovement in oral health changes. thus why not use the same original indices that been tried and tested in the past
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to	Monitoring of disease rates amongst care home residents

Respondent type	Response	Additional comments
	incorporate?	
Dentist	No	
Dentist	No	
Dentist	No	
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	I do not know as I am not involved in this area
Dentist	No	
Dentist	No	
Dentist	If "Yes" (please describe below) and consider if there are any other need, outcome and/or risk factors that would be useful to incorporate?	DMFT scores, whilst it's a crude measure, it does show whether or not oral health is changing.
Dentist	No	

Paper 2: The Clinical Philosophy

Responses to Question 9

Are there any changes to the approach described that you think we should consider when using it with patients who rely on carers to maintain their oral health on a daily basis?

NB Respondents answering “yes” were able to make free text comments.

Respondent type	Response	Additional comments
Dentist	No	
National Body	Yes (please describe below)	Presumably this will be covered under a bespoke contract for the dentist overseeing the care home ô but key is training the carers how to look after their charges oral health and what to look out for.
National Association	Yes (please describe below)	Patients in residential care will not always have access to the same carer at consecutive appointments, so there may be an issue with continuity of care, and resources must be made available to all those who may be involved in the patients care. If it is home based, an easily accessed care plan, app or video would be helpful, and if it is residential, materials that can be stored centrally by the care home. We are also of the view that the National Vocational Qualification for carers must include a compulsory module on personal care (which includes oral health), rather than continuing with this an optional addition. The Department should take this opportunity to improve the situation regarding consent and charge exemption for patients who are accompanied by carers. We believe that there is also a need to clarify some perceived conflicts in the Mental Health Act in respect to carers role in oral health, as some have concerns that invading a patients mouth with a toothbrush may constitute assault. In parallel to reforms, steps must be taken to resolve some of the commissioning and resource issues that the community dental service faces: it cannot deliver this kind of care without investment in service infrastructure and ensuring that clinicians can spend as much time as possible in clinic and not on administrative duties. An increased number of pilot sites would be especially beneficial to assist in the analysis of the experiences of patients who rely on daily care, something which should form a specific strand of research evaluation. This may assist with the development of a more detailed understanding of high needs patients, as the results of the current evaluation are looking at large groups of patients which will hide poor results of patients with particular needs that might be

Respondent type	Response	Additional comments
		helped with modifications to the pathway.
Dentist	Yes (please describe below)	With vulnerable patients much of the risk lies with the standard of care in homes rather than with the patients themselves. The current RAG system that is being tested in the pilots does allow clinicians to override the score and alter appointment intervals based on clinical judgement. An example would be a patient that currently scores £Green who is about to enter a care home should have the score altered to £Red to reflect the increased risk to oral health when entering a care home. This can always be altered later. Better training of carers is needed with an emphasis on oral health as part of the care plan for each resident on entering a care home. Better guidance for care homes to improve nutrition.
Dentist	Yes (please describe below)	Again the basic approach of a risk-based preventive approach is still valid, but it is more complex with this group due to challenges with accessing care and patient capacity. This group of patients require a multi-disciplinary approach and true engagement and cross-professional working between health and social care. Dental networks need to work closely with other stakeholders e.g. PHE, local authorities, CCGs to target these vulnerable groups to develop oral health programmes designed to manage these specific risks, not only within dental practices, but also the wider community. Oral health messages and training needs to be built into programmes for carers, health care workers and others to raise the profile of oral health issues and provide the necessary information to manage them. Access to domiciliary care needs to be reviewed and services developed and appropriately resourced to provide care for those patients who are unable to easily access dental practices routinely.
Dental Care Professional	Yes (please describe below)	Very few people have 1 carer. Normally many share the task ,which means having to educate many people. The oral health message can be prevented by being too dilute by allowing the dental team the time to visit the patient for assessment, where the patients regular carers can be spoken to and included in the care pathway
Local professional network	Yes (please describe below)	Giving specific target training to carers and care homes. This has been done in our area with EDDN in Smile4life programme in Cumbria.
Dentist	No	
Dentist	Yes (please describe below)	Often patients in this group require domiciliary care or care within an environment outside of regular dental practice. For such patients the level of equipment available can be severely diminished and pathways need to take this fact into account. In spite of this, it is this very cohort of patients who often require more intense preventative and recall procedures to maintain oral health. There is little commissioning of domicillary contracts across the country and the most dentally compromised patients have no dental provision. This can be addressed in the new contract but an interim solution should be found. Either additional tenders need to be put in place now, or a UDA allowance given to cover these visits (within existing contracts). Possible solution guidelines need to be drawn up specific to this group

Respondent type	Response	Additional comments
		of patients to be used within the clinical pathway which are designed to include: the carer(s) role within the pathway with respect to availability and level of care required location of service delivery and potential limits thereof alternative service delivery points guidelines on levels of care to be extended at each point along the pathway with realistic expectations as to the levels of care possible to be delivered in a non-dental practice environment clear guidelines on community services available and how to access these for patients for stabilisation, preventative and advanced care should these form part of the pathway Unfortunately without solutions to these issues which are laid out clearly by the NHS, for this group of patients, the pathway could easily become purely an academic exercise due to the physical inability to follow such a relevant pathway in the absence of adequate carer and, or, physical resource.
National Body	Yes (please describe below)	Care must be taken to ensure that both the patient and key carer remain fully engaged with this process.
National Body	Yes (please describe below)	The [redacted] has no comment to make on this question other than the Special Care Dentistry team at [redacted] could contribute to this debate. The clinical pathway groups working on the commissioning guide for Special care are highly likely to be able to make recommendations on how the pathway in primary care can be adapted for patients who rely on careres to mainatian their oral health.
National Association	Yes (please describe below)	Just as an emphasis on patient understanding and public attitudes to oral health will be critical to the success of the preventative pathway in a general practice setting, ensuring that the full range of individuals involved in a patients care are aware of the pathway, the principles of good oral health and the individual patients care needs will be critical to the success of the approach in a care setting. Proper funding and resources, both educational and practical, should be made available to all those involved in the patients care. Additionally, an expansion of the number of practices testing the pathway would allow a better understanding of the needs of patients relying on daily care.
Dental Local Professional Network	Yes (please describe below)	Particularly in relation to the aspiration to offer a more preventative service, it would be very helpful if the review did not consider dentistry in isolation to other health and social care providers; or oral health in isolation to other health issues. In order to ensure joined up health and social care, we need to find means by which every aspect of service provision plays a part in overall health care. For example, how can dentists and dental practices link into Making Every Contact Count? How can dentists treat/support the whole person rather than simply their teeth? Good dentistry is essential for good nutrition. A proportion of CDS patients would not be able to report their experience. Maybe in these cases, indicators could include carers' opinions? Carers often have a challenging time with their day to day life. Practices having mechanisms in place to alert appropriate recall intervals can make things easier for the carer.

Respondent type	Response	Additional comments
National Body	Yes (please describe below)	The approach needs to be a simple as possible to carry out and understand. Care may need to be supported or carried out in the patients home or care home with a community program to assist the treatment thats happening in the surgery.
Dentist	No	
Dentist	Yes (please describe below)	need to be exempt from rag system before allowed care
Dentist	Yes (please describe below)	This data should be captured as p[art of the pathway
Dentist	Yes (please describe below)	It may not always be possible for a carer to proide the best oral hygiene regimen for a patient and this should be taken into account.
Dentist	No	
Local professional network	Yes (please describe below)	Again the basic approach of a risk-based preventive approach is still valid, but it is more complex with this group due to challenges with accessing care and patient capacity. This group of patients require a multi-disciplinary approach and true engagement and cross-professional working between health and social care. Dental networks need to work closely with other stakeholders e.g. PHE, local authorities, CCGs to target these vulnerable groups to develop oral health programmes designed to manage these specific risks, not only within dental practices, but also the wider community. Oral health messages and training needs to be built into programmes for carers, health care workers and others to raise the profile of oral health issues and provide the necessary information to manage them. Access to domiciliary care needs to be reviewed and services developed and appropriately resourced to provide care for those patients who are unable to easily access dental practices routinely.
National Organisation	Yes (please describe below)	A pragmatic approach individualised to what could be considered "optimal" oral health for the patient
Dentist	Yes (please describe below)	Care plans need to be very specific and the carers themselves should receive oral health training . Oral health assessments should be included in the child protection plans for those children who have them or are under the care of social services.
Dentist	Yes (please describe below)	Yes. Great idea. We could input this in to the software in the social/medical history to generate a Dedicated care pathway/ home prevention pathway for these patients that may/should include DCP education in the place of residence.

Respondent type	Response	Additional comments
Dentist	Yes (please describe below)	Make care homes more aware of importance of oral health? Many carers report that they would like to spend more time on this area but are simply too busy
Dentist	No	
n/a	Yes (please describe below)	Need to ensure links with social care and mandate daily mouth care in care plans for individuals and that care staff are training in oral health and that assessment on entry to a care home includes oral health as in Caring for Smiles in Scotland.
Dentist	Yes (please describe below)	The carers will need to take an active role however whether this will be possible with success is debatable
Dentist	Yes (please describe below)	Carers must attend their dental appointments and be 'registered' on the IT system as a contact and be made aware that it is them that is responsible for the patients care as well.
Dentist	Yes (please describe below)	As this philosophy is accepted nationally and coming through the NHS England. their shall be some funding kept aside for working with young and old like schools and care homes. to train the staff and school to promote the dental health at ground level and move to generations.
Community dental service	Yes (please describe below)	written advice and the generation care plan will be useful, however there is a culture of 'not forcing' the patient/client to receive oral care
Community dental service	Yes (please describe below)	As a Salaried service, we have responded to most of the previous 8 questions from this perspective. See in particular Q7 and Q8 above. Additional weighting is required for these groups, to reflect the additional time and resources required when working with these individuals and groups. The BDA weighted system adopted by the current salaried services is a very useful approach as it helps to take these additional factors into account. There is scope for that weighting system to be modified further, but as it stands it is fairly practical and widely used. It is important to recognise the large amount of work carried out by community dental services outside clinical practice, including community-based oral health promotion programmes, carer training programmes, working with carers and care organisations, working with secondary care providers to provide treatment under GA, working with other health and social care professionals and organisations to promote oral health and improve access to care and ensure that issues such as mental capacity and consent and access and involvement of relevant parties and safeguarding are addressed thoroughly, systematically, properly and consistently. It should also be recognised that there are many people with mild or moderate additional care needs who can be and currently are managed effectively within the GDS, often with

Respondent type	Response	Additional comments
		support from the salaried community dental services. This approach should be encouraged, possibly based on the tier model outlined within the contract reform proposals. The salaried dental services are often driven and provided by teams motivated more by their values than by financial incentives. We are strongly of the view that the salaried services are the most appropriate type of service and approach to take to work effectively with people with additional care needs and that these services should be commissioned and monitored separately to a GDS type contract.
Dental Local Professional Network	Yes (please describe below)	The key to assisting carers is making things as easy as possible for them to deliver care, so assuming they have the time to attend at the practice with the patient for a RAG assessment then it is about time and resources to assist the patient with their oral hygiene and manage their diet. The approach outlined in the philosophy should be applicable for all patients though clinicians may need to be given more latitude in how it is used for patients with special needs.
Dentist	No	
Dentist	Yes (please describe below)	I don't know
Dentist	Yes (please describe below)	As described above
Dentist	No	
Dentist	No	
Community dental service	Yes (please describe below)	Yes, a more positive and supportive approach, abilities in carers varies and perhaps a more formal training pathway for them may have its merits.
Dentist	No	
Dentist	No	
Dentist	No	
Dentist	Yes (please describe below)	Include oral health monitoring policy in CQC registered care homes. Available training for careers.
Community dental service	Yes (please describe below)	spot checks in homes

Respondent type	Response	Additional comments
Community dental service	Yes (please describe below)	Oral care plans should be part of overall care plan Carers training important
Dentist	Yes (please describe below)	see above
Dentist	Yes (please describe below)	impractical to expect carers to comply
Dentist	No	
Dentist	Yes (please describe below)	I see a great deal of poor care for the elderly in homes or with carers coming into their homes. Often due to ignorance. I fear we do not see many of them in general practice. More salaried dentists are needed with a simplified system to start based on oral hygiene and function.
Community dental service	Yes (please describe below)	I think there needs to be recognition in the contract that whilst oral health advice has been provided there may be no or little improvement. Many of these patients require more frequent oral health care and support yet the results will not evidence this and the service could be penalsied financially.
Dentist		
Dentist	Yes (please describe below)	Education
Dentist	Yes (please describe below)	These patients need entirely different amounts of care. General practitioners either have to be remunerated correctly for the time necessary to treat these patients- or a completely separate system such as community care must continue no
Dentist	Yes (please describe below)	Recognised training pathways should be set up for carers
Community dental service	Yes (please describe below)	As above I also think it would be wise to consult with BSDH and take guidance on this
Dentist	Yes (please describe below)	As mentioned previously remuneration must reflect that more complex treatment is required by some patients despite being high risk

Respondent type	Response	Additional comments
Trainee Dentists	Yes (please describe below)	Contract with care home to allow management to have some responsibility for the oral health of their residents.
Dentist	No	
Dentist	No	
Dentist	Yes (please describe below)	How do we get actively get involved with Care Home providers and influence them of the importance of good oral hygiene.
Dentist	Yes (please describe below)	Yes
Dentist	No	
Academic	No	
Dentist	Yes (please describe below)	Better education of carers
Dentist	Yes (please describe below)	See them more frequently, get them to actually brush the patient's teeth in front of the dentist
Dentist	Yes (please describe below)	these patients must not be penalised within the system if their carers fail to modify behaviour. I have seen patients where care homes or private carers are failing to achieve a good standard of oral hygiene, this is not always the patients fault and it needs to be recognised.
Academic	Yes (please describe below)	assessment of the carers understanding? also be mindful that this usually needs a visit to the care home / residence and access to the computer system is unlikely unless a laptop / iPad / remote version is developed. a paper based system for such visits would be labour intensive and timely on an already difficult appointment for time etc.
Dentist	No	
Dentist	Yes (please describe below)	A system of a shared appointment to advise carer and patient or tailored advice that can be printed or downloaded for the patent to share with a series of carers
Dentist	Yes (please describe	Education and training of carers. Oral health care should be a manadatory part of carers training with regular updates. Commisioners should be required to provide domicilary care sufficient to meet local

Respondent type	Response	Additional comments
	below)	needs and demonstrate that this has been done.
Dentist	No	
Dentist	No	
Dentist	No	
Dentist	Yes (please describe below)	The carers MUST be appropriately trained and there MUST be good communication between stakeholder groups to help this very vunerable group. Do not forget that DIET is a major factor in this group.
Dentist	No	
Dentist	Yes (please describe below)	Make it about caring for patients rather than meeting targets or traffic lights.
Dentist	Yes (please describe below)	Are you considering trialling a domiciliary pilot contract?

Paper 2: The Clinical Philosophy

General comments

Respondent type	General Comments
Community dental service	At the outset it was stated that one of the aims is to have an equitable centred patient care sysytem. Sadly this may never be achieved where the ability to pay enhances patient options . A starting point would be for the Department to actively seek a unified dental service that we all share and all use. Whilst the department accepts the position that currently exists in the public/private world of dental care provision this "equity" concept will always be an ideal that over time wanders further from reality.
National Body	We recommend that oral medicine is defined as a separate clinical pathway in the pathway approach model as patients with relevant diseases are often referred initially to Oral and Maxillofacial Surgery services of District General Hospitals, rather than directly to oral medicine units. This pathway should be developed in collaboration with Oral and Maxillofacial surgeons to ensure a joined-up approach. More generally, it will be important that dentists in primary care have clear guidelines on when and where patients should be referred to tiers 2 and 3 for specialist advice and/or treatment. The specialist societies will continue to work with NHS England to develop these referral guidelines. In addition, patients should have access to clear information about the level of training dentists have received in the tier 1, tier 2 and tier 3 levels of proficiency. We were disappointed that the Law Commissions recent draft Bill to give professional regulators the power to annotate their register and indicate specialisms or other qualifications will no longer be advanced. This would have enabled patients and professionals to easily identify and check the status of a dentist in the different tiers of proficiency. We hope any future Government after the general election in 215 will prioritise this legislation. In the absence of legislative change, we hope that the Department of Health and General Dental Council will consider how else to communicate to employers and the public a dentists relevant skills and experience this will be a particular issue for dentists with enhanced skills.
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Respondent type	General Comments
	longer be advanced. This would have enabled patients and professionals to easily identify and check the status of a dentist in the different tiers of proficiency. We hope any future Government after the general election in 215 will prioritise this legislation. In the absence of legislative change, we hope that the Department of Health and General Dental Council will consider how else to communicate to employers and the public a dentists relevant skills and experience this will be a particular issue for dentists with enhanced skills.
Local professional network	Summary Good pathways adopted consistently IT and time challenging Capitation will encourage participation Community RAG on special patients only Carers specific info Comms and Info sharing vital prior to roll out Publish case studies Adopt buddy system
National Body	Thanks for the opportunity to contribute.
Dentist	Concerned that balance may switch too far to preventive line at expense of providing ongoing maintenance to existing restorations. The system needs to be underpinned by a preventive approach but there needs to be adequate provision for ongoing restorative care
Local professional network	Train the carers
Local professional network	To incentivise dentists to buy in to a new contract , the new arrangements must properly recompense dentists. The current expenditure levels should be ringfenced as a pre-requisite to contract reform and any overall savings retained within dentistry for re-investment. --- LDC can demonstrate innovative working in schools, in public health initiatives, in prevention and providing outreach to the seldom heard. The LDC would be very open to participation in pilots that the NHSE / Doh may wish to commission to take forward work in these areas.
Dental software supplier	The current approach is very reliant on the accuracy of basecharting. Experience suugests that the standard of basecharting is mixed and this could cause transition isssues when rolling this approach oit nationwide. Suggest that in the meantime a proactive focus on improving te standard of basecharting (ideally using the basecharting codes currently being used on teh pilot) would pave the way to a smoother transition/
Dentist	Special consideration needs to be given to patients in prison and mental health patients . Patients in care homes should have oral health assessments and plans for their care . Staff looking after them need better awareness and training .
Dentist	The pre pathway questionnaire needs to be linked to the software so that patients can complete the pathway before their appointment and is automatically updated on the practice computer system. This is because a lot of time is wasted waiting for patients to fill in questionnaire at their appointment. It is not a lean approach for healthcare. Read Were not Japanese and we don’t make cars (Fillingham, 28a). A Also because of this wastage dental appointment often run late and therefore patients will become more dissatisfied for waiting. If this is not done the pathway questionnaire will be rushed or worse made up if the patient has not filled out a questionnaire which will lead to inaccuracies. This much be a priority.

Respondent type	General Comments
Dentist	This philosophy sounds good but like all philosophies when turn into action there are challenges and ups and downs and perseverance's on the way wish you all good luck
Community dental service	are there enough DCP's?
Community dental service	These are our general comments in relation to Q7, rather than identifying specific issues for specific groups, we prefer to address the issues in a more general term as below Many patients may not be motivated by preventive approaches until they see the results of some treatment. Focussing on prevention prior to providing treatment, may result in patients not receiving any treatment. It would appear that has been identified within the findings of the pilots. If the system is too rigid, preventing and penalising dentists from providing treatment until patients have achieved certain levels of demonstrable positive oral health behaviours, for example, then that may pose an insurmountable hurdle from providing any beneficial treatment. Those situations are most likely to be seen in the higher need patients, almost by definition, as those patients are often faced with more challenges in devoting time and resources towards their oral health. Those barriers may be more grounded in social and material deprivation for example, to the extent that positive behaviour changes are not really realistic. If the proposed preventive pathway approach is too rigidly applied, that could lead to an increase in oral health inequalities. The time taken within clinics trying to achieve behaviour change in certain groups, where change is extremely challenging, will mean that there is an in-built perverse incentive. Dental teams may look to taking the easier option by cherry-picking the healthier patients and trying to avoid taking on patients where treatment needs and barriers to behaviour change are particularly high. The particular groups where this approach is likely to be difficult therefore are those with highest dental and self-care needs: e.g. people living with more social and material deprivation; people with learning difficulties, people with mental health problems, people with physical disabilities, people with dental phobias, people with dementia, people who are cared-for by others, the frail elderly, people with long-term chronic health conditions etc. etc.. These are the same groups who are currently the harder to reach groups.
Dentist	No
Dentist	No
Community dental service	With regards carers, they bring the patients to the clinics, so we need to encourage their participation more.
Dentist	Good on paper but unless all dental practices are standardised with UK-trained dentists all with VT numbers who understand the basic principle concept of the NHS.
Dentist	Clarity on how patients will pay needed. If the process were to lead to taking twice as long, as the current pilots would indicate, and PCR needs to remain the same, it will be cheaper for patients to come and see me privately!
Community dental service	Many Commissioned primary care services employ dental surgeons that have input into DGHs. Thus the costs are woolly at present and a firm grasp cannot be got of Hospital and Primary care.

Respondent type	General Comments
Dentist	I do hope that the pathway approach to clinical care is not set to become a eugenic/ neo fascist approach to dental healthcare where only the dentally righteous (aka sanctimonious and dentally aryan) will receive the state's blessing to receive full healthcare in violation of fundamental human rights legislation.....I shall be interested to read the other documents and see what they have to say
Dentist	It would be realistic to think that none of these comments will make the slightest difference to what will happen. However, it would be gratifying if the individuals who will impose this new system were to be recognized and their career trajectory adjusted appropriately dependent upon the success or failure of the changes imposed.
Dentist	This is a good start and hope will continue to evolve. I feel that we need to assess the wants as well as the needs of the population and educate the public that the NHS provides for their needs and they have responsibilities too. Many 'wants' can be addressed outside the NHS sector.
Dentist	Looks like more education needed. People are not always receptive.
Dentist	No
Dentist	The current dental contract was only implemented to control the cost of NHS dentistry, this has resulted in many patients loosing valuable teeth instead of having them root filld, children with multiple cavities are neglected because there is a perverse incentive for some dentists to do multiple restoration. the pilots are trying to change the philosophy to a more preventative approach, this is what all the good dentists do all the time, the proposed new dental contract will alienate the patients and will force more dentists to leave the NHS, in our region there are hardly any British qualified dentists who work in the NHS and the few that are left are thinking about leaving it as well, overwhelming majority of current Foundation Dentists are not applying for jobs in general practice because they are frightened of the new contract, instead they are pursuing positions in hospitals.
Dentist	Speed the process up. Clinicians on the Pilot are able to see the benefits and shortcomings much more quickly than the DOH boffins seem to appreciate - lets communicate more
Community dental service	Not at the moment
Dentist	Make it a fair contract rather than the expected 'setting us up to fail' contract
Dentist	Is this another whitewash?
Dentist	Your system won't work, because the treasury will not accept it. PFR dropped in the pilots, meaning an increase in central costs. Waiting time increased drastically, meaning a failure to increase access is inevitable. The only way forward, the only way that will keep the profession in the NHS, and meat the health needs of the majoirty whilst meeting the budget constrains by the treasury is a core service.
Dentist	How do we classify a patient with Lichen Planus in your RAG approach? Or a patient with an acute TMJ problem? Is box-ticking the only thing to be included in your DQOF? What about, say, doing a good restoration? What about restorations which last longer, or alternatively which are repeatedly having to be replaced? Who decides what is

Respondent type	General Comments
	acceptable health? If a patient has an acceptable partial denture, but they want a bridge, who decides?
Academic	2 year recalls for adults when the incidence of oral cancer has trebled in the last 2 decades, yet the survival rate remains extremely poor, are unconscionable.
Dentist	Your main concern is PCR. You will never be able to get a decent return of PCR using any prevention-based approach.
Dentist	Some patients simply do not care. You cant engage in a pathway like this with irregular attenders, with all the will in the world some/many will not engage. Make sure they are still catered for at a reasonable remuneration level and hopefully be drawn into the system eventually, or they will simply drop out and be seen privately.
Dentist	Please get this right so patients and dentists alike can enjoy stable NHS dentistry
Dentist	I offered my inner city practice in the third most deprived local authority area with extremely poor oral health and a 9% ethnic minority patient base as a pilot but it was turned down. My understanding is that this has not been properly piloted with most pilots being located outside derived inner city communities with substantial ethnic minority populations. this needs to be rectified immediately and additional pilots/blended contracts need to be trialled outside the leafy suburbs.
Dentist	No mention of fluoridation, the cheapest most effective method of dental health prevention
Dentist	My main concern is the dental profession is at risk of being told how to work (pathway recommendations). I fear as an associate there will be difficulty in finding jobs if dental therapist are bring given a wide range of scope of care with the risk of not being able to deal with emergencies as and when they arise hence poor quality of care delivered to patients. I feel the pathway system is a good way forward as long as it is swift and easy and relatively quick to go through and appropriate remuneration system is in place which will address both quality time spent with patients on prevention and also in meeting treatment need. if it does not then the system will fail on a large scale and dentist will move away from the NHS and patients will be left with limited Access to quality NHS care.
Dentist	I would like to see results of pilots in this field.
Dentist	The CDO and Lord Howe are not competent to deal with dentistry. Capitation does not work in dentistry and you should really engage with the dentists who provide the GDS. And I do NOT include those financial opportunists taking part in the trials.

Paper 3: The measurement of quality and outcomes

Responses to Question 1

Do you think that the areas of clinical effectiveness, patient experience and safety are the right ones for the Dental Quality and Outcomes Framework?

Respondent type	Response	Additional comments
Dentist	They are the right areas	
Local Professional Network	They are not the right areas (please elaborate)	We believe that clinical effectiveness, patient experience and safety are valid domains for a DQOF. However, we are concerned about their measurement. Whilst patient experience is captured by an existing BSA patient survey and safety is monitored by the CQC, clinical effectiveness cannot be measured objectively without dental reference officers or an equivalent. We firmly believe that the DQOF, if used, should be a tool to inform practices and commissioners and not something forming any part of the contractual payment system.
National body	They are the right areas	
Dentist	They are not the right areas (please elaborate)	Patient safety/experience should be widened to include evidence of critical incident reporting, development of never ever events for dentistry and learning from patient feedback. Incidents should not be used as a quality marker and should not lead to contractual sanctions, but evidence of an appropriate system and team learning should be applauded. Sceptical about the clinical effectiveness markers especially caries - very reliant on accurate diagnosis by clinicians and accurate recording and transmission of data. High risk of abusing this system to make practice look better than it is. Need to have some consideration of radiographic recall intervals to verify diagnostic attention to detail Clinical effectiveness data should be used as an incentive instead of a clawback mechanism PE1 could be unhelpful depending on the time at which patients asked this i.e. if shortly after oral surgery likely to be a negative response Need to recognise the inclusion of FFT from April 2015
National association	They are not the right areas (please elaborate)	We agree that the domains of clinical effectiveness, patient experience and safety are fundamentally sound. However, we believe that the principle of payments for achievement in the Dental Quality and Outcomes Framework (DQOF) within an agreed contract value is not appropriate. We will explore these issues further below, but if there has to be a requirement to link DQOF measures to GDP

Respondent type	Response	Additional comments
		payment, it is far better to develop a system which rewards the delivery of improved patient experience and outcomes by introducing an element of DQOF which sits outside current contract values. Using a motivator rather than a penalty seems in our view an infinitely more positive and effective approach to patient care. We are of the view that the DQOF, in its current form, requires a great deal more testing before the BDA would commit to supporting its inclusion in a reformed contract. We are fundamentally opposed to a system which puts at risk a percentage of agreed contract values, and we do not believe that this represents a sufficient departure from the target-driven system under which dentists currently work. The current proposals for DQOF would mean that a percentage of an individual contract value would essentially need to be ÿwon back by the practice through the achievement of metrics, a concept which we find deeply concerning. Although we agree that there should be quality assurance measures in place, we believe that peer review, clinical audit, and the use of Dental Reference Officers (DROs) are the most appropriate means of assessing quality and health outcomes. Data can only tell us so much, and it is the BDAs core belief that the assessment of the performance of professionals in improving health should be undertaken by fellow professionals, rather than through the analysis of data on a spreadsheet. This approach is, we believe, in the best interests of patients and their health outcomes, and for the preservation and strengthening of professional standards. Alongside this, we are extremely concerned to note the experience of our colleagues in general medical practice, who have seen the bar set ever higher on their quality and outcomes targets, and have reported that QOF has, in some cases, become a treadmill or ÿtick box approach to practice. It is proposed that the DQOF would take a chunk out of existing contract values and tie that to the achievement of metrics, and then over time the metrics become more challenging to achieve, particularly for contractors looking after populations with very poor oral health. Our concern is that there will be a point in future when the full sum of an agreed contract value is impossible to achieve for many contractors, depending on the relative health of a practice population. We have seen an unfortunate trend in the financing of NHS dentistry over recent years: year-on-year rises in costs and expenses, resulting in a decline in income. It is our considered view that the DQOF could be construed as a means to reduce contract values by stealth, something which we oppose in the strongest terms. If the Department is seeking to incentivise a preventive approach to care, this requires investment in dentistry, and not another system which relies on the achievement of targets which drive the direction of activity. If there has to be a requirement to link DQOF measures to GDP payment, far better is to develop a system which rewards the delivery of improved patient experience and outcomes by introducing an element of DQOF which sits outside current contract values. Using a motivator rather than a penalty seems in our view an infinitely more positive and effective approach to patient care, and when developed in conjunction with the effective use of DROs, peer review and clinical audit, would be a system that was straightforward to monitor,

Respondent type	Response	Additional comments
		and would mitigate against concerns that a capitation-based system might be at risk of abuse.
Dentist	They are not the right areas (please elaborate)	Clinical effectiveness Happy with the 3 indicators for caries and periodontics. Patient experience Surveys should be sent out 1 month after completion of a course of treatment. PE:01 needs to be rephrased as cause of eatingØ may not be dentally related. PE:07 needs to be more specific about types and timesØ of treatment appointments. Patient safety Consider inclusion of CQC reports and staff training records
National Body	They are not the right areas (please elaborate)	We agree that clinical effectiveness, patient experience and safety are appropriate for the Dental Quality and Outcomes Framework. However for Special Care Dentistry, it is also important to consider family or carer experience, engagement and expectations, alongside the patient experience.
Local Professional Network	They are the right areas	
Dental care professional	They are the right areas	
Dental body corporate	They are the right areas	
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are not the right areas (please elaborate)	It should focus more on whether a patient actually received appropriate oral hygiene instructions and preventative measures (i.e Fluoride) and whether the patient actually followed the advice given - A practice has a duty to give diet advice etc but it should also not be penalised if patients do not follow the advice. A practice should also be rewarded if it has a good approach to CPD/audits etc as this usually implies it works towards a high standard of care.
National body	They are not the right areas (please	The domains of clinical effectiveness, patient experience and safety are embedded within existing overall health quality frameworks and are considered fit for purpose within dentistry. Clinical effectiveness needs to include the assessment /diagnostic process as well as the

Respondent type	Response	Additional comments
	elaborate)	effectiveness/outcome of post-diagnostic clinical care, and therefore it should be more clearly defined, or even renamed 'Clinical Process.'
National body	They are the right areas	
National association	They are not the right areas (please elaborate)	We broadly support the areas of clinical effectiveness, however please also see our response to Q5.
Dentist	They are the right areas	
Local Professional Network	They are not the right areas (please elaborate)	Basically yes but more of a reference to Delivering Better Oral Health (DBOH) would be welcomed.
National association	They are not the right areas (please elaborate)	The design of the DQOF questions does not pick up issues around patients not being able to access dentistry. It would be good to have a measure of patients who were unable to get an appointment because they were turned away or the practice was closed/not doing NHS when they needed treatment. Could this information be collected through the out of hours services and possibly through NHS choices? There is nothing in the framework which indicates that a practice is committed to growingØ the NHS service for patients given the financial position I would hope that if the funding is remaining consistent, then we are expecting to see more patients benefiting as practices become more efficient?
Dentist	They are not the right areas (please elaborate)	Should we not consider an output component and be rewarded for that. Volume of pts seen seen should bring some credit.
Dentist	They are the right areas	
National organisation	They are the right areas	
Local Professional Network	They are the right areas	

Respondent type	Response	Additional comments
National body	They are the right areas	
Dentist	They are the right areas	
Software supplier	They are not the right areas (please elaborate)	Geenrally they are right however if you compare the proposed Dental QOF with the QOF that has been in established use for over 10 years there is one key aspect that stands out as a difference. The majority of the QOF points are not awarded for diagnosis of new clinical conditions, but for the successful ongoing management / improvement of existing patient cases. In other words strong emphasis is placed on the GP to get patients to return to his surgery (normally according to recall periods advised by NICE) to have their condition checked and careplan realigned as necessary. Should there not be a similar mechanism in DQOF with dentists rewarded for both general alignment with NICE recall intervals, including getting patients to return for their recalls.
Dentist	They are not the right areas (please elaborate)	Yes. However we have reservations about: P.E.01 does not adequately take in to consideration the level of complexity or invasiveness of the procedures undertaken and so it it could be misleading. For example following difficult exodontia or in a situation where a denture patient has unrealistic expectations. PE .06 appears to cover the general issue of satisfactory treatment. The sample size must be large for it to be a valid interpretation of quality at least 20% of C.O.T. Indicator PE.01 Patients reporting that they are able to speak & eat comfortably PE.02 Patients satisfied with the cleanliness of the dental practice PE.03 Patients satisfied with the helpfulness of practice staff PE.04 Patients reporting that they felt sufficiently involved in decisions about their care PE.05 Patients who would recommend the dental practice to a friend PE.06 Patients reporting satisfaction with NHS dentistry received PE.07 Patients satisfied with the time to get an appointment TARGET : This should be monitored in the pilot period and a reasonable target agreed that is reasonably achievable. In addition PE.07 Values must also represent a change in service levels with regard to appointment time expectation due to appt book clogging with OHA.
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are not the right areas	They are the correct areas, but getting improvements in BPE's is very difficult to achieve

Respondent type	Response	Additional comments
	(please elaborate)	
Dentist	They are the right areas	
Local Professional Network	They are the right areas	
Community dental service	They are not the right areas (please elaborate)	Yes, largely they are the correct measures for the DQOF. Could also include measures of access, accommodation, acceptability, equity. Waiting time from contact to first appointment for routine and, in particular, urgent care. May want to include a measure of antibiotic prescribing on the expectation that it should be low for public health reasons and Possibly a measure of repeat appointments due to inability to get patients out of pain.
Community dental service	They are not the right areas (please elaborate)	increased use of minimal intervention may make DT indicators less important.
Dentist	They are not the right areas (please elaborate)	Clinical effectiveness' and 'patient experience' should not be used in my opinion as, to a large extent they are completely out of the control of either the dentist or practice. For example, a dentist may go out of their way to help a patient improve their oral health and repeatedly provide them with OHI and prevention. But if that patient simply doesn't care about their oral health (and there are so many patients like this) then their oral health is never going to improve and possibly will even deteriorate over time. Therefore, it doesn't seem right that the dental practice should be deemed to have underperformed in the 'clinical effectiveness' domain and suffer financially just because the patients didn't listen and couldn't be bothered. I am concerned about the 'patient experiences' domain because, although patient views are very important, I don't think that they should then feed into practice finances. A patient's view of the care they've experienced can be a complete misrepresentation of what actually happened, because unless a patient becomes a dentist themselves they will never fully understand why things are done the way they are. My fear is that it this domain will be heavily based on patient surveys, meaning that dental practices are reduced to competing for good patient reviews in a similar manner to hotels and customer reviews on ÿTrip Advisor. Are dentists going to have the opportunity to challenge (and possibly correct) the comments made by patients, or is the patient's word just going to be taken as the truth every time? The ÿpatient experience can be judged completely differently between the dentist and patient. For example, a dentist may extract a grossly carious, but pain-free, tooth that has the potential to cause the patient a

Respondent type	Response	Additional comments
		painful abscess in the future. However, following the extraction, the patient develops an agonising dry socket and requires a second emergency appointment to sort out. From the dentists point of view they have removed a potential source of infection and prevented a possible abscess in a patient, who unfortunately developed a common, but easily managed, complication following the extraction. To the patient, however, the dentist extracted a tooth from which they had never experienced any problems and caused them to then suffer extreme pain that required them to take more time off work to have treated. The patients opinion of events is entirely different, regardless of whether the dentist explains that a dry socket is an unfortunate side-effect that can be difficult to predict. The patient may also not have followed the advice given by the dentist to avoid the dry socket in the first place. A similar example is that a patient is kept waiting 15 minutes after their appointment time before being seen in surgery. There may have been a very legitimate and unforeseen reason for this delay occurring, and the treatment provided for the patient is still of exactly the same high standard. However, the dentist is still penalised because that patients experience can be viewed as being below par.
Dentist	They are the right areas	
Dentist	They are not the right areas (please elaborate)	Patient experience can absolutely not have any bearing on dental quality and outcomes. For example if I take a BPE measurement of 3 and scale deeply and effectively to remove deposits, this could be a very unpleasant experience for my patient, especially if he is new to the practice and has not experienced deep scaling before. His assessment of his treatment is subjective and cant possibly be appropriate in any QOF and ultimately a proportion of a dentists income.
Dentist	They are the right areas	
Dentist	They are not the right areas (please elaborate)	patient experience oght to be qualified and claibrated, evolution of the expert patient
Unknown	They are not the right areas (please elaborate)	there is so little evidence about whats effective in dentistry more reaearch is needed,how does this link to pathways and tiers
Dentist	They are the right areas	
Dentist	They are the	

Respondent type	Response	Additional comments
	right areas	
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are not the right areas (please elaborate)	what will happen if patients fail there appointments ,some patient do not want preventive advice
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are the right areas	
Community dental service	They are the right areas	
Dentist	They are not the right areas (please elaborate)	Patient experience is useful, however is very subjective to patients perception, and what they've been used to in the past.
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are not the right areas (please elaborate)	Whilst for most patients these are the right indicators for some CDS patients whilst the correct process is followed - and frequently - it is not clinically effective however hard the dentist tries. It is also difficult to gain the patient views on their experience and we have to rely on the views of the carer.
Dentist	They are the right areas	
Dentist	They are the	

Respondent type	Response	Additional comments
	right areas	
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are not the right areas (please elaborate)	Clinical effectiveness is going to be very difficult to measure in prison
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are the right areas	
Trainee dentists	They are not the right areas (please elaborate)	Mixed views on this area. Many Fds felt that there should be a measure of process as they felt measuring outcome alone could lead to abuse of the system. They also wondered how the differing patient engagement from the diverse practices they work in would be reflected in the outcome measures.
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are not the right areas (please elaborate)	It's all an open-ended philosophy.....what is excellence and what is perfect (when there is no perfection in nature)
Dentist	They are the right areas	
Academic	They are not the right areas (please	The actual quality of the clinical work delivered seems to be ignored. Was the subgingival debridement complete? Was the caries fully removed or appropriately stabilized? Patients cannot judge this and may still be free of pain but with active disease present. It is therefore meaningless.

Respondent type	Response	Additional comments
	elaborate)	
Dentist	They are not the right areas (please elaborate)	Patietn experience is not a fair measure, particularly withiin busy nhs practices. Sometimes patietns are happy regardless of outcome whereas other patients are very difficult to please. Alsp it is difficult with certain socioeconomic groups to encourage them to improve their own oral health, which cannot be blamed on the dentist
Dentist	They are not the right areas (please elaborate)	I have concerns about reporting the patient experience - patients will only comment if very satisfied or very dissatisfied - difficult to measure accurately
Dentist	They are the right areas	
Dentist	They are not the right areas (please elaborate)	You need to be solely concerned with whether or not the treatment carried out has been effective. The patient experience surely is entirely irrelevant if the treatment carried out doesn't work.
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are the right areas	
Dentist	They are not the right areas (please elaborate)	these are all quality markers, but they have no numerical value, other then the percentage assigned to them. you cannot assess quality based soley upon a patient perspective. the overall practice performance has to be assessed locally on site, like the CQC come in to do
Dentist	They are not the right areas (please elaborate)	CLINICAL EFFECTIVENESS ALSO DEPENDS ON THE PATIENT RESPONSE EG. PERIO PATIENT EXPERIENCE IS VERY SUBJECTIVE. EG WE SEE EMERGENCY PATIENTS THE SAME DAY. THIS IS THE NORM WITH US, BUT COULD BE SEEN AS EXCELLENT IN ANOTHER PRACTICE THAT MAKES PATIENTS NORMALY WAIT LONGER. EVERY PRACTICE AND PATIENT SHOULD BE SAFE, STANDARD.
Dentist	They are the right areas	
Dentist	They are not the	It is very difficult to moniter dental quality as dentist diagnosis vary from dentist to dentist there aren't

Respondent type	Response	Additional comments
	right areas (please elaborate)	any hard and fast pathways. Quality should refer mainly to the clinical treatment given not if the patient likes the decor!!!
Dentist	They are not the right areas (please elaborate)	Any system based on patient feedback has to be treated with caution. In the past, patients have sometimes been unhappy that a dentist will not provide anticipated care that is not in a patients' best interests, eg the destuction os healthy tooth tissue to veneer or crown teeth unnecessarily or failure to provide treatment not indicated under NHS contract such as cosmetic treatments and implants. These patients may show dissatisfaction without any fault on the part of the practitioner
Dentist	They are not the right areas (please elaborate)	In. Pedodontics specific teeth should be followed with outcomes . Because the graduates from the last 5 years are incapable of filling a deciduous tooth with filling that lasts more than a few months if that . And keep doing sticky adhesive dentistry on adult molars tha equally keep falling off every few months untill the tooth is extracted or has endodontics for pain
Dentist		
Dentist	They are not the right areas (please elaborate)	They are not absolute criteria and cannot be standardised
Dentist	They are the right areas	
Dentist	They are not the right areas (please elaborate)	Patients' experience is such a nebulous concept. You cannot please all the people all the time. If patients are not happy they should move on. If this parameter is included in the final contract, I will get rid of my difficult patients. Safety? You have to be nuts
Dentist	They are the right areas	

Paper 3: The measurement of quality and outcomes

Responses to Question 2

Do you think that the focus on outcomes is correct or should some indicators measure process as well?

Respondent type	Response
Local Professional Network	In a true quasi-market, the emphasis should be exclusively on outcomes. This stimulates practice innovation as it focuses on the outcome for patients, not how the practice achieves that outcome (the process or activity). The problem with this system is that all practices will have different patient cohorts, with different motivations and opportunities to improve their oral health. In this way, a single focus on outcomes is problematic as it can mask practice achievement (for example, hard-working practices in areas of high need). The measurement of outcomes must rely on the clinical assessment of the clinical care being provided, if it is to be realistic and fair. Basing the measurement of patient outcomesØ on their RAG score at their next visit is not a suitable way to assess the efficacy of most clinical interventions. We are concerned to see maintenance of good oral healthØ as a suggested clinical outcome indicator. If patients choose not to look after their mouths outside of the few minutes they spend with their dentist, why should the dentist be penalised? Encouraging behaviour change must be managed through wider public health initiatives, support for low-income families and economic incentives to choose healthy lifestyles (e.g. special tax rates for particularly unhealthy foods). Although we do not believe contractual payments should be attached to a DQOF mechanism, we feel that there is an opportunity to incentivise practices in a positive way by attaching any DQOF payment in addition to the full contractual payment for service provision. Any threat to existing contract values could destabilise practices, undermining the provision of patient care.
National body	Outcomes is the most important indicator. Presumably having the correct equipment in the practice would be covered under safety.
Dentist	Correct to focus on outcomes as process can be very varied. However, does need to be some consideration of process as otherwise hugely reliant on the quality and accuracy of the data on outcomes.
National association	The second report of the Departments Evidence and Learning group noted that the collection of standardised data was a core ambition of the programme, and it is our view that the submission of data should be incorporated into the DQOF as a process measure. An adequate amount of necessary data is vital to the effective monitoring of outcomes and provides a comprehensive snapshot of oral health across the population, one that possibly renders the data collection exercise for the Adult Dental Health Survey (ADHS) obsolete. We are entirely supportive of the move to make regular submission of returns mandatory within the pilots, and believe that this process measure would be a sensible inclusion

Respondent type	Response
	in the DQOF provided that the amount of data was reasonable and proportionate. One of our main concerns about the DQOF is that its achievement is reliant on patient compliance. Differences in practice populations will mean that dental teams deploying the same amount of skill, time and effort may achieve very different outcomes. It is for that reason that we would be most supportive of a package which saw a much smaller percentage allocated to clinical outcomes.
Dentist	Yes Agree that the focus is correct.
National body	We strongly believe that the focus on outcomes will drive improved processes and patient care. It is important that any new outcomes data is led by the dental profession to encourage clinician support and to ensure a robust methodology. Any new audits and data need to be properly funded and consideration needs to be given to how clinicians are encouraged or mandated to participate. There should also be a central registry of audits in primary care to check that outcomes data is being collected.
Local Professional Network	Outcomes versus indicators of process need to take in to consideration patient choice. E.g. compliance with pathway splitting out adherence/non adherence measurement against expected pathway There should be measurement of NICE guidance adherence. If outcomes are to be measured then clinicians need to be involved /engaged in consultation process. Dont want focus on achieving target rather than process of providing prevention and appropriate care. A balance is required Monitoring realistic metrics may be necessary.
Dental Professional	Not all patients respond well. Some will have conditions that need to be addressed differently. Patients with certain medical conditions need a different process. Eg. Diabetics, immuno-suppressed, dementia sufferers.
Dental body corporate	The ultimate focus on outcomes is desirable for most patients. There are cases, however, where despite all actions being taken by the clinical teams, the lack of patient engagement through either inability or unwillingness to adopt recommended advice will result in a non desirable outcomes despite good process. It would be therefore be unfair to penalise a conscientious team and as such some process indicators should be applied.
Dentist	Process as well as some patients will not respond to treatment even with our best efforts.
Dentist	There should be some credit for treating the high needs patient
Dentist	maybe including process for the high needs patients so an example would be credit for quality when a certain number of patients have to go through a pathway that involves ohi / perio / fluoride varnish / fissure sealents etc
Dentist	The measurement of process should be incorporated into DQOF as outcome measures often need to be measured over longer periods but process measurement can enable effective early monitoring at individual performer level. Individual performer level monitoring is required to enable commissioners and providers to monitor contract delivery effectively. It is important that the process measurement does not increase the level of manual administration by the smart use of IT systems. The process measures need to be chosen to have upstream outcome benefits.
Dentist	There should be more focus on whether a patient felt they had felt involved in decisions as this is the core of valid consent however there needs to be a distinction from this and patients who are denied treatment due to poor pathway scores. There should also be less emphasis on waiting times for appointments as to carry out the pathway properly

Respondent type	Response
	takes a significantly longer amount of time and hence waiting times can easily triple over night - it would be unfair to penalise a practice that is doing everything properly.
National body	There is increasing recognition that process (patient experience) is paramount to overall assessment of the quality of care provided. Thus valid indicators should be developed for dentistry to measure and compare this aspect. Within medicine there are a number of patient feedback mechanisms embedded within the care pathway (GP and hospital online patient surveys) to allow measurement of process. Dentistry has not demonstrated the same degree of innovation or development in this area. The use and usefulness of patient indicators for children remains even less developed, especially within dentistry and should be a priority for development in the future.
National body	The [redacted] team think that the domains of clinical effectiveness, patient experience and patient safety are the correct areas to focus on for any new Dental Quality and Outcomes Framework. They believe that the focus on outcomes is correct but they would wish to see some indicators measure process as well. For example some measurement of wait time between the oral health assessment and interventions could be included
National association	Whilst the collection of standardised data has been noted as a core ambition of the programme, we believe that failing to include the submission of data as a process measure within the DQOF represents a missed opportunity. Such submissions would enable much more meaningful monitoring of outcomes and could potentially provide a broader and more effective means of data collection than has been seen in the Adult Dental Health Survey.
Dentist	allowance for local factors of population ie deprived areas should be reflected in outcomes achieved
Local Professional Network	Outcomes are always difficult to measure; following evidenced based processes that should lead to an improvement in oral health is an easier quality measure. Process indicators that would support improvement in outcomes would be beneficial for example maintaining up-to-date patient registers on particular health conditions would be useful in under-pinning preventative care, e.g. diabetes and smokers.
National body	Process measures would look at data quality although it appears unclear from the two documents what the clinical dataset would be. We hope that we can use this data to measure the range of treatments being delivered within a practice. Being able to monitor the range of treatments will flag what access to NHS dentistry the NHS patients are receiving and should help and evaluate the value for money.
Dentist	Process is important Credit should be given / allowances should be made if process reduces / affects outcomes Structure should reflect this
Dentist	Process monitoring is useful
National organisation	Donabedian's principles of Structure Process and Outcome are all applicable. Process measures including effectiveness of decontamination, effective clinical audit and team development are examples
Local Professional Network	Dentists should be able to demonstrate that evidence based processes that support an improvement in oral health are in use throughout the practice.And that basic good practice is followed e.g. good clinical record keeping, up to date patient registers for particular conditions.

Respondent type	Response
National body	Outcomes are the essential measure; process would be complicated, variable and hence open to debate. Improving outcomes for the patient are the most important thing.
Dentist	We feel that data collection should be a process measure.
Software supplier	Focusing on outcomes is definately the end game. However during the adoption phase providing some indicators that will drive the process to become engrained would probably be a good idea.
Dentist	The outcomes focus is correct but we would balance that with a process framework and a Scored Peer Review Practice Visit. We would propose using a DQOF to measure process as well as outcomes: QUALITY AND OUTCOME FRAMEWORK We propose that the following indictors are assessed within the Q.O.F. Both sets of indicators combined are worth 3% of contract value. The first group are simply policies that are in place. 1.Smoking Cessation on-line training certificate / log of referrals to smoking cessation services. Numbers of smoking cessation referrals to be within average numbers. This can be transmitted with the C.O.T as ; SMOKER BUT NO INTEREST IN CESSATION SMOKER INTERESTED IN CESSATION (COULD THESE PATIENTS BE AUTO REFERRED BY SELECTING THIS RESPONSE ON THE SOFT WARE?) 2. Referral log Numbers of referrals to be logged and transmitted. Referrals to be within average numbers. 3. Provision of urgent care slots Average values to reflect remuneration. 4. DCP training for prevention services. Where a DCP is used for this service certification of training and C.P.D is required. 5..Satisfactory CQC report. 6..Completion of audits on clinical notes/ radiography/referrals. (These will form part of the Scored Peer Reviewed Practice Visit). The value of these in total will be 1% of contract value. The following will be scored . Payment of 2% of contract value providing the practice achieves the regional average value +/- 10%. 3. NICE guidelines for recalls. As previously stated , the majority of the recall intervals generated by the care pathway software were over ridden by the clinicians in the pilots. Some re-design is required to allow practitioners to develop full confidence in the system. Providing this is achieved at reasonable intervals a QOF indicator within regional averages would be a sensible measure. 4. Numbers of free replacement restorations provided. Average values to reflect remuneration. 7.Fluoride Varnish applications 8. Fissure sealants SCORED PEER REVIEWED PRACTICE VISIT This element of the Quality matrix is time consuming and expensive but in our opinion there is no substitute for a practice visit in relation to assessing quality of care for patients. We propose a practice visit is made to all practices. This will assess: General practice accommodation Assessment of prevention clinics Assessment of referral audits by the specialist providers in primary and secondary care see below. Assessment of audits in this case the peer review group will look at the audits produced by the provider and discuss them. Random clinical notes assessment and to also include: Cases including endo/ perio/ simple restorative care/ complex restorative care The value of the scored QOF elements is 2% of contract value. The Scored Practice Visit will require development to ensure that it is seen as both a quality measure and also a driver for education and development. If a practice scores highly a visit will not be required for at least three years unless there is a significant change in ownership. If a practice score poorly an early second visit will be triggered. We propose that the Scored Practice Visit is funded through a process of paying sessional fees to a group of trained active NHS GDS practitioners. The costs to be exchanged for normal activity within the existing capped remuneration.

Respondent type	Response
Dentist	yes
Dentist	outcomes is a main focus otherwise the more complicated or greater the information the more complicated and less accessible it will become
Local Professional Network	Dentistry exists to assist patients in attaining the oral health they wish so outcome measures seem appropriate but clinicians should not be penalised for failing to achieve outcomes which are beyond their control, eg improvements in oral health if patient co-operation is poor or patients fail to attend.
Community dental service	Yes, but process is very important and in particular communication and taking into account patients expectations of the outcomes of treatment. i.e. during the process of a dental consultation is there evidence that the patients wishes/expectations/demands have been listened to and are taken into account.
Community dental service	outcomes are the most important, not process
Dentist	Outcomes should NOT be used because, again, a lot of the outcome is determined by the patient and how they manage their oral situation themselves at home, completely out of the control of the dentist. The dentist should be judged on whether they have provided the care that the patient needs, and therefore adequately equipped the patient to manage things themselves at home. If the patient then chooses to completely ignore this advice then that is their problem, and shouldn't impact upon the dentist. For Clinical Effectiveness, the focus should be completely on process indicators. The dentist should be judged on things like: Have they taken a BPE and informed the patient of what these numbers mean. Identified areas that the patient isn't brushing well and highlighted these to the patient with guidance on how to improve things. Screened for oral cancer and discussed results with the patient. Taken necessary routine radiographs and thoroughly searched for caries. Etc. These above points are things that are completely within the control of the dentist. They should be doing these things for their patients, and it is completely right that they should be penalised (financially) if they fail to do them because they are then not enabling patients to have the best chance of improving their oral health.
Dentist	I think measurement of process is important too. For example you could preach Diet, fluoride and OHI until you are blue in the face but a lot of people are not going to listen and so your outcomes would be poor. I mean, come on, realistically who in the UK does not know how to avoid routine OH problems ie perio and caries? Very, very few people indeed. Most people know what to do, many people do not do it. These people are unlikely to listen to their dentist (or other OH /health professional) whatever the framework used. Especially in certain areas/segments of the population. So for this reason process is in some ways more important than outcomes, if the process is sound outcomes should be as good as possible anyway depending on who in society your are trying to treat.
Dentist	I think outcomes is more important than process. Dentists have historically had a mindset that process is all and thus needs to change if reform is to be successful
Dentist	Inclusion of process is vital

Respondent type	Response
Unknown	outcomes are in reality a generational issue may need a 3 year period to begin to see improvements especially in high need areas/ hard to reach groups what about long term treatment planning; how to police/monitor the accuracy /validityof this so a process indicator annually might help with some outcome indicators being measured incrementally or over 3 to 5 years
Dentist	Measure process as well
Dentist	process as well
Dentist	Focus on outcomes is very hard to measure without some sort of independent body measuring it.
Dentist	waiting time for appointment is not a good factor unless we can employ more dentists to reduce waiting times
Dentist	process measures should be included, like number of visits for each risk category in a course of treatment, and number of interventions undertaken for each risk category in a course of treatment.
Dentist	Indicator measures should matter too.
Community dental service	Process would be helpful for e.g. appropriate referral to secondary care/advanced mandatory services
Dentist	Certainly need to assess process too. Some patients respond well to treatment, others don't take on board advice given to them by the dentist even when they've followed the correct protocol, and hence show no improvement in outcome.
Dentist	yes
Dentist	My problem is that we have a huge amount of patients who are over 80.pay for their treatment and have very over restored dentitions. their wants,needs etc are to different from a young adult.nowhere in your papers has there been any consideration for this age group.in fact there is data collected re yhe over 80s as an age group.it is a great failing of all dental data collection and i feel we are being penalised.their care is much lengthier just in getting them into the chaire etc
Dentist	For the above reasons some outcomes should measure process.
Dentist	some indicators should measure process as well
Dentist	Yes, and yes
Dentist	Correct
Dentist	it is correct
Dentist	See previous answer
Dentist	Process has to be measured. Some of the "outcomes " are subjective
Dentist	Process as well but keep it simple to start with.
Dentist	There can be genuine reasons for not achieving the desired outcomes despite the best efforts of the clinicians. They should be recognised for trying to achieve

Respondent type	Response
Trainee dentists	They are broadly keen to see some measure of process too. Such as measures of topical fluoirde applications and prescriptions of high dose fluoride tooth paste.
Dentist	One is perhaps professionally concerned about measuring process since it could imply that incorrect treatment had been metered out. What's the point in being trained if it is presumed that we may make mistakes in treatment planning?Perhaps process could be measured but possibly this could be instituted later as further KPI's just as the GMP contract has done. Of course, that also involved a large pay increase first.....!!
Dentist	Its all far too complex
Dentist	I think that outcomes would be the correct measures, if only you had better ones. A filling which lasts 10 years is a considerably better outcome for the patient than an equivalent one which lasts 2 years.
Academic	Outcomes is correct but they are being looked at in the wrong way. It requires a third party human being to use their eyes and experience to be the judge.
Dentist	I don't think a focus on outcomes is helpful or indicative of a good dentist. Measuring process, however would be very difficult and time consuming.
Dentist	should measure both
Dentist	all you are every interested in measuring outcomes
Dentist	Only the outcome of the treatment is important. Has the decay been removed? Is the patient out of pain? Has the periodontal disease been resolved?
Dentist	i think outcomes is tricky as you need to factor in (which may already be considered) patient compliance or lack of. often despite the best efforts of the whole team to deliver OHI to patients, they just dont take it on board or are not willing to adopt those changes even when they know it is seriously affecting their oral health.
Dentist	Although a dental team can educate patients about preventative approaches, it is ultimately down to the patient to maintain their dental health. If a patient ignores the advise and education provided and his / her dental health fails ..... is it right that the dental team should suffer on the DQOF due to that paients poor decision????
Dentist	i agree. processes are also important to assess.
Dentist	A SYSTEM THAT ALLOWS FOR A CLINICIAN TO BEHAVE PROFESSIONALLY WILL ENDEAR HIGH STANDARDS OF CARE. CURRENTLY WE DO NOT, HENCE THE DILEMMA.
Dentist	It is difficult to measure outcomes but mainly the patient should eventually be pain free and able to eat. As an example is a difficilt extraction that was very successfully and skillfully carried out developes into a dry socket which causes excruiating pain??? Would this be classified as a negative outcome even though the dental treatment was exemplary
Dentist	I am happy to provide preventative advice in all aspects of care my patients need, eg oral hygiene, diet, smoking cessation etc. and I try very hard to encourage good habits but I cannot force a patient to comply. It would be the equivalent of refusing to pay a doctor if his patients did not all attain a BMI of 20, stop smoking and drinking, and work

Respondent type	Response
	out at the gym daily. You can advise, you can encourage patients and inform. To suggest we would like to paid based on a patient achieving all aims is naive.
Dentist	The process should be the success of the work done . It is obvious from your statistics that everyone over over stated the patients perio condition in the first place so of course they improved
Dentist	Process as well. Outcomes are not always an indicator of the time, effort and perseverance that has been used
Dentist	Focus is correct, but needs to be wider.
Dentist	I will just fiddle the figures with this stupid measure.
Dentist	there should be a measurement of process. Process is actually at the heart of clinical quality. There are clinical protocols available to support many clinical interventions and a mechanism should be developed to identify the key criteria for a successful intervention and clinicians would then be expected to work to these criteria. Adherence to the criteria could be a proxy measure for process quality e.g in endodontics. These could be aligned to the complexity pathway approach to facilitate implementation.

Paper 3: The measurement of quality and outcomes

Responses to Question 3

Are there any other considerations that would apply to devising indicators for patients with additional needs, often seen in community dental services?

Respondent type	Response	Additional comments
National body	Yes (please describe below)	Working with and educating carers
Dentist	Yes (please describe below)	Broadly speaking the markers and indicators should be the same as aspirations are identical. However need to be realistic expectations for these groups and tolerance level especially for clinical effectiveness probably need to be broadened.
National association	Yes (please describe below)	In our early conversations with the Department of Health, we have raised numerous concerns regarding the development of indicators for patients in the community dental service. Perhaps the most pressing concern is the wide variety of desired and expected outcomes for patients of this service, which span otherwise healthy individuals with dental phobia, through to patients with the most complex of needs who are reliant on carers. The [redacted] Salaried Dentists Committee (SDC) has recently discussed concerns about where the responsibility for ÿfailure lies e.g. patients who move to a different care setting, or have a change in regime or medication can see significant change in their oral health status. In such situations, months of a dentists hard work can be undone very quickly, and this is something over which the dentist has no control. It is imperative that the system is able to cope with such situations, and that community dentists are not penalised for failures which are outside of their control. The same can also be said for patients in the GDS who are disengaged and difficult to motivate. The [redacted] Casemix model is an indicator of patient complexity and should be a significant indicator of what is practical and possible and what outcomes might or might not be appropriate to be used with any particular patient. We are not of the view that the DQOF as it currently stands is an appropriate measure for CDS patients, particularly those individuals for whom improvement in oral health is not possible. Alongside this, patient reported outcomes may frequently be difficult to capture or may distort a services ratings. The Friends and Family test, for example, would be inappropriate for many who

Respondent type	Response	Additional comments
		access the service through referral, or are transient, homeless, or have severe learning difficulties. We would not support a weighting for this element in the CDS. The [redacted] is working closely with the Department on the CDS pilots, and has established its own evaluation group to consider in more detail the proposals that emerge for the service. We would welcome further discussion of outlines and the utility of Casemix over the coming months. As per our response to the clinical philosophy exercise, we would be keen to explore an additional quality of life index.
Dentist	Yes (please describe below)	The clinical care pathway approach seems to work well in the community dental services. However, it is just difficult to demonstrate an improvement in oral health for many patients using the RAG system. Often the best thing that can be done is ensure that they are not getting worse rather can getting better. Also due to medical conditions many of the patients will always be AmberØ for example a patient with dry mouth will always score AmberØ with little chance of that ever changing. Even if oral heath advice is provided with prescriptions of fluoride toothpaste and applications of varnish the rating will remain at AmberØ albeit less AmberØ. This is important if the RAG rating is used to be a way to measure and moderate payments to clinicians. There will always be some patients that will never improve their scores.
National body	Yes (please describe below)	For patients with additional needs, it is important to ensure that all communication tools are developed in user friendly versions and all possible methods of communication are considered e.g. pictorial tools, videos, apps. It is also imperative that each clinical pathway has modifiers for Specialist Care Dentistry to manage patients with complex medical and mental health needs and identify increased challenges to the provision of care.
Local Professional Network	Yes (please describe below)	Case mix indicators already being collected in [redacted] Partnership trust (Community Dental service) is this more suitable? May be unfair to impose same indicators thresholds or triggers may need to differ to reflect complexity of the service that is provided Baselines need to be flexible: Locally Nationally Individually to reflect the type of service provided. Should there be more emphasis on patient, carer or refer experience or satisfaction than Clinical outcomes.
Dental body corporate	Yes (please describe below)	Presence/absence of suitable carer who is engaged - this could be a parent/carer demonstration of referral to appropriate resource - e.g oral health educator Liaison with other healthcare sectors - e.g. GMP/Social Care
Dentist	Yes (please describe below)	credit for quality should be given to practices who see patients with learning difficulties / disabilities
Dentist	Yes (please describe below)	Consideration will have to be given to devising indicators for the delivery of any complex treatments: ó Perio for BPE 3+ ó Molar endo ó Surgical extractions ó Domicillary treatment ó Sedation treatment ó Under 5 provision ó Elderly care ó Vulnerable groups in deprived areas

Respondent type	Response	Additional comments
National body	Yes (please describe below)	Patients with learning disabilities, behavioural challenges, significant medical conditions or who are from vulnerable groups, such as those seen within the CDS may need more patient/condition- specific indicators due to the presence of predisposing risk factors for disease and poor dental attendance. A more comprehensive tool kit for risk assessment thus needs to be developed and utilised for this group. Furthermore, BSPD must stress that every CDS should have a specialist in paediatric dentistry as part of the team/clinical network. This workforce is mandatory to quality-ensure care for children with more complex needs and should therefore be involved in the development of quality indicators for this group.
National body	Yes (please describe below)	The [redacted] team believe that some clarification of the patient groups being treated in the CDS would be helpful. Likewise clarification of the role of the CDS as to whether the CDS is primarily treating adults with special needs and hence practising special acre dentistry or whether her they are treating children with high dental needs as the indicators for these two populations maybe very different.
National association	Yes (please describe below)	We believe that there should be close liaison with colleagues at the BDA in determining additional considerations affecting indicators for patients with additional needs.
Local Professional Network	Yes (please describe below)	Monitoring uptake among key groups in relation to health inequalities
National association	No	
Dentist	No	
Dentist	No	
National organisation	Yes (please describe below)	Examples might include plaque score improvement; dietary conformance and adoption of lifestyle changes - according to the ability of the individual patient
Local Professional Network	Yes (please describe below)	May require enhanced uptake monitoring in relation to health inequalities
National organisation	Yes (please describe below)	Within patient experience: ÿAdequate allocation of time and ÿaccess to home-based care.
Dentist	Yes (please describe below)	Patients may be unable to provide PROM,s and this will need to come from the carer . Some process measures in comparison with healthy able patients may be beneficial as it may take longer to achieve improvements

Respondent type	Response	Additional comments
Dentist	No	
Dentist	No	
Dentist	Yes (please describe below)	The DQOF payments need to be flexible to allow those with special needs.
Dentist	No	
Local Professional Network	Yes (please describe below)	Measuring outcomes is important but if an outcome is mainly determined by the patient and they lack the capacity to achieve them then other measures, which may be process related, need to be considered.
Community dental service	Yes (please describe below)	Largely the same measures, but would require a weighted indicator to show degree of additional care required. Plus a whole raft of additional measures required to reflect additional activity required to provide a smilar level of treatment to someone without additional care needs. The CDS is very different to GDS in a lot of areas of its work and would need to be commissioned differently to a GDS contract
Community dental service	Yes (please describe below)	there are considerations, but very difficult to provide ideas for indicators. The Case Mix measure provided some level of indicator. Can this be adapted?
Dentist	No	
Dentist	Yes (please describe below)	I don't know
Dentist	No	
Dentist	No	
Unknown	Yes (please describe below)	how to measure patient motivation understanding committment dentists should not be penalised but also not have an opening to claim patients are not motivated to avoid treatment PROMS very important
Dentist	No	
Dentist	Yes (please describe below)	limitations re third party invovlement
Dentist	No	
Dentist	Yes (please describe	if a dentist extract a tooth is that good rather than spending time to do complex work to save it ,,how will this be measured .

Respondent type	Response	Additional comments
	below)	
Dentist	No	
Dentist	No	
Community dental service	Yes (please describe below)	Oral care plans for those in residential care Availability of sedation/GA options
Dentist	Yes (please describe below)	extra resources
Dentist	No	
Dentist	Yes (please describe below)	The number of additional visits should be taken into account and the time needed at each appointment to explain not only to the patient but also the carers.
Dentist	Yes (please describe below)	more process, less outcomes
Dentist	No	
Dentist	No	
Dentist	Yes (please describe below)	Access to treatment
Dentist	Yes (please describe below)	Some measure of clinical time needed that could be remunerated correctly The community system currently does a very good job. Why change it? The reason can only be financial
Dentist	No	
Dentist	Yes (please describe below)	Changes in dietary habits like those of smoking and alcohol measures could be recorded
Trainee dentists	Yes (please describe below)	Plaque & bleeding scores
Dentist	No	

Respondent type	Response	Additional comments
Dentist	Yes (please describe below)	Yes
Dentist	No	
Dentist	Yes (please describe below)	patients anxiety - incomplete treatments as a result of
Dentist	No	
Dentist	No	
Dentist	No	
Dentist	Yes (please describe below)	yes the post code of the practice is not the way to assess it. the post-code of the patients seen, is part of it as well as the BSA data on the history of treatments received is important to consider because that indicates the future demand expected upon the service.
Dentist	No	
Dentist	No	
Dentist	Yes (please describe below)	It is very difficult to devise indicators to reflect patients treatment. Possibly the best indicator used to have a selection of treatments assess by a dental reference officer
Dentist	Yes (please describe below)	outcomes for these patients could indicate a dentist providing poor care where they are providing the best possible care tailored to the patient's wishes and ability to cope. As a CQC indicator for care homes is to ensure all clients have access to regular dental care, if general dentists can no longer treat these patients without the risk of appearing to have low outcomes (and therefore less remuneration) these patients will still have to be seen and will end up swamping CDS or the hospital/ medical profession instead. Current systems have no way of knowing how many general dentists such as myself, continue to treat anxious, medically compromised, elderly or neurologically impaired patients. I continue to treat these people in GDS after leaving CDS and people like me relieve pressure on an already skeleton CDS service in our area. If I can no longer afford to do this, patients will merely move from us to the salaried profession.
Dentist	No	
Dentist	Yes (please describe below)	Weighting of any improvements.

Respondent type	Response	Additional comments
Dentist	Yes (please describe below)	waiting times?

Paper 3: The measurement of quality and outcomes

Responses to Question 4

If you would like to see some process indicators, what areas should the framework consider?

Respondent type	Response
Local Professional Network	We are reluctant to suggest any additional indicators unnecessarily as such indicators would only add to the complexity of commissioning and monitoring NHS dental services. This creates more bureaucracy for practices and commissioners to manage. Regulating businesses in this way has the potential to stifle innovation, which would be to the detriment of patient care. If any mandated processes were introduced, they should be designed simply to enhance clinical freedom.
National body	If we take endodontics as an example and reference the current Tiers / complexities then much Tier 2 work could be avoided if Tier 1 was done correctly in the first place. This requires a re-visit of how GDPs are remunerated for providing endodontic care which takes time to do properly. The expected standard for endodontics has risen over the past 10 years but the remuneration to the GDP has reduced. In this regard the obvious process indicator would be the post operative radiograph as there are a wealth of clinical outcome studies that contribute to define the quality of outcomes associated with healing.
Dentist	Need to be able to demonstrate that clinicians are following some local care pathways to manage conditions appropriately without restricting judgement. E.g. ensuring that patients with BPE score of 3 are managed in a suitable fashion and not just with a simple scaling.
National Association	We would support the inclusion of data submission to the BSA as a process measure.
Dentist	Are care plans issued to all patients with an explanation? Is there evidence of preventive interventions such as fluoride toothpastes and varnishes? Ability for Area Teams to monitor treatment items similar to what is happening currently.
Local Professional Network	Rationalisation-keep simple Could measure process of appropriate referrals to other pathways. (E.g. Oral surgery and orthodontic)
Dental Professional	Maybe there should be a section for patients who arent expected to respond due to their risks but still need time spent with them to help them?
Dental body	In patients with significant dental need, process indicators could include advice given, onward referral to appropriate

Respondent type	Response
corporate	skill base e.g. smoking cessation services, application of topical fluoride. In elderly patients this could include carer information supplied, education of carer, as well as indicators above This would also apply to socially deprived groups. This would allow teams to demonstrate that all feasible steps had been taken to engage with the patients and that the failure to achieve the desired outcome was outwith the control of the dental team. This will also encourage these groups to be treated more readily in a primary care environment
Dentist	pathways that involve ohi perio and fluoride interventions , often from therapists and extended duty nurses
Dentist	As the new contract needs to encourage effective treatment delivery with a preventative approach, DQOF measures need to be a combination of Outcome and Process Measures. The process measures are likely to have upstream outcome benefits. Possible measures to deliver this include: ó Compliance with Delivering Better Oral Health Toolkit recommendations ó Prescription of radiographs ó Periodontal treatment ó Compliance with CQC requirements ó Patient satisfaction measures ó Longer term health improvement measures
Dentist	As mentioned above, there should be indicators as to whether the patient has complied with advice given.
National body	For children and young people, there are some suggested key process indicators that could be considered: ó Caries indicators need to include primary teeth in addition to permanent teeth ó BPE should be undertaken for all children who have erupted first permanent molars not just patients over 19 years ó As good behaviour management is key to successful dentistry for children, measures of anxiety (and subsequent reduction in anxiety) might be appropriate process indicators ó Use of bitewing radiographs, so often omitted in general dental practice, are evidence based approaches for caries diagnosis which should be used as process indicators for children
National body	(See answer to question 2) The [redacted] team would like to see some measurement of wait time between the oral health assessment and interventions included. Likewise whether referrals onto specialists conform to the national guidelines (yet to be finalised via the clinical pathway commissioning guides) could be included, although a tolerance for exceptions should be accommodated in any metric
National association	As per our response to Q2, we believe that the submission of data should be considered as a process measure. Beyond this measure, we believe that the BDA is best placed to suggest additional indicators.
Local Professional Network	The process indicators as outlined in DBOH eg Fluoride application. Process indicators that would support improvement in outcomes would be beneficial for example maintaining up-to-date patient registers on particular health conditions would be useful in under-pinning preventative care, e.g. diabetes and smokers.
Dentist	History recording, patient feedback, RDO type of checks
Local Professional Network	Delivering Better Oral Health process indicators would be a good start e.g fluoride application
Dentist	The experience and satisfaction of the carer and from services that refer patients. This could include timeliness of response .

Respondent type	Response
Software supplier	Dentists should be rewarded for establishing an ongoing relationship with patients, especially those patients at high risk. As per question 1, the DQOF should embed rewards for getting patients back for their OHR in a timely manner. Similarly there should be compensation for proactively driving that, where ever possible, courses of treatment are completed in a timely manner . If we are going down a capitation route then a measure of access will also be important this will drive practices to be more proactive about filling white space in their appointment book etc.
Dentist	If I had my time again, I would have attended a hands on perio course. I thought that my BPE's were accurate going into the pilot but have realised that if more time is spent on careful perio assessment, the BPE's can be very different.
Local Professional Network	Process indicators could relate to clinical activity compared with similar practices, availability of routine and emergency appointments. How often the emergency/ urgent are is resolved in one visit. This would hopefully reduce patients having multiple attendances for the same clinical problem.
Community dental service	Antibiotic prescribing Evidence of OHI and Diet advice given Adherence to any national guidance on prevention or clinical interventions Communication and evidence of listening to patients' wants/demands/expectations
Dentist	OHI, TBI, diet advice recorded as given. 6/12 checks and f- varnish for children and at risk groups (eg caries prone individuals, OAPs, special needs). Adequate perio tx for those with BPE over 3 in any sextant. Assessment of average time taken for treatments (to highlight suspect 20minute crown preps/molar endodontic treatments).
Dentist	Evaluation of treatment provided where there is choice
Unknown	needs further thinking but one or two might be useful if correctly linked to outcomes
Dentist	trying to do complex work .
Dentist	process measures should be included, like number of visits for each risk category in a course of treatment, and number of interventions undertaken for each risk category in a course of treatment.
Community dental service	Appropriate referral to secondary care/advanced mandatory services
Dentist	does the treatment work?
Dentist	as above.the over 80s who are dentate
Dentist	Periodontal treatment visits and oral hygiene instruction. There needs to be a process indicator for domiciliary visits which are not currently taken into account in the current contract.
Dentist	Patient numbers
Trainee dentists	Topical fluoride application High strength fluoride TP prescriptions Fissure sealants oral hygiene instruction
Dentist	All
Dentist	restoration longevity
Dentist	volume of work

Respondent type	Response
Dentist	I don't know what process indicators are, it sounds like some management [redacted].
Dentist	those assessed by the CQC. those done by the dentist in house assessed directly by a LAT representative
Dentist	Practice location Patient population makeup consider using the ethnicity data to determine the split on patient populations, ditto age, and using these to assess against the local population to estimate whether the practice is providing access to all sectors of the local populace.
Dentist	The use of Dental reference officers to check work possibly using retired or part time dentist with enough experience to guide dentists
Dentist	Stop trying to measure everything. The best way forward, and I cannot believe that I am suggesting this, is to have a proper Dental Reference Service.
Dentist	please see answer to question 2. The framework should consider the protocol for the intervention that will lead to the outcome. The protocol will have criteria which can be used for measuring process quality

Paper 3: The measurement of quality and outcomes

Responses to Question 5

For the clinical effectiveness indicators, do you think the focus on caries and BPE is correct?

NB Respondents who answered ” no” were invited to elaborate

Respondent type	Response	Additional comments
Dentist	Yes	
Local Professional Network	No (Please elaborate)	As the two main diseases treated by dentists in primary care, we would support the focus on caries and periodontal health as indicators of clinical effectiveness. We would reiterate though, that focusing on these indicators leads to the measurement of outputs, rather than outcomes.
National Society	No (Please elaborate)	Only at a superficial level. When more advanced care is provided there should be a mechanism of random external checking such as DROs
Dentist	No (Please elaborate)	Concerns with this as highlighted above
National Association	Yes	
Dentist	No (Please elaborate)	Yes - Needs to be kept simple and relevant. Consideration and guidance on appropriate longevity of restorations needs to be discussed with future guarantees being set accordingly.
Local Professional Network	Yes	
Dental Professional	No (Please elaborate)	[redacted] would like to see a better point system applied to the clinical effectiveness indicators section. It is common knowledge that undiagnosed Periodontal disease has the highest growth in claims in all dentistry. It also has huge effects on general well being and needs the rate applied to increasing periodontal health to reflect its importance. Having such a small number of points available will decrease its importance in the remuneration process. The BPE is a screening tool, therefore not always accurate. It will fail to detect gingival overgrowth as a drug side effect and likewise it cannot determine a patients

Respondent type	Response	Additional comments
		history of bone loss as it only measures what is presented. It also is not recommended to assess patients bleeding especially as a stand-alone tool when assessing smokers. BOP should be used instead.
Dental body corporate	No (Please elaborate)	The focus on caries is correct. However most patients will not comprehend a BPE score. Also it can be demotivating as in cases where an improvement is visible the nature of the BPE scoring does not always allow this to be demonstrated.
Dentist	Yes	
Dentist	Yes	
Dentist	No (Please elaborate)	could include extractions related to teeth of poor prognosis
Dentist	No (Please elaborate)	These are important indicators but the inclusion of radiograph prescription rates should be considered.
Dentist	Yes	
National body	Yes	
National body	Yes	
National Association	No (Please elaborate)	In addition to the Basic Periodontal Examination, we suggest that patients are routinely screened for signs of oral cancer during their treatments.
Dentist	Yes	
Local Professional Network	No (Please elaborate)	Yes, but when the BPE scores 3 a pocket chart is required.
National body	No (Please elaborate)	Figure 2 provides a list of indicators but it does not enable us to work out how many healthy teeth a patient has. (Patients with missing teeth could skew results?). Also, will the dataset enable us to pick up on failed (repeated) treatments?
Dentist	No (Please elaborate)	We are missing extractions !
Dentist	Yes	
National organisation	No (Please elaborate)	In part only - see Q6.
Local Professional	No (Please elaborate)	Code 3 and above should use pocket charting

Respondent type	Response	Additional comments
Network		
National organisation	Yes	
Dentist	No (Please elaborate)	BPE May be difficult or impossible to record for some patients eg phobics. There needs to be some additional measure of periodontal health .
Dentist	No (Please elaborate)	However we need to be very careful in terms of attaching remuneration to these indicators at reasonable and achievable levels. What we want to encourage is accurate assessment of improvement, deterioration and remuneration mat effect the scoring. Also the use of BPE is problematic as indicated by the improvements generated. BPE is a screen and is operator sensitive , however it is still useful.
Dentist	Yes	
Dentist	Yes	
Dentist	Yes	
Dentist	Yes	
Dentist	No (Please elaborate)	As BPE and Caries risk is based on the patients behaviours this may be unfair to base contract values on this. The dentist may spend a lot of time giving preventative advice however if the patient does not follow this advice improvement will not be evident. Therefore the dentist has spend a considerable amount of time only to be penalised if the patients does not follow the advice.
Local Professional Network	Yes	
Community dental service	Yes	
Community dental service	No (Please elaborate)	01.02- DT for 6-18 years covers mixed dentition stage and will be complex and misleading?
Dentist	No (Please elaborate)	I think that there should be a focus on IF THESE THINGS HAVE BEEN DONE - eg. has a BPE score been taken and have all possible caries been identified, but not if these factors have improved because they are too patient-dependent. For example, unless a patient is keeping their teeth spotlessly clean (and some patients just won't be capable of this), there is going to be some bleeding from somewhere when doing a BPE score - so how can this possibly be used as a judgement of clinical effectiveness? Even taking into consideration a Plaque Index would be more indicative of clinical effectiveness than BPE, but even this is too patient-dependent. See answer to Question 2 above.

Respondent type	Response	Additional comments
Dentist	No (Please elaborate)	BPE too vague and imprecise, six point pocket charting with appropriate remuneration and time allocated to encourage compliance to do this time consuming, tedious and mundane task. It is the best way we have to measure perio health over time.
Dentist	Yes	
Dentist	Yes	
Unknown	No (Please elaborate)	answer is yes but cannot comment so had to say no to be able to/ societal /population/ impact of fluoridation issues
Dentist	Yes	
Dentist	Yes	
Dentist	No (Please elaborate)	possibly should include an educational questionnaire that each patient answers to find out whether a dental team is delivering the message not just treating the disease
Dentist	Yes	
Dentist	No (Please elaborate)	host resistance
Dentist	Yes	
Dentist	No (Please elaborate)	...in that BPE's for patients with few or no teeth will skew the figures.
Community dental service	Yes	
Dentist	Yes	
Dentist	No (Please elaborate)	in areas of high demand there will be high levels of disease
Dentist	Yes	
Dentist	No (Please elaborate)	Again for those working in CDS, it can sometimes be impossible to gain sufficient cooperation to do a BPE. We can't always catch our patients!
Dentist	Yes	
Dentist	Yes	
Dentist	Yes	
Dentist	Yes	
Dentist	Yes	

Respondent type	Response	Additional comments
Dentist	Yes	
Dentist	Yes	
Dentist	Yes	
Trainee dentists	Yes	
Dentist	No (Please elaborate)	I think recording of BPE alone is sufficient and the Bleeding site index is superfluous to requirements and over complicates the computer work.
Dentist	No (Please elaborate)	BPe and caries in a deprived area is hard to improve, an additional large weighting is required.
Dentist	Yes	
Dentist	No (Please elaborate)	Not exclusively.
Academic	Yes	
Dentist	No (Please elaborate)	Largely these are out of dentists control especially BPE. One cannot force patients to improve their own diet or oral hygiene
Dentist	Yes	
Dentist	No (Please elaborate)	you cannot make some one brush their teeth. The fact is that the dentist will be blamed.
Dentist	Yes	
Dentist	No (Please elaborate)	Erosion/ attrition should be measured too
Dentist	No (Please elaborate)	BPE is not (as stated by the guidelines) a good way to measure improvements or monitor perio. this can ONLY be done using a 6ppc. it is purely designed to screen for patients who are at risk or need intervention / ohi. equally bleeding present in a sextant is highly unreliable and very simplistic.
Dentist	No (Please elaborate)	BPE is difficult to reproduce consistentely... even by the same operator!! BPE is not an accurate measure of disease.
Dentist	Yes	
Dentist	No (Please elaborate)	DEPENDENT ON PATIENT RESPONSE ULTIMATELY.
Dentist	Yes	
Dentist	No (Please	Yes and no you have to ask patients what they want you can'y ignore their concerns. They might be very

Respondent type	Response	Additional comments
	elaborate)	concerned about an ulcer that has not cleared up
Dentist	No (Please elaborate)	Again we cannot make patients improve. I have patients who will not consent to the treatment I know they need to improve their oral health. Should I accept I will lose pay because of this or refuse to see them? Again they will end up in A and E next time they are in pain.
Dentist	No (Please elaborate)	A clinician will spend the most time with the neediest people and achieve the lowest results
Dentist	No (Please elaborate)	Should be DMFT and BPE from the stage that a patient has a full set of second teeth. Ideally should include 6PPC for those patients who require it. How long does a restoration last before it fails? What is the success rates of RCT, perio etc.?
Dentist	No (Please elaborate)	Those in high needs areas will be at a disadvantage.
Dentist	Yes	

Paper 3: The measurement of quality and outcomes

Responses to Question 6

What other areas of clinical effectiveness could be included as an indicator?

Respondent type	Response
Local Professional Network	Following the patients oral health assessment and a discussion with them about their options, the dentist will record the agreed treatment plan in the patients notes. Indicators of clinical effectiveness must pay attention to the appropriateness of the agreed treatment plan and the efficacy of the clinical treatment undertaken, rather than relying on a rigid set of indicators defined by central Government. Measuring all practices against the indicators included in this paper runs the risk of identifying practices in the areas of highest need as being the lowest scorers. For this reason, the indicators provided here must be reviewed.
National body	DRO inspection are clearly not possible for everything , however, re-introducing the treatment database might be useful, such as the one held at Eastbourne, as this would allow tracking of treatments, how long they last etc.
Dentist	Restoration survival rates Endodontic longevity Some of the current DAF data e.g. extraction:endo ratios Ceiling for individual performer activity e.g. 10,000 UDAs/year and if exceeds automatic investigation.
National Association	We do not believe that there are any other areas of clinical effectiveness that should be included in the DQOF for general practice. Areas of clinical effectiveness which could, in our view, be incorporated for the CDS include: patient cooperation (comparing the situation at the first appointment with the end of the treatment); ability to communicate with the patient (first appointment to end of treatment); achievement of oral soundness (as opposed to oral health); and whether a general anaesthetic has been repeated within a specified number of months.
Dentist	The frequency of replacement of restorations that were placed within 12 or 18 or 24 months? The exact filter needs to be decided. It could be different for different types of restorations.
Local Professional Network	The rate of antibiotic prescribing could be monitored- reduction could be measured.
Dental Professional	Smoking cessation.-
Dental body corporate	The presence/absence of plaque and also presence/level of bleeding. Patients will more readily understand that the deposits of plaque will contribute to inflammation and thereby bleeding. Reduction in these can be measured and communicated readily to the patients and is also motivational where improvement is noted.
Dentist	ó Compliance with Delivering Better Oral Health Toolkit recommendations ó Prescription of radiographs ó Periodontal

Respondent type	Response
	treatment ó Compliance with CQC requirements ó Patient satisfaction measures ó Longer term health improvement measures
National body	[redacted] supports the focus on caries and BPE but would stress, that for young patients, there needs to be additional focus on tooth surface loss and monitoring of the developing dentition. More child-specific outcome measures should be considered which may relate to factors such as sleeping/eating/social integration/school attendance.
National body	The [redacted] team agrees that the caries and BPE indicators are the basic clinical effectiveness indicators as covers the two of the most important areas of oral health however they would like to see some indicators of mucosal health included. Radiographs may have been taken as part of the oral health assessment and therefore consideration should be given as to align the clinical effectiveness indicators to the IRME regulations and particularly whether the findings and interpretation of any image have been recorded in a patients records
National Association	We support the existing range of clinical effectiveness indicators.
Local Professional Network	There should also be a particular emphasis on older people which isnt reflected in the indicators. It would be worth including indicators that capture an integrated approach to care e.g. referrals to other services, smoking cessation, offering a NHS Health Check to maximise the potential offer that dentists can make to primary care.
National body	Proportion of patients returning ahead of their recall interval?
National organisation	Longevity of restorations and frequency of unplanned symptomatic visits could be included
Local Professional Network	There should be a focus on older people which is not reflected in the indicators And indicators that capture an integrated approach e.g. referrals to other services, smoking cessation, NHS Health Check etc
National body	Anti-smoking results, in particular offer and uptake rates of and results of anti-smoking counselling, would have wider and far-reaching health and financial benefits. This would also allow a link between remuneration and such counselling which can be time consuming if done properly.
Software supplier	Detection and reversal of early caries.
Dentist	Fluoride varnish and sealants. These indicators are very important as the evidence behind the process is strong and practices should be providing this care. The proposed Alt Contract Reform incentivises these elements of care up to a point.
Dentist	The clinical effectiveness areas collected is very broad however I don't think there is an ideal indicator to monitor
Local Professional Network	Number of repairs or replacements of restorations in a given period for a tooth may be important. Care though is needed that dentists do not prescribe treatments that avoid this data being captured whilst not being the optimum for the patient. Eg crowning a tooth rather than patching it. Extracting a tooth rather than restoring. The % of patients in each RAG category could be compared with recall frequency to look at appropriateness of care.

Respondent type	Response
Community dental service	Out of pain Functional dentition
Dentist	For Clinical Effectiveness, the dentist should be judged on things like: Have they taken a BPE and informed the patient of what these numbers mean. Identified areas that the patient isn't brushing well and highlighted these to the patient with guidance on how to improve things. Screened for oral cancer and discussed results with the patient. Taken necessary routine radiographs and thoroughly searched for caries. Etc. These above points are things that are completely within the control of the dentist. They should be doing these things for their patients, and it is completely right that they should be penalised (financially) if they fail to do them because they are then not enabling patients to have the best chance of improving their oral health.
Dentist	Length of time between replacement of fillings, crowns, number of endodontic procedures that work/don't work. Number of extracted teeth as compared to averages of similar patient demographic. DMF scores compared to same averages every 5yrs or so.
Dentist	I think some measure of whether clinical interventions work for the patient.
Unknown	go abck to do some research on what is effective; real gaps with this even NICE recalls are not based on sound peer reviewed research
Dentist	Teeth replaced
Dentist	indicators that record risks e.g. for oral cancer
Dentist	Ability to perform all type of surgery in house, such as extractions minor surgery and sedation
Community dental service	Self declared change in practice by the patient
Dentist	how long does the filling last & did it hurt?
Dentist	asking the patient what they would like as their indicators
Dentist	Erosion, non carious tooth substance loss
Dentist	Patient Satisfaction
Dentist	Patient knowledge, possibly.
Trainee dentists	Plaque & bleeding scores. Some FDs worried that they would be measured on outcomes they had little control over, such as patients compliance with home care regimes that they could only have a minimal influence upon. Other FDs felt that some form of independent patient inspections service would provide better evidence of delivery of good quality care.
Dentist	Assessing all 11 year olds for impacted canines and the application of fluoride to all under 18's should be made specific clinical indicators and not just as an overall view of effectiveness.

Respondent type	Response
Dentist	Patient inspection at the practice.
Dentist	There are more dental diseases than just caries and periodontal disease. If you wish to target the provision of NHS dentistry purely on those diseases, carry on, that's what we'll end up doing, and your Minister will be able to continue to make disingenuous and misleading statements. Dentists are at least as clever as Civil Servants, and whatever system you devise to try to control some aspect of their behaviour, Dentists will find a way to make a living from it. History should have taught you that by now.
Academic	Long-term monitoring of regularly-attending capitation patients to ensure that the number of fillings or perio treatments is appropriate the the RAG band to which they have been assigned.
Dentist	smoking, diet, plaque scores
Dentist	you have very little understanding of clinical dentistry, all you are interested in is measuring outcomes. If we measured the effectiveness of the civil service and its outcomes, the county would be in for a shock. Although no civil servant ever gets penalised for failure!
Dentist	Emergency treatment, pain.
Dentist	6ppc, BEWE for tooth wear, bleeding indices (as per the literature, not a sextant present or not present). plaque scores etc. its all timely but it is the only true acruate methods (perhaps a BPE score of 1 or more might instruct the dentist to do something more on the computer?)
Dentist	Duraphat application in kids. Referal rates... appropraite referals.
Dentist	Fluoride varnish application
Dentist	Patient involvement needs to be considered
Dentist	If you pay for better dentistry you will get better results. You will not get quality dentistry on the cheap.
Dentist	linking diagnosis of pain to the intervention delivered.An algorithm to align thes etwo would add value in my personal opinion

Paper 3: The measurement of quality and outcomes

Responses to Questions 7 & 8

Question 7: For the patient experience indicators, do you think they cover the right areas?

Question 8: What other areas of patient experience, if any, should be included?

Respondent type	Question 7	Question 8
Dentist	Yes	
Local Professional Network	No	None. The introduction of the Friends and Family Test (FFT) across the NHS will provide all the information needed for this domain. Any additional indicators used to disaggregate patient experiences must not duplicate the information recovered from the FFT.
National body	No	Patient experience at the surgery is very important. The pilot system does seem to allow more time with patients, this is a good thing and it should result in improved patient experience. However different procedures lead to different levels of stress and therefore experience at the dentist and modification factors may need to be considered. Again these are comprehensive at a high level, one assumes pain is considered under PE 01.
Dentist	No	FFT needs to be included as will be implemented in April 2015. As mentioned previously PE1 has some pitfalls, but generally good.
National Association	No	Patient experience indicators should focus on the provision of patient centred care rather than patient satisfaction alone. We are also concerned about the inclusion of an indicator on patient waiting times. There are numerous reasons why a patient appointment may exceed its allotted time, and these reasons are almost exclusively for the benefit of the patient being treated. The idea that dentists might be penalised for spending the required amount of time to treat their patients appropriately is unacceptable to us, and would in our view, have the potential to compromise patient care, outcomes and safety. Dentists must be supported to provide urgent treatment and deal with complex treatments which may impact their appointment schedules, and soliciting patient feedback on delayed appointment times is unhelpful. To be valuable to practices, it is important that where patients express dissatisfaction, that they are asked to give reasons. We note with interest that pilot practices have scored less well on the indicators relating to patient

Respondent type	Question 7	Question 8
		satisfaction, and we would welcome confirmation from the Department that this data is carefully analysed to ensure that flaws within the collection system itself are removed as much as possible. The [redacted] would welcome the publication of this data from the pilots so that respondents to this exercise are able to make a fully informed decision about how patient experience indicators may be used in a reformed contract. The [redacted] is represented on NHS Englands Friends and Family test (FFT) working group which is responsible for developing arrangements for the roll out of the test to dental practices in 2015. The current DQOF includes the friends and family question and we recommend that the BSA collects this data rather than it having to be collected at practice level. We understand through our participation in the working group that there is no financial incentive to completion of the test but the announcement letter to dentists states that it will be a contractual requirement. Its inclusion in the DQOF suggests otherwise and clarity on this point would be welcomed. We have some concerns about how friends and family will be applied in dentistry which we will want to discuss further with NHS England. If the test is to be applied as a contractual requirement, there will need to be formal consultation. No other areas are needed for patients in general practice.
Dentist	Yes	Ask patients if they were provided with a care plan. Appointment waiting times and diaries should be divided into urgent and routine care. The overall number of question need to be reduced. This could be done by not asking all the questions at the first visit and asking them in rotation.
Local Professional Network	Yes	PE.05- Should this read friends and family to tie in with NHS Englands plan to introduce Friends and Family Test to NHS dental practices in April 2015 PE.07-Waiting times may actually initially increase so support needed nationally to inform patients that this may happen and this indicator should be monitored with this in mind.PE.05- Should this read friends and family to tie in with NHS Englands plan to introduce Friends and Family Test to NHS dental practices in April 2015 PE.07-Waiting times may actually initially increase so support needed nationally to inform patients that this may happen and this indicator should be monitored with this in mind.
Dental Professional	Yes	
Dental body corporate	Yes	
Dentist	No	Appearance is mentioned. Aesthetics has never been included with NHS dentistry, the department would need to be very careful with asking patients whether they are happy with the appearance of

Respondent type	Question 7	Question 8
		their teeth and using this as a means of OFT payment. Patients will always want to improve the appearance but we are constrained by NHS funding and this is they way the department wants it to stay as the remuneration is capped. Being pain free, clear of infection and functional should be the only areas NHS dentistry covers.
Dentist	Yes	Difficult in practice to apply patient experience to associates. They are not responsible for friendliness of staff, but are responsible for patient's satisfaction with treatment. How do you apply that to associates pay?
Dentist	Yes	
Dentist	Yes	No additional.
Dentist	Yes	
National body	No	A recent funding call by the NIHR highlighted the need for more robust research on the use and usefulness of patient experience indicators. BSPD strongly questions the validity of the patient experience indicators used within the pilot studies, and furthermore stresses the need for child-appropriate indicators. Children should be actively included, and their experiences and perspectives not just given by a proxy (parent/carer). Appropriate methodologies should be used to capture child experiences, which we know to be very different to those of adults. In addition, we know that good communication and empathy are key aspects of a childs experience, and this could be measured as part of the overall patient experience domain.
National body	Yes	The [redacted] team believe that the patient experience indicators should be aligned to the national outpatient questions and the Friends and family test and the yet to be determined market forces factor. This would align dentistry to all the other areas of health care delivered in an outpatient setting. PE.01 is the only patient experience related to dentistry. Adding patients satisfied with their appearance (particularly after a course of orthodontics) may be very difficult to interpret, as the aesthetic component and function may not be aligned.
National Association	No	The inclusion of an indicator based on patient understanding and/or patient attitudes to oral health would be welcome. As we have emphasised elsewhere in our response, both of these factors are of critical importance to the success of a preventative approach.
Dentist	Yes	

Respondent type	Question 7	Question 8
Local Professional Network	Yes	Making sure that the patient has been given a costing of the treatment eg FP17DC.
National body	No	The principles on page 5 talk about the patient being free from pain, eat, speak and socialise and have good oral health that will continue into the future. With these in mind, would patients be directly asked if they are free from pain following their treatment? We recommend splitting out the three descriptors of functionality and aesthetic form as asking a patient to comment on multiple factors with a single answer is bad question design. There is nothing relating to the last principle good oral health should we ask patients their perception of their oral health and whether they understand how to maintain good oral health (i.e. they were given understandable advice).
Dentist	Yes	
Dentist	Yes	
National organisation	No	Refer to research (M Phil dissertation) by Busby M et al (2012) who defined key issues of importance for the measure of satisfactory patient experience. See: Br Dent J. 212(8):E11
Local Professional Network	Yes	
National body	Yes	The communication skills of the treating clinician are often vital to the patient experience. Language skills are sometimes poorly test and can lead to a dependence on translators or dentists who lack these skills. When a patient is confused or in pain translators and poor language skills can make it difficult to reach decisions based upon informed consent as discussed above. Also, more generally, there is always more all clinicians can do. Even those with good language skills do not always take the time and effort to communication effectively and empathetically with all patients. This must improve and is a common source of patient anxiety and dissatisfaction.
Dentist	Yes	Patient waiting times should not be included. The patient could be asked if they felt that they had been aided with their self care of teeth and gums
Software supplier		With the focus moving towards getting patients to take more responsibility for their care then there is increasing importance connected to effective communication and establishing patient understanding of what they need to do. So questions like: Do you understand the advice on the

Respondent type	Question 7	Question 8
		careplan? Do you understand the p[otential outcome from not following the advice on the careplan? What advice on the careplan will you / did you find hard to follow?
Dentist	Yes	Yes. But we need a large sample Remove PE.01. as it is too insensitive.
Dentist	No	the patient experience question cannot generate satisfaction from a large cohort of the population because of Rising patient expectations. Patients are told by NHS Choices web site; You're entitled to have all clinically necessary treatment on the NHS. This means that the NHS will provide any treatment that you need to keep your mouth, teeth and gums healthy and free of pain. This includes: ó dentures ó root canal treatment ó crowns and bridges ó any preventive treatment needed, such as a scale and polish, an appointment with the dental hygienist, fluoride varnish or fissure sealants ó white fillings ó orthodontics for under-18s NHS Choices is wrongly interpreted by many patients as them being entitled to anything they choose because the DoH does not define clinically necessary. NHS Choices creates a mismatch between what patients expect and what NHS dentists are able to provide. Patients who have been lead to believe they should be able to have any treatment will logically feel aggrieved if this is not offered to them. If a dentist has a different view to the patient of what is clinically necessary there is no clear guidance to justify their decision. Patients increasingly demand written explanations, which frequently disrupt the working day of a NHS dentist and create disputes that are unpleasant and stressful for all concerned. This unremitting pressure on dentists significantly affects their well being and it has been cited as the reason for many dentists leaving the NHS. Contrary to accusations that NHS Dentists take advantage of the lack of clarity in the current contract to underperform, most dentists strive to provide the best possible service they can to meet their patients expectations. Frustratingly however, it is not possible within NHS budgets to provide the level of treatment that patients increasingly request. Dentists who attempt to do so risk failing to meet their UDA targets and the reward they would get for their efforts would be a cut in their funding. As well as having higher expectations, patients are more willing than ever to complain and this is set to continue. In 2014 [redacted], chair of General Dental Council (GDC) said; The volume of patients complaints about poor dentistry is likely to increase. Service users will become increasingly consumerist in their outlook many already are - and so the pressure will not lessen for services to be designed around the needs of patients and for care to be delivered in ways that patients are happy with. For patients to be happy with the service they receive they need to know from the outset what that service (the NHS) is prepared to provide.
Dentist	No	These are extremely subjective for example a patient who has never attended is seen with a day wait may give a negative response even though it was the only practice able to see them in the area. It might have been better not to see them at all . We have to be careful that the DQOFS

Respondent type	Question 7	Question 8
		aren't the 'tail wagging the dog' as the driver for what is carried out
Dentist	No	It can be difficult to achieve successful results with dentures. Sometimes a dentist can provide dentures correctly following all the correct steps only to find that the patient can not wear them. From a dentists perspective, if they look good, occlusion is fine etc, they have been a success. If patient can not wear them, from their point of view = failure. Difficult extractions can also cause problems here. Dentists and patients do not like difficult extractions. Most patients are understanding, some blame the dentist for post operative discomfort such as an infected socket.
Dentist	Yes	
Dentist	No	mostly except the time the patient was able to get an appointment. this is ambiguous and patients may respond negatively if they weren't able to get a treatment appointment after work for example, many practices may only offer select appointment for premium time slots. a practice should not be penalised for not having these appointments available. Also dentist need to prioritise urgent appointments sooner, this would mean for routine appointment such as a small occlusal filling may not be able to be booked in for a number of months depending on how busy the diary is. This patient may be upset that they are not seen promptly and the practise will be penalised despite prioritising patients for example that have higher needs - for example are likely to be in pain if treatment is not carried out soon.
Local Professional Network	No	Consideration as to whether patients should be asked about being provided with all information to assist with their care/ treatment and cost of treatment in advance of treatment might also reduce patient concerns. Whilst quantitative data is useful it does not always give the clinician the information they may need to improve a service, inclusion of the opportunity for the patient to add qualitative data would assist this, though reporting of this may not be needed for contract quality monitoring.
Community dental service	Yes	Need clearer definitions of current experience indicators Did the dentist listen to me and address all of my concerns Were my treatment options explained to me clearly Did I feel respected?
Community dental service	Yes	Cost, value for money
Dentist	No	I don't feel that 'patient experiences' should be included in the DQOF at all, as they are too subjective. Please see my response to Question 1 for my reasons and explanation for this.

Respondent type	Question 7	Question 8
Dentist	No	"Patient felt that adequate explanation of oral disease processes and prevention was given".
Dentist	Yes	
Dentist	No	See Above
Unknown	Yes	ask patients; there will likely be a wide range but patients know whats important to them the suggestions are fine but you need patients to review and understand what they mean in the longer term
Dentist	Yes	
Dentist	Yes	issue of trust
Dentist	Yes	The ability to see the same dentist The ability to see a dentist in their local area
Dentist	Yes	
Dentist	Yes	
Dentist	Yes	waiting in the practice for their appointment
Dentist	No	There are too many, and these should be used to inform the practices, yes, by not to financially penalise the practice. No one can please all of the people all of the time, many people are just indifferent to what they receive, especially when they have never been any where else to know the difference!
Community dental service	Yes	Wether there has been full Discussion of treatment options
Dentist	No	
Dentist	Yes	would they go back?
Dentist	Yes	communication skills-eg deafness and blindness
Dentist	Yes	
Dentist	Yes	
Dentist	Yes	
Dentist	Yes	Time keeping
Dentist	Yes	
Dentist	No	Not other areas- but I would like to register that care should be used when considering purely subjective measures

Respondent type	Question 7	Question 8
Dentist	Yes	I think that is enough for now.
Dentist	Yes	
Trainee dentists	Yes	Our FDs felt that on the whole the areas covered were reasonable, but felt that the measures currently used were inappropriate. Some didn't think that a response of having less knowledge about how to look after your teeth was appropriate.
Dentist	No	I think the question of the cleanliness of the practice is a duplication of a CQC inspection.
Dentist	Yes	
Dentist	No	The patient experience is irrational.....they are too scared.....You might as well ask someone who is tortured to rate their experience. Could it have been made better? People hate having to visit the dentist
Dentist	No	How long do their Dentist's fillings last
Academic	No	None. It is what we pay the CQC for. You use Medical History updating as an example of how things are not duplicated, and yet this was one of the main items the CQC inspector checked when our practice was looked at!
Dentist	No	
Dentist	Yes	
Dentist	No	
Dentist	No	None. Stop concentrating on the patient experience. It's a crock of [redacted].
Dentist	Yes	
Dentist	Yes	
Dentist	Yes	
Dentist	No	these areas should be included, but those done by the dentist in house assessed directly by a LAT representative
Dentist	No	
Dentist	Yes	No additional areas but the indicators must be based on a statistically valid sample n>30 if lees than this they should be discounted
Dentist	No	Yes it is important for patients to have a good experience but unfortunately some patients(quite a lot) don't like coming to the dentist so this can affect the results
Dentist	No	Patient satisfaction is not a good indicator. At a recent check of our patient satisfaction questionnaires, one criticised us for not providing gaming consoles for them to use. Should this mean I get paid less? Unfortunately unless you are asking very specific questions, there could be problems with the system. How do you ensure compliance in responding? When do you ask the

Respondent type	Question 7	Question 8
		questions? I'm sure straight after a quite necessary extraction we would get a sarcastic response to asking if they could eat, smile and socialise after their treatment! Not all experiences are positive for patients, even when needed to improve their health and would be subject to a negative response from some patients.
Dentist	No	
Dentist	No	Aesthetics, time keeping of the dentist/hygienist (how long did the patient have to wait for treatment?), how quickly were emergencies dealt with.
Dentist	No	None.
Dentist	Yes	will you be returning to the practice for future care? This is a critical question because the patient will process the relevant metrics that are important to them before they answer the question. If they answer 'yes' it means that the metrics they have chosen to consider are in the main positive.

Paper 3: The measurement of quality and outcomes

Responses to Question 9

Aside from the sort of measurement approach outlined in this paper, do you have other views and ideas about ways of assuring and promoting clinical quality?

Respondent type	Response
Dentist	Perhaps some link to CPD AND PROVISION OF COMPULSORY CLINICALLY ORIENTATED COURSES
Local Professional Network	We have described above our views on the importance of independent clinical assessment of treatment provided to patients. Clinical quality is very different to quality in general. Whilst patient feedback might be an essential aspect of assessing overall quality, the quality of clinical treatment can only be assessed by another dentist. KPIs (key performance indicators) and other complex and dynamic metrics for the assessment of quality may look good on paper. However, when it comes to the practical application of such metrics in managing a practice and for NHS England managing contracts, the maxim applies that: the simpler the better.
National body	DROs
Dentist	Contract needs to reward practices for commitment to prevention and compliance with Delivering Better Oral Health. Need to penalise practices for repeated replacements of restorations Annual record card checks of at least 50 patients per performer and randomly
National Association	As noted above, we are of the view that there are numerous options available to the Department in relation to the assurance and promotion of clinical quality, and that these options must be explored. At our recent roadshows with Local Dental Committees (which in total, attracted an audience of around 5000 dentists), one of the most consistently heard messages was the call for DROs to be introduced into the pilot programme and/or reformed contract. To safeguard and promote clinical quality it is essential that there is proper funding for care and enough time to enable dentists to focus on care rather than bureaucratic and administrative activities. This also applies to assurance frameworks, as Area Teams have very limited resources and requiring them to analyse and monitor complex KPIs and contractual systems, as in the PDS Plus agreements, has proved impossible. We are very clear that PDS Plus style agreements must not be used in the new system.
Dentist	The reintroduction of DROs would be of huge benefit to the probity of the dental work that is carried. There should be a reward for the longevity of treatments provided.
National body	We recommend that the GDC introduces revalidation as soon as possible to ensure minimum standards are met by all

Respondent type	Response
	dental professionals. This will provide the opportunity for dentists and managers to discuss performance; and reflect on good/poor practice, thereby promoting clinical quality. Clinical quality outcome measures will only be meaningful and have a positive impact on health care if they are: ó Patient friendly - access and communication should be measured. Continuity of care within the dental team, seamless care, referrals and transition of care from childhood to adulthood are all areas which patients have raised as being important to them. Furthermore oral care plans for vulnerable patients should be incorporated into heath and social care plans. ó Part of everyday practice - for instance, morbidity and outcomes could be included in training portfolios and log books so that trainees can learn from their quality of care and improve where needed. Open accounting and comparison of outcomes should also be encouraged across all sectors of dentistry by using audit tools such as the Peer Assessment Rating (PAR) or the Index of Complexity, Outcome and Need (ICON) that are being considered in orthodontics. ó Related to general and specific risk/morbidity factors that are preventable and evidence based ó Implemented consistently by method (e.g. text/telephone call/proforma/online) and timing for example, a homecheck follow-up telephone call the day after surgery is a useful way to collect valuable audit data on outcomes for surgery, is reassuring for the patient, and optimises treatment. ó Implemented as procedure specific and the same for all health sectors by using the same coding and reporting systems examples of procedure specific indices are provided in answer to question number 10 (a) below. ó Monitored effectively data should be analysed consistently and re-audited to check compliance and specificity. ó Collected appropriately - there should be an agreed reporting system for results, with a consensus on consequences of poor outcomes
Local Professional Network	Employ RDOs or similar assurance roles for quality control/spot checks of patients. Implement a national appraisal system. It is essential that results for the Dental Quality and outcomes frameworks are available on an individual performer level so that the practice can monitor and assure practice quality. Triangulation is essential; no single measurement should be used in isolation to measure quality. Local NHS England team knowledge needs to contribute also.
Dental Professional	The GDC and CQC cover most requirements ensuring staff are adequately trained
Dental body corporate	The re introduction of the dental reference service where patients will be examined randomly following teh delivery of care would be desirable. This will ensure that the correct processes, advice, pathways and outcomes are being followed and also increases compliance with these aspects.
Dentist	Bringing back the dental reference officer. I myself am involved in managing poorly performing practitioners the quality of care I have has dropped dramatically as there is no safeguarding and checking of clinical competency. Dentistry seems to be the only profession where clinical skill is going backwards. Dental reference officers are need to ensure there is some fear around inspection. Not just box ticking and paper work, the clinical work should be check to keep all in line.
Dentist	The re-introduction of adequately trained assessors who have the ability to evaluate treatments provided for patients in terms of relevance of treatment provided and also quality of treatment result. This could be based around a peer

Respondent type	Response
	review system provided by experienced GDPs.
Dentist	It should start at undergraduate level - If a student does not follow the ethos of good clinical and professional care then they should not be graduating in the first place. A practice should be rewarded if it shows they have a good level of CPD run for all staff.
National body	To assure/ensure and promote quality in paediatric dentistry, key workforce issues need to be addressed. We need more dentists with extended skills in paediatric dentistry (ie traditional CDS dentists) and more specialists in paediatric dentistry (special care dentists are not an appropriate replacement for a specialist in paediatric dentistry) to ensure excellent specialist-led clinical networks (training posts and clinical posts). We need to develop the whole dental team nurses/ therapists/ DES / Specialists to ensure effective clinical networks.
National body	The [redacted] team believe that practices should be encouraged to participate in improvement programmes on a regular basis in order to assuring and promote clinical quality. Wther this should be added to the remuneration of added to the Dental QOF is debatable. Engaging with the CQC on this issue by the contract reform team may help delineate further indicators of value
National Association	We firmly believe that a requirement to keep up-to-date with developments in the field of dental technology would benefit the profession and, in turn, patient care. Whilst we believe that a large component of this effort should be associated with the CPD requirements of dental professionals, there is significant scope for the Department of Health to promote the importance of dental technology to practices by working closely with the dental industry.
Local Professional Network	Ensure that the contract adopts best practice as recommended by the appropriate organisations such as the GDC Standards and the CQC guidelines.
National body	Patients are often confused about what they can expect from their NHS dentist. Therefore it would be good for the dentist and the patient to have a simple standard contract which outlines what each of them will do to maintain oral health. This should include advice about what a patient can reasonably expect from the NHS and what to do if they feel the dentist is not meeting the terms of the contract.
National organisation	Effective clinical audit; indpendent peer review and assessment
National body	The CQC has specific measures but these are not as far reaching as needed and do not, usually, use dental professionals in their inspections. HIW practice inspections in Wales will, rightly, use dentists. Some form on annual inspection along the lines of the old RDO/DRO visits is essential to look at record keeping, radiographs, application of pathway care, cross infection control etc.
Dentist	Reintroduction of the DRO 's Clinical audit and peer review
Software supplier	Should be actively promoting preventative treatments such as appropriate application of fluoride varnishes so treatment indicators. Also support for addressing risk factors such as demonstrating proactive engagement with local GP smoking cessation services so referral to third party services indicators.

Respondent type	Response
Dentist	See above for DQOF. In addition : SCORED PEER REVIEWED PRACTICE VISIT This element of the Quality matrix is time consuming and expensive but in our opinion there is no substitute for a practice visit in relation to assessing quality of care for patients. We propose a practice visit is made to all practices. This will assess: General practice accommodation Assessment of prevention clinics Assessment of referral audits by the specialist providers in primary and secondary care see below. Assessment of audits in this case the peer review group will look at the audits produced by the provider and discuss them. Random clinical notes assessment and to also include: Cases including endo/ perio/ simple restorative care/ complex restorative care The Scored Practice Visit will require development to ensure that it is seen as both a quality measure and also a driver for education and development. If a practice scores highly a visit will not be required for at least three years unless there is a significant change in ownership. If a practice score poorly an early second visit will be triggered. We propose that the Scored Practice Visit is funded through a process of paying sessional fees to a group of trained active NHS GDS practitioners. The costs to be exchanged for normal activity within the existing capped remuneration.
Dentist	by removing from dentists the relentless targets and threats of complaints by giving us a realistic workload. this will allow dentists to practice the dentistry they were taught to provide instead of the dentistry a panel of regulators choose to see as appropriate in an ideal world. we cannot provide ideal dentistry because we are working with inadequate budgets and with too high expectations from our patients
Dentist	The whole contract is geared to ward assuring and promoting quality which is correct and commendable. However within this there has to be a responsibility for the patient to be involved in the importance that its their habits and compliance with thee advice given which is more important then 4 clinical interventions per year. There also has to be a responsibility to attend even now the patient has'the right'to miss 3 appointments before we can do anything and there as there is no financial penalty it is difficult to provide this quality when on average 10 hours of missed appointments is regular per week This coupled with no extra funding means to ensure increased quality on the same number of patients is an almost impossible thing to do patients outcomes and the profession outcomes are 2 different things and although they should be the same this is not always the case meaning the measurements may not be promoting clinical quality only the patientds perception of quality
Dentist	Bring back the DRO's!!!! Statistics on paper can only tell so much. If I am doing something wrong clinically, I want to know and I NEED to know!
Local Professional Network	The key to clinical quality is having the provider of care, the dentist, monitor their own quality and have systems in place for continuous improvement. The development of IT systems that make it easy to conduct audits of activity would make it easy for practitioners to monitor their clinical work. If anonymous data on audit results were available they could bench mark themselves. Systems that encourage practices to audit activity and work on improving quality should be encouraged/ incentivised.
Community dental service	Independent inspections of clinical work by a fellow dental clinician (a dental reference officer or DRO). CQC inspections are not sufficient to assess clinical quality, but are helpful for structures and processes Evidence of

Respondent type	Response
	appropriate antibiotic prescribing Adherence to NICE guidelines Adherence to other national guidelines
Dentist	Stop using dentists as scapegoats and the "greedy dentist" stereotype as a way to cover up limitations in the system. Be honest with the public about the costs of dental care and the limitations of funding. Openly arrive at an impartial assessment of the costs of providing high quality clinical care and provide enough funding to achieve this. Or in the absence of sufficient funding explain to the public that this is the reason that certain limitations will exist or that certain treatments will be unavailable in NHS dentistry. Be open and honest about those limitations and the reasons for them. Support NHS dentists in this message rather than using and abusing them. Support the message that certain treatments require more funding and remuneration for clinicians and establish whether people want to pay for these treatments privately or through taxation and the NHS. Reassess periodically to see if the public is willing to pay more to fund NHS dental care of high clinical quality or not. Repeat. See? Easy!
Dentist	Whatever was wrong with patients being called in by the dental officer to assess treatment?
Unknown	rioutine unannaounced monitoring visits, get rid of CQC, patients/ public to assist in monitoring DEFINE QUALITY use the contract to exactly specify what is expected; current one is too woolly reward prevention activites prohibit nhs patients from also receiving private treatment alongside NHS
Dentist	encourage more peer review and audit
Dentist	Remunerate for the quantity of work done per patient if they are high need
Community dental service	no better way than old DRO system
Dentist	┬úrd party inspection
Dentist	It should not be difficult to promote clinical quality but for those of us in CDS it is not always possible to achieve the highest standards of clinical quality. However we strive to achieve the best possible care for that patient at the time in the circumstances and within the level of cooperation.
Dentist	Including an element of patient feedback.
Dentist	A measure of the growth in patient numbers of the practice
Dentist	It is a start
Trainee dentists	Many FDs wanted to see independent assessors coming into practices checking on things like recording of BPEs and cross checking patient details from a sample. Others felt that they should be trusted more to deliver good health care and that the existing regulatory framework of the GDC and CQC were adequate to ensure the quality of care.
Dentist	Submission of examples of audit. This will cause practices to measure and reflect themselves on the quality of their work.
Dentist	Practice and patient inspections
Dentist	Good remuneration, with good checking by RDOs

Respondent type	Response
Dentist	You do not mention, anywhere in any of the 4 papers that I can find, any concern about, or even interest in, the quality of the work done. Most work done under the NHS now is poor to shoddy. If maintaining that standard is your intention, you are not patient centred, as you claim, and the only motivation left for you is cost containment.
Academic	Bring back Dental Reference Officers. Do not rely on patient mail surveys - compliance and knowledge is poor.
Dentist	I don't think these measures will promotoe better quality of treatment anyway. I don't agree that there is a way to measure quality through these statistics and patient surverys etc.
Dentist	Audit
Dentist	pay the dentists the going rate
Dentist	DROs.
Dentist	Improved support and long term training programmes specifically for NHS dentists that are a comprehensive study programme...similar to an MSc but that is affordable to all (including part time and lower earners so patients are not disadvantaged due to their dentists financial situation)
Dentist	the dentist or practice should have real time access to this data so they can act on it before begin told by the NHS. not waiting until each quarterly report etc. (perhaps using the portal and open it up to all performers not just the provider). or built into the software system as a report function.
Dentist	Inspect patients who have had recent treatments, review the quality of work.
Dentist	CQC assessments are excellent, because they assess the practice as a whole. and those done by the dentist and tem in house assessed directly by a LAT representative
Dentist	DESIGN THE CONTRACT RIGHT.
Dentist	The vital signs data for free of charge replacements within 12 months higher figures suggest poor clinical performance Vital signs data for patients returning for contuinuation treatment- high figures suggest poor treatment planning, missed treatment or failed treatment.
Dentist	Yes return to examining patients randomly to check treatment and quality
Dentist	I currently undertake complex treatment plans for patients in high need, sometimes under prescription from a consultant. Sometimes this involves treatments which are better for a patient but with a less predictable outcome, (eg composite build up of the severely worn dentition which may require replacement of restorations occasionally rather than crowns which are now no longer seen as the best treatment in these cases) It is sad that occasionally I find I am treating these patients whilst earning less than minimum wage. If I am to be assessed on outcome only, high need patients and those with high risk treatments will have to be treated in hospital instead. If I wish to treat my patients in compliance with the best possible evidence based dentistry, this may be very difficult to see based on proposed data collection. I would be worried that this would be overlooked in the desire to provide predictable outcomes.
Dentist	quality is proportional to time spent on delivering quality interventional care. Rushed dental work fails prematurely like

Respondent type	Response
	any other manual work type skill
Dentist	There was a lot to be said for the older system of recording every filling/extraction etc, though the information wasn't used to best effect.
Dentist	Have a dental reference service and if you want high quality dentistry you will have to pay for it.
Dentist	re-introduce random inspections of patient's oral health. (eg DRO system that existed pre-2006)

Paper 3: The measurement of quality and outcomes

Responses to Question 10

What monitoring tools and indicators can be used to assess: (A) patient safety? (B) Clinical effectiveness? (C) Patient experience?

Respondent type	(A) Patient Safety	(B) Clinical effectiveness	(C) Patient experience
Dentist	Questionnaire practice inspections compliance reports	Monitor number and type of post treatment appointments, questionnaires, longevity of treatment	Questionnaire written or verbal ie follow up call
Local Professional Network	We have concerns about unnecessary and time-consuming duplication. The CQC already monitors patient safety. Patient experience will be captured by the FFT. Provided clinical effectiveness can be appropriately assessed via dental reference officers or something similar, we do not believe additional (and potentially burdensome) monitoring tools are needed.		
National body	a) Appropriate use of equipment e.g. rubber dam and adherence to DoH rules re instrument usage	b) Random checking of post operative radiographs, inclusion in a peer review group to help set and evaluate standards	c) As described I the documentation, however one needs to be mindful of the challenges in managing patient expectations e.g. some care may not be available because the oral hygiene does not improve to an adequate level. The patient may be dissatisfied when they have themselves excluded themselves from further treatment.
Dentist	Record card checks, audit of incident	Record card checks, clinical data	Patient questionnaires and feedback forms,

Respondent type	(A) Patient Safety	(B) Clinical effectiveness	(C) Patient experience
	logs and staff feedback/training	set	patient complaints
National Association		We are of the view that the main contribution can be made through the piloting and implementation of a DRO system to monitor clinical effectiveness. Patient centred care should be monitored as now by centralised survey or if another method is used at practice level, it must be fully funded by NHS England. Practices will not be able to analyse data themselves.	
Dentist	CQC feedback. Risk assessments of premises with a health and safety inspection. Staff training records.	Longevity of restorations	Patient satisfaction surveys. Patient focus groups Mystery Shoppers similar to the monitoring that is carried out by Denplan.
National body	We believe that the reporting of never events and serious event recording should be improved across all sectors of dentistry. In order to ensure consistency in reporting, there should be agreed outputs, such as incident reports, shared learning and training records. We welcome the Care Quality Commissions review of its approach to dental inspection and hope that the new focus on learning and improvement will lead to improvements in patient safety. The collection of data by the CQC should also help to increase transparency around standards in dental practices and units.	We suggest that, along with audits and peer review, general indicators and treatment specific indicators could identify levels of clinical effectiveness. For example, the Index of Orthodontic Treatment Need and the recently developed Index of Orthognathic Functional Treatment Need that are used to assess need and eligibility for treatment could be utilised as a monitoring tool for clinical need and effectiveness. General indices for oral health could include: Adult Dental Health Survey, Gingival Index, dental caries and missing teeth. Procedure specific indices could include: third molar surgery-dry socket rate, nerve injury,	Monitoring tools and indicators to assess patient experience could include: a homecheck follow-up telephone call the day after surgery for patients undergoing high risk procedures, customer satisfaction questionnaires and use of comments books in waiting areas. In orthodontics and orthognathic surgery, there is currently a discussion as to whether Patient Reported Experience Measures (PREMs) should be used.

Respondent type	(A) Patient Safety	(B) Clinical effectiveness	(C) Patient experience
		readmission and repeat treatment.	
Local Professional Network	Practice visit by inspectors who have experience of walking in dental practice		See question 8 and 9
Dental Professional	Regular audit of these three topics by staff.	Regular audit of these three topics by staff.	Regular audit of these three topics by staff.
Dental body corporate	CQC Compliance status,	Measures already in use plus DRO examinations	surveys, feedback questionnaires, patient involvement at practice level, comments boxes, complaints
Dentist	CQC/ Medical emergency training/ Dental reference officers.		
Dentist	As for the current DQOF the measurement of the recording of an appropriate medical history is a valid safety measure, other patient safety issues are covered by CQC.	Practitioner level auditing of treatment quality and outcomes using trained assessors taking local practice patient populations into account	Development of NHS choices web based feedback mechanisms.
National body	Whatever monitoring tools and indicators are developed and put in place, they must not present a burden to the dentist and must be easy to administer and record. Furthermore, central resources and expertise must be provided to analyse the resultant data, share the findings and ensure that they feedback into improving services. Changes as a result of this feedback should then also be widely disseminated.		
National body	The [redacted] team believe that the number of wrong teeth extracted should be included as they are in secondary care under the never events programme		
National	We believe that this should be	We believe that this should be	We believe that this should be addressed

Respondent type	(A) Patient Safety	(B) Clinical effectiveness	(C) Patient experience
Association	addressed working in conjunction with BDA colleagues.	addressed working in conjunction with BDA colleagues.	working in conjunction with BDA colleagues.
Dentist	BDA good practice scheme	Bda good practice scheme	Patient questionairres
Local Professional Network	Whether medical histories have been taken.Whether certain essential training has been undertaken eg cross infection control, medical emergencies, IRMER.CQC reports, Significant event reporting.	Contract monitoring eg restoration failure rates.	Monitoring of NHS choices. However some indemnity organisations advise against practices responding on NHS choices. But practices could give reports on the audit process of complaints received.
Dentist	MH recording	Return for emerge tmt	surveys
National organisation	Complaints and significant issues log; curency of medical history;compliance with CQC fundamental standards	As noted in Q6.	As noted in Q7
National body	This is a GDC issue; absence or awareness of GDC determinations such as conditions on an individuals practice. Such constraints are in the public domain and on the Dental Register	Both of these would be assessed by inspections as detailed at our answer to question 9	Both of these would be assessed by inspections as detailed at our answer to question 9
Dentist	This is done by CQC	DRO system	Friends and family test will cover this
Software supplier		Currently focused on the physical outcomes of poor dental health. If we assume that emphasis is moving towards prevention then clinical effectiveness must start to include the holistic treatment of the patient and demonstrate that good dentistry involves getting patients to remove dental risk factors from their lives.	More regular surveying of patients, automatically done in practice or perhaps on line.
Dentist	Medical History Audits/ CQC compliance/	The outcomes based approach on caries/ periodontal health in the pilots is valid.	Audits of complaints and complaints management/ surveys as per experience approach in the pilots

Respondent type	(A) Patient Safety	(B) Clinical effectiveness	(C) Patient experience
Dentist	this should be done by GDC and CQC we are already monitored twice by 2 separate agencies at a cost of ┬ú1000+ per year - how much monitoring do we need is there that many reports on compromise of patient safety that further monitoring is needed		Those used are as good as any although these are not always accurate/correct
Dentist	DRO visit?	DRO visit - checking record cards with patients in the chair	Questionnaires?
Local Professional Network	audit data inter-practitioner comparison. Critical incident analysis, never events.	Audit and comparative data. , % treatment complete on 1st visit data. for emergencies/ urgent care.	Patient satisfaction surveys, appointment availability data. Comparative practice data. Rates of cancellations and do not attend may also give an indication of satisfaction.
Community dental service	DRO inspections and CQC inspections and infection control inspections and HSE inspections	DRO inspections, including seeing random and non-random patients	Regular patient satisfaction questionnaires; comments books and compliment letters and robust complaints processes
Community dental service	evidence based practice	repeat restorations,	
Dentist	CCTV	CCTV	CCTV
Dentist	Externall validated practice quality assessments		Expert patients
Unknown	patients to visit and questione alongside commissioners	give us the evidence base	patients to review and decide if ok or not alongside commissioners and in practices
Dentist	medical history/smoking cessation/bitewings/number of emergency appointments in between exams	number of non-routine appointments required in a year	satisfaction with the same dentist over 2 years
Dentist	questionnaire and inspection	Audit of patient records and analysis from BSA returns	questionnaires
Community dental service	audit/incident reporting	Audit/DRO	Questionnaire/Interview
Dentist	anybody hurt?	did it work?	would you go back?

Respondent type	(A) Patient Safety	(B) Clinical effectiveness	(C) Patient experience
Dentist	Audit - national annual audits.		
Dentist	CQC reports	outcomes	surveys
Dentist	Feed back questionnaires	As above plus Exams by Dental Reference Officers	Feed back questionnaires
Dentist	CQC already fills this role	Monitoring dental health. Random patient samples would have to be examined clinically	Visit the practices. Sit in the waiting area/ pt surveys? Unreliable. Often only completed when a negative aspect arises. Much like this survey
Dentist	direct monitoring. Inspection of protocols, policies	Records. radiographs.	Questionnaire, interview.
Trainee dentists	CQC, incident reports, complaints records	RAG score changes, Independent assessors, restoration replacement rate, re attendance figures within a short time frame	Pt questionnaires before & after, more reflective questionnaires perhaps 1 month after treatment.
Dentist	Regular audits	Regular audits	Free dental treatment, and conscious sedation for all procedures (no pain)
Dentist	How many died?	How long do fillings last?	Do they come back?
Academic	CQC	Dental Reference Officers	CQC
Dentist	Dental practice visits, audit	audit	audit
Dentist	the have enough regulation. I thought the CQC inspected practices ?	this varies between patients and with biological variability- but I would not expect a bureaucrat to understand	this is not a Disney ride
Dentist	Death statistics.	Lack of need for treatment to be re-done.	Irrelevant.
Dentist	inspections, self audit submissions		
Dentist			questionaires
Dentist	cqc can do this with compliance assessment and in house audits and external audits	cqc can do this with compliance assessment and in house audits and external audits	cqc can do this with compliance assessment and in house audits and external audits
Dentist	inspect practices	impossible to say what is the correct pathway	take with a pinch of salt and question randomly picked patientsw

Respondent type	(A) Patient Safety	(B) Clinical effectiveness	(C) Patient experience
Dentist	BDA good practice, CQC compliance	No clear solution	
Dentist	Already monitored by CQC	See above	Already monitored by CQC
Dentist	audit -	use of clinical protocols in delivering the intervention	exit survey - revise questions

Paper 3: The measurement of quality and outcomes

Responses to Question 11

What quality measures would enable a practice to demonstrate that they are appropriately treating high risk patients?

Respondent type	Response
Dentist	Long term improvement in rag score
Local Professional Network	We have concerns about practices dealing with large numbers of high needs patients (a term we prefer to high risk), as we believe they may face greater challenges to achieving oral health improvement for their patients than those with more moderate and low needs patients. Since deprivation is a reasonable proxy for poor oral health and so also links closely to the inability of individuals to care effectively for themselves, it is highly likely that those practices with the highest needs patients will also face the greatest challenges in galvanising the self-care required by their patients to support the long-term improvement of their oral health. With regard to the above, it must not be ignored that some practices may have many red patients because they are located in an area with many older patients nearby, whereas other practices may have many red patients as a result of being located in an area of extreme deprivation. Therefore, it should not be assumed that all red patients will be approximately similar in terms of the challenge facing practices, whose objective will be to move them from red to amber, or from amber to green. The system risks missing significant nuances in patient need. Simplifying the system in this way runs the risk of undermining the practices facing the greatest challenges to providing care.
National Body	Define high risk patients, look at care given and referral patterns for the defined group.
Dentist	Specific remuneration package for this group. Evidence base care pathway approach with staged treatment planning to address disease in a logical fashion.
National Association	The term high risk patients has many potential meanings and without a clear definition, we will endeavour to address each potential group separately. It should be noted here that, in our meetings with the Department, we have on numerous occasions suggested the development of a glossary of terms to ensure that there is a common understanding of the fundamental principles of the programme. A clear definition of patient groups, alongside an articulation of their needs, is vital to ensure that dentists are able to engage with the clinical philosophy of the programme, and feed back on the challenges and requirements for each group. From our perspective, high risk could cover any of the following patient cohorts: patients who are high users of alcohol and tobacco; those with poor diet; those with conditions which potentially have an impact on their oral health and/or on their ability to manage their oral

Respondent type	Response
	health; patients with high needs including those treated within the community dental service; patients presenting with symptoms of or in treatment for oral cancers; hard to reach groups or patients with any of the above issues combined with irregular access to health services . The quality measure for each of these groups will vary significantly, and the Department must ensure the development of a system which is sufficiently flexible to accommodate all patient groups, and be sensitive to their outcomes, which again, may vary considerably. For example, we would anticipate that practices which see a high volume of patients with oral cancers would rightly have a comparatively high referral rate to secondary care. When such a practice appeared on a spreadsheet, it may be flagged as an outlier, and its data would need to be analysed to understand why it had a higher-than-average referral rate. Practices which find that they have a higher volume of patients who do not engage in an effective self care programme may see their full contract value at risk, despite doing everything to attempt to motivate their patients. For these practices, for example, it might be possible for there to be funding for the supply of toothpaste and toothbrushes for children and encouraging follow up visits. Providing this service would be demonstrating appropriate care. Using some of the techniques of social marketing in dentistry, funded and supported by NHS England and operated by relevant practices, would also be useful. Outcomes will continue to vary, and although we strongly support the endeavour to close the inequalities gap, it has to be done through investment. Again, we refer back to the need for a DRO system which will enable the Department to dip test at practice level and make sure that patients are getting the most appropriate care for their needs.
Dentist	Numbers of RedØ RAG status patients, coupled with monitoring of prescribing patterns. There needs to be a system of quality control at the Area Team level. Patient demographic lists should correlate to appropriate treatment items. Such as fissure sealants, fluoride supplements, quit smoking referrals and monitor number fo referrals for complex/specialist care.
Local Professional Network	What are high -risk patients???? If high risk equates to complex medical needs then an indicator or marker could be added. Then the process could be monitored to ensure the appropriate treatment. If high-risk means high caries or patient with periodontal disease then the RAG system will identify these and the process can be monitored.
Dental Professional	There could be an extra process for treating patients with high risk, or complicating factors.
Dental body corporate	This would be the process measures already referred to:- In patients with significant dental need, process indicators could include advice given, onward referral to appropriate skill base e.g. smoking cessation services, application of topical fluoride. In elderly patients this could include carer information supplied, education of carer, as well as indicators above This would also apply to socially deprived groups. This would allow teams to demonstrate that all feasible steps had been taken to engage with the patients and that the failure to achieve the desired outcome was outwith the control of the dental team. This will also encourage these groups to be treated more readily in a primary care environment
Dentist	Red rating regular attendance, regular radiograhs being taken. No radiographs is a sign of potential poor performance.

Respondent type	Response
Dentist	ó Compare percentage of inter-disciplinary referral letters against national average for consultation letters between medical consultants and medical GP colleagues and treating dental professional treating patients ó Clinical audits of specific categories of high risk patients including: categories of medically compromised patients (bleeding disorders, post chemo-therapy, post radio-therapy etc.) and infective risk patients. ó Recording and then reporting via audits of complications and/or adverse reactions to treatments prescribed for the various categories of high risk patients.
Dentist	The number of new patients registered who have more than a certain number of DMF teeth.
National body	For children these could include: ó care index ó Number of children referred for specialist services ó Safeguarding procedures and outcomes ó Demonstrable use of the whole dental team ó Use of radiographs for caries diagnosis ó Continued provision of evidence-based prevention and regular recall for children , even after referral to a specialist-led service for an item/course of treatment It is also important to stress, that unless dentists are remunerated properly, many will not want to provide care for high risk patients, therefore there needs to be appropriate services to refer these patients to.
National body	The [redacted] team believe that vulnerable patients with dementia, other health needs and a wide variety of complicated medical history should be seen within a primary care setting. However some practices may not be in areas of high incidence of certain diseases and therefore a straightforward percentage of patients treated in that practice may not be a good indicator. However this type of indicator maybe of more benefit for the CDS to help clarify the groups receiving care in that environment
National Association	Owing to the wide range of factors that can contribute to a patients risk status; we feel that the term high risk patientsØ covers too broad a spectrum of circumstances to address adequately in this response. Obviously, colleagues at the BDA will be able to contribute more information here. However, one measure that we would like to see to ensure proper treatment of a high risk patient group is the provision of additional funding for practices found to deal with a higher than average volume of patients struggling with self-care. This funding would be dedicated to the provision of toothpaste, toothbrushes and dental for such groups and would serve to support the preventative approach.
Dentist	Audit of medical histories
Local Professional Network	Practices being able to demonstrate compliance with Delivering Better Oral Health.
National body	There should be some measures around the proportion of patients at a practice who are deemed high riskØ as there is the possibility here to create some unintended consequences for patients placed into different strata based on the remuneration for those patients.
Dentist	What does the question mean by high risk.... of caries of HIV positive?
National organisation	"High risk" is undefined. In terms of risk of oral disease, patients so coded can be identified and treatment evaluated.

Respondent type	Response
Local Professional Network	Define high risk patients
National body	All patients should be considered and treated as high risk. This should be correctly covered by access to treatment, patient safety and cross infection control measures
Dentist	Any system must not disadvantage practices with populations of high needs patients . The best way of assuring appropriate treatment is being provided is the DRO system
Software supplier	Success rates on getting patients to return for ICs. Oral health is atleast stabilised (not getiing worse).
Dentist	Use of trained DCP educators Use of Fluoride varnish application Provision of Fissure Sealants Interim Care Appointments for high risk patients. Assessment of referrals see QOF and Scored Peer Review Visit.
Dentist	Following the clinical pathways should be an effective way of showing appropriate treatment of both low and high risk patients- once the tools are provided to the patient it has to be their responsibility to comply with the advice - showing recall and treatment provided will demonstrate high risk patients are being treated appropriately -whether there is an improvement isn't solely attributable to the profession
Dentist	DRO visits will need to be essential for any system that has a large capitation base to it.
Dentist	number of fluoride prescriptions.
Local Professional Network	The measures may relate to comparing RAG ratings, especially those relating to caries on initial appointment, between practices and then reviewing the ratio of fillings and extractions between practitioners with a similar practice profile. This is an area fraught with difficulties to be certain one is comparing like with like and that measuring it does not alter the practices acceptance of these patient or penalise the practice for not achieving an outcome due to lack of co-operation of the patient.
Community dental service	Difficult Could analyse patient list profiles e.g. by post-code and linked to socio-demographic data to ensure that patients from high need areas are being seen. Selective inspections, by a Dental Reference Officer or equivalent clinician, of high need patients with full access to notes
Community dental service	prescribing level of duraphat
Dentist	Same as before as compared to averages of those patient groups.
Dentist	I think this is important but am not sure how it can be achieved
Dentist	Analysis of FP17s compared to stats for the area
Unknown	define quality, find a way to describe high risk patients; perhaps casemix style of scoring system reward prevention pathway to show progress to commissioner and to patient how to measure patients interest/ motivation. committment etc develop public health profiles related to deprivaiton per contract/ practice clinical outcome measures and possibly a couple of process indicators

Respondent type	Response
Dentist	numbers of patients seen in each category, being fairly specific
Dentist	number they are initially treating care pathway to show increase in recall time and drop in treatment needed the use of DCPS to increase accesss
Dentist	number of new patients seen per moth who have not been to a dentist in more than 2 years
Dentist	Incentivise treatment for high needs patients.
Dentist	All measures should apply to all patients therefore high risk patients no different
Dentist	It is difficult to demonstrate if the treatment is appropriate as this may differ according to the patient, e.g. challenging behavior is a risk, so are some medical and physical problems, hoisting a patient is a risk as is a domiciliary visit etc.
Dentist	Records i.e. notes radiographs and photos.
Dentist	What if the practice simply does not have many high risk patients?
Dentist	Patient experience.
Trainee dentists	RAG score monitoring, plaque score measurement. Auditing of the preventative measures; Fluoride varnish applications, incidence of high strength fluoride prescriptions, fissure sealants etc. The FDs were also keen on some sort of spot checks on dentists records and random patient examinations.
Dentist	High Risk = RED RAG score. There will be some red patients who will never improve to AMBER, but that may be because, for various reasons,they cannot engage in the necessary preventative measures. This is not necessarily through lack of appropriate treatment so perhaps a declaration with brief explanation may work to demonstrate it.
Dentist	Lack of out of hours contacts
Dentist	Bonus payments
Dentist	We can't identify most high risk patients, because you won't allow their identification and they won't admit to it, so all patients have to be treated as high risk.
Academic	Long-term monitoring of interventions by BSA as appropriate to the RAG category.
Dentist	we have to comply with all the regulatory bodies, is this not enough?
Dentist	Pay them more to do so.
Dentist	assessing their response to the treatment outcome, ie looking at the change in their treatment history
Dentist	Examine practices by dental officers rather than people who know nothing about dentistry
Dentist	If you mean high risk of dental disease, I fear practices will no longer want to treat them at all. They will lower our outcome statistics and lead to a drop in income or loss of NHS contracts! If you mean high medical need, you will unfortunately see an increase in referrals to hospital or CDS services.
Dentist	Not a system that requires them to show progress from appointment to appointment, or that penalises them when things go wrong.

Respondent type	Response
Dentist	more detailed patient questionnaire to establish the value and quality of advice given to change behaviour - this is not easy to do but worth the effort in my view. It would measure 'effectiveness' of communications.

Paper 3: The measurement of quality and outcomes

General comments

Respondent type	General Comments
Local professional network	ADDITIONAL INFORMATION RE: Question 7 There is one particularly vague indicator here: patients reporting satisfaction with NHS dentistry received. Presumably, given the range of other indicators focusing on patient experience, this indicator is designed to pick up the level of patient satisfaction with the clinical dentistry they receive. We are interested in how you expect patients to be able to answer this question, when they are likely to have only a very limited understanding of clinical treatment (and what constitutes the difference between an average and a high quality clinical intervention). The likelihood is that patients will not be satisfied with NHS dentistry for a number of reasons. In particular they are more likely to be dissatisfied than satisfied because: ó Only what is clinically necessary can be provided on the NHS (this is not necessarily what is aesthetically desirable for the patient and may, therefore, not meet with their expectations) ó There is a charge for NHS dentistry that is levied by the practice (patients are generally not charged for services elsewhere in the NHS) For the various above reasons, we object to the inclusion of this indicator as one within the set of patient experience indicators. We are concerned also, to see an indicator measuring satisfaction with the time taken to get an appointment. The time it takes to get an appointment is a direct function of NHS investment in services. Patients should not be misled into believing that it is within the gift of NHS practices to see patients more or less quickly. Utilising such an indicator is likely to have the perverse consequence that the most popular practices receive the poorest rating. Quite obviously, this needs to be rethought
National body	We call for a thorough review of the current tools that are used to measure quality and outcomes in dentistry. It is clear that the methods of collecting data for dental care should be improved. For example, improving coding and the definitions within coding would help to identify patient need and the most appropriate location for care. Taking advantage of technology by introducing apps to encourage patients to complete satisfaction surveys in waiting rooms would improve the logistics for collecting data, rather than relying on lengthy paper-based surveys.
Dentist	Dental Reference officers must be brought back. Although we are one of the most highly regulated professions with regards to paper work and inspections of environment, the clinical care provided is no longer assessed or checked as it used to be pre-2006. The quality of dental students and their experience has dropped dramatically, random checks need to be carried out to safeguard NHS patients. Dentistry is operative work the clinical work must be assessed to ensure quality.
Dentist	The supporting document mentions that the new contract should not become too prescriptive. Working on the pilot myself, I do find that I don't feel in control of my patients anymore and it does make me feel much less engaged with them in my professional capacity. The new contract must make dentists feel that they have some responsibility for

Respondent type	General Comments
	their patient's management otherwise this will easily become a tick box exercise just so practices can enure their funding is not cut rather than actually trying to do their best to improve their patient's oral health.
National association	Further response to Q7: We broadly support the patient experience indicators as described. However, given the issues surrounding patient waiting times as described in the evidence and learning reports, we question the utility of an indicator tied to patient waiting times. Until concerns around increased patient waiting times are addressed, we believe that such an indicator could mask structural problems with the care pathway approach itself, such as those relating to the implementation of the OHA. As such, we would like to stress the importance of streamlining and simplifying the OHA process as addressed in our response to Paper 2. Additionally, we do not believe that a patient waiting times indicator would generate useful information for the assessment of a practice, as there are numerous reasons why a patients waiting time could increase. Reducing this complex information to a single indicator would be a reductionist and overly simplistic approach. Further, the presence of this indicator does not seem compatible with the prioritisation of high quality care as it suggests that patient care could be sacrificed or compromised in order to meet waiting time targets.
National association	Thanks for the opportunity to contribute.
Dentist	There must be a balancing system in place to ensure - that practices in high needs areas will find it harder to achieve the outcome indicators than low needs areas
Local Professional Network	Practices in deprived, socially challenged areas with traditionally poor uptake of services have high risk, high need patients who do not present routinely. But when they do present multiple complex treatments are frequently needed.
Dentist	It is important that PROM's over which the practitioner has little control are not used to reduce the contract value of the practice or service .
Dentist	we have to allow our patients to exercise their opinion by voting with their feet. if one practice is performing badly and another is performing well the patients should be able to move to the better practice. currently with capped inflexible budgets providers of good services are not able to expand their services. we don't need all these measures , patients are intelligent enough to know when they're getting a good service and should be able to choose where they can go to find this.
Dentist	All as above
Dentist	If I can be of any further help= [redacted]
Dentist	The pre pathway questionnaire needs to be linked to the software so that patients can complete the pathway before their appointment and is automatically updated on the practice computer system. This is because a lot of time is wasted waiting for patients to fill in questionnaire at their appointment. It is not a lean approach for healthcare. Read ÿWere not Japanese and we dont make cars (Fillingham, 2008a). A Also because of this wastage dental appointment often run late and therefore patients will become more dissatisfied for waiting. If this is not done the pathway

Respondent type	General Comments
	questionnaire will be rushed or worse made up if the patient has not filled out a questionnaire which will lead to inaccuracies. This much be a priority.
Community dental service	Strongly recommend value of a Dental Reference Officer to inspect practices and a selection of both random and targeted patient groups.
Dentist	A dentist could spend hours on, for example oral hygiene instruction, but patient compliance will always be an issue. If a patient continues to have gingivitis is that because the dentist clinical effectiveness is at fault? If patient compliance was reliable no one would smoke, there would be no obesity and mouths would be perfect in every way.....what Utopia but please dont link my pay to that!
Dentist	Dentists need encouragement and reward for taking on patients that need a lot of treatment
Unknown	I do not believe the reforms relate to the pathways / tiered approach and think this needs to be stated or this consultaiton will be meaningless
Dentist	Measuring quality and quantity needs to be fair an should apply to all practices in the same exact way. Practice costs should be taken into account when measuring all of these indicators.
Dentist	i have earlier about the over 80s age group.
Dentist	Whilst this is not easy. We need more simplification so that everyone understands. A blend of capitation and item of service with more DRO checks would be my preferred framework. There is no reason why prevention cannot be delivered via IOS.
Dentist	I still feel the idea of one system to suit every way dentistry is delivered is an impossible dream. Prison and special needs patients simply do not fit in to "normal" practices.
Trainee dentists	Some FDs expressed their dismay that that they felt that they were not trusted to do the best thing for their patients. They felt that some of the measures would not reflect the efforts they had put in to help their patients achieve a better standard of oral health because lifestyle factors have such an important role in determining disease experience. The practices in more deprived areas were felt to be most at risk.
Dentist	Ensure the patient survey is large enough so one or two disgruntled patients do not skew the results.
Dentist	Pay your workforce well , and allow them excellent working conditions....Put your workforce first
Academic	The whole QOF section of the contract is a thinly-veiled excuse for the potential withholding or clawback of a certain % funds from the total contract values of practices. In an environment where the total available is capped, some has to be able to be freed up for potential redistribution.
Dentist	The measurement of outcomes and quality is completely flawed. I feel either this new system should be capitation based or treatment based, nothing to do with quality and outcome, as these are unfair judgements, particularly in deprived areas. If you wnat better outcomes, move certain treatments which general dentists are not doing so well on, espcially root canal treatment as a specialist field only. dentists should not have the duty of carrying out every single

Respondent type	General Comments
	treatment possible, and also have their effectiveness measured. som eof the burden needs to be removed from them to improve the quality of care for patients.
Dentist	you are only interested in measuring outcomes etc in order to penalise dentists . Why dont you spend the money that the nation requires on NHS dentistry? At present you spend about 1.5 billion (0.1% GDP), when you give the EU ┬ú55 million per day (and a total annual cost of ┬ú150 billion). This is without all the extra tax payers money that is given away. There is plenty of money for the NHS general dental services,but the government would rather waste tax payers money elsewhere.
Dentist	IF YOU ALLOWED COMPETITION BETWEEN PRACTICES THEN THE STANDARD AND QUALITY OIF CARE WOULD GO UP AND THERE WOULD NOT BE THIS PROBLEM. THIS IS WHAT HAPPENS IN EVREY OTHER BUSINESS.
Dentist	It is impossible to judge quality by collecting data the only way is examine treatmenr carried out randomly by assessors any other way is pure guess work
Dentist	For the first time in a 20+ year career in the NHS including CDS, salaried PDS and GDS with good feedback from my patient base, I am honestly so concerned about the newest proposals that I have arranged to speak to a Denplan advisor to discuss a possible conversion. I am known to colleagues to be ethical, hard working and to put patient need consistently above my desire for remuneration or working less hours. I update medical histories, carry out regular periodontal examinations and treatment and preventative advice and treatment already and I am still very worried about these plans. I can only feel that this will be a backdoor method of moving all dental funding to hospital services at the detriment of access and care for many patients who will be forced to pay privately for something they were previously entitled to under NHS care.
Dentist	Yoou must focus additional funds for high needs patients in vulnerable groups and deprived areas. I would prefer to see NHS dentistry with its limited funding targeted to vulnerable deprived groups. i.e. low socio economic, children to age 19, the elderly over 67 years, chronic medical conditions affecting the oral health, special care needs patients, mentally ill,
Dentist	I think this sort of monitoring will alienate the profession
Dentist	We're already an over regulated profession. Patient care should be the main focus of any monitoring and penalties for failing/dangerous dentists should be severe. Any monitoring system is open to abuse and until something is done to remove the 'old boy' network, changes are going to be minimal.
Dentist	I'd get prosecuted if I told you what I really think.
Dentist	A lot of progress has already been made and whilst a number of challenges have been identified from the Pilot site experience, it is important to remember the successes too - that is sometimes easily forgotten. The hard work of the back office team so to speak deserves recognition.

Paper 4: Remuneration

Responses to Question 1

What percentage of contract value do you think should be used for DQOF?

Respondent type	Response
Dentist	10%. Some of these quality assessments may be negatively skewed if we have a patient population who refuse to take responsibility for their oral health and hence a practice may be financially 'punished' for something that is not their fault
Dentist	10% is fine as long as data can be trusted and pt feed back isn't biased by the more negative aspects of their experience eg frequent form filling! increased waiting time for appointments etc
Local Professional Network	A DQOF does not need to be linked directly to payment, in order to be effective. Simply reporting the results and practice positions in comparison with other practices might be a good way to incentivise practices to satisfy any DQOF. Linking the DQOF to contract values is unhelpful and serves only to threaten practices into a certain way of behaving. Should it be something the Department of Health is intent on doing, we would remind them that using incentives rather than threats is far more likely to yield positive results. If a DQOF is to be linked to payments, we believe that the money saved from the removal of dentists seniority pay could be used to provide a useful financial incentive for practices to meet the expectations of any DQOF. This would form an additional payment (or potential payment) on top of existing contract values.
National Body	10%
Dentist	10% would be a realistic figure, but if NHSE are serious about achieving quality and have correct outcome measures in place this could be higher.
Dentist	It was suggested that this should be relatively low ô 10%. This was to maintain practice stability, less strain on admin and reduction in the time spent at the Area Team to manage contracts. Historically clinicians are not good at keeping records, recent history with PDS plus contracts would indicate that a safe option would be to start low and build up with time. »
National Association	We recognise that there is a place for monitoring of quality and outcomes, but do not accept that there is a strong case to link payment directly to those measures. The publication of comparative data on DQOF will in itself motivate quality care. Five per cent should therefore be the absolute maximum, but we think there is a strong case for no quality and outcomes measures unless it is additional money for contractors outside their agreed contract value.
Local	DQOF 10% now the loss of 10% practice income would not be feasible for some practices to continue trading. Is 5 -

Respondent type	Response
Professional Network	10% fair? The pilot practices represented today seemed happy with the DQOF payment and thought it was fair. DQOF Penalise as well as reward Measuring practice needs to be as a whole and down to individuals /performers level so the provider is be able to look at information on system and be able to see to analyse DQOF appropriately
Dentist	This is the main change in the contract and will need to be reflected in the way payment is made. A higher percentage than 10% should be allocated to it.
Dentist	5%
Dental Corporate	15%
Dentist	10 % is good
Dentist	As low as possible because outcome is related to patient cooperation and cannot always be relied upon
Dentist	10%
Dentist	The DQOF provides the minimum risk to the clinician - but potentially - safe guards the to for quality. Why only 10% ? Seems low 30%. Allowing a further 20% for activity and 50 % weighted capitation. Could the % change according to need and practice profiles. Ie hi needs - could have a higher remuneration for weighted capitation - allowing more time fur treatments ?
Community dental service	10% DQOF ô as suggested, but we would suggest that the bonus for very good practice should be greater than 2% (possibly 4%)
National Association	We believe that further liaison with the BDA and other organisations will be required to address this question.
Dentist	5%
Local Professional Network	About 10% gives enough of a financial incentive for practices to want to engage in the DQOF without it being a challenge to any patient charge revenue system.
National body	We understand this will depend on what is covered as capitation vs what is recorded as activityØ?
Dentist	10% seems like a good figure.
Dentist	less than 10 %
Community dental service	The DQOF payment should not be a top slice from current contract income. This gives out the wrong message by linking quality with potential penalisation. It also leads to the response that the percentage should be as small as possible. There is concern that a treadmill could inadvertently be reintroduced, as if the payment is linked to achievement of threshold percentages, these percentages will inevitably be increased if most dentists achieve them. Any payment depends on the actual DQOF indicators. If a number are based on patient satisfaction, outcomes from the pilots have demonstrated increased waiting times which lead to more dissatisfied patients. There would be more enthusiasm and engagement if the DQOF payment was transparently a new income stream for practices

Respondent type	Response
National organisation	10 - 20%
Community dental service	Less then it is now
Local Professional Network	10 - 15%
National Body	Much more than 10% - perhaps up to 50% to allow far greater emphasis on measures of quality and outcome.
Dentist	Reserving any of the pay subject to patient experience is fraught with problems, generally patients do not like visiting the dentist and their experience can be affected by factors outside of the treatment, such as wait times as well as discomfort of treatment, OH advice, quit smoking, not getting the treatment they wanted or seeing another member of the team for treatment. 5-10% max for this such that only 1-2% is at risk (according to estimate of 800 points figure). Any lump sums should not be taken back through clawback. Perhaps 900 points would give 100% of contract and 1000 would give 105 ô 110% paid for from the deductions of those achieving less.
Dentist	I don't know, that would be for statisticians etc to decide
Dentist	5% maximum We do not accept the case for linking payment to DQOF
Dental software supplier	2% is too low, it doesnt incentivise practices to invest in improving their efficiency and effectiveness to deliver better outcomes. The DQOF must make a significant impact on practice income, especially when you consider that a large proportion of the DQOF payment is just covering basic good practice. A larger proportion needs to be available for exceptional work if its going to be used to drive improvement. Suggest that we should start at atleast 10% and ramp towards 30-40 %.
Dentist	QUALITY We support the Quality agenda of the reformed contract. However quality is a difficult thing to measure. As Einstein famously stated Not everything that counts can be counted and not everything that can be counted countsØ Our Reformed Contract proposal has the following breakdown for Quality: QUALITY - 15% Based on: Patient experience -4% Patient safety-2% Clinical Effectiveness ô 4% QOF-3% SCORED PEER REVIEW PRACTICE VISIT ô 2% The Outcome indicators used in the pilot reform seem reasonable. Our ideas broadly support these. PATIENT EXPERIENCE With the possible exception of PE.01 we are happy to support the patient experience indicators. P.E.01 does not adequately take in to consideration the level of complexity or invasiveness of the procedures undertaken and so it icould be misleading. For example following difficult exodontia or in a situation where a denture patient has unrealistic expectations. PE .06 appears to cover the general issue of satisfactory treatment. The sample size must be large for it to be a valid interpretation of quality ô at least 20% of C.O.T. Indicator PE.01 Patients reporting that they are able to speak & eat comfortably PE.02 Patients satisfied with the cleanliness of the dental practice PE.03 Patients satisfied with the helpfulness of practice staff PE.04 Patients reporting that they felt sufficiently involved in decisions

Respondent type	Response
	about their care PE.05 Patients who would recommend the dental practice to a friend PE.06 Patients reporting satisfaction with NHS dentistry received PE.07 Patients satisfied with the time to get an appointment TARGET : This should be monitored in the pilot period and a reasonable target agreed that is reasonably achievable. In addition PE.07 Values must also represent a change in service levels with regard to appointment time expectation due to appt book clogging with OHA. The remuneration of the Patient Experience element of the Quality Framework will be 4% of contract value. The levels will be on a scale and will require planning. PATIENT SAFTEY We are supportive of this measurement of patient safety. The Patient Safety element will provide 2% of remuneration. Indicator SA.01 Recording an up-to-date medical history at each oral health assessment/review CLINICAL EFFECTIVENESS. We recognize the sense of including these indicators of clinical effectiveness within the contract reform. We have some reservations with regards to the accuracy of the data in the pilots. It is very important that this data is accurate as the data will be useful in terms of delivering targeted care to certain communities. For example in communities where a larger proportion of children are identified as red an increased proportion of contract value devoted to prevention may be indicated. As such the remuneration attached should not bias scoring and this should be balanced within contract reform. At the very maximum level remuneration should initially be based around maintaining RAG scores or very small improvements. In real terms it is in the providers interests within this system to improve the oral health of its patient base as this will allow the patient base to remain stable and to register 5% of new patients annually. We propose that the remuneration is as follows: Caries indicators 2% of contract value for a 2% improvement. Periodontal Indicators ô 2% of contract value for a 2% improvement. These targets will require assessment during the pilot period Indicator OI.01 Decayed teeth (DT) for patients aged under 6 years old OI.02 Decayed teeth (DT) for patients aged 6 years old to 18 years old OI.03 Decayed teeth (DT) for patients aged 19 years old and over OI.04 BPE score for patients aged 19 years old and over OI.05 Number of sextant bleeding sites for patients aged 19 years old and over QUALITY AND OUTCOME FRAMEWORK We propose that the following indictors are assessed within the Q.O.F. Both sets of indicators combined are worth 3% of contract value. The first group are simply policies that are in place. 1.Smoking Cessation on-line training certificate / log of referrals to smoking cessation services. Numbers of smoking cessation referrals to be within average numbers. This can be transmitted with the C.O.T as ; SMOKER BUT NO INTEREST IN CESSATION; SMOKER INTERESTED IN CESSATION (COULD THESE PATIENTS BE AUTO REFERRED BY SELECTING THIS RESPONSE ON THE SOFT WARE?) 2. Referral log: Numbers of referrals to be logged and transmitted. Referrals to be within average numbers. 3. Provision of urgent care slots; Average values to reflect remuneration. 4. DCP training for prevention services. Where a DCP is used for this service certification of training and C.P.D is required. 5..Satisfactory CQC report. 6..Completion of audits on clinical notes/ radiography/referrals. (These will form part of the Scored Peer Reviewed Practice Visit). The value of these in total will be 1% of contract value. The following will be scored . Payment of 2% of contract value providing the practice achieves the regional average value +/- 10%. 3. NICE guidelines for recalls. As previously stated , the majority of the recall intervals generated by the care pathway software were over ridden by the clinicians in the pilots. Some re-design is required to allow practitioners to develop full confidence in the system. Providing this is achieved at reasonable intervals a QOF indicator within regional averages

Respondent type	Response
	would be a sensible measure. 4. Numbers of free replacement restorations provided. Average values to reflect remuneration. 7.Fluoride Varnish applications 8. Fissure sealants SCORED PEER REVIEWED PRACTICE VISIT This element of the Quality matrix is time consuming and expensive but in our opinion there is no substitute for a practice visit in relation to assessing quality of care for patients. We propose a practice visit is made to all practices. This will assess: General practice accommodation Assessment of prevention clinics Assessment of referral audits by the specialist providers in primary and secondary care ô see below. Assessment of audits ô in this case the peer review group will look at the audits produced by the provider and discuss them. Random clinical notes assessment and to also include: Cases including endo/ perio/ simple restorative care/ complex restorative care The value of the scored QOF elements is 2% of contract value. The Scored Practice Visit will require development to ensure that it is seen as both a quality measure and also a driver for education and development. If a practice scores highly a visit will not be required for at least three years unless there is a significant change in ownership. If a practice score poorly an early second visit will be triggered. We propose that the Scored Practice Visit is funded through a process of paying sessional fees to a group of trained active NHS GDS practitioners. The costs to be exchanged for normal activity within the existing capped remuneration. Reducing Inappropriate Referrals There is anecdotal evidence that following the introduction of the contract in 2006 referrals to secondary care have increased. The increased bands and UDA reward for more complex care should help to reverse this trend. In addition we propose a referral audit of all referrals to be undertaken by specialist provider which will indicate whether a referral is appropriate or not. Some work is required on this to ensure that the grading is reasonable. Inappropriate referral may indicate a number of things , misunderstanding, poor knowledge of mandatory services , an educational requirement. All these issues require exploration in situations where inappropriate referrals are higher than average. This report will form part of the Peer Reviewed Practice Visit. The Peer reviewed Practice Visit would be triggered where this is highlighted. Greater communication between Area Teams and Health Education England will be required to ensure that where necessary educational supervision is provided
Dentist	5%
Dentist	At the most 5% you've already stated that most practices will achieve 800 points almost accepting that most practices will have to accept a further 2% pay cut which is on the whim of feedback whether justified or not To say then that some practices will receive 102% is fanciful to say the least- I fell it is a way of a cost saving excercise
Dentist	none
Dentist	10 - but have to be reasonably achievable otherwise practice stability may be affected
National Body	NHS Protect believes the contract value for the Dental Quality and Outcomes Framework should be as low as possible, unless appropriate levels of resources are invested to monitor performance against it. In NHS Protects experience, insufficient resources have been invested in contract monitoring in primary care, and this increases the risk of fraudulent claims being made to meet the targets set. The Quality and Outcomes Framework in GP services has been subject to fraud. In March 2014, a GP was sentenced to nine months in prison for fraudulently making over 7,000 changes to patient records in three days, in order to hit Quality and Outcomes Framework targets. The GP falsely

Respondent type	Response
	claimed for patient checks they had not carried out and received payments of over ┬ú62,000. It is possible similar fraud will be experienced in the Dental Quality and Outcomes Framework unless the risks are appropriately addressed from the outset.
Dentist	10% ACV
Local Professional Network	The % needs to be high enough to make it worthwhile for practitioners to put effort in this area, but with few indicators so there is a reasonable chance of attaining the DGQAF funding, between 2-5% and possibly up to 10% might be appropriate but the group had mixed views on this issue.
Dentist	5 - 10% However, I would prefer this element is based on a bonus system rather than a penalty system, i.e. more in-line with GPs. There is no anxiety, apparently, for GPs not to focus on quality without incentives, so, I'm not convinced that dentistry should be regarded differently to General Medical Practice. I'm not convinced that every element of DQOF should apply to all practices at the same time either, so would hope that there is some flexibility, so that dental teams could focus on some elements of DQOF in one year and different elements in the next. Perhaps, depending on reports on quality outcomes or locally identified needs. For example in areas of low need it will not be necessary for all children to receive fissure sealants, so there should be no need to incentivise teams to provide all children with fissure sealants unnecessarily
Dentist	2%
Dentist	0%
Dentist	
Dentist	
Dentist	Less than 5%
Retired Dentist	At least 10% but able to ruse to 20% over time
Dentist	>5%
NHS Area Team	depends what the DQOF contains and depands on the financial mixture of capitation and activity you need to provide some example for consultees to work through
Dentist	10%
Community dental service	
Dentist	Not sure but it should not be fixed and able to change as the contract develops to the benefit of the patient and should not be used as a money making exercise by the government
Dentist	
Dentist	95%

Respondent type	Response
Dentist	
Dentist	
Dentist	Unsure but probably a high percentage assuming the dqof s really do address improved patient outcomes, in terms of patient experience and clinical provision
Dentist	
Dentist	5 per cent
Dentist	Unsure
Dentist	10%
Dentist	2
Dentist	4%
Dentist	40%
Dentist	0.50%
Dentist	10% is about right
Dentist	Nil
Dentist	30%
Dentist	5
Dentist	i dont know
Community dental service	20%
Dentist	DQOF seem fundamentally flawed as they are mostly subjective, or can be easily circumvented/exploited. Either a very small percentage should depend on them or a large percentage, but with serious consideration on ensuring objective DQOF are implemented.
Dentist	2%
Dentist	75
Dentist	25
Dentist	At least 20%
Dentist	2%
Dentist	10% is OK provided that an appropriate sample size is taken, and this should allow for areas where there is poor compliance as in these areas only disgruntled patients will make the effort to respond
Dentist	0%

Respondent type	Response
Dentist	2%
Dentist	25%
Dentist	5% I feel that as with GP initially a number/complicated DQOF system is not put in place and amendments required
Dentist	5-10%. Any higher than this would be unfair as a lot of the factors that current to the DQOF's are outside of the dentists control despite the amount of effort he/she may put in e.g. Patient motivation
Dentist	2%
Dentist	40
Dentist	10% is reasonable - my concerns are around patient questionnaires - as historically, patients that are slightly unhappy with the service tend to respond whereas those that are happy tend not to - would this not skew the stats?
Dentist	5%
Dentist	10%
Dentist	A small percentage e.g the 10% previously mentioned. The frameworks are not really indicators of actual quality of treatment. They are a tick-box exercise. Practices can alter data to fit in with targets.
Dentist	Between 5% & 105 IT SHOULD BE AN ADDITIONAL PAYMENT RATHER THAN A DEDUCTION - A CARROT IS ALWAYS BETTER THAN A STICK TO IMPROVE QUALITY
Dentist	20%
Dentist	10%
Dentist	Between 5 - 10%, though some FDs had concerns about how this could be done fairly.
Dentist	I think 10% is adequate. Since the DoH cannot afford to pay us anymore, it would be completely unrealistic to expect dentists to risk more than 2% of their income with a myriad of what are effectively KPI's and expect it to be done with good grace. The introduction to Paper 4 is very assertive in making the point there is no more money for contract reform. I think the DoH needs to be very careful not to alienate the current work force with their dictatorial demands of expectations without pay rises after a fallow four years. The business models just won't be able to cope. The risk is there will be wholesale migration to the private sector just as happened in 1990 when we had a 7% pay cut. The private sector could not get away with reforming contracts on this scale without financial incentives. The DoH will be making a mistake if they think they can get away with it.
Dentist	10%
Dentist	0%
Dentist	I recognise almost all of those words yet I have no idea what this question is asking. Try to use English, not acronyms.
Dentist	0% This is the responsibility of our regulators who we already pay to do this for us and police it. We have finely-tuned businesses to run which are at risk owing to the whims of this idea. It is an obvious attempt by Govt. to withhold or claw

Respondent type	Response
	back some of the contract value more easily. It will just make more unnecessary administrative work at BSA and end up actually taking away money from primary patient care as a result.
Dentist	5
Dentist	100%
Dentist	110%
Dentist	Probably 10-15% is correct. Really should be some element of "new money" for this. The current plan does indicate the possibility of an actual fee cut as 1000 points is liklely to be unobtainable. Perhaps 950/1000 should recieve the full percenage
Dentist	2%
Dentist	5%
Dentist	10% seems fair
Dentist	10% seems fair. However, as the system evolves it may be more appropraite to alter the percentage of DQOF.
Dentist	50%
Dentist	50%
Dentist	AN ADDITIONAL 10% NOT A DEDUCTION OF THE CONTRACT VALUE.
Dentist	It should be an extra 5% added to original contracts
Dentist	Minimal amount.
Dentist	No more than 10%
Dentist	less than 10%
Dentist	0 %, it's difficult enough to a run a practice and get to grips with patient demands. This will be another burden to worry about.
Dentist	
Dentist	2%
Dentist	Less than 10%
Dentist	5%
Dentist	0%, people are going to cheat and give misleading or outright untrue figures if their livelihood depends upon the numbers.
Dentist	20 percent
Dentist	10% I think it will be a fair amount.
Dentist	0%

Respondent type	Response
Dentist	50
Dentist	As little as possible.
Dentist	In the example you give most practices would be expected to loose out in converting to the new system. IE most are expected to achieve 800 points that's a -2%'reward' for implementing a new contact, with all the extra time, training and investment involved being born by the practice. AGAIN. In truth you (the DH) misrepresented the last contract, the +5% promised simply was not there! We do not trust you and this planned cut is evidence of of a planned repeat performance. A more honest approach would be to plan DQOF so that in the first year it's calculated but not used to determine any contact adjustment, with this national data in hand it is then planned so that those practices that achieve the average outcome retain the same + agreed uplift, if you under perform you loose out, if you deliver better outcomes for your patients you can increase your contact value by say a maximum of 5%. If you implement a new contact with all the inherent costs and risks, then can only maintain your current contact value by achieving a perfect DQOF, it's actually a cut. This would be dishonest, unprofessional, and certainly not in the interests of the public in general, patients or hard working staff who provide NHS care.
Dentist	15%

Paper 4: Remuneration

Responses to Question 2

We assume there will be an element of remuneration for quality and outcomes. Beyond this element, what are your views on the options for remuneration and how the challenges associated with them can be managed?

Respondent type	Full activity	Full capitation	A blend of capitation and activity
Dentist	Avoid any uda type system, but I still feel the pre 2006 contract provided a more fair system for patients and practitioners	Again not a bad idea but financially can be hazardous depending on the degree of complex work needed	Best system,
Dentist	Been there before doesn't work, usual perverse incentives terrible for prevention unless strictly monitored	Doing this now but impossible to maintain pt numbers due to new working approach. Can see how it can be cost neutral for dentists without replacing associates with therapists or foreign dentist prepared to work for less but big concerns here that if language issues pt do not understand the prevention message as well	Wasn't that what we had before UDA's
Local Professional Network	An activity-based system has the potential to be an effective way of remunerating professionals for carrying out treatments. However, within the highly restrictive confines of a three band system, the UDA contract fails to deliver the potential benefits of an activity-based system and has now		

Respondent type	Full activity	Full capitation	A blend of capitation and activity
	been widely discredited. A capitation-based approach could work well within a framework that is prevention focused and, with appropriate clinical assessment of patients by dental reference officers, could be made to work for the provision of care, too. In order to materially improve their oral health, patients do need dentists to actually do things to them, as well as saying things. Currently, there is simply not enough money in the system to support prevention-based care alongside the delivery of much needed treatment. We have concerns that the constraint of no additional moneyØ will mean there will not be sufficient money within the system at the introduction of any contractual reforms and this will leave the profession open to criticism that they are failing to provide sufficient care under any reformed contract. If the Government is serious about delivering better dental healthcare to more people (within a fixed overall dental budget) then the Department of Health must secure savings from secondary care spending		

Respondent type	Full activity	Full capitation	A blend of capitation and activity
	before the roll-out of any reforms, so that such savings can be used to support a capitation payment that reflects fair remuneration for practices and is able to account for the range of needs between various high needs groups of patients.		
National Body	There should be a minimum expected standard which should be remunerated through a blended method		
Dentist	Treadmill as per current contract and does not incentivise quality or prevention	Risk of supervised neglect and teams registering very large list sizes that they cannot effectively manage	Most appropriate system
Dentist	This would be the system of remuneration that was present prior to April 2006. There were issues with that which is why it was changed.	There would be little incentive to accept high needs patients. This would reduce access to treatment.	This would be the model of choice. It was suggested that a 30% weighting would be appropriate to encourage activity
National Association		Our view is that as much of contract remuneration as possible should be based on capitation with Dental Reference Officer monitoring to provide reassurance on activity levels. We believe that full capitation would work, given appropriate monitoring. Full activity along the lines of the current contract would not be in the interests of patients or professionals and would be inconsistent with a prevention based system. A blend of activity and capitation would also not work if the	

Respondent type	Full activity	Full capitation	A blend of capitation and activity
		activity amount was more than ten per cent. Blending capitation and activity will be complex for practices to manage and will dictate clinical priorities which must be potentially damaging to patients. If dentists are working on a risk based system and using clinical pathways it will be extremely difficult to set national percentages in a blended system because the treatment needs and behaviours of populations vary. It would be much more sensible during the first three years, whilst practice populations are receiving their first oral health assessments, for there to be no activity requirements. These should only be introduced once the health risks of practice populations are known. It will also give practices with large numbers of RedØ patients some opportunity to stabilise them.	
Local Professional Network	It is felt this has been tried with the present contract and the UDA and fixed number of UDA contract. The pre 2006 contract was an activity based contract and this was not remuneration capped and did not encourage prevention so we will this is not an option to explore.	It was felt this in isolation (i.e. not blended) was not the answer. Capitation would increase access as it would be beneficial for practices to take on patients and it may also lead to practices delivering more preventative care. However it was felt that in some cases monitored neglect might occur. It is difficult to monitor this as outcomes cannot detect whether caries and periodontal disease is failing to be treated. Therefore if the system were	Full activity It is felt this has been tried with the present contract and the UDA and fixed number of UDA contract. The pre 2006 contract was an activity based contract and this was not remuneration capped and did not encourage prevention so we will this is not an option to explore. Full capitation It was felt this in isolation (i.e. not blended) was not the answer. Capitation would increase access as it would be beneficial for practices to take on patients and it may also lead to practices delivering more preventative care. However it was felt that in some cases monitored neglect

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		introduced clinical monitoring by examination of selected patients by an RDO would be essential to monitor treatment or lack of treatment. This system may encourage practices to allow patients to be taken on as an NHS and then offered cut-price private dentistry thus increasing practice profit but decreasing PCR.	might occur. It is difficult to monitor this as outcomes cannot detect whether caries and periodontal disease is failing to be treated. Therefore if the system were introduced clinical monitoring by examination of selected patients by an RDO would be essential to monitor treatment or lack of treatment. This system may encourage practices to allow patients to be taken on as an NHS and then offered cut-price private dentistry thus increasing practice profit but decreasing PCR. A blend of capitation and activity Yes it is felt this is the way forward. It was difficult to comment without specific models. Please see any other comments about general feedback about this.
Dentist	make the fees reflect the areas that are important so that adequate time is spent on these. Prevention is the ethos here and therefore this should be remunerated highly.	it might be better to increase the % attributed to the DQOF on full capitation as the outcomes can be measured.	
Dentist	Tread mill approach	open to abuse	Probably the best option
Dental Corporate	A degree of capitation is a good way to balance treatment with maintaining access to a broad patient base	Unlikely to maximise patient access	This would be ideal,The pharmacy contract serves as quite a good model, with base capitation, some quality and majority activity. We recommend circa 30% capitation and the balance (55%) activity
Dentist			preferrd option of blended capitation
Dentist	May encourage dentists to actually trat high needs patients	May lead to neglect	
Dentist	This system used pre 2006 has been shown to be flawed and should not be reintroduced	A remuneration system based entirely on capitation has the potential to encourage supervised neglect without	This is the preferred model for remuneration. This element of the contract, based on the historic provision of Band 3 treatments, must

Respondent type	Full activity	Full capitation	A blend of capitation and activity
		very close monitoring and thus is not desirable.	provide an effective activity measure for quality and commissioning purposes, and ensure effective treatment for the higher need patient. The planned Oral surgery, Endodontics and Periodontology clinical pathways will enable complex treatment to be assessed for either delivery in practice or in a more specialist setting which may lead to more specialist treatment being delivered in primary care. The current care pathway used in the Oral Health Assessment must be streamlined and simplified to enable efficient treatment planning together with all the benefits of using a care pathway.
Dentist	No good. We have thus already. Doesn't encourage prevention. Output only. Not outcome.	Good for steady income. Must be weighted but Also regularly and well monitored	Good compromise. Must be more % of capitation than activity.
Community dental service	With respect to full activity ô we already have this and does not incentivize treatment of disease, which should be a goal of NHS dentistry	Full Capitation doesnt reflect activity and can lead to disease left untreated, but the benefits of capitation payments mean that in pilot practices where we have seen a long waiting time between appointments, the risk of losing patients through increased waiting time means the capitation quota provides an incentive to treat patients effectively and efficiently to continue to ensure enough patients can be seen to reach the capitation ÿquota. It has been reported by colleagues working in a pilot practice with an hourly salary, that they initially started to slow down the pace of their treatment, but with	A blended approach covers benefits of both systems but to ensure actual good care of patients must involve the reintroduction of DRO visits where patients are spoken to and dental care received is inspected. Good treatment and good care should be recognized. There will always be practices that are either oversubscribed and having to turn away patients they cannot see and others who are trying to actively attract patients in order to meet capitation quotas. The blended approach needs to ensure that practitioners in either type of practice can manage their capitation quotas without compromising on the quality of care delivered, this cannot be achieved simply through payments and a DRO visit needs to be

Respondent type	Full activity	Full capitation	A blend of capitation and activity
		increasing waiting times, they had to increase the pace of work and manage time effectively and still work efficiently This time it is not to hit a UDA target but to increase access slots to keep waiting time between appointments shorter. It has also made clinicians spend that little bit extra time ensuring that their treatment had a better prognosis and patients can better manage their own health so they dont keep re-attending with recurrent problems or new cavities.	reintroduced.
National Association	Introducing an activity-based element could introduce difficulties of how preventative advice could be remunerated and raises potential problems of over-treatment.	We believe that a fully capitation-based system is the most suitable remuneration option for a preventative approach. However, the implementation of full capitation would depend on the ability to accurately and reliably predict demographic care needs and we believe that the range of care to be provided within the NHS offer should be clearly defined. We also feel strongly that the new Contract should cover complex dental treatment where needed and that this provision should be adequately funded.	A blended approach would run a high risk of being too complex and introducing an unnecessary burden on practices.
Dentist			Blend
Local Professional Network			A blend of capitation and activity is the only sensible solution. The need to get patients registered with a practice so they have the obligation to see and treat which they dont

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			under the present system balanced with the incentive being there to provide treatment. This will be dependent on the approach that commissioners want to drive but if the aim is to avoid frequent and unnecessary attendance then it would not make sense to encourage a solely activity-based approach.
Dentist	Too much like the present system and not rewarding prevention. However - encourages - efficiency / and pays according to delivery of volume / access / rewards for high needs pts who need high activity	This is possibly subject to supervised neglect - not rewarding any interventions	Ideal scenario and preferred
Dentist			Best option by far
Community dental service			We have noted the intention to commission care using a care pathway approach with a very preventive focus. This lends itself to a move away from counting activity towards a full capitation model. This would need adequate and effective monitoring and we support the reintroduction of a properly resourced, trained and managed DRO system. We propose that the activity counted is number of patients made dentally fitØ, applying a definition of dental fitnessØ that is individually agreed and signed up to by the patient and dentist working in partnership. The timescale that would apply to this needs to be long term, as prevention takes time to demonstrate an effect. We suggest 3 to 5 years, which might fit with a registration period too. Capitation could limit the number

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			of patients who can access care, in a cash limited funding system but we anticipate that the preventive approach, properly applied, would result in patients requiring fewer OHAs carried out at greater intervals, this making time for the dentist to take on new patients. Current NICE guidance on the recall interval was not based on the new preventive pathway so will need revisiting so that the impact of recall intervals on periodontal health is taken into account. There could either be an entry payment into the scheme or else three schemes/pathways with capitation payment weighted by patients home postcode plus other demographic factors. The three pathways would be; occasional attender, new patients, regular patients. In this system any financial risk is borne by the dentist, so careful prototyping will be required to gain the confidence of the profession.
Denplan Ltd	Has been tried and failed overall - inapprorpiate for contemporary dental practice	Ideal for a preventive approach where remuneration is seen as appropriate	A pragmatic balance between accountability (performance) and equity
Local Professional Network			Need to get patients registered with a practice so they have obligation to see and treat.
National Body			Full activity and full capitation are far too open to abuse and would work against the preventive philosophy with either over-treatment or ÿsupervised neglect risks. A blend is the only sensible option.
Dentist	Full activity: might as well stick with UDAs	Full capitation : no incentive for treatment. If the NHS wants to go down the route that only check ups, x-rays, s&ps and preventative advice	Mixed: Extremely difficult to get the balance right, huge effort and cost to develop and will anyone try to develop the system or just treat it as a lost cause and start from scratch as

Respondent type	Full activity	Full capitation	A blend of capitation and activity
		are free and patients pay privately for treatment then this would be perfect way to do it.	seems to be the case with UDAs. The only benefit to this is if it will generate completely new contract values which reflect the needs of an area and the ability of a practice to deliver effective treatment. How will capitation be measured ô some patients only want to attend when they are in pain others want to be seen every 3 months whether there is clinical need or not. Also, the likely (certain) existence of a cap to payment for treatment will again just create a UDA style situation where some dentists engineer treatments to those profitable. To target those with the highest need treatment should reflect either per item or on a per hour/part thereof. Carrying out lots of fillings on one patient is currently not cost effective. Dental practices must be able to return to better profitability levels in order to invest, train, grow and to encourage new recruits. Morale is low as costs are increasing up to 10 times faster than uplifts and red tape continues to consume ever more time.
Dentist	Depends on the stats of greedy dentists abusing the system. I hear they tried increasing payments in the past (1960's?) and dentists just thought "blummin eck this cant last, better make hay while the sun shines" and over-treated even more!	I think it would feel like a salary which I think would be a good thing. Dentists wanting more money could work in areas with more need, those happy with an easier life for less money could seek areas with less need.	Depends on the blend, cant comment without stats.
Dentist	Not appropriate	Would work with sufficient monitoring eg DRO system	Complex . Will only work if activity is no more than 10%

Respondent type	Full activity	Full capitation	A blend of capitation and activity
Dental software supplier	Full activity could be made to work better going forward if dentists were better rewarded for preventive effort (which may not just include treatment).	Full Capitation ô could be made to work but only if the DQOF element is made more significant to balance out the inertia effect of the capitation payment.	Blend ô probably the model with the most potential to deliver best outcomes across the board but likely to evolve into a complex maze if not ruthlessly managed.
Dentist			Our Reformed Contract proposal has the following breakdown for Remuneration: We support the idea of a Blended Contract Reform. The key drivers for remuneration to be centered around: ACCESS ACTIVITY QUALITY The framework for remuneration to be around the following: ACCESS - 40% Broken down in to; 35% list size dependant 5% patient turn over/growth. ACTIVITY ô 45% UDA scored and managed ô but with more sensitive banding encouraging prevention and hopefully reducing referral rates. QUALITY - 15% Based on: Patient experience -4% Patient safety-2% Clinical Effectiveness ô 4% QOF-3% SCORED PEER REVIEW PRACTICE VISIT ô 2% ACCESS In real terms the success of a provider can usually be measured by the numbers of patients choosing to access care. In simple terms if access is a driver for provider remuneration and therefore performer remuneration this system should result in greater quality of care for patients and greater patient retention. Currently the driver is mainly activity which may be remaining on target in spite of reduced patient numbers and falling access. Remunerating access should drive up standards of care across the board and also stimulate competition within the NHS dental care market which in turn will result in

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			improved services for patients. The Access payments are made up of: Patient list ô 35% of contract value Patient turnover -5% of contract value ACCESS 1 This part of the reformed contract needs to support the development of a philosophy of payment in return for caring for a geographically sensitive number of patients. If we assume that current levels express a reasonable average list size then this average can be applied. Providing a practice supports 90%-110% of this average list size 35% of the existing contract value will be accrued. Some work is required around the average list size and the values applied to various age groups. Access 1 ô will support 35% of contract value Practices will have a THREE YEAR LEAD IN PERIOD in which to stabilize list size. After the lead in period financial recovery will operate if the practice has a 10% variance. Less than 10% may be held over through to the following year and be balanced by additional activity/ list size growth. Financial recovery/ roll over will be based on a percentage of the 40% of contract value attributed to Access. For example if a practice has a negative of 12% on list size, the claw back would be 12% of 35%. To avoid a situation where a practice misses the target by greater than 20% the practice will be required to provide a written explanation and risks contract reduction the following year if this is repeated. ACCESS 2 It is anticipated that this concept will drive access. However in order to further drive access each provider will have an access target of registering a

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			number of new patients equaling 2.5% of their average list size. This will effectively be patient turn over as it is expected that at least this number of patients will leave the list naturallyØ during the course of a year. The Access 2 payment will not be enforceable if the practice already has 110% of the list size registered. This can be measured and will allow for financial recovery. If a practice does not achieve this level of growth/ patient turnoverØ it will face financial clawback of 5% of contract value. ACTIVITY The requirement for metrics to allow measurement of activity and to support financial recovery probably mean that some form of activity Unit is required. The UDA has been universally derided as a poor method of delivering quality care. This is mainly because the three bands are not sensitive enough and do not support more complex care. We propose an extended band scheme with SEVEN BANDS. Whilst we acknowledge that this introduces a change in terms of increased complexity we believe that the additional bands allow a fairer way of measuring activity. The additional UDAs attached to more complex restorative care should reflect the time required for the procedure and not disincentivise more complex care. This approach goes some way to achieving this. In addition improving the funding of more complex care should reduce the numbers of referrals to secondary care for procedures that can be treated in primary care leading to cost savings. We also propose that the UDA is valued around the national

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			average taking in to consideration the dental health status and treatment needs of the relevant community and the demography of the patient lists. We understand that some work has already been done with regard to this. This will mean that a practice working in a fluoridated area within a high socio economic area will be required to register a larger number of patients to achieve a given income level. This seems to be reasonable. Band 0 is for the Interim care appointment for at risk groups of patients or patients with a red oral health status. It is expected that this service will be delivered in general by trained DCPs. The excellent P.C.C. prevention course could be used to train DCPs to the correct standard and license them for this kind of care. Continued support of licensed DCPs will be required through education. We recognize that this element of our reformed contract will require monitoring to ensure that the prevention element is delivered appropriately. We will look at this in the QUALITY section of the reformed contract proposal. In any event the maximum proportion of the contract value that can be used to support this service provision is 7%. The provision of urgent care will be discussed later in our proposal however it is clear that driving an access agenda will result in practices being more open to accepting urgent care patients. In addition we propose that providers demarcate urgent care slots within clinical care sessions to provide care for emergency patients who are registered

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			with the practice or un-registered. A session of 30 mins per day per performer would seem reasonable. Where these slots are not filled 24 hrs before the session is planned the time can be used by the practice as required. The numbers of urgent care patients treated will form part of reporting and these reports will Form part of the Scored Peer Review Practice Visit. We have also introduced additional P/C/R band charges. We recognize that this will not be universally popular with consumer groups. However a maximum charge of over ┬ú300 was in place prior to the 2006 contract. We would also suggest that we examine the evidence behind the exemption of pregnant and nursing Mothers for dental charges. This is historical and has very little supporting evidence base. Additionally we support the removal of the exemption form charges for patients returning for equal banding treatment within two months. Whilst we understand the philosophy behind this exemption it is a na├»ve regulation and should be withdrawn. We also support the re-introduction of failed to attend (F.T.A) fees. Activity targets in the absence of any sanction for F.T.As is poor regulation. We propose an F.T.A fee of ┬ú5 for each ten minute slot is appropriate. This fee would be split between the provider and the B.S.A. In this way collection of the FTA fee is incentivized. Perhaps we also need to consider a ┬ú5 annual registration fee for adults. This would raise substantial fees. BAND O ô (up to a maximum of 7% of contract value). Targeted prevention

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			appointment provided by DCP or GDP. ô 0.75 UDAs P/C/R ┬ú19 BAND 1 ô Recall examination following initial Oral Health Assessment. 1 UDA P/C/R ┬ú19 BAND 2 ô Initial Oral Health Assessment / Urgent care including active treatment./placement of three or more fissure sealants ô for patients under 16 yrs. Fissure sealants have an established evidence base and as a result should form part of the prevention agenda. Work will be required on a care pathway approach to the use of sealants. The use of sealants will be capped at a level of 5% of contract value. Fissure sealant stats will also form part of the QOF Quality remuneration. Any sealants placed subsequent to the 5% level being breached will be paid at Band 1. 2.5 UDA P/C/R ┬ú27 BAND 3- Simple restorative care / exodontia/ perio tx of cases with 1 sextant of 3. 3 UDA P/C/R ┬ú50 BAND 4 As above but including more endodontics / complex exodontia/ treatment of TMJ problems using a soft acrylic splint. Also to ensure that the reformed contract provides care of high needs cases where there are 6 carious lesions present the case will receive band 4 remuneration. These cases will be monitored electronically to assess Prescribing behavior against regional averages and will be assessed in the PEER REVIEW VISIT 5 UDA P/C/R ┬ú85 BAND 5 As above but inc. molar endodontics/ More than 2 sextants with a B.P.E of 3 or over. It is expected that a clear care pathway is developed for advanced periodontal care involving plaque scores/ pre

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			treatment charts/ RSD under la/ post tx charts. 6 UDA P/C/R ┬ú99 BAND 6 As above but inc. acrylic dentures/ up to two crowns , inlays , veneers/ single chrome denture. 12 UDAs P/C/R ┬ú225 BAND 7 As above inc upper and lower chrome dentures / more than two crowns, inlays , veneers. 16 UDAs P/C/R ┬ú350 Using this system activity can be measured. Using this method underperformance can be measured allowing for financial recovery. Financial recovery however should only be as a percentage of the activity element of the contract value. So for example if a practice under delivers by 12 % Only 12% of 45% is clawed back. QUALITY We support the Quality agenda of the reformed contract. However quality is a difficult thing to measure. As Einstein famously stated Not everything that counts can be counted and not everything that can be counted countsØ The Outcome indicators used in the pilot reform seem reasonable. Our ideas broadly support these. PATIENT EXPERIENCE With the possible exception of PE.01 we are happy to support the patient experience indicators. P.E.01 does not adequately take in to consideration the level of complexity or invasiveness of the procedures undertaken and so it icould be misleading. For example following difficult exodontia or in a situation where a denture patient has unrealistic expectations. PE .06 appears to cover the general issue of satisfactory treatment. The sample size must be large for it to be a valid interpretation of

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			quality ô at least 20% of C.O.T. Indicator PE.01 Patients reporting that they are able to speak & eat comfortably PE.02 Patients satisfied with the cleanliness of the dental practice PE.03 Patients satisfied with the helpfulness of practice staff PE.04 Patients reporting that they felt sufficiently involved in decisions about their care PE.05 Patients who would recommend the dental practice to a friend PE.06 Patients reporting satisfaction with NHS dentistry received PE.07 Patients satisfied with the time to get an appointment TARGET : This should be monitored in the pilot period and a reasonable target agreed that is reasonably achievable. In addition PE.07 Values must also represent a change in service levels with regard to appointment time expectation due to appt book clogging with OHA. The remuneration of the Patient Experience element of the Quality Framework will be 4% of contract value. The levels will be on a scale and will require planning. PATIENT SAFTEY We are supportive of this measurement of patient safety. The Patient Safety element will provide 2% of remuneration. Indicator SA.01 Recording an up-to-date medical history at each oral health assessment/review CLINICAL EFFECTIVENESS. We recognize the sense of including these indicators of clinical effectiveness within the contract reform. We have some reservations with regards to the accuracy of the data in the pilots. It is very important that this data is accurate as the data will be useful in terms of delivering

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			targeted care to certain communities. For example in communities where a larger proportion of children are identified as red an increased proportion of contract value devoted to prevention may be indicated. As such the remuneration attached should not bias scoring and this should be balanced within contract reform. At the very maximum level remuneration should initially be based around maintaining RAG scores or very small improvements. In real terms it is in the providers interests within this system to improve the oral health of its patient base as this will allow the patient base to remain stable and to register 5% of new patients annually. We propose that the remuneration is as follows: Caries indicators ô 2% of contract value for a 2% improvement. Periodontal Indicators ô 2% of contract value for a 2% improvement. These targets will require assessment during the pilot period Indicator OI.01 Decayed teeth (DT) for patients aged under 6 years old OI.02 Decayed teeth (DT) for patients aged 6 years old to 18 years old OI.03 Decayed teeth (DT) for patients aged 19 years old and over OI.04 BPE score for patients aged 19 years old and over OI.05 Number of sextant bleeding sites for patients aged 19 years old and over QUALITY AND OUTCOME FRAMEWORK We propose that the following indictors are assessed within the Q.O.F. Both sets of indicators combined are worth 3% of contract value. The first group are simply policies that are in place. 1.Smoking Cessation ô on-line

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			training certificate / log of referrals to smoking cessation services. Numbers of smoking cessation referrals to be within average numbers. This can be transmitted with the C.O.T as ; SMOKER ô BUT NO INTEREST IN CESSATION SMOKER ôINTERESTED IN CESSATION ô (COULD THESE PATIENTS BE AUTO REFERRED BY SELECTING THIS RESPONSE ON THE SOFT WARE?) 2. Referral log ô Numbers of referrals to be logged and transmitted. Referrals to be within average numbers. 3. Provision of urgent care slots ô Average values to reflect remuneration. 4. DCP training for prevention services. Where a DCP is used for this service certification of training and C.P.D is required. 5..Satisfactory CQC report. 6..Completion of audits on clinical notes/ radiography/referrals. (These will form part of the Scored Peer Reviewed Practice Visit). The value of these in total will be 1% of contract value. The following will be scored . Payment of 2% of contract value providing the practice achieves the regional average value +/- 10%. 3. NICE guidelines for recalls. As previously stated , the majority of the recall intervals generated by the care pathway software were over ridden by the clinicians in the pilots. Some re-design is required to allow practitioners to develop full confidence in the system. Providing this is achieved at reasonable intervals a QOF indicator within regional averages would be a sensible measure. 4. Numbers of free replacement restorations provided. Average values to

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			reflect remuneration. 7.Fluoride Varnish applications 8. Fissure sealants SCORED PEER REVIEWED PRACTICE VISIT This element of the Quality matrix is time consuming and expensive but in our opinion there is no substitute for a practice visit in relation to assessing quality of care for patients. We propose a practice visit is made to all practices. This will assess: General practice accommodation Assessment of prevention clinics Assessment of referral audits by the specialist providers in primary and secondary care ô see below. Assessment of audits ô in this case the peer review group will look at the audits produced by the provider and discuss them. Random clinical notes assessment and to also include: Cases including endo/ perio/ simple restorative care/ complex restorative care The value of the scored QOF elements is 2% of contract value. The Scored Practice Visit will require development to ensure that it is seen as both a quality measure and also a driver for education and development. If a practice scores highly a visit will not be required for at least three years unless there is a significant change in ownership. If a practice score poorly an early second visit will be triggered. We propose that the Scored Practice Visit is funded through a process of paying sessional fees to a group of trained active NHS GDS practitioners. The costs to be exchanged for normal activity within the existing capped remuneration. Reducing Inappropriate Referrals There is anecdotal evidence that

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			following the introduction of the contract in 2006 referrals to secondary care have increased. The increased bands and UDA reward for more complex care should help to reverse this trend. In addition we propose a referral audit of all referrals to be undertaken by specialist provider which will indicate whether a referral is appropriate or not. Some work is required on this to ensure that the grading is reasonable. Inappropriate referral may indicate a number of things , misunderstanding, poor knowledge of mandatory services , an educational requirement. All these issues require exploration in situations where inappropriate referrals are higher than average. This report will form part of the Peer Reviewed Practice Visit. The Peer reviewed Practice Visit would be triggered where this is highlighted. Greater communication between Area Teams and Health Education England will be required to ensure that where necessary educational supervision is provided. COMMISSIONED SPECIALIST /ADDITIONAL CARE The reformed contract needs to have the potential to be flexible in order to meet individual communities requirements and to reduce referrals to secondary care where necessary. This can be achieved at no increased cost by exchanging a block of normal activity for a block of specialist activity. For example for Oral Surgery where a provider demonstrates that they can deliver a service an agreed level of service can be struck around sessional payments or payments per case. In this case

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			the provider concerned would be asked to audit referrals as per the arrangements discussed above. URGENT CARE The access component of the contract should increase access for urgent care treatment. In general in-hours emergency care can be provide by providers within a strict criteria agreement of what constitutes an emergency care situation. These patients can be sign posted by And E ,111 etc and media advertising could be used to make patients aware that urgent care sessions in all NHS practices are available. Where additional urgent care sessions are required during the day or in to the evening care could be commissioned through the commissioned specialist/additional care route. LEAD IN TIME We propose an initial pilot period of at least two years to assess data. We recognize the requirement for some practices to increase patient numbers in the early part of the reformed contract and the requirement to prepare properly for the introduction of the QOF and clinical effectiveness framework and so in view of this we propose a three year lead in time where access and quality payments are guaranteed at 100% providing activity levels of 80% are met. CLAW BACK FUNDS If practices fail to reach 80% of target for three consecutive years contract value appraisal may result in a contract value being reduced permanently. In this case the funds should be re-commissioned within the framework of a transparent and fair process. This may lead to contract value enhancement

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			or when/where required the creation of new practices. This could lead to the introduction of new practices to the market place. Any claw back funds between 10% and 20% to be accounted for and ring fenced for dental commissioning. This could take the form of commissioned additional care/ specialist care as described above in the following financial year. Any performance between 90 and 100% can be rolled in to the following year and a practice can elect to make this up as activity or increased access.
Dentist	Over treatment, poor quality, it is so stressful to work to UDA's currently too target driven	Under treatment, over simplification of complex treatment needs, cherry picking patients	Best and worse of both worlds
Dentist	Is totally at odds with a preventative approach unless prevention is measured as it should be as an activity. If carried patients adhere to advice it may be more cost effective in the longer term	Wouldbe difficult to ensure the correct work is carried out .Perhaps a componet of charges would be related to patient charge where morte clinical intervention is needed this carries a charge-This would at least incentive patients to have a value to the amount of treatment required	I think this has the potential to work well. It would need to be piloted in the correct way to ensure the correct blend is achieved as otherwise we would end up with a similar siltation to our current plight
Dentist	no this will be another treadmill	yes this will allow dentists to exercise clinical freedom and provide what they see as necessary	this will reintroduce the treadmill target driven problems we know do not improve patient care
Dentist	I personally prefer this as it is much fairer to both dentist and patient	May encourage supervised neglect	
Dentist	not recommended as need to move away as encourages over treatment	not recommended as encourages under treatment and supervised neglect	recommended as a balance, but there must be flexibility between the 2, so that in high need areas more treatment is rewarded compared to stable patient base where more patients should be registered. This is crucial

Respondent type	Full activity	Full capitation	A blend of capitation and activity
			to ensure high need irregular attenders are welcomed and rewarded appropriately in practices
Local Professional Network	the principle is easy to understand by patients, but complex pricing has confused them in the past and they cant assess whether what they receive is correct or appropriate. It is fair to dentists as it pays for activity but risks over prescription by a few practitioners.	this is good for the NHS as it allows a finite budget to be set but puts all the risks on the practitioner and may result in them excluding patients who are deemed high need. If more patients access services in a year than the notional number budgeted for then there is a political risk if the profession declines to treat once they are at capacity	ô the capitation model may be appropriate for examinations, oral hygiene provision and advice and the odd restoration for Green RAG rated patients. Activity payments may be needed to cover multiple restorations/ extractions, crowns, bridges, root fillings as fewer patients will require these and
Dentist	Rather than a direct fee-per-item system a UDA approach is preferable as it does have less perverse incentives and is relatively easy to understand and does provide a fairly predictable patient fee structure. We are not convinced that there is a lot wrong with UDAs.However there are inherent perverse incentives with any full activity system, particularly in low need areas. A tweaked UDA system may offer the best way forward. Where there is weighting applied to UDAs, based on factors such as additional care needs, high dental needs and potentially area based measures of deprivation. Also scope to	Good for low need areas, not so good in high need areas. Not sure about how well a full capitation system would work in high need areas	Sounds ideal. But complexity of how much is capitation and how much activity based likely to be a problem. However, could have weighted capitation and weighted UDA pricing to encourage dental teams to take on and treat higher need individuals

Respondent type	Full activity	Full capitation	A blend of capitation and activity
	increase the range of bands and attached numberof UDAs. For excample could have an additional banding between current band 1 and band 2 to cover prevention and another band between Band 2 and Band 3 to cover relatively high unmet dental needs (e.g. for people with four or more decayed teeth requiring extractions or restorations or for endodontics		
Dentist	Not a good system as you will see patients being over treated	Not a good system as you will see patients under treated	IDEAL SYSTEM.
Retired Dentist	This encourages overprescription or UDA chasing	Thus dies not differentiate between patients with smaller ir greater treatment needs	This is the better system
Dentist	Lack of funding	Incentive not to treat	Continual adjustment may destabalise practices
NHS Area Team	no	no	better mix; add an extra couple of charge bands for high needs patients so a band 2 for example covers 1 or 2 fillings and band 2b covers 3 to 5 fillings etc;this gives longer term treatment planning a chance and the UDA should match; would see a change in dentists behaviour and patients can pay for what they can afford
Dentist			
Community dental service	has its flaws but clear data is available	as previously can have supervised neglect	potentially has promise if funded adequately
Dentist	Should be reserved for complex treatment oral surgery/tooth wear/perio and high risk patients	Good but practices run risk of short falls ask their costs are usually fixed year in year out	Good but again there should be a change for clawback culture due to fixed costs of running practices

Respondent type	Full activity	Full capitation	A blend of capitation and activity
Dentist	100%		
Dentist			
Dentist	Would need to be fee for item to reflect treatment need and therefore encourage practice to take new high need pts	Would need to be based on DMF not weighted capitation model as this penalises practices taking on high need pts	As above. Capitation aspect perhaps cover practice fixed costs, activity for dentists would reflect different work rates but would need to be refined to take into account increasing speed of new graduates.
Dentist			
Dentist	This encourages unnecessary work,whatever the ethics of the situation	This encourages the reverse	This would seem to be appropriate, however what aspect of the service that should be provided under capitation and what under activity needs to be carefully considered
Dentist	will put people on a incentive for over treatment	under treatment will be edemic	appropriatepreventative part should be covered by capitation
Dentist	As a practice owner this is the best method to get productivity from the dentists that work for me	Will lead to dentists doing the bare minimum amount of work that they have to do	Seems overly complicated, would be easier to stay with UDA's
Dentist			Best option
Dentist	easy to operate	easy to abuse	will get more for less
Dentist		This seems to be the best option if you really want dentists to focus on prevention.	
Dentist	Not appropriate	Not appropriate	This is the best approach
Dentist	has been successful since 1948	leads to supervised neglect	
Dentist	Not an Option	There is too much of a risk for supervised neglect unless this can be supervised by dentist from BSA	Best option with enough incentive to restore patients to full oral health and then maintained. A ring-fenced pot for activity should cover this.
Dentist	I feel we should be fully renumerated for all work we do	This has not worked in past	Potentially this could work it encourages new patient enrolment
Dentist	the old system prior 2006	will be unpopular and disadvantage	best option

Respondent type	Full activity	Full capitation	A blend of capitation and activity
	worked better than udas for patients	associates grossly , will NOT provide quality for patients	
Dentist			Yes
Dentist			is it workable
Community dental service	This could encourage over activiy and not prevention	This could encourage under activity but would be an indicator of patient satisfaction if patients stay with a practice	I prefer this option. It blends continuing care with activty
Dentist	Limitation on the amount/type of treatment that can be delivered will reduce the load on the NHS budget and largely reduce the tendency to overtreat. This of course can never be completely eliminated.	Inapplicable concept in the current situation, in my opinion. The undertreatment is evident in even the current system, a fully capitation based will further stimulate this. The variation in people's need is great. And finally the full capitation relies on patient's responsibility, which, also is a large variable.	As a balanced system it sounds the best option. In my opinion, some kind of limit on treatments should be placed, and removing the complex treatments altogether, or placing very precise conditions (not like the current vague guidelines) for their delivery.
Dentist	The UDA system is unfare. Any activity based system should pay enough compating to the complexity of the work and the equivalent PRIVATE prices.	Who will pay adequately for 3 to 5 member bridge. Your statistics doesn't catch high caries because the teeth are already extracted and sorry but NHS ensures verry GAPPY Mouths.	The balace of the above.
Dentist	already tried, doesn't work	leads to supervised neglect	The best way
Dentist			Yes
Dentist	Possible		Preferred
Dentist	not paid for prevention so it will not be done	potential for undertreatment. hard to measure. However this is the most ideal form of dentistry	Potentially a good system provided this allows payment for prevention and not just nominal lip service
Dentist	Very good contractual model	Bad model	Reasonable model
Dentist	not good	best	better than full activity
Dentist	Best option	worst option	complicated

Respondent type	Full activity	Full capitation	A blend of capitation and activity
Dentist		Mainly capitation	Small weighting of activity
Dentist	Most fair system as you get paid for the work you do. However this must be monitored by inspectors to prevent over prescribing	Would promote pressure on associates to under treat and will not place any emphasis on quality of clinical work	This is a good idea as it will reward those who work hard and efficiently but at the same time allowing payment for prevention.
Dentist	Please show exactly how this system limits access. It is more the restrictive contracts that limit access. A dentist can only offer NHS in their area if they will a tender from NHS England.	I don't understand your implication that this system will result in more private treatment being provided that should be provided on the NHS	This has been done in the past. Why are you pretending it is something new?
Dentist			blended is reasonable
Dentist	There is no change 'you will still get what you always got'. If this is maintained then providers with low UDA values will still have problems recruiting and there is an obvious inequality between providers which is purely historic and has no relevance to current practice.	The risk of supervised neglect is greater.	This initislly appears to be the most equitable option but it depends on the split as to how it will work for practices
Dentist	I work in a sedation clinic which is very high needs. Whilst in the UK as a whole the dental needs has fallen, this does not reflect pockets where needs are still very high.	I believe this will be very badly abused.	Logically, where treatment has been carried out, the dentist should be fairly renumerated. It is a sad state of affairs that we can openly state that Full activity renumeration "can lead to over treatment" and therefore the renumeration system must account for this. Is it really the renumeration system's fault that this happens??
Dentist	This is the worst system imaginable. I work in a high need area with higher than average rates of periodontal	This would be ideal. It would be nice to see a dentist able to treat patients as they see fit (within guidelines) without monetary influence. All GDPs	The risk of full capitation would be that practitioners might do little work, but could be addressed by having a system of monitoring the number of patients seen over a month or

Respondent type	Full activity	Full capitation	A blend of capitation and activity
	disease and caries. I have two major problems a./ motivating patients for whom teeth are a low level concern and b./ stabilising dentitions that are already heavily damaged. For my 3 UDAs (for which I get less than a lot of practitioners) I work twice as hard at least than dentists working with established books in affluent areas. (not to mention the fact that they do large amounts of private work.) The system needs to encourage skilled experienced practitioners to work on those with the greatest need and the most complicated to manage.	should be on similar wages (unless doing specialist work or priv work.)	so. Or by having a simple system whereby if questioned a dentist would have to justify why they booked so long for one persons treatment. For example a dentist who sees a full list of 15 min exams and 25 min fillings all day could be seen as fair. but if you were booking 45 mins for a simple filling and 40 mins for simple examinations then it could be justified that you could have worked quicker.
Dentist	Perverse incentive - will be abused by Clinicians AND Managers - not conducive for a preventive pathway	Supervised neglect - requires regular monitoring by DROs	A blend of both problems as stated above
Dentist	'core service' only essential treatment options on the NHS	unworkable unless very strict core service treatment options available	capitation but with a clear 'core service' of NHS available treatments
Dentist	Practices would be more prepared to accept high needs and complex cases but there is a risk of over treatment. In a fixed budgetary system this could lead to a smaller number of patients being seen but with a lot of expensive work being done on them thereby reducing	As with the UDA, this would discourage GDPs from accepting high needs pts and those requiring complex dentistry as treating these patients would be likely to cost more than received from the capitation fee. There is also a risk of supervised neglect with dentists taking the capitation fee but not providing	The introduction of an activity payment would mitigate reluctance to accept high needs patients. The risk is that some of the less scrupulous would then use an activity payment to over treat some cases eg. wall to wall crowns. The NHS does have quite sophisticated measuring systems through vital signs and clinical data however and monitoring of service provision can be used

Respondent type	Full activity	Full capitation	A blend of capitation and activity
	access	necessary treatment. Robust monitoring to ensure this does not happen would be required. Return of the RDO?	with dentists deviating from the norms being asked to explain and justify their action, this is already done with vital signs monitoring but not with the clinical data.
Dentist	Potential for over treatment. Paid for what work has been done, so fairer.	Capitation does not work in dentistry	Most Fds in favour of this as they tended to see it as a best of both systems.
Dentist	The paper suggests this won't happen.	The paper suggests this won't happen	This appears to have been decided.
Dentist		Use this model with practice/patient inspections by dental officers (DRO)	
Dentist	This is the only way, based on VERY defined criteria, not the wishy washy situation we have at the moment	All that will happen here is patients will be taken on, but the length of time they are recalled will be stretched	
Dentist			The only way forward, and please stop assuming that we Dentists are all crooks trying to work the system.
Dentist	I don't mind the present system at all personally. One can work ethically within it.	I would not change the way I work in my practice, it would be fine.	Most sensible given the pros and cons of each system and accepting that every dental practice is different.
Dentist	easy to manage but not if practice income capped	best option for preventive philosophy	probably best model but more weight on capitation
Dentist			
Dentist	This will lead to over-treatment	This will lead to under-treatment	Is mental
Dentist	back to the same old grindstone	risk of supervised neglect - bring back the BSA DROs	increases complexity. Cherry picking patients. Our "regulars" are already quite healthy so need less effort to get up to scratch and maintain
Dentist			This does seem sensible as it should reflect both overall care and specific treatment
Dentist	it has worked well since 2006	its increases the risk of supervised	it doesnt get over the disadvantages

Respondent type	Full activity	Full capitation	A blend of capitation and activity
	and prior to this over the 40years	neglect	
Dentist	risk of drill to fill but allows dentists to be paid for what they perform for patients.	risk of supervised neglect to control budgets but encourages dentists to take on more patients improving access.	seems like an acceptable compromise of the two systems minimising the risk of each but merits of both retained.
Dentist			best option.
Dentist	Please, please don't. It would be awful. The current system does this and it is awful- I feel like everyone who comes in has a 'value' attached. I just want to treat my patients according to what they actually need!	Yes- I'd like to see up to 60% capitation. I have worked with capitation before and it liberated me to really put the patient at heart. You must have effective policing to avoid supervised neglect.	Only a smaller amount based on activity- 30%
Dentist	THIS WOULD NOT BE AN IMPROVEMENT ON PREVIOUS CONTRACTS	IDEAL AS IT GIVES THE CLINICIAN CLINICAL FREEDOM TO DO HE RIGHT THING FOR THE PATIENT.	THIS WOULD BE COMPLEX TO ADMINISTER AT PRACTICE LEVEL AND THE % SPLIT WOULD BE CRUCIAL
Dentist		The best option if you want to encourage prevention	
Dentist	Will end up as the current contract	I like the idea of a pot of money and population and keep them fit	A fee per item to make patients Denrtally fit the Capiation to keep them there
Dentist	This is the best we get paid for what we do. Just make it a bit more generous.	Not workable in dentistry, it's to practical a field.	Not workable not tested.
Dentist			
Dentist	Like to see the detail but it is what we have ?	Like to see the detail but a possibility, not that keen. Supervised neglect ?	Probably best.
Dentist	Fairest method	Good idea but lack of incentive to provide care	Difficult to implement fairly
Dentist	risk for over treatments.	risk for under treatments	probably the best approach.
Dentist	Is going to encourage unnecessary treatment as the	Would be a much better system but would need monitoring within dental	Worst of both worlds

Respondent type	Full activity	Full capitation	A blend of capitation and activity
	previous system did. Not much can be done if you are going to incentivise dentists to do more work.	practices by outside observers to make sure that supervised neglect was not a problme	
Dentist	no	should be full capitation fo rthe rest ..banded like denplan	
Dentist	UDA system failed to provide preventive care	People in high need of treatment will do be treated properly	I think is the best solution, but the access problem will still be there. Access will be increased if more dentists will be contracted to offer NHS treatments.
Dentist	if there is full activity why not just keep udas?	how will you account for practices taking on more patients and those losing patients	this is a better approach
Dentist	100%	Capitation does not work in dentistry	
Dentist	At least you get data to monitor	Only works if funding is sufficient, which it will not be.	You need dentists to monitor quality, ie looking at patients, TPs and care delivered. No metric matches this.
Dentist	too many risks and a reversion to the old system which may encourage over treatment - this is difficult to manage	possible but the risks as outlined in the paper are very real and a new mechanism for Patient Charges will need to be developed.	this would be my personal preference. Activity fee scale would need to be aligned to complexity indices ideally.

Paper 4: Remuneration

Responses to Question 3

If a blend of capitation and activity is used, what elements of the care spectrum do you feel should be covered by capitation and why?

Respondent type	Response
Dentist	Patient should pay for complex treatments eg crown/bridge/multirooted endo/chrome denture work/ oral surgery. The capitation should cover preventive care and basic dental care eg, fillings, extractions, acrylic denture and perio treatment
Dentist	All prevention and perio because if a fee was attached then potentially it could be abused, however treatment and outcomes would need to be closely monitored
Local Professional Network	In a blended model of care delivery, capitation should cover the whole range of treatment available under the NHS. The NHS offer must be clarified beyond all treatment that is clinically necessary. This definition satisfies neither patients nor clinicians and places dentists in the awkward position of being forced to take responsibility for the decision to introduce a capped system. Disastrously, this has led to many more dentists facing litigation from patients than might otherwise have been the case. This situation must be resolved by any contract reforms. Patients, as taxpayers and service users, deserve to know what the NHS can afford and what it cannot and they deserve to be told by those making these decisions, not by those delivering the services. We believe that the patient charge should be incorporated into the capitation payment and taken directly from registered patients by the NHS. With money following patients (under a capitation-based system), rather than it following treatments (as it does in the UDA system), this should be easy to achieve. Such a move would have a number of benefits: Wasteful churn in the NHS payments processing system could be eliminated. Patients would not need to pay at practices for treatment. Practices would be able to build stronger relationships with patients, rather than being undermined by being required by law to charge them for an NHS service (a cause of many a practice complaint). This would support more effective patient engagement in the prevention-based system. Exempt patients could be more accurately identified and efficiently dealt with by a centralised charging system. Practices would not have to deal with the time-consuming bureaucracy of managing patient charges and exemptions. Instead, they would be able to use the time saved to support better prevention-focused care for patients. Without a dedicated funding stream for practice IT, any capitation payment would need to take account of the ongoing practice needs for IT, software, internet connections and regular maintenance. These costs cannot be met by a one-off investment in practices but they need to be accounted for in the ongoing capitation payment.

Respondent type	Response
National Body	Continuing care and basic provision under the contract should be covered by capitation.
Dentist	Full spectrum of care should be covered within capitation apart from more specialised care including oral surgery, orthodontics, sedation, special care dentistry and advanced restorative care. Contract needs to have the flexibility to deal with the complexity of some GDPs being involved in the specialist care pathways as tier 1 or tier 2 providers. These patients are likely to require more time, infrastructure and resource to manage and this needs to be recognised. There also needs to be a system of resourcing new high needs patients to be rendered dentally fit before being accepted into a continuing care capitation system.
Dentist	Preventive advice. Preventive treatment to include, fissure sealants, fluoride applications, and radiographs. Patients value active treatment and are happy to pay for it. They are not happy to pay for prevention.
National Association	If DH decides that there must be an activity element, then everything that is mandatory under the current contractual arrangements with the exception of complex care (which we define as current Band 3 procedures, molar endodontics and surgical removal of 8s) could be covered by capitation. Dentists will be following care pathways which mean that the provision of these complex items may well be limited (or at least limited for the first few years) and activity targets may not be able to be met. There needs to be full discussion with the [redacted] about this question and proper testing in the prototype phase will be needed. Once the revised contractual system has stabilised, capitation should cover the range of care included in the NHS offer, which must be described clearly.
Local Professional Network	It was felt Oral health assessment, preventative treatment and advice, and routine treatment should be included. It was difficult to agree what should be routine care. Should it be molar endodontics and laboratory work included this could not be agreed on?
Dentist	OHA and OHR should be included along with regular indices to back up both. OHI, Pl and BL, these are the areas that are important and should be covered for every patient regardless. by covering the OHI and assessments NHS dentistry is showing how important prevention is to them.
Dentist	Exam, radiographs, emergency access.
Dental Corporate	Capitation should be used as a base remuneration for the number of patients on the practice list and should be proportionate. The measurement of patient base is critical. a sensible starting point is patients who have visited in the last two years, and then those that return within 2 years, that being the outer limits for a recall requirement in line with NICE guidelines. The capitation should also be seen as remuneration for the introduction of clinical pathways, assuming these are sensible and streamlined There is case here for more clearly defining what is and is not available within NHS treatment. Our view is that the current 'greyness' around this is restricting the development of a broad range of services, and if it were clear that a service were private only the market would pick this up and become much more open and price competitive, as is seen in Ireland and many open European markets. By doing this NHS funding could then be reallocated to more critical services e.g. domiciliary care and periodontal treatments
Dentist	capitation must be weighted and include the full care spectrum apart from complex care enhanced payments must be

Respondent type	Response
	made for clinicians who carry out complex treatment
Dentist	The capitation element of the contract should include the current Band 1 and Band 2 items with the exception of: Perio for BPE 3+ Molar endo Surgical extractions Patient requiring 4 or more treatments in a course The inclusion of routine items within a capitation system gives the potential for clinicians to be rewarded for managing their patients preventatively whilst encouraging appropriate prescribing of more complex treatments.
Dentist	All elements apart from complex care care could be provided Purely due to the reason of costs for complex care.
Community dental service	Capitation should cover full assessment and re-assessment visits only. Practices that actively encourage attendance for fluoride varnish and interim care management between full examinations do not have this added time and the staff cost recognized within capitation. This contrasts with those practices who simply undertake and assessment and treatment. For high risk patients (and pre-cooperative younger patients needing additional behaviour management), the activity related to prevention appointments and interim care management is not effectively remunerated through oral health outcomes or through capitation. Such evidence-based preventive interventions are imperative for children and interim care visits help to reinforce positive behaviour change. Unless these appointments are recognised as activity there is no incentive for clinicians to provide them, particularly when there are demands on their time and waiting list targets to meet.
National Association	We believe that further liaison with the BDA and other organisations is be required to address this question. However, as previously stated we believe that the new Contract should cover complex dental treatment where needed and that this provision should be adequately funded.
Dentist	Examination and preventive advice simple cleaning treatments fee per item. Total capitation system for children tried in 1990s didnt work blend of capitation + fee for treatments did
Local Professional Network	Preventive treatments such as fluoride application & OHI.
National Body	Preventative advice, examination (OHA) and issuing of prescriptions.
Dentist	
Dentist	
Dentist	OHA, prevention, free of pain caries removal and basic restoration
Community dental service	The reformed contract appears to be predicated on a preventive care pathway approach, which involves a culture change in a profession that is largely trained, and has previously been incentivised, to collect activity. Any payment for activity will help to retain this culture or at least make it more difficult to change the culture, so it might be worthwhile from a cost and benefit perspective (looking at the new system holistically) to remove any activity counting at all. There is a view that any payment for activity incentivises that activity, so it might be interesting to pay for prevention in this way. Any measure of activity should form a small part of the overall contract as a high proportion will reintroduce the

Respondent type	Response
	treadmill. We note that one of the parameters for the reformed contract is that there should still be the ability to provide private treatment. This has always caused confusion for patients and one way to provide clarity for patients and dentists would be to clearly define what is covered by capitation. If advanced treatment was not available as part of capitation (and the care pathway approach indicates this to be the case) then this would give the option to the patient to have this provided either by a Tier 2 dentist under the NHS or else pay privately. Any tiered system must take account of patient preferences and the existing skills of dentists who have been providing tier 2 care for many years. The requirements for entry as a tier 2 dentist must be carefully considered, with proper transitional arrangements for current practitioners.
National Organisation	Assessment/diagnosis; preventive advice and care; urgent care for (non-specialist) relief of pain or significant detriment; routine non-specialist care and treatment
Community dental service	
Local Professional Network	Prevention and integrated approach to wider public health and wellbeing, health promotion activity, fluoride applications, smoking cessation, oral cancer, healthy lifestyle choices incl. alcohol and healthy eating. And patients should be incentivised for attending regularly at intervals advised by dentist, at least once every 2 years as NICE Guidelines, by having any patient charge associated with their attendance/treatment waived .
National Body	Being numerically based, capitation primarily will relate to numbers of patients registered, seen and cared for; OHAs, OHRs and prevention could be encompassed within this framework. However, care must be taken that large group practices and the corporates do not see this as a money driven opportunity to sign up as many patients as possible and push them through a tick box type of pathway merely to boost profits for themselves and/or shareholders. A cap could be applied to limit the number of patients registered per dentist to prevent such abuse and encourage a greater emphasis on quality and outcomes.
Dentist	Capitation should only encompass the current band 1, exam, scale, periodical x-rays and OH advice and perhaps Flouride varnish for children. An individual dentist may choose to perform a small filling on a patient at their discretion as many do now but this should be the exception and not the rule.
Dentist	The more predictable ones based on average need of the particular practices demographic.
Dentist	Capitation should cover all the activity needed to care appropriately for the patient following the care pathway and deemed part of the NHS offer. If activity is to be measured it should be preventive activity.
Dental software supplier	The first three elements form the foundation of a preventative care based service. The routine treatment for disease needs to be part of the capitation model to incentivise emphasis on prevention over treatment.
Dentist	Our proposal seeks to separate remuneration form intervention to an extent. Dividing the remuneration in to chunks for Access, Quality and Activity should mean that all three factors are incentivised .In addition the Scored Peer Reviewed Practice Visit places clinicians at the centre of regulating and improving services. This places responsibility on clinicians

Respondent type	Response
	to share good practice through the Scored Peer Reviewed Practice Visit and to work collectively to wards improving care for patients. This subtle change should result in a more clinician led approach to driving up standards of care through the process of the visit and education of under performing practices.
Dentist	I believe that oral health reviews and preventative advice should be included in the capitation further work should be covered by activity. This can be used to incentivise the patient, some patient do just pay lip service to advice given by health care professionals,
Dentist	certainly all current band 1 treatments and even perhaps minor restorations(single surface). However this shouldn't be a penalty in other words if this the case the capitation component needs to be set high enough to incorporate this Perhaps orthodontic extractions should also be included however this again would be difficult to measure
Dentist	Ability to access emergency care
Dentist	Please see paper submitted by ADG; Contract reform View from the ADG The existing dental contract in England is currently being reviewed and new ways of working are being piloted nationally. ADG members have a number of practices involved in the pilots and the experience from these practices has helped to shape our proposals. A new contract needs to be flexible enough to enable high quality and effective treatment delivery for all patients, provide a preventative focus and improve access in an equitable financial model. Current proposals are for a blended contract made up of 3 elements: Registration / Capitation Activity measure for complex treatment Outcome measure DQOF Registration / Capitation This element of the contract is to be based on patient registration numbers. This has been effectively trialled in the national pilots and this experience should influence how this part of the contract is scoped. Proposal Baseline funding levels for registration and capitation can be based on historic delivery levels of Band 1 and 2 courses of treatment. The link between dental need and IMD appears to provide an effective capitation remuneration system which is sensitive to patient need and should be used to set the capitation remuneration value. To be successful an efficient and effective IT system is required to track patients at performer level. Performer level data in all categories of the blended contract will be essential in ensuring success of a new contract. Provider flexibility in managing the allocation of patients to performers will be a necessity. The pilots have shown that IT suppliers need sufficient time to develop effective systems before implementation and need to work in tandem with the NHS BSA to ensure accurate registration data. Activity measure for complex treatment This element of the contract, based on the historic provision of Band 3 treatments, must provide an effective activity measure for quality and commissioning purposes, and ensure effective treatment for the higher need patient. The planned Oral surgery, Endodontics and Periodontology clinical pathways will enable complex treatment to be assessed for either delivery in practice or in a more specialist setting which may lead to more specialist treatment being delivered in primary care. The current care pathway used in the Oral Health Assessment must be streamlined and simplified to enable efficient treatment planning together with all the benefits of using a care pathway. Proposal To encourage delivery of more complex treatments in primary care and to introduce a balance between treatment delivery and prevention two bands of activity, with appropriate fees, should be considered. Band 3a would include the following treatment items: Perio for BPE 3+ Molar

Respondent type	Response
	endo Surgical extractions Domicillary treatment Sedation treatment Patient requiring 4 or more treatments in a course Band 3b would include all of the current items in Band 3. Each band would require a defined list of treatment rules to ensure clear distinction to be drawn between NHS and Private, ensuring clear and transparent effective treatment choice is offered to all patients. The definition of treatment items must avoid the complexity found in the previous fee for item system. This treatment definition is essential to remove the current uncertainties as to where the boundaries between NHS and private treatment lie. This banded activity payment system would encourage more complex treatment to be delivered in primary care, reducing inappropriate referrals, reducing secondary care provision with subsequent cost saving, improved career progression opportunities and greater funding for primary care. Quality measures DQOF DQOF must enable clinical quality and effectiveness to be measured at both contract and performer level. The set of measures used must provide reproducible and meaningful data over a reasonable time period. DQOF has been trialled in the national pilots with mixed success and the learning from this can help to influence future quality measures. Proposal As the new contract needs to encourage effective treatment delivery with a preventative approach. If DQOF measures need to be a confirmation of Outcome and Process Measures. The process measures are likely to have upstream outcome benefits. Possible measures to deliver this include: Compliance with Delivering Better Oral Health Toolkit recommendations Prescription of radiographs Periodontal treatment Compliance with CQC requirements Patient satisfaction measures Longer term health improvement measures Implementation The introduction of a new contract should be phased in over a 3 year transitional period to allow for the management of change, new ways of working, including a changing skill mix, to become embedded. The pilots have shown that practices are less efficient at delivering treatment in the early months of implementation of a care pathway approach and a defined level of remuneration flexibility is required to protect practices to ensure a smooth transaction and get the profession to champion the new contract. Care pathways should be introduced in stages into different patient age groups over the transition period to reduce the impact of any initial reduction in efficiency. Flexibility between the balance between the capitation and activity elements of the contract is required to take into account the differing treatment needs in patient populations. This flexibility will be required throughout the transitional period and subsequently at mid and end of year reviews to allow for adjustment as future treatment needs decline. In order to achieve this flexibility there needs to be a correlation of weighting between activity measure and patient numbers giving an overall target, for example: 1 unit of activity band (3a) = 2 * patient capitation remuneration value 1 unit of activity band (3b) = 4 * patient capitation remuneration value Year No of patients Activity measure Weighted activity Total Target % achievement Remuneration flexibility 1 1550 975 1950 3500 3750 93% 20% tolerance 2 1700 950 1900 3600 3750 96% 10%tolerance 3 1850 900 1800 3650 3750 97% 5% tolerance 4 2000 875 1750 3750 3750 100% 5% carry forward During the transition period the remuneration flexibility in the transition period moves from a tolerance level to a carry forward. The remuneration flexibility levels will ensure that practices can introduce new ways of working, including changing skill mix with a degree of financial protection whilst encouraging access and activity. The initial remuneration flexibility level may be set using previous contract delivery achievement, as is currently used in Type 2 and 3 pilots. IT suppliers need sufficient time to enable them to develop software solutions to support this model and the care pathway must be as simple and efficient

Respondent type	Response
	as possible. Timeline Pre contract period: Testing and piloting Training and engagement for teams IT supplier engagement Year 1: Training and engagement for teams Introduction of care pathway by age category Midyear and end of year reviews to fine tune the balance between activity and patient numbers Year 2: Training and engagement for teams Contractor engagement and training National training of extended duty nurses and therapists Introduction of all care pathway categories Midyear and end of year reviews to fine tune the balance between activity and patient numbers Sharing of best practice Year 3: Training and engagement for teams Contractor engagement and training National training of extended duty nurses and therapists Midyear and end of year reviews to fine tune the balance between activity and patient numbers Sharing of best practice
Local Professional Network	The challenges associated with the three contract models are well summarised in the document. Its too simplistic to state that full renumeration has the potential to lead to over treatment and capitation to supervised neglect. We would like a system that recognises that most dentists want to provide care of good quality and preventive advice - and does not penalise us for doing so. We agree that a Blended Activity/Capitation approach is the most sensible.
Dentist	The elements of the preventive pathway. Everything up to the current band 2 UDA. Were not sure how patients would pay in a capitation system. If they do not pay for the capitation element, then the Activity-based element is likely to be more expensive (for patients) to ensure the patient charge revenue remains roughly the same as at present. Wed stick with a tweaked UDA approach with some additional bands to cover prevention and an additional band 2 to cover individuals requiring endodontics for example or more than a certain number of decatyed teeth (e.g. four or more teeth with untreated decay). Generally, we think that the UDA system has a lot of merits but could be tweaked.
Dentist	IDEAL SYSTEM. I believe if you want to drive standards and quality of patient care up, more focus on performer incentives will be the key issue here as they are the clinicians which will be treatment planning. My suggestion - 1)Having a capitation element for basic care i.e preventative advice and also fillings/extraction. - The performer should be paid a basic set NHS fee for basic care (Preventative advice and fillings/extractions) 2)Having an activity element for lab associated treatments (Crowns/bridges/dentures) and root canal therapy would be also be an ideal aswell. - The performer should be paid for an additional fee for each advance treatment carried out on NHS i.e lab work treatments and RCT. What you will find is that if there is no incentive for advanced lab work treatments they will not be done as all lab fees will be taken out of set NHS wage. However this advanced treatment pot for each practice is capped so you will not see overtreatment. The aim is to provide all the skills the dentist has to offer, to the patients that really need it. If targets were removed for performer this would be a great for patients. Pilot Performer
Retired Dentist	Capitation is best where care needs including prevention are relatively predictable and can be provided by a DCP or dentist without additional postgraduate training. Payment by activity should not be confined to certain treatments but related to the complexity of care required by an individual patient.
Dentist	Band 1
NHS Area Team	more advanced treatments could be activity based if pathway approach is implemented; how about an entry payment does this take us towards tiers?? where is the funding for tier 2?? what about special needs/ care home patients etc

Respondent type	Response
Community dental service	prevention, so it is then actively supported not just a quick add on
Dentist	exams/ perio / fillings / willingness to take on new patients every year the basic needs of patients will never go away so the most common disease process should be covered by capitation as this is what all dentists have been trained for.
Dentist	Capitation to cover prevention. Practices will need to use DCP's for this role. The whole remuneration for dentist will have to be reconsidered and practices need to have some financial stability to cover fixed costs especially as different dentist have different levels of productivity. But this will be difficult to implement if the future dental contract uncertain.
Dentist	I would consider paying for examination and preventive care and covering routine fillings and extractions and single dentures under capitation.
Dentist	preventative care and risk assessment should be paid by capitation
Dentist	Don't know
Dentist	All except exam/diagnosis and prevention (including fluoride and fissure sealants). otherwise, too much difference between population groups leading to unfairness.
Dentist	preventive and Oral health education
Dentist	all
Dentist	Routine examinations, reviews, and simple scaling and polishing.
Dentist	Essential Care
Dentist	examination OHA only
Dentist	All preventative treatment, basic restorations and partial and full acrylic dentures to incentivise patient responsibility if they want any advanced treatment.
Dentist	Capitation for oral health and prevention and maintain fee per item for other work
Dentist	capitation based on dqof assessments, high need = high capitation rates so we can spend time with those that need us
Dentist	Exam, prevention
Community dental service	Capitation should cover the routine dental care to make a patient dentally fit within the remit of a shortened dental arch. Any molar endo, dentures and crown and bridge work should be activity based working within strict guidelines. The NHS cannot afford to pay for extensive cosmetic and reconstructive treatment.
Dentist	Examinations, preventive treatment, basic treatment. This will allow the immediate maintaining of a reasonable oral health level for the responsible patients. There should be a set of conditions connecting responsibility with more complex treatment (oral hygiene level, attendance records, etc.)
Dentist	OHR ,OHI and stops here.
Dentist	part of prevention and OH promotion

Respondent type	Response
Dentist	OHI, most dental disease is preventable
Dentist	prevention, education,
Dentist	Preventive advice. Recall system. And registration. And why not? Plainly the system cannot or will not pay for more.
Dentist	Examinations, X Rays, and prevention. Possibly a limited number of simple fillings if there is an appropriate level of capitation and allowance is made for the time this will take out of the week. NOT labwork, and not root canal treatment as clearly these are more involved and should be remunerated appropriately.
Dentist	everything but items involving lab work
Dentist	Preventive advice
Dentist	Capitation should include routine and preventative work and options of additional treatment for independent work outside of the Nhs funded by the patient to ensure a continual deterioration in income to gdp is not enhanced and a avenue for increased income to practices
Dentist	Capitation should cover prevention based aspects of care as these would be very hard to monitor if they had been done. If prevention was renumerated on an activity basis some dentists may spend 30s others 10minutes giving oral hygiene advice. If dentists knew that if they gave excellent preventative advice and this was rewarded by a increase in the patients rag score this would give an incentive to do it properly.
Dentist	Examination, advice and simple periodontal care.
Dentist	OHA and OHD, periodontal care(not advanced), sealants, fluoride
Dentist	the number of OHAs should reflect your capitation then the items carried out should reflect activity. any FD activity should be included as part of the practice capitation list - these patients should not be discluded. these patients will always regard themselves as patients of the practice. FDs will come and go. My concern is that when practices find out that these patients are not included in their capitation lists, they are likely to stay away from becoming training practices and we are nationally short of good quality training practices
Dentist	Routine examination and preventative care only. It will provide reward for prevention whilst reducing the temptation s of supervised neglect
Dentist	Emergency out of hours cover, preventitive regimes.
Dentist	Dentists must, must, must loose the situation where income directly relates to activity. Why should I have to do 8 fillings and examination and a scale to receive ┬ú30. That's less than minimum wage and in a high need practice its not uncommon. imagine if doctors were told they would be paid per operation. You would quickly see quality fall and times for ops dropping and people doing the bare minimum. For this reason all dentists consider leaving the nhs system. What all dentists want is to provide good care and have a known income at the end of the month. (an income appropriate to someone with an equivalent level of training and responsibility) Activity i.e. number of patients cared for should be a target, but not directly related to income. If you pay a dentist a set fee for a certain number of patients per

Respondent type	Response
	year. Practices will register huge numbers and then will be unable to care for/treat them, or will under treat the patients. The NHS needs to be much, much clearer about what exactly is covered by the NHS and what isn't. for example chrome dentures. The current system does not pay enough to make them without the associate dentist losing money (not just not making money- actually paying out of their own pocket) why should a dentist pay towards a patients denture? Consquently no-one really makes these on the nhs, but the dentist blames it on the nhs funding, when all the websites/policies say they are available. This just causes anger The same applies to conventional bridges and periodontal treatment. If I treated all periodontitis I saw without referring to a hygienist (who is private) I would spend all day doing periodontal tx and have no time to do any other treatment.
Dentist	Any activity will be looked upon as an expense which may have to be avoided where possible. OR it will be a target to achieve resulting in over-treatment.
Dentist	examination, OHI and basic preventive care. limited periodontal treatment. 'core service' restorative treatment only available on NHS
Dentist	Examination including all elements now in Band 1 All elements currently in Band 2, except molar endodontics and minor oral surgery
Dentist	Preventative care was considered appropriate by all, but some FDs also felt that simple direct restorations would also be appropriate.
Dentist	Core service 5-5 rct and crowns 8-8 fillings Emergency work
Dentist	At most, a patient list fee. Non of the actual clinical care should be covered by capitation. Capitation will just end in supervised neglect for hundreds and thousands of people.
Dentist	I have no idea what this question means
Dentist	Capitation should cover examination at all recalls which can be justified within NICE guidelines as well as advice/ oral hygiene instruction to patients and prevention - fissure sealants and fluoride. It should cover issue of all prescriptions and immediate management of genuine emergencies which should be defined, e.g swelling/ trauma/ bleeding.
Dentist	examination, diagnosis, preventive advice, restorative work
Dentist	there is no more money, the contact value is staying the same,n fact NOTHING is changing except the name of the system of remuneration! It does not matter what type of remuneration is in place if it is chronically underfunded. There is no will at government level to have a properly funded dental NHS service.
Dentist	Children
Dentist	Capitation for core service(gasp) Posterior RCT/lab based items only when "deserved" by being in green bands.
Dentist	Diagnosis, advice, basic periodontal care and basic restorative (not lab work or extensive wear cases or extensive periodontal care)
Dentist	history of previous dental treatment per patient. age, gender and deprivation arent the only things to consider. some

Respondent type	Response
	highly affluent people neglect their mouths and need more care and vice versa
Dentist	OHA, OHR, band 1 items only - preventative care etc. although some incentive to undertake these may prove beneficial. certain items such as fissure sealants take time to be done well, so this should be moved to activity. equally practices need incentives to use DCP skills such as fluoride application or OH education, currently its hard to adopt this with no additional funding to take that nurse out of clinic and replace her.
Dentist	Basic exam, simple scale and polish Simple replacement fills and ortho extractions
Dentist	Check-ups, fillings, extractions and essential dental work.
Dentist	THIS IS A LEADING QUESTION THAT ASSUMES THIS IS THE DH FAVOURED MODEL. EVERYTHING THAT IS SUBJECTIVE RATHER THAN OBJECTIVE SHOULD BE CAPITATION.
Dentist	Capitation gives you the ability to cover any care spectrum introduced because it doesn't require a volume of treatment to be carried out A blend won't work if you want to introduce a care spectrum
Dentist	Examination and radiographs All other treatment needs are subject to variation depending on patient needs, even preventative advice. Patients will vary in their ability to understand or comply with things as "simple" as oral hygiene instruction. They will have varying desires for a successful outcome and the need for treatment. Current benefits include the ability to change treatment plans to meet patient needs without additional fees for patients and to take patients wishes into account. Any system based on an improvement in oral health will not allow for those with declining medical health and one based on patient feedback will be subject to abuse by patients... "I'm giving you a bad report because you wont give me the 16 veneers I want" etc. I currently treat a number of patients in high medical need who will never improve their oral health and are likely to get worse due to physical or neurological decline. These patients will therefore have a negative outcome despite me treating them to the best of my ability. What should be done for them? Hospital or CDS referral for treatment they could have with less distress with their regular GDP? Again deflecting care to other services at an increased cost to the NHS. This also does not cater for patient choice where patients may refuse preventative care completely.
Dentist	All of it AS LONG AS THE PATIENT IS DENTALLY FIT TO START and cooperates with advice given
Dentist	Just checks ups and children's check ups.
Dentist	Core dentistry, exams, scaling simple fillings.
Dentist	Capitation should cover basic oral examination and X-rays only. Any thing else becomes complex and unfair to categorise
Dentist	examination/advise, preventative measures, oral health assessments. These are the repeat services given to each patient that is time consuming and that will have to be done again and again from year to year for each patient.
Dentist	Capitation should take account of patients ages, needs and socio-economic groups. Those who require more work should be given more weight for capitation to encourage dentists to take them on. The current system leads to neglect

Respondent type	Response
	of those most in need (eg ┬ú50.50 for several hours work!).
Dentist	Preventive care Emergencies Up to 3 items at a time of "band 2 " treatments It is not fair for the dentists and for patient who really care about the teeth band 2 treatment to include unlimited items for the same patient(I.e. More than 3 fillings, extractions,scaling etc on the same COT) Over 3 items an activity element should be taken in consideration. It will be fair the dentist to be paid more and of course the patient to pay more.
Dentist	number of registered patients, as this is a clear indicator of the number of patients being seen by the practice
Dentist	Capitation should cover the bits you want everyone to have, and you needed clearly specify what these are. Capitation could then fund ED nurses, OHEs and outreach for Smiles 4 Life etc. A standard annual assessment, x rays and OHI. Activity for the rest, so the assessment determines the risk category, which may mean further assessments, or access to further care pathways. Periodontal treatment or restorative work. You need to be seen to pay an honest, fair and realistic amount of the care which is delivered. These should not be an incentive to either over treat or under treat. You need to incentivise deli every of the correct, appropriate care by making this the most profitable course to follow.
Dentist	all preventive aspects - can me measured by codes or time spent. It will allow practices to develop skill mix model and resources required can be paid for from cap. fees. If the remuneration is heavily bias towards treatment, it will limit the potential to use EDDNs and implement skill mix. For skill mix to work, the Provider must have the ability to configure the practice (in terms of HR) to the most appropriate configuration.

Paper 4: Remuneration

Responses to Question 4

What safeguards need to be in place to ensure that patients with high treatment needs are appropriately treated in any remuneration system?

Respondent type	Response
Dentist	A payment cap for the patient but the correct fees for the actual treatment should still be given to the practice. Similar to the old 2006 system of prior approval.
Dentist	Back to approved treatment plans and close monitoring of outcomes,ensuring that an appropriate number of individual courses of treatment are provided to achieve the desired results
Local Professional Network	London weighting is an accepted norm within industry and businesses in London. With every year that passes, the wage gap between Londoners and the rest of the country widens. Industry recognises the variation between London and the rest, so why not the commissioning of NHS dental services? Business expenses are far higher in the Greater London area than they are elsewhere and the capital has some of the highest needs patients in the country. We believe there to be a strong case for investing more in primary care provision in London. As part of any contract reform process, this must be urgently looked at. We have serious reservations about the capacity of a national capitation system to offer the required flexibility to ensure the reasonable remuneration of London dentists in the above context. We recommend the provision of an enhanced capitation payment for dentists within the Greater London area and an additional mechanism to enable patients to be capitated at the point of their oral health assessment, when their potential care needs are likely to be more accurately understood. The transient population in many parts of London is of particular concern to us, especially in the context of a capitation and registration-based system. Under such a system, patients moving in and out of practice registration could significantly destabilise practice finances. Any activity payment, however, would move us back towards the UDA treadmill and so would not be a move in the right direction. For these reasons, we believe that the capitation values for contracts within Greater London need to be carefully considered. Practices caring for large numbers of transient high needs patients must not be disadvantaged. This is challenge but one that must not be ignored if the Government is serious about delivering services to ensure care is provided for those with the greatest need. Ultimately, we fear a standardised capitation system may be too simplistic and so might run the risk of simply transferring the problems associated with an over-simplified activity-based system (the UDA contract) to an overly-simplified capitation-based one.
National Body	This is an issue with the current contract, as previously alluded to patients with the highest needs are least attractive to

Respondent type	Response
	practices. These patients of course need to embrace the need for them to take control of their own oral environment in the first instance and this is a good aspect of the pilots. One way this might be managed is through a network where a Tier 2 or Tier 3 dentist/consultant (depending on the complexity) advises on a treatment plan and complexity. However this should not be necessary for basic care under the core contract. In an ideal world this would be covered by dentists behaving appropriately and professionally fee per item would address this. Suggest that this is just the type of area which needs to see different solutions trialed through the pilots. It is good to see that the process is one of evolution rather than revolution, as there are many complex issues to deliberate over.
Dentist	Additional resources need to be made available for managing new high needs patients. If monitored through activity the system and regulations need to allow for appropriate clinical staging of courses of treatment to help the transition to a stable and sustainable dentition. It is often not realistic to complete all treatment in one course of treatment as the regulations currently would suggest.
Dentist	Oral health assessments must be able to identify this group of patients as requiring special attention. Red RAG scored patients could receive a higher weighting and extra funding. Clinicians must not be disadvantaged by patients that waste valuable time by missing appointments. High needs patients will historically have a high proportion of missed appointments. The introduction of a small nominal charge for missing appointments (FTAs) was suggested - ┬ú10 or the system that is currently in place where if a patient misses 2/3 appointments in 12 months then they must seek treatment elsewhere. Re-introduction of patients being REGISTERED to a practice. Patients value this concept and are used to it with GMPs.
National Association	Patients with high need are often unable or unwilling to attend practices on the regular and long-term basis that is required to meet their needs. If they can be encouraged to engage, they need to have time with a dentist to help build trust and confidence and be given the motivation to change their behaviour in relation to oral hygiene and diet. This time impacts on practice resources and requires proper and increased funding for NHS dentistry. We support basic capitation payments being linked to deprivation assessed via the patients postcode. Necessary funding to practices could be delivered by additional weighting for patients identified as particularly high needs at an oral health assessment, entry payments or care being paid for by item of service payments. We would welcome discussion on these proposals to develop appropriate provisions for inclusion in the prototypes. The safeguards that we believe will work best are a properly funded network of Dental Reference Officers and comparing the data obtained from the oral health assessment with the care provided. Provided that the care pathways are correct and have been adequately tested in the pilots, this will help to ensure consistency,
Local Professional Network	Incentives for patients in this group safeguarding extra payment
Dentist	Time spent on patients, especially for prevention, is remunerated for adequately. This could be covered by a higher percentage given when the DQOF are met.
Dentist	Prior approval, high needs patients with multiple quadrants involved should attract a higher tariff that has to have prior

Respondent type	Response
	approval. Radiographs and images sent off then payment is received to treat all effected areas. Currently practitioners fail to take enough radiographs of high needs as they only want to restore the minimal number of cavities they see with the eye otherwise it is costing them money to treat this kind of patient.
Dental Corporate	The majority of payment should be on activity, and UDAs are a perfectly sensible measure of this. The opportunity should be taken to add some new bands to accomodate complex cases with significant treatment needs. It would be essential that the pathway shows clear demonstration of having followed clear treatment pathways to avoid inappropriate treatment. The system needs to firmly emmphasise patient responsibilty - and excluding certain treatments fromt the NHS whilst maintaining a commitment to clinical oral health - is likely to reinforce this.
Dentist	extra / enhanced payments must be applicable for pts who are high needs this could be proportional to the number of pts who enter the perio / stabalisation care pathway
Dentist	payments for actually doing treatment
Dentist	It is important to avoid a "one size fits all" approach with any remuneration system and the adequate provision of treatment for the high need patient requires additional funding arrangements. By introducing fee for item funding arrangements for the following treatments would help to ensure that high needs patients are offered equitable access to dental treatment: Perio for BPE 3+ Molar endo Surgical extractions Patient requiring 4 or more treatments in a course Sedation Domicillary treatment It is important that any new system is clear of what can be provided under the NHS. Under SDR system pre 2006, it was clear what could and could not be provided under NHS. Since 2006 the rules are grey and unclear for both dentists and patients. The contract should not go back to the 600ish codes we had previously, but we do need to be honest that the NHS cannot fund all dental treatments and be clear to both dentists and patients what is available. NHS England has identified the following high need patient groups but have been slow to commission services to tackle them. Elderly care There is little commissioning of domicillary contracts across the country and the most dentally compromised patients have no dental provision. This can be addressed in the new contract but an interim solution should be found. Either additional tenders need to be put in place now, or a UDA allowance given to cover these visits (within existing contracts). Vulnerable groups in deprived areas Incentives for this group of patients must be considered for the new contract. The current UDA system is not flexible enough and in the short term additional bands could be introduced, alongside a NHSHE national campaign to raise awareness. Under 5s The other group identified is the under 5s highlighted by the number of GA cases. Incentives should be put in place now to encourage both under 5s and dentists to target, the money should be taken from secondary care to fund, as will payback more in future with decline of GA extractions at later stage. This should also be accompanied by NHSHE campaign to raise awareness. Minor oral surgery The new contract has the potential to allow the move of minor oral surgery provision from secondary to primary care. This will enable cost savings within the wider healthcare system allowing additional money to be allocated to the dental system.
Dentist	There must be a weighted / financial incentive to allow clinicians TIME for these ots.
Community dental	DRO visits should be undertaken for every performer within a practice. NHS numbers and software should be utilised

Respondent type	Response
service	to flag up practices where patients are having to constantly re-attend at neighbouring practices or EDS services due to lack of appropriate care in their own practices. There should be some mechanism in place to ensure that general practitioners are not simply referring their child patients with caries to hospital and the CDS for restorative/surgical care with no attempt at providing initial prevention and acclimatisation. IT systems for entering patient data and outcomes should be programmed so that the clinician cannot progress to the next page until all mandatory fields are completed. This would act as a prompt to ensure that all key risk factors following the clinical/radiographic examination are properly identified and recorded.
National Association	We believe that further liaison with the BDA and other organisations will be required to address this question.
Dentist	If have fee per item for treatments the treatment should occur RDO visits as was done before new contract
Local Professional Network	Contract monitoring so practices can be compared to similar in the area. Using the DQOF. In the monitoring process taking FD1s out of the practice profile as they can skew the figures.
National Body	Consideration could be given to a definition of high treatment needs? Is this the same as a high risk patient?
Dentist	appropriately weighted capitation
Community dental service	This is fundamental to the success of the reformed contract. The weighted capitation payment must incentivise dentists to look after patients with high treatment needs or who take longer to treat because of anxiety or other special needs. The number and proportion of people with special needs is increasing and will continue to increase and these patients largely need to be able to get their dentistry from GDPs, leaving specialist services to concentrate on those with the most complex needs. In addition, dentists must not be penalised if patients or their carers are unwilling or (more importantly) unable to look after their mouths. This also impacts on any DQOF that includes such measures. The weighted capitation payments could either be linked to individuals or else defined by the practice population. Practice population might be simpler to plan and organise, but will be a blunt measure. Linking to individuals is more cumbersome and might be open to over-recording, but this could be addressed by benchmarking practices and identifying outliers. The DRO system would also be helpful here.
National Organisation	That the remuneration of the clinical team is approppriate to the time taken, skill employed and the quality of care provided
Local Professional Network	Dental allocations are currently based on resident population. Yet there is clear evidence that oral disease is highest in deprived areas. Dental allocations to Area Teams, and onward to practices, should reflect the health and social characteristics of the population served to appropriately resource the practice to meet the challenge presented.
National Body	This problem has arisen in the past. Patients with high treatment needs will fall into 2 groups those willing and those unwilling to accept a long-term pathway of healthcare. The unwilling are already provided for but the willing will need extra time and cost to achieve health and financial provision could be applied for and allocated on a case basis, perhaps in a similar fashion to IOTN scoring but using measures of existing disease.

Respondent type	Response
Dentist	All payment for treatment needs to reflect the time taken and the lab bill, perhaps the practice could claim for these 2 factors! It would discourage speed and cheap products. Practices would balance treatment time and patient numbers as they do now, ie there should be no real benefit in unnecessarily long treatment time as it would reduce patients seen. The cost of time would be a much easier factor to calculate for regions of the UK based on rents, wages, etc
Dentist	Ensure that the dentist feels adequately paid and well looked after by the system and so is content and not bitter. Either pay a good salary and let them concentrate an being a good dentist or pay well for difficult/time consuming/very tedious treatments to incentivise them. Offer realistic, fair and clear boundaries on what is available and what is not available on nhs and why. No more [redacted] blaming the dentist for not providing treatments that are obviously not economically viable on the NHS with current payments and preventing them from explaining to their patients why (eg co-cr dentures, expensive lab work/materials, complex endodontics with expensive equipment, issues of dentist time/lab time etc etc). So sick of the [redacted].
Dentist	Capitation payments need to be linked with deprivation and perhaps there should be weighting for patients identified as high needs at the oral health assessment. This would need monitoring by the DRO system
Dental software supplier	Greater weighting in the DQOF for moving patients out of the Red combined with a higher overall DQOF contribution (as per Q1).
Dentist	Good design of the care pathway should result in the appropriate care for high needs patients. In addition the use of the DQOF should enable monitoring of: Fluoride varnish Fissure sealants Use of trained DCPs to deliver preventive care. In addition the Scored Peer Review Visit should highlight any areas of service delivery that require improvements. In this event education and a second Peer Reviewed Practice Visit would be triggered.
Dentist	I think that the treatment that is available on the NHS should be more prescriptive i.e. are composites in posterior teeth NHS or private - I feel that this is left to the discretion of the individual dental practitioner and leads not only to unfair distribution of what is and what is not NHS treatment and although it is stated it is at the discretion of the dentist this is the found wanting leaving the dentist vulnerable to complaint. In some cases there needs to be an external accessor available to say what complex treatment is available to this particular patient similar to what there was on the fee per item contract, he/she can say yay or nay to, for example, complex endodontic treatment & veneers on peg laterals.
Dentist	Dentists should not be penalised for treating patients with high needs- these patients should not be a burden to the practice as they involve more time and a stretch on resources and as a result compromise ones ability to achieve 'targets' Therefore any system should allow the correct treatment of high needs as well as low needs. Therefore perhaps a loading factor should apply to certain patients that are high needs- I realise this may be difficult to administer however neither dentist/patient should be penalised due to high needs
Dentist	a tiered level of capitation payments relative to the level of need of the patient
Dentist	Regular Dental Reference Officer visits
Dentist	must get an appropriate reward mechanism for activity so that the dentists are rewarded appropriately. If this is set too

Respondent type	Response
	low there is risk there will be undertreatment or not accepted as permanent patients and just treated as access patients if at all.
Local Professional Network	The key is to fund dentists to undertake the necessary work by item of service and appear to penalise them for looking after these patients by using a standard capitation rate for all adult & child patients, irrespective of need and evidence of previous disease experience. A recognition that managing such patients is time consuming and any factors affecting poor oral health are outside of the control of the dentist (for example social deprivation). A remuneration system that rewards dentists for both preventive advice and treatment of oral disease.
Dentist	May wish to have a UDA system with an additional one or possibly two more bands, so that those with more than four decayed teeth requiring four or more restorations or four or more extractions or a tooth requiring endodontics should fall into a Band 2a, with an intermediate number of UDAs attached. However, I think that current UDAs, if fairly priced, based on local needs, rather than chance would offer an opportunity to incentivise dentists to work in areas of higher need. Alternatively have a weighted system for UDAs, so that keep the current banding, but have different prices based on individual needs assessed through the RAG system So, we would recommend a weighted UDA pricing system (weighting based on a combination of patient characteristics such as 1) additional care needs and 2) dental care needs and possibly 3) based on demographic information such as locality-based quintiles or quartiles of social and material deprivation. Any capitation element should also be weighted in the same way.
Dentist	In my experience in working in the Pilot the patients in the high treatment needs category require - preventation advice and stabilisation before any complex treatment. Unfortunately in the UDA system these patients have been negleted. Again an removing the activity element from the basic care side of the spectrum and placing activity for the more complex treatment would be ideal. If there is no activity element involved at all what we will see is that Exempt patients not ever being able to have complex treatment as there is no incentive to provide this.
Retired Dentist	Each case needs ti be supervised by a dentist who has the experience and training even though the actual treatment may be carried out by others within the dental team
Dentist	Additional entry type payments where more than a certain number of teeth need intervention
Community dental service	monitoring, documentation and evidence of what is needed
Dentist	That practices willing to treat these high need patients aren't doing at a cost higher than reasonable basically other practices shouldn't be able to cherry pick to easiest route of remuneration make it a fair playing field.
Dentist	You can not have a swings and roundabout system as the present UDA system is.(Actually more like snakes and very small ladders system) we need to be paid for the work we do based on the patients treatment need using the DMF it is irrelevant there postcode age or sex to determine this. A pt with high needs will need more clinical time and therefore reduce capacity this needs to taken into account at year end. Year end targets are silly on rolling contracts we need to look at trends.

Respondent type	Response
Dentist	Patient needs to undertake and demonstrate compliance with a preventive regime before definitive treatment is carried out. Need to restore inspection system and prior approval using photography and appropriate case presentation
Dentist	All practices providing NHS care have to be computerised. Pt data capture will raise concerns if the number of visits and number of items of treatment per course of treatment for the High treatment needs patient are not aligned to a national average
Dentist	That is the problem with capitation systems, patients can be neglected, it's very difficult to provide safeguards.
Dentist	Payment per item rather per complexity of course of treatment
Dentist	more referal facility in sreasing the numbeecondary care centres with big fundings. small dental practices with small contract valuer ofs cannot be expected to provide complex treatments under any system. also giving contract value directly to each dentist and not only practice owners can increase the quality of treatment. Goverment should support young dentist with funding for providing NHS treatment with better income rather than working for practice owners/principals/corporations.
Dentist	transition and postcode bonus rebase healthier contracts
Dentist	Ensure that dentists won't be penalised for spending longer with high treatment need patients, as they are with the current UDA system.
Dentist	If the algorithm acknowledges it is an outlier, then there could be say a 120% weighting in terms of payment for that cohort of patients.
Dentist	extra money for these patients
Dentist	Ring-fenced monies for high need patients.
Dentist	By paying appropriately for the treatment to be completed. And bring back RDO's
Dentist	you need to speak to associates and not just contract holders. the things going on in practice are criminal. Because associates are self employed contractors and have no voice, they have no say. poor materials/support/ bureaucracy . A simple visit from cqc does not make a practice safe. whistleblowing is a joke as you effectively lose your job should you question contract holders. Empower the workers to deliver the care patients deserve NOT contract holders!!!
Dentist	Regular random patient exams by dental officer
Dentist	thereby leads to my comments.i have an incredibly high percentage of 80 year olds who are dentate,but their teeth are well worn and need to be patched up.they should not be banded with over 6 0 yea rold
Community dental service	Within the oral health assessment there should be an indicator of need and a higher remuneration to treat these patients who will need more work both from a preventive and restorative perspective.
Dentist	Laboratory charges (for prosthetic work) being paid separately - either by patient or by the NHS (or split), but very strict conditions and safeguards will need to be in place. Specialists access needs to be improved. With increased access, the time consuming procedures could be referred out, which will allow better access to general care. It is unreasonable

Respondent type	Response
	to expect highly complicated and precise procedures to be carried in general practice, especially with the existing time and financial limitations.
Dentist	Adequate payment for each item of treatment. Now the more you work the less you earn. You are in the humiliating situation to perform rct for 6 pounds a piece.
Dentist	DRO
Dentist	Centralised claims system. Many more Dental reference officers, and put them out there inspecting and reporting .
Dentist	Comparison of treatment to local area practices. Have the contract monitored statistically, and also consider dental reference officer visits to check outliers
Dentist	Remuneration should be related to the amount of treatment that needs to be provided. Remuneration should be appropriate to the amount of time, quantity and complexity of treatments required.
Dentist	In addition to the contract value ,there should be a prior approval system for patients with high needs ..the money coming from a centrally kept pot and paid as extra to the contract
Dentist	Bring back RDOs
Dentist	A fair contract where an expectation that a large increase in patients to be seen in a fairly efficient system where GDP ate working at a fast pace
Dentist	Allowing dentally qualified inspectors to inspect practices to ensure that there is no "supervised neglect". This would ensure the profession is delivery high quality care to its patients.
Dentist	Extra remuneration available.
Dentist	Suitable remuneration for complex and lengthy treatments
Dentist	if practices are weighted against activity as well then this should not be an issue - the issue for the practice will be if any high needs patient is not motivated then the clinical effectiveness related to this patient will go against the practice -some patients no matter what you do you will not be able to get them to change their ways - this will adversely impact dqof for the practice through no fault of their own
Dentist	Reintroduce independent clinical examination of patients.
Dentist	Appropriate treatment planning and monitoring of the standard of clinical work and not that of the paper trails. The system does not reward high quality, extensive work because the rate of renumeration is so prohibitive. There needs to be a body to check the treatment being carried is clinically acceptable, which simply cannot be done by computers and numbers.
Dentist	Simple. Dentists need to be salaried as they are in community services so that they can spend the time required educating patients, spend the time on their treatment and lab bills without their income being either positively or negatively affected. We are all willing to work hard if we are being paid appropriately to do so.

Respondent type	Response
Dentist	Regular monitoring by DROs!!!
Dentist	remuneration has to be based on item of 'core' service
Dentist	This can be monitored through vital signs and the clinical data set. As now dentists who are outliers should be challenged but the monitoring could be expanded to encompass the number of patients receiving more than 2 crowns in a course of treatment, the number of endodontic procedures undertaken, Pts requiring more than 3 fillings etc (my numbers are arbitary but these can be properly estimated). Based on what happened under the old pre 2006 fee per item system, monitoring of treatment patterns against exemption. In all cases challenge outliers. Reintoduce RDO examinations
Dentist	Auditing of computerised clinical records. Methods introduced for outliers to justify their clinical decisions.
Dentist	Definable measurement of outcomes.
Dentist	Ensure that the remuneration is appropriate!
Dentist	Firstly you need a realistic remuneration. If you want world class care, you have to pay for it. And the only way you can do that is to instigate the theory of the reduced dental arch for anyone over 16. You need mandatory yearly practice inspections by equivalent to the DRO's. Without these, there is no way to monitor the standard of actual care. The CQC can't do it. Monitor can't do it. You need dentally qualified individuals actually looking at patients
Dentist	Not very many, because on the whole we are dealing with high-need patients at the moment, even though we are even further financially penalised for doing so. You're going to need to trust us, you won't be able to regulate and have metrics for everything. This is biology, not train-spotting.
Dentist	BSA can check their RAG band against recall interval. This is a particularly difficult area of course, as this tranche of patients are likely to be the ones who do not attend as advised. Nothing is going to change this behaviour pattern - perhaps irregular attenders could be flagged as such and their names not included within capitation schemes but command a higher activity payment in compensation.
Dentist	weighted capitation depending on restorations placed, possible fee for treatment provided - rather than entry payment of 1990 contract for children
Dentist	the proper level of pay. Are you really that naive to think that high demand patients will receive the correct treatment? That has not worked under this new contract so why should it work under any other? Especially when the money is the same!!!!!
Dentist	Ensure that practices are appropriately remunerated for seeing them.
Dentist	Some sort of prior approval type mechanism for patients with high initial needs. Bring back the DROs for this?
Dentist	Recognition of the fact that some patients require more time than others in the remuneration system
Dentist	why wont they be treated appropriately, if the "Full activity" over 40 years has led to an improvement in dental health?
Dentist	to start with dentists MUST be fairly remunerated, the current system discourages these patients from being treated by

Respondent type	Response
	text book care plans. if the patient needs multiple items of work done then this MUST be paid for, one price does not fit all situations. the risk is over treatment, and perhaps the old approval system may need to be reconsidered? or consider referral of such patients to level 2 practitioners who have been vetted / approved by the LAT as trust worthy etc.
Dentist	routine inspection of patients by trained dental officers.
Dentist	Some form of prior approval and targeted observation of a percentage of patients
Dentist	DROs?
Dentist	REWARD DENTISTS OVER AND ABOVE THEIR CLOSED CONTRACT VALUE TO TREAT THEM. MAYBE AN INTRO PAYMENT. ALLOW FOR OPEN CONTRACTS SO THAT DENTISTS CAN GROW THEIR PRACTICES. THEY WOULD WELCOME THESE PATIENTS.
Dentist	Give them more value ie increase the amount of UDA for extensive treatment root fillings and multiple fillings and multiple crowns
Dentist	If suitable remuneration is not included in the new contracts, Dental professionals will no longer stay with the NHS and then all patients unable to pay private or scheme fees will turn up at A and E or their GP expecting treatment. This will waste time and ultimately cost more. It is likely that any patient with high needs will not fit easily in any system unless remuneration is based on that need specifically. The only safeguards are those already in place, those of ethics and trust which can be subject to abuse, or a second inspection prior to the treatment of each patient which is an unreasonable demand on patients and resources.
Dentist	A guarantee to give more money for patients with high needs but random inspections to ensure no abuse of the system
Dentist	There could be an element of approval like before, or we could just have more bands of Uda activity, a really top band. This will cover a more complex case, such as extensive crown,bridge work or multiple restorations, or multiple roots canals. Pt with high needs should be expected to pay more. Upto 500,700 pounds.
Dentist	Make sure that certain aspects of treatment are adequately reminerated as part of an activity payment.
Dentist	Realistic remuneration for their treatment.
Dentist	time taken to treat these patients needs to be reflected in the remuneration system. A dentist who does a lot of complex treatments need to be paid for the time and effort.
Dentist	See my comments above about unnecessary work if dentists are being paid for it. Pay the dentists appropriately for the work that they do and perhaps weight it so that those with higher treatment needs are more valuable to teh dentist.
Dentist	More funding for these patient after special application Or special clinics which will have specialists working who will make decisions and treat these high demanding cases. Afterwards these patient can return to GDP for regular care.
Dentist	return of dental reference officers cqc to be maintained increased patient feedback
Dentist	You need to pay for item of service. There is NO way a high needs patient can be treated for a fixed income. I will not

Respondent type	Response
	loose the roof over my head by providing dentistry at a loss.
Dentist	Try paying a realistic and honest fee for these cases. If you are serious about quality, it needs to be based on time, not necessarily outcome. As a provider of IS and IVS in primary care, and under the nGDS, I just feel my honesty and professionalism are being exploited, it's unsavoury and disheartening.
Dentist	an element of activity based remuneration. 15% DQOF 30% activity and 55% cap. This ratio sends a clear message that the focus will be on prevention because the majority of the fees are in capitation which is also politically a good message to get across.

Paper 4: Remuneration

General comments

Respondent type	Other comments
Local Professional Network	[redacted] The seven principles described as underlying the approach to developing a reformed system are set out in the Overview document (Paper 1). Of these, two of the principles are to: ensure an appropriate number of patients are offered care support the goal of increasing access We are interested in how these two principles can be simultaneously fulfilled under a reformed contractual system. We ask the Department of Health to clarify what is meant by appropriate and how it expects the contract to increase access if the budget is to be fixed. Much more information is needed here. The document also states the following, as one of the parameters within which any changes to the existing system will be made: overall expenditure by the NHS on dentistry is not expected to alter as a result of these system changes When read in conjunction with the above expectation that a reformed system will further widen access to NHS dentistry, this suggests that the funding to support increased access to primary care will come from savings made within the overall dental budget. We think it is import to make clear, therefore, that we are fundamentally opposed to the suggestion of further NHS savings being made from primary care budgets. Practices have been asked to make efficiencies time and again and there is simply now no room within which to manoeuvre. More investment is needed in the system urgently. Although it may be possible to make savings by redistributing money within the overall dental budget from secondary care to primary care, we are anxious that the potential for savings is not exaggerated. The precise potential for savings must be understood in detail, before this is relied upon by the Department of Health at the introduction of any reformed contract. We believe that the use of words such as right and appropriate in the consultation are misleading as they rely on being accurately defined in the papers (which they are not) and yet they instil a sense that they should just be agreed with instinctively. We would like to make it clear that, despite there being no mention in the engagement papers of time-limitations being placed on NHS primary dental care contracts, we object in the strongest possible terms to any future introduction of a time-limitation to contracts. Our objections are based on a number of important factors for patients, dentists and the NHS: Time-limiting services would not suit the commissioning of primary care dental services as they would financially destabilise practices, so risking the long-standing relationships between clinicians and their patients. Time-limiting contracts would have the perverse effect of reducing, rather than increasing, competition in the market as fewer potential market entrants would exist (fewer dentists would be able to secure the confidence of lenders to raise the investment capital needed to open a practice). This would lead to an inefficient market and would undermine the Government objective of achieving best value for money. Time-limited contracts would be likely to undermine the quality of NHS commissioning as commissioners could wait for the expiration of contracts, rather than tackling directly with the providers, any issues with their provision of services.

Respondent type	Other comments
	Providing primary care dentistry is not the same as taking out a mobile phone contract and treating it as such would only damage the capacity of the NHS to commission and maintain first class care for patients. In relation to caring for the oral health of children, we were extremely concerned to see no specific mention of children within any of the documents, particularly as improving the oral health of children was stated as the key objective for the coalition Government in relation to dentistry. As a group, children must be carefully considered in the design of any reformed contractual system. It is alarming that they have not been discussed in some detail within the papers. Children are in a unique position, as their capacity to care for their own oral health is largely determined by adults (their parents or guardians). Their diet and many other lifestyle factors, which may also impact on their oral health, are also determined by adults. Similarly, their ability to attend dental practices (and their confidence in doing so) is likely to be different from that of adults. In many cases, the commissioning of dental services will need to allow for children and parents attending at the same time. Once at the practice, the interest children may have in self-care plans and preventive advice about oral healthcare may be very different from most adults. We do not believe it is sufficient for those leading contract reforms to simply view children as adults and we call for more information about the aspects of contract reform that the Department of Health believes would benefit children.
National Body	We believe there should be a greater focus on undergraduate and postgraduate training, and a larger consultation specifically looking at how postgraduate training immediately following graduation can be used to improve the efficacy of primary care and reduce the need for secondary and specialist tertiary care, would help you achieve your objectives for NHS dentistry. The [redacted] would like to see appropriate funding for training courses for NHS dentists, to improve the provision of endodontic care in order to provide a good standard of service to patients. The system needs to ensure that Tier 1 GDPs are able to undertake simple root canal treatment to an acceptable standard - this is delivered through undergraduate training and development at Foundation Dentist level. The system needs to ensure there are properly trained and funded Tier 2 GDPs to undertake the more complicated treatments properly, so that they do not end up being referred to specialists or the hospital services when they fail, as this is not cost efficient. We also need to develop managed clinical networks using the Tier 2 GDPs, specialists and the hospital services so that root canal treatment is delivered by the person most appropriate to undertake it, thereby improving cost effectiveness and minimising pain and inconvenience to the patient. This will involve the training of enough GDPs to sit at Tier 2 level, and also appropriate funding for them, along with specialists in both primary and secondary care to help manage more complex root canal treatment. The [redacted] is keen to be involved in the development of training programmes for Tier 2 GDPs and their quality assurance. The [redacted] is also keen to help ensure that specialist endodontic service is available in hospitals (Tier 3) to help manage complex problems and that both training and service delivery are funded to create and make available monospecialty consultant services.
Dentist	The Dental LPN held an event on 10th July 2014, 6.30pm at [redacted] postgraduate medical centre which was open to all dental stakeholders that wished to participate. It was widely publicised through the LDCs and the database of contacts developed by the LPN. Electronic and conventional mail was used to ensure maximum coverage. The event was

Respondent type	Other comments
	organised into workshops so that the discussions could be more focused on specific questions rather than an open discussion. This would enable a much clearer and meaningful response to the consultation. The comments that have been made are from the discussions that we had.
National Body	We believe that remunerating dentists for providing preventive advice will be beneficial to patients and should hopefully reduce the level of intervention required in the future. However the remuneration system must be designed to support and incentivise the delivery of the clinical model and pathways therein. Although the consultation paper states that there will be no alteration in costs by the introduction of the remuneration approach, this will depend on the idea of flexibility and capitation to work, which will depend on the level at which: (a) Dentists decide on the frequency of return of patients and (b) at what level the capitation is set. It would be useful to see some very robust evidence on this before stating that it will be truly workable.
Local Professional Network	It was difficult to devise a model that satisfied all the requirements of increasing access, cost the same and be acceptable and fair to patients, practices and commissioners. We felt the system should follow the following principles: 1. Incentivise practices/clinicians to maximise application of the oral health pathway and optimise the quality of care and health outcomes that will result. 2. Not disincentives practices/clinicians from seeing and treating irregular practice attendees, those patients who choose not to follow the oral health pathway or urgent in hours care provision for unsolicited patients who are not regarded as expected practice patients 3. Be fair to all contractors so that the payment system does not result in pro-active practices/practitioners being disadvantaged financially or otherwise by trying to adopt best clinical practice. It would not be acceptable that practices that have been applying NICE guidelines and following Delivering Better Oral Health be disadvantaged as their access will not increase and there may not be dramatic improvements in RAG scores because they were already providing a Good Practice preventative dentistry before. 4. Remove existing and not introduce new perverse incentives that results in financial drivers being considered ahead of patient experience/outcome. It was also felt that the inequalities re UDA value should be addressed. UDA values in Cumbria vary from ┬ú23 to ┬ú45 this is unacceptable. How can there be such variation for provision of essential what should be a high quality service by all? Comments provided by engagement event of Cumbria LDN
Dentist	The department mentions that all practices were independently assessed to arrive at a fair UDA rate. Liverpool was not we have found ourselves all with the same UDA rate that is 30% less of than those who in neighbouring areas within our LAT. This inequality must not carry on into the new contract to effect Liverpool dentists who have high needs patients.
Dental Corporate	As the pilots progress they are proving economically unviable. In order to deliver the pilots we have invested heavily in training, extra dentist time, additional therapists, extended opening hours with extra staff costs and central overhead to monitor the outcome. Despite this it has simply proved impossible to maintain patient numbers and still deliver the care pathway as required. As a result LATs are in addition penalising the practices with significant financial clawback, which would not have been experienced under UDAs. This makes some of these practices financially unviable, having previously been sustainable. Oasis chose not to force dentists to accept clawback on the pilots, as they were highly

Respondent type	Other comments
	reluctant to participate otherwise, thus further impacting the practice economics. Were the current pilots in any form of the current economics presented to practice owners and associates as a future model, depsite the good clinical experience, it would have to be rejected as unworkable. The proposals we have made here are much more likely to constitute an acceptable evolution in our view, assuming a streamlined clinical pathway used sensibly where needed, to minimise the efficiency impact on patients seen. Quite separately it is hugely disappointing to have engaged enthusiastically in pilots, and then be clawed back on a model which all accept does not work financially. The LATs are showing no ownership of the pilots and providers seem to be left paying for a trial not of their instigation. In addition the money being clawed back is not as far as can be seen being redistributed in dentistry and therefore the pilots are leading to reduced dental spend. We may call upon the DoH to investigate this further.
Dentist	weighted capitation is important system must reward clinicians more who treat in deprived areas to reduce in equalities have a system where clawback does not exist (for practices that have ensured high clinical quality) and underperformance is not related to output we must ring fence and protect pt funding and try to re commission to the same practice that has underperformed but in a different way must provide a lower financial risk to the practitioner to ensure pts best interests are maintained and viability of the high street practice consider a carrot not a whip to regulate remuneration reduce financial penalties and allow local / regional variations in structure of remuneration to reflect pts needs consider regular monthly payments of fixed amount to prevent financial de stabalistion maintain a high % for capitation _50% high degree of importance to ensure there are NO time limited contracts to protect pt continuity of care,and allow further investment by practitioners and thus financial stability of the high street practice
Dentist	I was in a pilot practice until April 2014. The capitation in our practice fell. It had actually been falling since before we joined the pilot scheme. We were in a situation of being really busy because of spending more time on OHA, pt education etc and having to take on more patients. We have now withdrawn from the pilot scheme and our practice has returned to being steadily, not excessively busy. Patients are happier because they do not have to wait so long for an appointment. We have fewer patients needing emergency appointments because we fewer patients waiting for treatment.
Dentist	A blend of capitation and activity is the preferred model for remuneration. Registration / Capitation This element of the contract is to be based on patient registration numbers. This has been effectively trialled in the national pilots and this experience should influence how this part of the contract is scoped. Proposal Baseline funding levels for registration and capitation can be based on historic delivery levels of Band 1 and 2 courses of treatment. The link between dental need and IMD appears to provide an effective capitation remuneration system which is sensitive to patient need and should be used to set the capitation remuneration value. To be successful an efficient and effective IT system is required to track patients at performer level. Performer level data in all categories of the blended contract will be essential in ensuring success of a new contract. Provider flexibility in managing the allocation of patients to performers will be a necessity. The pilots have shown that IT suppliers need sufficient time to develop effective systems before implementation and need to work in tandem with the NHS BSA to ensure accurate registration data. Activity measure

Respondent type	Other comments
	for complex treatment This element of the contract, based on the historic provision of Band 3 treatments, must provide an effective activity measure for quality and commissioning purposes, and ensure effective treatment for the higher need patient. The planned Oral surgery, Endodontics and Periodontology clinical pathways will enable complex treatment to be assessed for either delivery in practice or in a more specialist setting which may lead to more specialist treatment being delivered in primary care. The current care pathway used in the Oral Health Assessment must be streamlined and simplified to enable efficient treatment planning together with all the benefits of using a care pathway. Proposal To encourage delivery of more complex treatments in primary care and to introduce a balance between treatment delivery and prevention two bands of activity, with appropriate fees, should be considered. Band 3a would include the following treatment items: Perio for BPE 3+ Molar endo Surgical extractions Domicillary treatment Sedation treatment Patient requiring 4 or more treatments in a course Band 3b would include all of the current items in Band 3. Each band would require a defined list of treatment rules to ensure clear distinction to be drawn between NHS and Private, ensuring clear and transparent effective treatment choice is offered to all patients. The definition of treatment items must avoid the complexity found in the previous fee for item system. This treatment definition is essential to remove the current uncertainties as to where the boundaries between NHS and private treatment lie. This banded activity payment system would encourage more complex treatment to be delivered in primary care, reducing inappropriate referrals, reducing secondary care provision with subsequent cost saving, improved career progression opportunities and greater funding for primary care.
Dentist	System - must be designed to minimise financial risk on a monthly basis. Re numeration - must be on a fixed monthly contract amount must - not vary - as this could financially ruin a practice. Reconciling at the end of the year
National Body	The [redacted] team as a secondary care providers is unable to comment on the issues of % of contract devoted to DQOF or the % of remuneration devoted to capitation & activity however the principles of a blended contrcat seem reasonable. The Guys & St Thomas Dental Directorate Management team as a secondary care providers is concerned that any change in the fiscal arrangement does not adversely affect the referral patterns as a result of the changes as was seen after the contract reform in 2006. The creation of prototype pilots with the proposed remuneration of any new contract will help give evidence as to whether this is likely
Dentist	Need to ensure system is funded for providing care for patients who have ongoing restorative needs ie rct etc
National Body	Thanks for the opportunity to contribute
Dentist	I would first like to state that I believe that we at our practice have been following a preventative pathway for a good number of years. We tell our patients why they have got holes in their teeth and what to do if they want to reduce the number of holes in their teeth before we restore them. We tell them why they have got gum disease and what to do if they want to stop the continued progression before we start their hygiene regime. And in an ideal world all dentist should be doing this. I understand that all dentists are not doing this and that maybe if it is taken out of their hands by a computer generated pathway following on from an assessment then maybe they will start providing a more preventative approach. However, if the reason that this approach has not been adopted is due to a lack of time/money by ô I would

Respondent type	Other comments
	like to hope ôa minority of dentists then a system that the according to the pilots that will take longer for no extra NHS funding will either not be adopted or fiddled. With the best will in the world we advise our patients as to what they should be eating and drinking, what they should not be eating drinking and smoking. How they should be living their lives, what sexual practices they should be up to, what ones they shouldnt be up to and what parents they should have. When to brush their teeth, when to floss when to TePe but at the end of the day the success of our preventative programme is going to be down to whether the patient can be arsed to carry out our advice every day 24/7. Not everyone is or will ever be arsed!!. Especially, it would seem, the type of people who were treated and appeared on the ITV television programme on Manchester dental Hospital!! We all in the medical profession know that smoking increases the risk of early death, not just might lose a tooth but might die, but has that fact stopped everyone in the medical profession from smoking? Giving up smoking has got to be easier than doing all of the above preventative procedures and more every day 24/7. And if you are some weirdo who does follow everything to the letter as advised, how frustrating when you find that you that the health of your mouth has deteriorated because of factors out of your control like your genetic make-up or the fact that you are going through a messy divorce which has transformed the nice healthy mouth to a pit almost overnight! Now that would be controversial the government stepping and deciding whether a couples genetic makeup should allow them to have offspring that may predispose them to conditions that may be a greater drain on NHS resources. I dont believe a computer alone can decide a patients health pathway. The documents I have just read state that pathways were developed from industry including aviation. Auto pilot is a fantastic innovation used to fly a plane. High tech algorithms and computer programmes checking thousands of times a second, hundreds and thousands of different pathways and circuits which is absolutely amazing, but it is switched off and an actual living pilot has to be in control to land the thing. A dentist must be able to retain autonomy. Not just to be able to override 10% 0f the computers decisions, but any percentage as they see fit and appropriate and justifiable. Every practice is different with a different demographic and so impossible to duplicate results from one practice to another. A 20yr old with BPE of 3 all-round a full mouth dentition has a different recall to an 90yr old with a BPE all round but who only has a single tooth in each sextant! Also if by chance the computer generated pathway leads to a detriment of a patients care. Who is liable? Would the dentist be able to stand up in court and say sorry but I knew the computer care wasnt adequate but the NHS wouldnt allow me to override any more pathways! Are the benefits of these pathways, seen by dentists, because it takes away their clinical autonomy and so they dont have to think too hard? What if it all goes wrong? What if the computer crashes? What happens about the decisions made when they were off-line not matching what the computer says when they are back on line? The pilot schemes have apparently seen a gradual change from treatment orientated to preventative care is this as a result that they have had less time to do treatment (that is still needed) as the OHA and OHR take up so much more time. I read with interest in the Philosophy document how the RAG status of patients had changed favourably from OHA to OHR during the three year period of the pilots, but then saw in the results that it was only by between about 2 and 6 percent which quite frankly is pathetic result considering the amount of money that has been invested in the pilots. Now I know its work in progress, but I am sure Professor Steele would have liked to have seen a better improvement. One has to question what would the RAG status

Respondent type	Other comments
	changes be for patients not on the OHA/OHR pilots. Are the improvements happening for patients of practices following best practice and NICE guidelines in the present system anyway? Is there any research on the current system and how it compares to the pilot figures? The validity of the results of the pilot have to be questioned as they only compare information from within the pilot. No comparison can be made with what providers are doing at present. Arent we seeing a general improvement in the oral health of the population anyway? Certainly better than 6% in three years NHS funding is to remain unchanged, yet access and quality have to be improved. So more patients squeezed into the day for the same money means less time per patient and yet quality will improve?!!!. I know by following NICE guidelines you may be able to reduce how often you see a patient which will create space, but what if you have been following those guidelines for years? Will you get penalised for not taking on more patients? If the length of time to carry out OHAs has led to a drop in access, it will mean we will; need more dentists. Where does that funding come from or does it come from the dentist who is diligently doing what they are told as part of the new contract but is docked pay as they are not keeping their patients as they have no time to do the treatment that perhaps the patient would like rather than this research would suggest they want/need. OUTCOMES. At the moment we get a vital signs report every quarter for the Provider but not for individual Performers which makes it difficult to address problems/out of the ordinary results when you dont know where they are coming from. This will be particularly important when remuneration is dependent on matching vital signs locally/nationally. Potentially a single performer could affect the whole practice income so they are the ones whose remuneration should be affected. We generally get 100% satisfaction with the service our practice provides- higher than average. Satisfaction with the time patients have to wait is only marginally above average at 92%. If OHAs are taking longer, time to wait for appointments and patient satisfaction will drop. Outcome aspect of remuneration might be 10%. Via the pilot schemes it has already been shown that outcomes are at the 800 out 1000 markers so the powers that be are already expecting a claw back of 2%. On a┬ú600k contract that is ┬ú1k a month. I think that it should be banded i.e. 800+ out of 1000 no claw back. 600-800 out of 1000 2% claw back etc. otherwise it could be potentially a few patients that could have a dramatic effect on income. One of the outcome questions I gather could be are you happy with the look of your teeth. Is this a cosmetic thing? Are we to provide cosmetic treatment on the NHS so we get a good outcome? BPE as a measurement of success does not take into account 1. Inter-operator differences in measuring 2. Patients different sensitivities/ ability to cope with the measurement process ôfalse reading 3. Patient susceptibility 4. Patient age/social status/habits etc It is just a snapshot of the current situation on a certain day taken by a particular person with a particular instrument without account of any modifying factors. It would seem to me that the change in the dental contract towards a more preventative slant is in theory a good idea. But I also think that the vast majority of dentists have been following a preventative approach for years, quite possibly as a result of hearing about the dramatic increase of litigation with respect to supervised neglect and undiagnosed periodontal disease the dental law company has been dealing with. I also think, talking to my colleagues, that we have also been following NICE guidelines for years with respect to recall intervals. I think that this piloting and research into a new way of working is just hashing up and changing and rebranding of a potentially good working system that we have at present that may have just needed a few tweaks, rather than a massive expensive overhaul. I think that the money that

Respondent type	Other comments
	it has cost could have been better spent re-educating the minority of dentists not following a preventative approach through ignorance or prosecuting the even smaller minority who have not been following it due to a greater interest in their wallets rather than their patients. After all the GDC is going to be a lot more financially buoyant come the end of the year!! Was it not the job of the local PCT to look more closely at the practices that it knew were not providing best practice, treating NHS patients privately for visits to the hygienist etc rather than let them get away with it because they were a Corporate and were not paying out as much per UDA as the practices that although were paid more per UDA were giving their patients an excellent service. Perhaps if they had done their job there would have not been as many dentists out there now fiddling the system.
Community dental service	I'm not sure the response to Q2 was captured, Here it is in full We have noted the intention to commission care using a care pathway approach with a very preventive focus. This lends itself to a move away from counting activity towards a full capitation model. This would need adequate and effective monitoring and we support the reintroduction of a properly resourced, trained and managed DRO system. We propose that the activity counted is number of patients made dentally fit, applying a definition of dental fitness that is individually agreed and signed up to by the patient and dentist working in partnership. The timescale that would apply to this needs to be long term, as prevention takes time to demonstrate an effect. We suggest 3 to 5 years, which might fit with a registration period too. Capitation could limit the number of patients who can access care, in a cash limited funding system but we anticipate that the preventive approach, properly applied, would result in patients requiring fewer OHAs carried out at greater intervals, this making time for the dentist to take on new patients. Current NICE guidance on the recall interval was not based on the new preventive pathway so will need revisiting so that the impact of recall intervals on periodontal health is taken into account. There could either be an entry payment into the scheme or else three schemes/pathways with capitation payment weighted by patients home postcode plus other demographic factors. The three pathways would be; occasional attender, new patients, regular patients. In this system any financial risk is borne by the dentist, so careful prototyping will be required to gain the confidence of the profession.
Community dental service	Serious investigations into the GDC need to be undertaken ASAP, they have completely lost the respect of the whole dental community
Local Professional Network	Patient charges are a substantial barrier to regular attendance and treatment for people on low incomes who do not quite qualify for exemption from patient charges. Waiving patients charges for regular attendance and good oral health would incentivise patients and increase access Area Teams are reluctant to reimburse dentists for domicilliary visits to the elderly housebound. this is perverse and needs to be rectified in contract reform. The seldom heard often have no address and there practices cannot be reimbursed for providing treatment. Another perverse incentive that needs sorting
Dentist	these are another colleagues thoughts as i am doing this survey on behalf of [redacted] LDC. What percentage of contract value do you think should be used for DQOF? 5%, but certainly no more than 10% - if a large practice loses e.g 2% of CV, in a large practice (CV=┬ú1m) this could equate to ┬ú20k, which could make the practice less financially viable.

Respondent type	Other comments
	Especially the case when CQC, GDC, indemnity costs rising so much and NHS fee increases being below inflation for so long. Also why should the practice loose money when much of the DQOFs are solely in the patients control ô dentists can give OHI til they are blue in the face, but the patients do not necessarily follow that advice. Question 2 We assume there will be an element of remuneration for quality and outcomes. Beyond this element, what are your views on the options for remuneration and how the challenges associated with them can be managed: Full activity ô no effective payment for active prevention will result in little prevention being delivered ô I dont think this could be properly managed ô there would be no incentive for prevention other than the dental teams caring nature + this would potentially financially penalize those caring practices Full capitation anecdotally full capitation can lead to supervised neglect ô no incentive to carry out full dental care. Again those caring practices would be financially penalized over those less caring practices A blend of capitation and activity possibly the best of both, or the worst of both. I think this is likely to be the better system, but will need careful planning in order to get the balance of capitation and fee per item right. In terms of remuneration for quality and outcomes, how will these be measured? Clinical data sets showing averages and identifies outliers from the normal assumes that average is good ô this is not necessarily the case ô outliers should be identified as being outwith the required standard e.g applying NaF varnish to all children should be close to 100%. Question 3 If a blend of capitation and activity is used, what elements of the care spectrum do you feel should be covered by capitation and why? Capitation should only cover maintenance care e.g. exam, scaling & polishing (bpe<=2), radiographs, preventative advice re diet + oh. Everything else is active treatment and practices should be remunerated for this. Demographic data is not sensitive enough to allow adequate calculation of capitation amounts for larger treatment amounts ô some high socio-economic groups (with a probable low capitation payment per month) can have high needs and vice versa. Again it would be unjust to have practice remuneration proportional to things that are in the patients hands and are outside of the practices control, despite their best efforts at education. Question 4 What safeguards need to be in place to ensure that patients with high treatment needs are appropriately treated in any remuneration system? See above Q3 payment for active treatment would ensure that high needs patients receive that treatment. However high needs patients should not have repeated courses of extensive dentistry ô dentistry is avoidable and happens because of poor hygiene and diet which only patients can change ô if they do not change and remain high needs then dentistry should only offer a basic service to these groups.
Dentist	Either pay dentists fairly based on their training and difficulty of the work they do or be honest about it and say you can't do that with current funding and explain to the public why not. Then be open, clear and honest about what will be covered by the NHS and what will not and why. Look into the economic realities of providing certain treatments, implants are not commonly offered on the nhs due to their expense, why should complex modern endodontics or Co-Cr dentures or bridge-work or any other expensive and time consuming treatment be any different? Essentially everybody knows to brush their teeth 2 x day with F- toothpaste and not have sugary snacks/drinks so dental disease is a choice for the majority. Therefore the NHS should provide preventative advice, especially to at risk socio-economic groups and children and basic functional dental care only. Complex treatments should be a luxury which should be paid for. Perhaps then people would learn to be more responsible with their health. Honesty is the best policy, no more b.s. and

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	stop using dentists and the "greedy dentist" stereotype as political scapegoats for economic realities in the difficulty of providing comprehensive care.
Local Dental Network	DENTAL CONTRACT REFORM ENGAGEMENT RESPONSE [redacted] Chair of the LDN. This is the response of the [redacted] to the Contract Reform Engagement. I have worked closely with the [redacted] LDCS. We have approached the Contract Reform Engagement by working collectively with local LDCs to develop a framework for an Alternative Reformed Contract. We have then answered the questions in the engagement package and referencing our proposal document. DENTAL CONTRACT REFORM Any contract reform must include: Neutral over all expenditure Maintain present scope of NHS care Capped contract remuneration Metrics for measuring delivery and financial recovery The ability to flex the levels of service. Patient charges to raise a similar proportion of costs Allow appropriate mixing of NHS and private care Firstly this basket of requirements leaves very little room for maneuver. Indeed as the pilots have demonstrated satisfying all these requirements is difficult and indeed requires a series of compromises. Secondly let us look at what really worked well with the pilots. 1.The care pathways approach has received universal support across Dentistry. There is a requirement for more work on linking some medical history / pharmacological / social history with risk status. In addition as up to 70% of recall intervals are being over ridden by pilot practitioners there is clearly a need to look closely at the soft ware drivers for recalls. On the whole though the care pathway approach is seen as very positive by practitioners and patients. 2.The prevention aspects of the pilots is excellent. For too long now prevention has been ignored in terms of funding. The pilots were able to place prevention at the centre of their practice. This means that targeted , individualized prevention can be delivered. The concept of Interim Care is an excellent one. The development of this concept , particularly in terms of using DCPs to deliver this aspect of the care pathway is important. 3.Practices felt liberated by the removal of UDA targets. Practitioners felt more relaxed about spending more time with patients to deliver treatments. As a result they felt tat the quality of care increased . Where possible we would propose retaining these elements of the pilots within contract reform. Thirdly lets look at what did not go so well. 1. The P.C.R levels were reduced resulting in the service becoming more expensive. 2. The access levels dropped resulting in fewer patients being treated and fewer new patients getting access to care. 3. The list sizes of practices were difficult to maintain and as a result even though the practitioners were working longer hours than under the UDA contract practice claw back was taking place. We propose that we look carefully at strategies that will hopefully reduce the impact of the above within contract reform. In summary Include care pathways Look at ways of incentivizing: Access Quality of care Prevention. Activity Urgent care Look at ways of disincentivising: Inappropriate referrals We support the idea of a Blended Contract Reform. The key drivers for remuneration to be centered around: ACCESS ACTIVITY QUALITY The framework for remuneration to be around the following: ACCESS - 40% Broken down in to; 35% list size dependant 5% patient turn over/growth. ACTIVITY ô 45% UDA scored and managed ô but with more sensitive banding encouraging prevention and hopefully reducing referral rates. QUALITY - 15% Based on: Patient experience -4% Patient safety-2% Clinical Effectiveness ô 4% QOF-3% SCORED PEER REVIEW PRACTICE VISIT ô 2% ACCESS In real terms the success of a provider can usually be measured by the numbers of patients choosing to access care. In simple terms if access is a driver for provider remuneration and therefore performer remuneration this system should result in greater

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	quality of care for patients and greater patient retention. Currently the driver is mainly activity which may be remaining on target in spite of reduced patient numbers and falling access. Remunerating access should drive up standards of care across the board and also stimulate competition within the NHS dental care market which in turn will result in improved services for patients. The Access payments are made up of: Patient list ô 35% of contract value Patient turnover -5% of contract value ACCESS 1 This part of the reformed contract needs to support the development of a philosophy of payment in return for caring for a geographically sensitive number of patients. If we assume that current levels express a reasonable average list size then this average can be applied. Providing a practice supports 90%-110% of this average list size 35% of the existing contract value will be accrued. Some work is required around the average list size and the values applied to various age groups. Access 1 ô will support 35% of contract value Practices will have a THREE YEAR LEAD IN PERIOD in which to stabilize list size. After the lead in period financial recovery will operate if the practice has a 10% variance. Less than 10% may be held over through to the following year and be balanced by additional activity/ list size growth. Financial recovery/ roll over will be based on a percentage of the 40% of contract value attributed to Access. For example if a practice has a negative of 12% on list size, the claw back would be 12% of 35%. To avoid a situation where a practice misses the target by greater than 20% the practice will be required to provide a written explanation and risks contract reduction the following year if this is repeated. ACCESS 2 It is anticipated that this concept will drive access. However in order to further drive access each provider will have an access target of registering a number of new patients equaling 2.5% of their average list size. This will effectively be patient turn over as it is expected that at least this number of patients will leave the list naturally during the course of a year. The Access 2 payment will not be enforceable if the practice already has 110% of the list size registered. This can be measured and will allow for financial recovery. If a practice does not achieve this level of growth/ patient turnover it will face financial clawback of 5% of contract value. ACTIVITY The requirement for metrics to allow measurement of activity and to support financial recovery probably mean that some form of activity Unit is required. The UDA has been universally derided as a poor method of delivering quality care. This is mainly because the three bands are not sensitive enough and do not support more complex care. We propose an extended band scheme with SEVEN BANDS. Whilst we acknowledge that this introduces a change in terms of increased complexity we believe that the additional bands allow a fairer way of measuring activity. The additional UDAs attached to more complex restorative care should reflect the time required for the procedure and not disincentivise more complex care. This approach goes some way to achieving this. In addition improving the funding of more complex care should reduce the numbers of referrals to secondary care for procedures that can be treated in primary care leading to cost savings. We also propose that the UDA is valued around the national average taking in to consideration the dental health status and treatment needs of the relevant community and the demography of the patient lists. We understand that some work has already been done with regard to this. This will mean that a practice working in a fluoridated area within a high socio economic area will be required to register a larger number of patients to achieve a given income level. This seems to be reasonable. Band 0 is for the Interim care appointment for at risk groups of patients or patients with a red oral health status. It is expected that this service will be delivered in general by trained DCPs. The excellent P.C.C. prevention course could be used to

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	train DCPs to the correct standard and license them for this kind of care. Continued support of licensed DCPs will be required through education. We recognize that this element of our reformed contract will require monitoring to ensure that the prevention element is delivered appropriately. We will look at this in the QUALITY section of the reformed contract proposal. In any event the maximum proportion of the contract value that can be used to support this service provision is 7%. The provision of urgent care will be discussed later in our proposal however it is clear that driving an access agenda will result in practices being more open to accepting urgent care patients. In addition we propose that providers demarcate urgent care slots within clinical care sessions to provide care for emergency patients who are registered with the practice or un-registered. A session of 30 mins per day per performer would seem reasonable. Where these slots are not filled 24 hrs before the session is planned the time can be used by the practice as required. The numbers of urgent care patients treated will form part of reporting and these reports will Form part of the Scored Peer Review Practice Visit. We have also introduced additional P/C/R band charges. We recognize that this will not be universally popular with consumer groups. However a maximum charge of over ┬ú300 was in place prior to the 2006 contract. We would also suggest that we examine the evidence behind the exemption of pregnant and nursing Mothers for dental charges. This is historical and has very little supporting evidence base. Additionally we support the removal of the exemption form charges for patients returning for equal banding treatment within two months. Whilst we understand the philosophy behind this exemption it is a na├»ve regulation and should be withdrawn. We also support the re-introduction of failed to attend (F.T.A) fees. Activity targets in the absence of any sanction for F.T.As is poor regulation. We propose an F.T.A fee of ┬ú5 for each ten minute slot is appropriate. This fee would be split between the provider and the B.S.A. In this way collection of the FTA fee is incentivized. Perhaps we also need to consider a ┬ú5 annual registration fee for adults. This would raise substantial fees. BAND O ô (up to a maximum of 7% of contract value). Targeted prevention appointment provided by DCP or GDP. ô 0.75 UDAs P/C/R ┬ú19 BAND 1 ô Recall examination following initial Oral Health Assessment. 1 UDA P/C/R ┬ú19 BAND 2 ô Initial Oral Health Assessment / Urgent care including active treatment./placement of three or more fissure sealants ô for patients under 16 yrs. Fissure sealants have an established evidence base and as a result should form part of the prevention agenda. Work will be required on a care pathway approach to the use of sealants. The use of sealants will be capped at a level of 5% of contract value. Fissure sealant stats will also form part of the QOF Quality remuneration. Any sealants placed subsequent to the 5% level being breached will be paid at Band 1. 2.5 UDA P/C/R ┬ú27 BAND 3- Simple restorative care / exodontia/ perio tx of cases with 1 sextant of 3. 3 UDA P/C/R ┬ú50 BAND 4 As above but including more endodontics / complex exodontia/ treatment of TMJ problems using a soft acrylic splint. Also to ensure that the reformed contract provides care of high needs cases where there are 6 carious lesions present the case will receive band 4 remuneration. These cases will be monitored electronically to assess Prescribing behavior against regional averages and will be assessed in the PEER REVIEW VISIT 5 UDA P/C/R ┬ú85 BAND 5 As above but inc. molar endodontics/ More than 2 sextants with a B.P.E of 3 or over. It is expected that a clear care pathway is developed for advanced periodontal care involving plaque scores/ pre treatment charts/ RSD under la/ post tx charts. 6 UDA P/C/R ┬ú99 BAND 6 As above but inc. acrylic dentures/ up to two crowns , inlays , veneers/ single chrome denture. 12 UDAs

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	P/C/R ┬ú225 BAND 7 As above inc upper and lower chrome dentures / more than two crowns, inlays , veneers. 16 UDAs P/C/R ┬ú350 Using this system activity can be measured. Using this method underperformance can be measured allowing for financial recovery. Financial recovery however should only be as a percentage of the activity element of the contract value. So for example if a practice under delivers by 12 % Only 12% of 45% is clawed back. QUALITY We support the Quality agenda of the reformed contract. However quality is a difficult thing to measure. As Einstein famously stated Not everything that counts can be counted and not everything that can be counted counts The Outcome indicators used in the pilot reform seem reasonable. Our ideas broadly support these. PATIENT EXPERIENCE With the possible exception of PE.01 we are happy to support the patient experience indicators. P.E.01 does not adequately take in to consideration the level of complexity or invasiveness of the procedures undertaken and so it icould be misleading. For example following difficult exodontia or in a situation where a denture patient has unrealistic expectations. PE .06 appears to cover the general issue of satisfactory treatment. The sample size must be large for it to be a valid interpretation of quality ô at least 20% of C.O.T. Indicator PE.01 Patients reporting that they are able to speak & eat comfortably PE.02 Patients satisfied with the cleanliness of the dental practice PE.03 Patients satisfied with the helpfulness of practice staff PE.04 Patients reporting that they felt sufficiently involved in decisions about their care PE.05 Patients who would recommend the dental practice to a friend PE.06 Patients reporting satisfaction with NHS dentistry received PE.07 Patients satisfied with the time to get an appointment TARGET : This should be monitored in the pilot period and a reasonable target agreed that is reasonably achievable. In addition PE.07 Values must also represent a change in service levels with regard to appointment time expectation due to appt book clogging with OHA. The remuneration of the Patient Experience element of the Quality Framework will be 4% of contract value. The levels will be on a scale and will require planning. PATIENT SAFTEY We are supportive of this measurement of patient safety. The Patient Safety element will provide 2% of remuneration. Indicator SA.01 Recording an up-to-date medical history at each oral health assessment/review CLINICAL EFFECTIVENESS. We recognize the sense of including these indicators of clinical effectiveness within the contract reform. We have some reservations with regards to the accuracy of the data in the pilots. It is very important that this data is accurate as the data will be useful in terms of delivering targeted care to certain communities. For example in communities where a larger proportion of children are identified as red an increased proportion of contract value devoted to prevention may be indicated. As such the remuneration attached should not bias scoring and this should be balanced within contract reform. At the very maximum level remuneration should initially be based around maintaining RAG scores or very small improvements. In real terms it is in the providers interests within this system to improve the oral health of its patient base as this will allow the patient base to remain stable and to register 5% of new patients annually. We propose that the remuneration is as follows: Caries indicators ô 2% of contract value for a 2% improvement. Periodontal Indicators ô 2% of contract value for a 2% improvement. These targets will require assessment during the pilot period Indicator OI.01 Decayed teeth (DT) for patients aged under 6 years old OI.02 Decayed teeth (DT) for patients aged 6 years old to 18 years old OI.03 Decayed teeth (DT) for patients aged 19 years old and over OI.04 BPE score for patients aged 19 years old and over OI.05 Number of sextant bleeding sites for patients aged 19 years old and over QUALITY AND OUTCOME

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	FRAMEWORK We propose that the following indictors are assessed within the Q.O.F. Both sets of indicators combined are worth 3% of contract value. The first group are simply policies that are in place. 1.Smoking Cessation ô on-line training certificate / log of referrals to smoking cessation services. Numbers of smoking cessation referrals to be within average numbers. This can be transmitted with the C.O.T as ; SMOKER ô BUT NO INTEREST IN CESSATION SMOKER ôINTERESTED IN CESSATION ô (COULD THESE PATIENTS BE AUTO REFERRED BY SELECTING THIS RESPONSE ON THE SOFT WARE?) 2. Referral log ô Numbers of referrals to be logged and transmitted. Referrals to be within average numbers. 3. Provision of urgent care slots ô Average values to reflect remuneration. 4. DCP training for prevention services. Where a DCP is used for this service certification of training and C.P.D is required. 5..Satisfactory CQC report. 6..Completion of audits on clinical notes/ radiography/referrals. (These will form part of the Scored Peer Reviewed Practice Visit). The value of these in total will be 1% of contract value. The following will be scored . Payment of 2% of contract value providing the practice achieves the regional average value +/- 10%. 3. NICE guidelines for recalls. As previously stated , the majority of the recall intervals generated by the care pathway software were over ridden by the clinicians in the pilots. Some re-design is required to allow practitioners to develop full confidence in the system. Providing this is achieved at reasonable intervals a QOF indicator within regional averages would be a sensible measure. 4. Numbers of free replacement restorations provided. Average values to reflect remuneration. 7.Fluoride Varnish applications 8. Fissure sealants SCORED PEER REVIEWED PRACTICE VISIT This element of the Quality matrix is time consuming and expensive but in our opinion there is no substitute for a practice visit in relation to assessing quality of care for patients. We propose a practice visit is made to all practices. This will assess: General practice accommodation Assessment of prevention clinics Assessment of referral audits by the specialist providers in primary and secondary care ô see below. Assessment of audits ô in this case the peer review group will look at the audits produced by the provider and discuss them. Random clinical notes assessment and to also include: Cases including endo/ perio/ simple restorative care/ complex restorative care The value of the scored QOF elements is 2% of contract value. The Scored Practice Visit will require development to ensure that it is seen as both a quality measure and also a driver for education and development. If a practice scores highly a visit will not be required for at least three years unless there is a significant change in ownership. If a practice score poorly an early second visit will be triggered. We propose that the Scored Practice Visit is funded through a process of paying sessional fees to a group of trained active NHS GDS practitioners. The costs to be exchanged for normal activity within the existing capped remuneration. Reducing Inappropriate Referrals There is anecdotal evidence that following the introduction of the contract in 2006 referrals to secondary care have increased. The increased bands and UDA reward for more complex care should help to reverse this trend. In addition we propose a referral audit of all referrals to be undertaken by specialist provider which will indicate whether a referral is appropriate or not. Some work is required on this to ensure that the grading is reasonable. Inappropriate referral may indicate a number of things , misunderstanding, poor knowledge of mandatory services , an educational requirement. All these issues require exploration in situations where inappropriate referrals are higher than average. This report will form part of the Peer Reviewed Practice Visit. The Peer reviewed Practice Visit would be triggered where this is highlighted. Greater communication between Area Teams and

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	Health Education England will be required to ensure that where necessary educational supervision is provided. COMMISSIONED SPECIALIST /ADDITIONAL CARE The reformed contract needs to have the potential to be flexible in order to meet individual communities requirements and to reduce referrals to secondary care where necessary. This can be achieved at no increased cost by exchanging a block of normal activity for a block of specialist activity. For example for Oral Surgery where a provider demonstrates that they can deliver a service an agreed level of service can be struck around sessional payments or payments per case. In this case the provider concerned would be asked to audit referrals as per the arrangements discussed above. URGENT CARE The access component of the contract should increase access for urgent care treatment. In general in-hours emergency care can be provide by providers within a strict criteria agreement of what constitutes an emergency care situation. These patients can be sign posted by And E ,111 etc and media advertising could be used to make patients aware that urgent care sessions in all NHS practices are available. Where additional urgent care sessions are required during the day or in to the evening care could be commissioned through the commissioned specialist/additional care route. LEAD IN TIME We propose an initial pilot period of at least two years to assess data. We recognize the requirement for some practices to increase patient numbers in the early part of the reformed contract and the requirement to prepare properly for the introduction of the QOF and clinical effectiveness framework and so in view of this we propose a three year lead in time where access and quality payments are guaranteed at 100% providing activity levels of 80% are met. CLAW BACK FUNDS If practices fail to reach 80% of target for three consecutive years contract value appraisal may result in a contract value being reduced permanently. In this case the funds should be re-commissioned within the framework of a transparent and fair process. This may lead to contract value enhancement or when/where required the creation of new practices. This could lead to the introduction of new practices to the market place. Any claw back funds between 10% and 20% to be accounted for and ring fenced for dental commissioning. This could take the form of commissioned additional care/ specialist care as described above in the following financial year. Any performance between 90 and 100% can be rolled in to the following year and a practice can elect to make this up as activity or increased access.
Dentist	Treatment available on the NHS should be more prescriptive at the moment I feel dentists are left hung out to dry - left to make the decision then criticised further down the line and dentists should have more of a voice, other organisations other than the BDA should be brought in (they're useless!) such as the royal colleges.
Dentist	this in theory would be the best system however the devil is in the detail and a realistic level of the balance needs to be set. This would need further piloting. Certainly if set at to onerous levels it would further stretch the ability to provide the intended 'quality service'
Dentist	A proposal to define the scope of care provided by NHS dentistry Introduction The Department of Health (DoH) has never produced meaningful guidance to detail what treatments should be provided to NHS dental patients. NHS dentists are told they should provide all that is clinically necessary but this expression is open to hugely varying interpretations, which constantly change with time, rendering it of little use to dentists as a guide. NHS dentists work with the uncertainty of no consensus within the profession as to what complexity of care the NHS should provide whilst

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	patients have ever increasing treatment expectations. To err on the side of caution and to avoid conflict with patients and regulators, dentists are driven to perform treatment above and beyond that for which they are being paid. This pressure on dentists significantly increases their stress and as a consequence compromises the quality of patient care. The burden on NHS dentists perform more than they fairly should is made worse by the NHS Choices web site, which misleads the public to believe they are entitled to more than dentists can properly provide within the GDS budget. By declaring on the site if your dentist says you need a particular type of treatment, you should not be asked to pay for it privately. Your dentist is not allowed to refuse you any treatment available on the NHS, but then offer the same treatment privately. Also, any treatment provided on the NHS has to be of the same high quality as treatments provided privately. The failure of the DoH to be open about what NHS dentistry can realistically provide will be perpetuated in the reformed contract unless the profession acts now. This document is a proposal to resolve the ambiguity around what exactly NHS dentists are contracted to provide. It outlines a solution using resources produced by the DoH. It clearly defines what a patient should expect from NHS dentistry and spells out what it is fair to ask a dentist to provide within the GDS contract. Furthermore it fully supports the call to action from the DoH to secure and improve high quality services in the face of demographic pressures and rising public expectations against a backdrop of financial constraint. The Standard Dental Services Contract The lack of transparency around what should be provided by the NHS is not made any clearer by the Standard Dental Services Contract which tells dentists they are contracted to provide mandatory services. The contract also tells dentists they are not contracted to provide advanced mandatory services which[a] by virtue of the high level of facilities, experience or expertise required in respect of a particular patient, the service is provided as a referral service;. The line between mandatory and advanced mandatory is ill-defined and relies on the variable definition of a high level. Dentists abilities contrast widely between individuals and throughout their careers, a high level for one dentist will not be the same as another and the point at which treatment becomes advanced is indistinct. Another cause for dentists to feel pressurised to provide treatment theyre not contracted to carry out is the inadequacy of provision of referral services for advanced mandatory services. In Northamptonshire for example dentists have access to a restorative consultant for only one day per month and this service is for clinical opinion only, not to carry out the treatment. Rising patient expectations. Patients are told by NHS Choices web site; You're entitled to have all clinically necessary treatment on the NHS. This means that the NHS will provide any treatment that you need to keep your mouth, teeth and gums healthy and free of pain. This includes: dentures root canal treatment crowns and bridges any preventive treatment needed, such as a scale and polish, an appointment with the dental hygienist, fluoride varnish or fissure sealants white fillings orthodontics for under-18s NHS Choices is wrongly interpreted by many patients as them being entitled to anything they choose because the DoH does not define clinically necessary. NHS Choices creates a mismatch between what patients expect and what NHS dentists are able to provide. Patients who have been lead to believe they should be able to have any treatment will logically feel aggrieved if this is not offered to them. If a dentist has a different view to the patient of what is clinically necessary there is no clear guidance to justify their decision. Patients increasingly demand written explanations, which frequently disrupt the working day of a NHS dentist and create disputes that are unpleasant and stressful for all concerned. This

Respondent type	Other comments
	unremitting pressure on dentists significantly affects their well being and it has been cited as the reason for many dentists leaving the NHS. Contrary to accusations that NHS Dentists take advantage of the lack of clarity in the current contract to underperform, most dentists strive to provide the best possible service they can to meet their patients expectations. Frustratingly however, it is not possible within NHS budgets to provide the level of treatment that patients increasingly request. Dentists who attempt to do so risk failing to meet their UDA targets and the reward they would get for their efforts would be a cut in their funding. As well as having higher expectations, patients are more willing than ever to complain and this is set to continue. In 2014 Bill Moyes, chair of General Dental Council (GDC) said; The volume of patients complaints about poor dentistry is likely to increase. Service users will become increasingly consumerist in their outlook ô many already are - and so the pressure will not lessen for services to be designed around the needs of patients and for care to be delivered in ways that patients are happy with. For patients to be happy with the service they receive they need to know from the outset what that service (the NHS) is prepared to provide. This proposal is a way forward for Dental Contract Reform In the Dental Contract Reform Engagement Papers dentists are told that the aim is to standardise best practice for all patients and; 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. For provision to be consistent a NHS-wide definition of what NHS dentistry will provide is essential. Without this, contract reform will worsen the position of NHS dentists because the DoH envisage that as in the pilots, practices will in the future be remunerated based on their relative performance against the DQOF. NHS dentists will be measured against outcome indicators including; 1. Patient experience - assessing the views of patients on their experience of care provided. 2. A patient being in good oral health by which it is meant; they are free from pain they have a good functionality and aesthetic form to their teeth- they can eat speak and socialise they have clinically assessed good oral health and we are confident that this will continue in the future For dentists to perform well against measures of patient experience, it is essential that from the outset of their treatment patients have realistic expectations of what is available. If dentists are to standardize best practice and produce clinically assessed good oral health these terms have to be transparently defined in a way that dentists and regulators can refer to. Resources already exist to clearly define what NHS Dentistry should provide The Department of Health in the report by the Information Centre for Health and Social Care entitled Oral health and function- a report from the Adult Dental Health Survey 20091 provides us with a clear and evidence based definition of excellent oral health prospects. It states; ..it is possible to combine several clinical measures to identify those adults with the best current health. As a minimum these are dentate adults with enough teeth to function, a large majority of these teeth sound and untreated, and with no active decay or periodontal disease. This measure of excellent oral health prospects comprised people who met all of the following criteria: 21 or more natural teeth; 18 or more sound and untreated teeth and roots; no decay detected at any site; no periodontal pocketing of 4mm or more and no loss of attachment of 4mm or more; no calculus or bleeding. The retention of 21 or more natural teeth is widely used to define the minimum number of teeth consistent with a functional dentition for most people[a]While this figure may be viewed as arbitrary, there is evidence to indicate that 21 or more natural teeth enable most dentate individuals to eat what they want in comfort without the need

Respondent type	Other comments
	for a removable partial denture In addition to the definition of excellent oral health another document exists, the production of which was funded by the Department of Health and administered through the Clinical Effectiveness Committee of the Royal College of Surgeons of England. The document is the Restorative Dentistry Index of Treatment Need and it can be found by pasting the following address into your web browser; http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/complexityassessment.pdf; The Restorative Dentistry Index of Treatment Need is a complexity assessment for the four aspects of restorative treatment; periodontal treatment, root canal treatment, fixed prosthodontics and removable prosthodontics. It provides a simple way of categorising the complexity of a patients restorative treatment need and provides a measure comprising 3 levels of complexity i.e. complexities 1,2 and 3 with complexity 1 being the least complex. The proposal This paper proposes that the DoH state what treatments NHS dentists are contracted to provide using the process described below. When a treatment plan for a NHS patient potentially involves periodontal treatment, root canal treatment, fixed prosthodontics or removable prosthodontics the dentist can use as references the Restorative Dentistry Index of Treatment Need in conjunction with the measure of excellent oral health prospects in their decision making process. Deciding whether a treatment is available on the NHS will be very simple and is explained here and also illustrated in an algorithm; How to determine if a dental treatment is available on NHS 1. The NHS will continue to provide all patients with guidance and support to achieve and maintain excellent oral health. All patients should be free of pain, have good functionality and aesthetic form to their teeth and be able to eat speak and socialise. 2. If, to reach oral health as described above a patient requires any periodontal treatment, root canal treatment, fixed prosthodontics or removable prosthodontics and that treatment is at complexity level 1 it is available to the patient under the NHS and in General Dental Practice. (Irrespective of the number of teeth the patient already has). 3. If treatment is at complexity level 2 or 3 and that treatment is required for the patient to achieve excellent oral health it should be offered on the NHS as advanced mandatory treatment and a referral service should be provided for this. 4. If treatment is at complexity level 2 or 3 and is not required for the patient to achieve excellent oral health, that treatment is not available on the NHS and an alternative treatment plan has to be offered. In this case the patient can elect to have the treatment carried out privately in General Dental Practice by the same dentist if that dentist has the appropriate skills to do it. The algorithm illustrating the decision making process is shown below; How this is different from what currently exists and how it will secure and improve high quality services in the face of demographic pressures and rising public expectations against a backdrop of financial constraint? It will provide NHS dentists with a clear guidance on the level of care they are contracted to provide It will explain to dental patients the evidence for the level of treatment the NHS will provide for them It will focus resources on treatment required to achieve excellent oral health by eliminating treatment that is not necessary to achieve this aim General Dental Practice and Restorative Referral Services will be freed from spending time and resources on the treatment of diseased teeth that are not necessary to achieve excellent oral health. It will free up time and finance to increase dental access to those most in need It will not require any additional investment in NHS dental services. References 1. http://www.dhsspsni.gov.uk/theme1_oralhealthandfunction.pdf 2. http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/complexityassessment.pdf

Respondent type	Other comments
	(These are not hyperlinks you need to cut and paste them into your browser)
Dentist	I have found that since being involved with the pilot that the provision of high quality care combined with teaching prevention takes time. This will obviously have an effect on access. The difficult part here is to combine all of this within the current NHS dental budget. I feel that the only way that this can be done is to drastically simplify the amount of data currently being captured and make the 'back end' of the appointment significantly simpler. Some thoughts (also submitted in document 2) To save time and make paper version possible Navigation/clicking between screens and different domains takes time and is very IT heavy. Whole system would be better to run as a paper version as well as on the PC Ideally be able to run from one screen/one sheet of a4 paper which can be electronically Needs to limit data capture Objectives Set appropriate and sensible recall intervals according to presence/absence of active disease number/type of restorations within existing dentition tooth wear social factors - alcohol and smoking Idea of how to achieve on one screen/ sheet of paper Record only Patients name, address, date of birth BPE in 6 boxes (pocket depths can be recorded within notes but not transmitted) Modified bleeding recording - perhaps record presence/absence of bleeding on probing in any sextant in a format similar to BPE Number of new carious lesions Signs of toothwear Increased risk of oral cancer developing - patient smoker/drinking in excess of max recommended amounts Improving access Could this be self generated (after the clinical exam)via the IT software to self populate the relevant boxes and produce a suitable recall? If the whole thing is speeded up, then access may increase. That said, we still need time to teach prevention! Is this enough info to generate a pathway? KPI's and prevention If a blended contract is going to be the way forward, could key performance indicators be captured from the above? If these are set at sensible levels, then this would also encourage prevention FTA's Finally, if something can be done about late cancels/ FTA's, that would be great. I am sat here typing this now during a late 40 minute cancellation appointment! If something is done, this may help increase access. [redacted]
National Body	In regards to question 2: In any contract and remuneration system, there is always a risk of fraud. When a new contract is introduced, it is important that these risks are identified, and appropriate measures implemented to prevent fraud from the outset. There is insufficient detail in the consultation paper to make a full assessment of potential fraud risks in the new contract. However, the current activity based dental contract has been subject to fraudulent claims by dental contractors. The results of a dental contractor loss analysis exercise published by [redacted] in 2012 concluded that the estimated loss to suspected contractor fraud during 2009/10 was ┬ú73.188m based upon an assessment of resolved treatment queries, with a potential for a further ┬ú5.31m of loss in unresolved queries. It is estimated that during this period almost one million inappropriate claims (FP17s) were submitted for payment. These risks may continue to exist in the activity based element of the new contract. Capitation models also have fraud risks associated with them. Remuneration based on patient numbers creates a risk of ghost patients being fraudulently created to increase income. In addition, patients may remain on a practice list even if they are no longer being treated by a dentist at that practice, to continue to attract a payment for them. Once a ghost patient is created, false activity based claims can then be made. [redacted] understands that there are plans in NHS dentistry to start requesting patients NHS numbers. This will allow

Respondent type	Other comments
	for better management of data and contract management, and could also reduce the number of ghost patients and assist in identifying duplicate claims for payment. [redacted] would welcome the opportunity to work with the Department of Health to review the new contract and remuneration system, and make recommendations to ensure the risk of fraud is reduced to an absolute minimum.
Dentist	2 areas are not mentioned through document; 1 What you are doing now before review of testing prototype which will be more than 18 months away. This is sensitive politically as will help demonstrate the coalition commitments on dentistry within this parliamentary cycle; NHS England have been slow to commission services to tackle the areas they have already identified as the greatest need. Firstly elderly care commissioning is sketchy at best across the country with few domiciliary contracts in place and the most dentally compromised patients have no dental provision. This cannot wait for contract prototypes to be tested. Either additional tenders need to be put in place now, or a UDA allowance given to cover these visits (within existing contracts). Secondly most vulnerable groups in deprived areas need to be encouraged to visit practices and the clinicians rewarded appropriately for high disease levels, the current UDA system is not flexible enough and in the short term additional bands could be introduced, alongside a NHSHE national campaign to raise awareness. The other group identified is the under 5s highlighted by the number of GA cases. Incentives should be put in place now to encourage both under 5s and dentists to target, the money should be taken from secondary care to fund, as will payback more in future with decline of GA extractions at later stage. This should also be accompanied by NHSHE campaign to raise awareness. Finally the move of minor oral surgery provision from secondary to primary care at a reduced rate has been talked about for over 2 years to ensure cost savings within the healthcare system. There has been little progress with only a few new tenders coming to market and this needs to be accelerated so that the additional money can be used within the dental system. 2 NHS/Private choice.....NHS cannot fund both and should not pretend to unless an additional ┬ú3B funds are made available; It is important that any new system is clear of what can be provided. Under SDR system pre 2006, it was clear what could and could not be provided under NHS. Since 2006 the rules are grey and unclear for both dentists and patients. I do not think we should go back to the 600ish codes we had previously, but we do need to be honest that the NHS cannot fund all dental treatments and be clear to both dentists and patients what is available.
Dentist	Would wish to see a blended system with an element of capitation, together with a tweaked and weighted UDA system, where there are more UDA bands to include Band 1a for prevention, Band 2a to include complex restorative care not involving lab work, on patients with four or more decayed teeth requiring restoration and/or extraction and for any endodontics. Would also weight the price per UDAs for additional care need factors and dental need factors and would also see a weighting for relative local social/material deprivation, based on quintiles of relative social deprivation scores at Commissioning level (e.g. Area Team level). Weighting of UDA values could be a way of incentivising location of practices and dental teams to then take on and care for higher need groups and individuals. Certainly better than the current fairly random nature of UDA values/prices
Dentist	Remember to not just focus on the the providers contract but ensuring the performers are not forgotten in this contract

Respondent type	Other comments
	reform as they are the clinicians that will be treatment planning and aiming to raise oral health within the practice.
Dentist	As there is no extra money available for a new contract, which I feel will take me longer appointment times, why can we not reduce NHS treatment options. For example why not remove more sophisticated treatment like crowns from NHS availability. I feel it would be much better for patients to have free dental exams, which was the case when I started dentistry decades ago. In that way a preventive approach would touch more patients. I believe NHS treatment should only offer basic treatments and lots of prevention. This would be the best use of limited recources.
Retired Dentist	Patients charges must be aligned to the remuneration system adopted. It is difficult to comment when the charges question is not addressed. Charges have historically been raised on activity, something that seems incompatible with a capitation system.
NHS Area Team	activity payments for specified prevention activities how will the software and computers be funded what about the situaiton where lots of average GDPs cannot do tier 2; will they lose money or will the tiering encourage the average \GDP to [now] provide the full range of treatments??
Community dental service	If the new system is not funded correctly there will be yet another move of dentists out of the NHS , and will not return, then there really will be a problem accessing care especially for the vulnerabler groups in society
Dentist	Remuneration should consider setting out wage bands for performers to reduce the risk of incentivising quantity over quality. Risks to practices should be assessed should there be any significant change in individual practice remuneration.
Dentist	yes the present system is flawed and the system proposed is becoming the laughing stock of the world.Reforms have never helped. and NHS is the worst system in the world!!!
Dentist	The pilots initially were a good environment to work in allowing the care pathway to be followed. Spending more time with pts meant that pt numbers fell and now we are faced with trying to maintain pt numbers to pre pilot levels. The structure of the pilot list size(3 years of pt seen prior to pilot)is impossible for us to maintain without taking on new pts, with high treatment needs in the majority of cases. This means our capacity falls and appointment waiting times increase. It is a vicious circle and demoralising. Makes UDA' s look attractive. Targets need to be dynamic and reflect a practices productivity not just patient numbers. The NHS remuneration model is perverse as unlike normal business improving quality and patient numbers actually reduces profitability as the contracts are fixed value.
Dentist	More emphasis of addressing periodontal gum disease in the uk
Dentist	I don't feel that a single contract will fit all practices I would like to see nhs dental practices responsible for all patients in their area including those in nursing homes/domicillary/anxious /schools early years and other seldom heard groups in a similar way to medical practice.referring on only those patients who ned specialised care.the contract value would expect an element of additional care to be delivered in local care homes for example. I would also bring into the same contract salaried services and secondary care producing differing contracts for differing situations in differing localities
Dentist	The general dental probationers with a dental public health speciality would have been more appropriate in designing

Respondent type	Other comments
	these new tools and new contract. the dental probationer with no public health training and public health specialist with no current or practice experience in last 10 years would have a very biased and one sided view
Dentist	As a practice owner with 4 associate dentists working for me the current UDA system works well. The associates that work harder and longer hours generate more UDA's and get paid more. The lazier associates generate less UDA's and get paid less, which is fair. If we change to a capitation system then there is no incentive to work hard and they will all do the bare minimum amount of work that they can get away with. The blended system seems confusing and complicated to carry out.
Dentist	Payments based on imrovement in risk factors biased against community dental services as special care patients less likely to be responsible for own oral care and challenge of improving oral health is greater
Dentist	Any system which relies too heavily on activity based renumeration, or will penalise dentists financially for spending longer stabilising high treatment need patients will drive them to offer treatments privately, or not spend long enough
Dentist	If payments are paid to the Provider, at present, they are "creaming off" massive profits. Performers who are incredibly valuable, who do the frontline work are being "cannibalised" by Providers who have acquired contracts, some pre-2006 and then due to an effective monopolisation and therefore rising practice prices, are able to take a large proportion of the payment, reduce their materials costs. They often do not do any clinical NHS work and treat their performers like inferiors, often paying them less than a thrid of the UDA fee. If there are rules put in place to protect performers this would incentivise performers to remain. At present, Providers are ammassing great profits for very little clinical work, cutting corners and pushing Performers to work with restricted materials, short-staffed. Often this is moreso in the corporate practices. What measures will be put in place to protect Performer interests, some of whom are very valuable and wish to clinically excel in caring for their patients.
Dentist	why can't you go back to fee per item?
Dentist	I do feel treatments like posterior root fillings need to be correctly funded or not available at all on nhs for ┬ú50.50 to use rubber dam rotary instruments at least an hour or more appointment a nurse and dentists time is completely infuriating. Practice costs have spiralled out of control with an incompatible increase in contract value Why are GDP potentially having part of contract held back when GPS are not and why are GDP forced and steam rolled into changing sorry reforming the contract when the pilots have seen a decrease in patient numbers and so many dentists on pilots have expressed so many difficulties with them. It is also extremely unfair that when the existing contracts were rolled out there was and is so much inequality in contract UDA value regionally When the UDA system was so rapidly dumped on dentists in the uk it was done so with ignorance and naivety by the health department / government I hope future change will be made slowly with more consideration
Dentist	we understand the reasons for change but you really do not understand dentistry. The consultants that are formulating the pilots have deeply flawed knowledge as they mostly do not work in practice as associates who carry out the vast majority of dentistry in the uk. YOU NEED TO SPEAK TO THE DENTAL ASSOCIATES OF THE UK to really

Respondent type	Other comments
	understand what is actually going on.
Dentist	i'm pleading for someone to look at the treatment of the over 80s who pay for their treatment,are dentate, but have complex other needs.walking to chaire etc,sitting uprigjt,need help with getting seated, deafness blindness and teeth that need to be regularly patching up.this has not been addressed.even now data is not collected for this age group.they are banded with the over 65 s i think.it is a completely different care band
Community dental service	It is difficult to see how the capitation element would work for patients referred to CDS for a course of treatment or for those who do not want a CoT only immediate care for a dental problem..
Dentist	A system that covers unlimited full range of treatment without conditions and disregarding the need for specialist care for a good portion of procedures, currently considered in the scope of general dentistry is bound to fail. The current UDA system is a perfect example. Remuneration based on statistics is flawed, as statistics are very easy to manipulate. Dentists should return to thinking and caring about people, not numbers - a challenging, but not impossible task, I think.
Dentist	The private dentists are paid 10 times more
Dentist	Its not easy paying dentists.The problem of "Skill-mix" needs to be addressed i.e. more DCPs fewer dentists for the 21st century disease level. The scope of NHS dentistry needs to be defined e.g. no veneers, no porcelain-bonded crowns etc. A clearly defined core-service for fee-paying adults?
Dentist	FD training reduced the number of patients a practice has, as once patients see them for an exam or emergency they will be removed from the practice total. This is a disincentive and will not only have an impact on training and the type of treatment that a trainee will be allowed to perform, but being an area where there are limited good training practices should they really be penalised in this way??
Dentist	A lot of time is lost by failed appointments, there should be a system of fines for non-attendance. Patients need to show compliance with advice and maintenance of oral hygiene.
Dentist	If this contract is focusing on prevention, a much more effective use of resources would be artificial fluoridation of water. Many areas of the UK are ready fluoridated, some naturally. This would decrease the rate of caries and therefore workload on the dental workforce allowing more time to improve quality of treatment.
Dentist	Quality indicators should not be subjective, overly difficult to achieve. Any retained funds should be redistributed within local NHS dentistry fairly.
Dentist	No
Dentist	i have serious concerns that FD training practices are being disadvantaged in that the patients seen by the FD are not counted towards the practice capitation list. FDs are a good way of improving access but if the practice's capitation numbers will be affected then we will start to lose training practices
Dentist	Overall it needs to be fair for all stake holders. The biggest issue I have with the DQOF is that measuring oral health

Respondent type	Other comments
	outcomes is difficult especially in areas of deprivation. It is not always easy to motivate parents to bring their child regularly or to institute any home prevention. It would be the dentist that suffers financially if their patients do not have the will or motivation to take responsibility for their own wellbeing.
Dentist	A fully qualified dentist should be treated like an NHS GP or consultant at hospital. We are as educated and specialist in our field, we have spend the same years training and are no longer in or on a pathway towards higher banded incomes. if you salary a dentist for 70-80,000 pounds they will happily treat whatever walks through the door without perverse effects if the patients mouth needs lots of treatment, or the patient is difficult to treat. Paying low amounts of money, though it saves the health service money, attracts poor candidates as it currently does at corporates in large cities where the number of UK graduates is dwindling and you end up getting a lower quality of work, more dissatisfaction from patients and a higher turnover of staff.
Dentist	The current system of fixed contract values is based on valuations which are now 10 years out of date; this no more sensible than having them based on a valuation made in 1948 when the NHS was founded. Over time practices evolve, the practice skill mix changes as do the abilities of the individuals working within those practices. Good practices are popular with patients but unable to expand, poorer practices lose patients but still receive their fixed sum, albeit subject to clawback. Technically the commissioning system allows area teams to redistribute funds but this seldom seems to happen (most ATs are too afraid of challenge and therefore tend to distribute any extra funding equally to all practices). A way needs to be found to allow popular/good practices to expand. My suggestion would be for money to follow patients. Start each practice with their given contract value. If a patient moves to a new practice their capitation element goes with them, the new expanding practice gains some funding the older contracting one loses a little bit. This need not imply an open ended budget if the overall dental budget within each AT area remains fixed. There would need to be some additional monitoring to keep the AT dental budget within its local envelope however.
Dentist	Trying to engage people by being dictatorial is never going to be a vote winner and trying to reform contracts with no extra money isn't going to be either. The GMP's would not have accepted their new contract without extra money so why would we? We can be told until the DoH is blue in the face that there is no more money, but it won't get people on side to make this work properly. Better financial incentives are required otherwise this initiative may fail which would be a great shame. The reality is we have businesses to run and we are not charities. Most of us work to earn money and contract reform will require more work from most practices. Without financial inducements the good will required from the workforce to roll it out nationally may not happen. There appears to be a lot of suspicion amongst my colleagues about Contract Reform which needs to be addressed in order to engage practices in the process. Money would inevitably help.
Dentist	Ensure there is a protection of earnings in the transition phase. Ensure the contract does not set us up to fail.
Dentist	There is no point instituting care pathways for patients, because subsequent governments will simply come along and re-invent the wheel. It is time for a core service, with a prolonged national Oral health campaign and a sugar tax. The public finances are close to melt down. Simplify the system, aim what money there is at the most vulnerable, and

Respondent type	Other comments
	instigate the principle of the reduced dental arch. And realise that whatever system you implement, it has to take into account of the massive caries time bomb that is ticking in the over 50's
Dentist	I have no over-riding objections to anything in the 4 papers, except for Part 2 in Paper 1. At the moment you are capping expenditure, telling the public that all things are available to all men, and then hauling us up in front of the GDC when Joe Public falls afoul of the gulf between speeches and reality. You are capping expenditure, you should have the courage and decency to tell the public that they cannot have everything they want. But in the second bullet point of this paragraph you say that the scope of NHS care is expected to remain unchanged. I have no problem with capping, but please be honourable enough to acknowledge it and explain the implications, don't use us as a whipping boy to save your embarrassment.
Dentist	Patient Charge Revenue can be dramatically increased by simply scrapping the utterly illogical "2 month rule", where if they re-attend within this time and require a treatment in the same band that they has previously paid for, they get it for free. The presenting complaints under this band are usually totally unrelated to what they paid for up to 2 months previously and the patients are always singularly amazed that they do not have to pay again. In short, it makes no sense; patients expect to pay and are willing to pay for further unrelated treatment within this time frame; it encourages gaming of the system; it is a total waste of public funds.
Dentist	department of health needs to be brave and go down the prevention route, accepting that patient charge revenue may suffer
Dentist	it does not what the results of the pilots are, they will be rolled out!
Dentist	Pay us more, not less. You pay peanuts, you get monkeys.
Dentist	how can you base a remuneration system based upon a capped figure which is based upon pre-2006 figures. the manner and patient profile has changed since 2004. im treating so many new patients, who have hgh treatment needs, yet my figures are based upon 2004-2006 figures. also, due changes in GDC guidelines/CQC/HTM/DoH ie mandatory changes in staff levels to cover HTM, information governance, decontamination nurses, nurses for hygienists, this has led to an increase is manpower requirements for the practice since pre-2006, yet all figures and paymenst have remained unchanged. how can manpower resources be allocated sufficiently without proper remuneration?
Dentist	Have to accept principle of core activity in NHS, then provide high quality simple treatments combined with good preventative measures. Do not rely on principle of monitoring purely by computer, need to accept some form of physical monitoring system to ensure high clinical standards, like the CQC except to cover clinical outcomes as well
Dentist	SEEMS TO ME YOU HAVE ALREADY DECIDED ON THE REMUNERATION SYSTEM.
Dentist	I used to have a PDS contract that was based on my practice looking after a specific number of patients and we were paid on a capitation basis If our numbers dropped we took new patients on but we were allowed to device our own treatment plans which involved having a pain hour were we treated patients immediately who contacted us implimented staff training during the day and took part in the clinical governace programme Everyone was happy with the progress

Respondent type	Other comments
	we were making Then it was decided we couldn't be monitered and UDA's were invented
Dentist	Please see previous form answers. Any system where practitioners are expected to jump through more hoops and earn less money will lead to the closure of more NHS practices... but then the cynical amongst us will assume this is the aim.
Dentist	I think fully activity models with multiple bands should be considered.
Dentist	There should be free dentistry for all patients up to 21, for over 70 and core service for exempt groups. Otherwise the rest of the general public should be removed from NHS care and pay privately.It is preposterous that dentists should have to spend hours filling in forms , taking away their clinical freedom ,whilst being paid peanuts for doing so.It is a complete waste of resources.
Dentist	If you want an extensive good quality system you will need to put more money in to it. Otherwise dentists will leave the NHS, or quality will be either neglected or unobtainable.
Dentist	patient charge revenue will kill this reform like PDS. patients will not pay for prevention..Steele has hopelessly misjudged patients..its such a shame. the doh should accept this and give us capitation..its the DOH that is going to ruin this opportunity by insisting on the same PCR
Dentist	I think the reform should consider the way patient pay for their treatment. Band 2 treatments can be split easily to sub band with different charges. It is not fair a patient with 1 or 2 fillings needed to pay the same as a patient who needs 4-5 fillings, rct and extractions. Access will be increased if more NHS contracts will be given to new practices. Of course the funding will need to be increased for the next few years until the preventive care will show results (usually after 10-15 years).If the funding cannot be increased because of the general financial condition, then definitely the patient's contribution should need be increased significantly. More patients will be able to be seen by more dentists, not the same number of dentists with more money. Quality will be increased if NHS will take in consideration the cost of running an NHS practice in different parts of the country.
Dentist	There is going to be no extra money for this, there needs to be the same patient revenue collected, all the proposed models have disadvantages. Why not just leave the uda system in place?
Dentist	Apart from a few cowboys, the more you pay the better quality you will get - just like in real life funnily enough.
Dentist	You need to be honest, transparent and pay for good quality care. If you want, as is apparent from this document, not to increase funding, but maintain current scope, you are REQUIRING providers to manipulate contracts as you just cannot deliver what a professional considers good quality care under the current funding arrangements. The DH would be better off admitting that it's is not possible to spend sufficient money to deliver modern dental care to all. Prioritise, delineate a level of service, and the cut you cloth to match the funding available. After all.... No implants, very very little specialist (RCS index of restorative need grade3, or for that matter grade 2), care is being delivered anyway. No sports mouth guards for goodness sake! Shop rearranging dental chairs, making ever more complex systems, and growing the corporate sector. I see plenty of patients cared for via my NHS LPN list. It is not going to deliver you better or cheaper care.

Respondent type	Other comments
Dentist	I have been developing a model based on cap plus activity for associate payment and skill mix - happy to share and discuss if it helps. (Pilot site [redacted])

Responses to the engagement exercise not received through the survey

DN: Title TBC

Respondent type: Software Supplier
Suggestions for a Proposed New Contract The stated objective of the Government's dental policy is to improve the oral health of the nation in the long term whilst increasing access to NHS dental care in the short term. The improvement in NHS dental care over the last 50 years has been significant to such an extent that the original basis of dental charges and practitioner remuneration on the basis of work done has become inappropriate. The Steele Report made the case for more prevention and less treatment. The reports by the Department of Health on the new contract pilots explained the potential conflicts and difficulties in creating a charging system based on prevention and clinical treatments. Whilst the details are complicated and numerous, there is no doubt that in overall terms we expect there to be less invasive dental treatments necessary for patients in the future. Thus I would suggest that we need to construct a charging system that enables us to manage the change in demand for preventive care and treatment. With this aim in mind we should create a new contract in which the contract value is capped separately for examinations and treatments. For example, if a Practice is given a contract of 1000 UDA's in total, it could be specified as 2 mini-contracts of 600 PUDA's (Prevention-UDA's) and 400 TUDA's (Treatment-UDA's). The work done would be categorised as 'Preventive' – examinations, medical questionnaires etc or 'Treatments' – fillings, crowns, other dental treatments… The PUDA value of the contract could be seen as the annual investment made by the State towards the benefit of a reduction in the TUDA value in future years. Over a period of years this would serve to provide a clear cost-benefit analysis of the operation of the Practice and enable the DoH to adjust the treatment element of the contract on an annual basis as appropriate. There would be a separate patient charge related to each PUDA and TUDA event and a contract cap on the PUDA and TUDA values in each contract. The performers would be paid for PUDA's on the basis of a capitation scheme and for TUDA's through the UDA system as at present. Over a period of time, in the simple terms of the example above, we would expect the annual contract to have a shift in balance from TUDA's to PUDA's. Whilst the contract could remain (say) at 1000 UDA's it might become 800 PUDA and 200 TUDA. It would be straightforward to see the cost-benefit value of the annual investment in PUDA's on the expenditure necessary on TUDA's at a national level over a period of time. In relative terms you would expect this value to fall in total.

The system would :-
1/ Permit variation, as now, in UDA rates across different parts of the country
2/ Permit more refined control of the contract spend between prevention and treatment
3/ Recognise investment in dentistry with the cost of dental treatment at a contract level
4/ Maintain overall capping of dental expenditure
5/ Give flexibility to incentivise prescriber behaviour through relative PUDA/TUDA rates
6/ Maintain basis of patient charge

Trust this is helpful,
Regards

[redacted]
For and on behalf of [redacted]

Respondent type: Local Dental Committee

Question 1
What percentage of contract value do you think should be used for DQOF?

5%, but certainly no more than 10% - if a large practice loses e.g 2% of CV, in a large practice (CV=£1m) this could equate to £20k, which could make the practice less financially viable. Especially the case when CQC, GDC, indemnity costs rising so much and NHS fee increases being below inflation for so long. Also why should the practice loose money when much of the DQOFs are solely in the patients control – dentists can give OHI til they are blue in the face, but the patients do not necessarily follow that advice.

Question 2
We assume there will be an element of remuneration for quality and outcomes. Beyond this element, what are your views on the options for remuneration and how the challenges associated with them can be managed:

Full activity – no effective payment for active prevention will result in little prevention being delivered – I don't think this could be properly managed – there would be no incentive for prevention other than the dental teams caring nature + this would potentially financially penalize those caring practices

Full capitation anecdotally full capitation can lead to supervised neglect – no incentive to carry out full dental care. Again those caring practices would be financially penalized over those less caring practices

A blend of capitation and activity possibly the best of both, or the worst of both. I think this is likely to be the better system, but will need

careful planning in order to get the balance of capitation and fee per item right.

In terms of remuneration for quality and outcomes, how will these be measured? Clinical data sets showing 'averages' and identifies outliers from the normal assumes that average is good – this is not necessarily the case – outliers should be identified as being outwith the required standard – e.g applying NaF varnish to all children should be close to 100%.

Question 3
If a blend of capitation and activity is used, what elements of the care spectrum do you feel should be covered by capitation and why?

Capitation should only cover maintenance care e.g. exam, scaling & polishing (bpe<=2), radiographs, preventative advice re diet + oh.

Everything else is active treatment and practices should be remunerated for this. Demographic data is not sensitive enough to allow adequate calculation of capitation amounts for larger treatment amounts – some high socio-economic groups (with a probable low capitation payment per month) can have high needs and vice versa. Again it would be unjust to have practice remuneration proportional to things that are in the patients hands and are outside of the practices control, despite their best efforts at education.

Question 4
What safeguards need to be in place to ensure that patients with high treatment needs are appropriately treated in any remuneration system?

See above Q3 – payment for active treatment would ensure that high needs patients receive that treatment. However high needs patients should not have repeated courses of extensive dentistry – dentistry is avoidable and happens because of poor hygiene and diet which only patients can change – if they do not change and remain high needs then dentistry should only offer a basic service to these groups.

Respondent type: Local Dental Committee

Q1. Agree this should be set fairly low as to some extent out of dentists control and subjective views of patient experience.
Q2. Again agree that a blend of capitation and activity seem most likely. The paper also mentions that the element of care covered by capitation may increase over time. So could we end up being asked to provide more services for the same capitation payments?
Q3. Capitation to cover the present Band 1 treatments?
Q4. ? Higher capitation payments for high need patients. However as [redacted] says payments for active treatment would provide for treatment for these patients which would be an improvement over present system.

Respondent type: Local Dental Committee

1. Reserving any of the pay subject to patient experience is fraught with problems, generally patients do not like visiting the dentist and

their experience can be affected by factors outside of the treatment, such as wait times as well as discomfort of treatment, OH advice, quit smoking, not getting the treatment they wanted or seeing another member of the team for treatment.

5-10% max for this such that only 1-2% is at risk (according to estimate of 800 points figure). Any lump sums should not be taken back through clawback.

Perhaps 900 points would give 100% of contract and 1000 would give 105 – 110% paid for from the deductions of those achieving less.

2. Full activity – might as well stick with UDA's

Full capitation – no incentive for treatment. If the NHS wants to go down the route that only check ups, x-rays, s&ps and preventative advice are free and patients pay privately for treatment then this would be perfect way to do it.

Mixed – Extremely difficult to get the balance right, huge effort and cost to develop and will anyone try to develop the system or just treat it as a lost cause and start from scratch as seems to be the case with UDA's. The only benefit to this is if it will generate completely new contract values which reflect the needs of an area and the ability of a practice to deliver effective treatment.
How will capitation be measured – some patients only want to attend when they are in pain others want to be seen every 3 months whether there is clinical need or not.

Also, the likely (certain) existence of a cap to payment for treatment will again just create a UDA style situation where some dentists engineer treatments to those profitable.

To target those with the highest need treatment should reflect either per item or on a per hour/part thereof. Carrying out lots of fillings on one patient is currently not cost effective.

Dental practices must be able to return to better profitability levels in order to invest, train, grow and to encourage new recruits. Morale is low as costs are increasing up to 10 times faster than uplifts and red tape continues to consume ever more time.

3. Capitation should only encompass the current band 1, exam, scale, periodical x-rays and OH advice and perhaps Flouride varnish for children.

An individual dentist may choose to perform a small filling on a patient at their discretion as many do now but this should be the exception and not the rule.

4. All payment for treatment needs to reflect the time taken and the lab bill, perhaps the practice could claim for these 2 factors! It would discourage speed and cheap products.

Practices would balance treatment time and patient numbers as they do now, ie there should be no real benefit in unnecessarily long treatment time as it would reduce patients seen. The cost of time would be a much easier factor to calculate for regions of the UK based on rents, wages, etc

Respondent type: National body

HOW CAN CPD SUPPORT WORKFORCE TRANSFORMATION?

Key Messages
Priorities for [redacted] across the UK when developing CPD programmes:

Population health and oral health needs should determine education and training priorities

- Communication about current and predicted population oral health statistics to dental teams
- CPD based on population needs
- National priorities matched to local needs
- Curriculum mapping linked to national priorities
- Focus on effective disease prevention
- Accessing 'hard to reach' patient groups
- Target education to needs of patients in priority groups
- Focus on improving DMF status (health outcomes)

Periodontal disease

- Periodontal disease – prevention, identification and treatment
- Smoking cessation - brief intervention training for dental teams

Meeting older adults' oral health needs

- Managing the existing heavily restored dentition
- Minimally invasive dentistry
- Complex care in the complex patient
- Developing appropriate specialist care
- 45 yr old+ cohort – ensuring adequate training programmes are developed and aligned to service provision to deliver complex treatment for the population

Team working and skill mix

- Development of multi-professional training programmes to include health care teams outside dentistry (e.g. joint

dental/medical/pharmaceutical training programmes)
- Team awareness of change and its management – multi-professional training for dental teams
- Influencing behaviour change of clinicians to deliver new ways of working
- Educate existing workforce to adapt to changing patient needs
- Better training for the dental team (and public) regarding use of skill mix
- Workforce redesign and opportunities arising from a revised dental contract

Care for vulnerable groups
- Delivering domiciliary care
- Paediatric dentistry - preventing unnecessary General Anaesthetic referrals

Barriers and Solutions

Ensuring access to relevant CPD for all members of the dental team
- Varying enthusiasm of workforce to attend CPD course –clarity needed about incentives and sanctions
- Workforce discrepancies – dentists often more able / likely to attend than DCPs

Possible solutions
- Work with commissioners, Area Teams and LPNs to influence dental team development
- Target Practice owners / contract providers
- CPD priorities should be linked to GDC's core and recommended areas, 5 year cycle and revalidation
- Incentives are needed for teams to access CPD during working hours
- CQC assurance and standards provide a driver for dental practices and care homes
- New contract could incentivize CPD
- Provide relevant courses for practices e.g.
- dental business skills
- leadership training
- change management
- Use of care pathways – appropriate referrals
- Special needs patients
- Careers advice
- New contract pilots – learning for the future
- 'Theme the issues'
- Ensure key/priority messages and subjects issues are included in other courses
- Effective marketing of less popular but essential subjects

- Multi-professional approaches – delivering and teaching similar heath messages to all groups

Specific work stream issues

Dental Contract Reform and Care Pathways

- Lack of information about what is proposed makes designing CPD difficult
- Need to connect and communicate with dental teams not involved with pilots
- Better understanding required about skills mix utilisation and training opportunities
- How to use care pathways – guidance about how it works and interpretation
- Effective prevention and behaviour change
- Managing patients' expectations
- Dental business and leadership training (this may be difficult)
- Change management
- Better advice about how to refer appropriately – local arrangements
- Proper careers advice
- Maintaining skill set of dentists with "DES" or Tier 2 skills

Prioritising Public Health Messages

- There is a need for culture change
- Appropriate funding of strategies is needed
- Prevention in practice e learning material should be revised
- Will there be a national educational programme for dental teams?
- There should be a link with GDC CPD requirements
- Smoking cessation brief intervention training should be incentivised

The Changing Population

- Dental practice teams don't see the direct relevance to their current work
- There are barriers to getting engagement from dental teams for CPD relating to older people, dementia, vulnerable adults
- There are opportunities to focus on oral healthcare in care homes – e.g. access and consent issues, multidisciplinary care
- New dental contract –provides an opportunity to include incentives for team CPD within working hours.
- Multi professional CPD and engagement with other health care teams - where will funding and contracts come from?

Respondent type: National Body

Dear [redacted]

As you know we were sent the four engagement documents about the pilots of the new NHS dental contract. We very much welcome the opportunity to engage in the discussions around the proposed new contract and to contribute our views to this important debate. Given that the questions in the engagement document focus largely on practitioners who have had experience of treating patients under the pilots, we have provided comments rather than answers to the questions but we hope that our observations will be of use.

Firstly, we welcome the efforts which the Department of Health is making to engage with stakeholders throughout the challenging process of developing a new contract for the delivery of NHS dentistry. We also welcome the commitment to piloting the proposed new arrangements and learning from the pilots.

Paper 1 notes that a reformed system must support dentists in offering appropriate prevention and active treatment. However, the GDC would like to see the opportunities offered by a new contract open to other members of the dental team. The Council's decision in March 2013 to allow other members of the dental team to treat patients without a prescription from a dentist presents considerable opportunities to increase the number of patients being seen, to re-structure the provision of services in ways that benefit patients and to make the best use of the skills of all members of the dental team. We would like to see the Department make use of this opportunity in the development of the new contract, for example by using dental care professionals to carry out screening. We realise that for direct access to work to the best effect there are further changes which need to happen, for example to medicines legislation, and we would encourage the Department to consider the new contract as an opportunity to make these changes.

While we do not have a view about the particular remuneration system which the new contract should adopt, we would stress that whichever system is adopted must be one which operates to the benefit of patients. Any contractual system may contain within it unintended perverse incentives but it is vital that, in moving away from a target-based system such as Units of Dental Activity, patients are not denied treatment which they need by a system which focusses on numbers registered. While we welcome the focus on prevention and improving the overall dental health of patients, those in need of significant treatment should not be disadvantaged.

In relation to the development of the care pathway, we welcome the early evidence that patients respond well to the RAG system, that it contributes to patients' understanding of the health of their teeth and gums and can facilitate behaviour change; and that the pathway is able to demonstrate improvements in patients' oral health. We also welcome the fact that the development work is taking account of the needs of particular patients.

While care pathways can provide consistency, we would not want to see the pathway become a restrictive system which limits the ability of healthcare professionals to take decisions about their patients' care, to the detriment of that care. A pathway should still allow for the exercise of professional judgement, especially in the context of an ongoing care relationship between a dental professional and a patient where the practitioner has an understanding of the patient's needs.

We note that the transition to the new system has had a significant impact on access in the pilot practices to date and welcome the fact

that this is being investigated further, as it will be important to implement any new system in the way that is least disruptive for patients and the profession. We would suggest that the OHA is another area where the Department should consider maximising the use of the skills mix in the profession, by considering whether it is necessary for all OHAs to be carried out by dentists or whether greater use can be made of dental care professionals.

On the measurement of quality and outcomes (paper 3), we welcome the inclusion of a quality element in the contract and the accompanying recognition that, while the amount of treatment delivered is important, quality care is also vital. We particularly welcome the inclusion of patient experience indicators, including whether patients felt involved in decisions about their care. The fact that pilot practices did very well on the indicator which records whether patients were able to speak and eat comfortably (which should perhaps be the bare minimum standard which they are entitled to expect) but less well on whether or not the patient would recommend the practice to others and on overall satisfaction may be indicative of the time taken to get appointments in the pilot practices or the times which initial appointments take to complete but does indicate that there is work to be done in the delivery of the new contract.

We note that dentists will be expected to respond to the quality and outcome indicators to develop better services and that there must therefore be a consensus among the profession about the main areas that should be measured. However, we would strongly suggest that it is vital that patients are also involved in that discussion.

As noted above, we do not have a particular view about which system of remuneration is adopted for the new contract. However, we note form paper 4 that, for most practices, only 2% of contract value is likely to be at risk for poor performance against the DQOF or awarded for particularly good performance. It will be important to monitor the cost to the practices of treating patients in ways that lead to the full 10% of contract value being received or the additional 2% being awarded, to ensure that the DQOF element does not become a disincentive. We welcome the fact that access for patients is one of the elements being considered for future inclusion in the DQOF.

Finally, good local complaints handling and local performance management are other factors which could help to make the new contract a success and to deliver a system which will be beneficial to patients and the dental team.

We will continue to monitor the development and piloting and look forward to further engagement.

With best wishes,

[redacted]

Respondent type: Local Professional Network

paper 2
Q1
Yes appropriate approach as need to provide a preventative focus for treatment services to improve oral health but also need wider oral

health improvement programmes and vast majority of dental budget spent on individual treatment and prevention vs community oral health improvement programmes. What about a national water fluoridation scheme or fluoride varnish scheme as in Scotland? Consideration should be given to support the engagement of dental practices in community oral health improvement programmes under the auspices of a specialist in dental public health.

Q2
NA

Q3
NA

Q4
NC

Q5
This is difficult as this is one of the dental health messages that patients have adopted. From the dental practice side it should be mandated and performance managed and clarified that if patient wishes to attend more frequently than required, this should be as a private vs NHS treatment. This is very important when you look at the number of band 1 treatments that are provided, the average recall interval between band 1 and band 1 courses of treatment and the cost to the NHS. This could also be addresses through undergraduate training on the use of the NICE guidance and the underlying evidence for the recommendations within it. Patient information clarifying recall periods and the NHS offer in this area as above.

Q6
By suggesting that this is what they are currently doing in applying the NICE recall interval guidance. Also by reminding GDC registrants of their requirements to put the patients' best interests above their own or the practices needs. By practices keeping up to date with emerging evidence.

Q7
It would not meet the needs of the population not attending on a regular basis or not attending at all. Studies have suggested that health education widens the health inequalities gap so people with the greatest need would be less likely to benefit. Fluoride vanish application in line with Delivering Better Oral Health should be mandated for all patients. Innovative contracting with hard to reach groups where there is evidence from local health equity audits showing these groups access services less in partnership with PHE.

Q8
Measure disease levels and impacts of oral conditions as current indicators are disease rather than health focused.
Q9

Need to ensure links with social care and mandate daily mouth care in care plans for individuals and that care staff are training in oral health and that assessment on entry to a care home includes oral health as in Caring for Smiles in Scotland.

Paper 3

Q1
The safety domain should be dropped as this is basic to patient care and practices should not be rewarded extra for this. Alternative more appropriate safety indictors should be included depending on how comprehensive the CQC process is.

Q2
Some indicators should measure process as well e.g. adhering to NICE recall guidance, local referral protocols and Delivering Better Oral Health eg smoking cessation advice

Q3
Not under clinical effectiveness and patient experience although appropriate tools would need to be available to measure outcomes for these groups. If process indicators were included, these may need to be tailored.

Q4
Adhering to NICE recall guidance, local referral protocols and Delivering Better Oral Health eg smoking cessation advice

Q5
The focus should be on caries and periodontal disease not the BPE and also on impacts and quality of life as currently the indicators are based on a narrow definition of health as the absence of disease. The BPE indicator should be dropped as this is not reflective of the pathology of periodontal disease. The dental caries indicator is not reflective of oral health as someone with 20 decayed teeth who subsequently has these extracted rather than filled would seem to have a dramatic improvement on oral health when they may not have had any symptoms with the decay but following extraction may not now be able to eat, speak or socialise

Q6
Impacts of oral disease on quality of life.

Q7
PE01 should include socialise and should be part of the clinical effectiveness indicator
PE02 should be removed as a patient is not able to judge the effectiveness of infection prevention control procedures in place in a dental practice
PE03 change to rate way treated by practice staff
PE06 should be reworded as overall satisfaction with NHS dental care

PE07 is useless unless the waiting time is captured too. There would need to be a standard set if this indicator was adopted.

Q8
Did receive treatment wanted
confidence/trust in dentist
amount of time dentist spent with patient

Q9
There are quality processes for quality assuring dental practices and there have been good examples nationally which are no longer in place. A comprehensive quality assurance programme should be in place to supplement the CQC process and should include:
Comprehensive dental practice visits by AT
Audit and peer review to AT
CPD approved/reviewed by AT
Service specifications
Occupational health clearance

Q10
see above

Q11
The measures should be no different. Practices should not be able to discriminate against high needs patients if the appropriate contracting mechanisms are in place.

Paper 4
Q1
As it stands, 10%. This could be increased if it is improved.

Q2
Full activity
This would not be feasible now that the dental budget is capped. This may result in inappropriate and over treatment. Full payment for preventive interventions could be considered with capitation payments for other treatments.

Capitation
This may not encourage preventive interventions but should reduce over treatment. Performance management would be needed to ensure contracts were delivering appropriate levels of service. Could learning from management of GP contracts be applied to a similar performance management system for dental services?

Blend of capitation and activity
Full payment for preventive interventions could be considered with capitation payments for other care.

Q3
All activity other than preventative interventions

Q4
Performance management of red patients to green, enhanced capitation payment for people with high needs until become green. This would need performance managing too for example by retrospective audits that could be verified by ATs.

Respondent type: Unknown

[redacted]

13/07/2014

Dear Minister,

I am writing to on two points that I would ask you to consider and may well fit within the open consultation ‘improving dentistry’.

Firstly, Dental hygienists/therapists and their role within dentistry. I would ask to look closely at their role to ensure they are being utilised to their maximum ability.

I have a daughter who recently qualified in the above role so write with a personal view on the matter.

Much is written regarding oral health and prevention particularly in children but I feel much more could be achieved if hygienists/therapists were given greater freedom i.e. direct access for treatment. I also feel that the above professionals are held back by the dentistry profession who are protective of their business interests.

Secondly, this may fall outside of the remit of the review but the ongoing supply of professionals into the jobs market. My daughter and a number of her colleagues struggle to get full time employment. Yet the universities continue to produce the same number of graduates’ year on year. In my daughters case the course is relatively short just 27 months; which is effectively flooding the market place and costing the NHS a great deal of money.

I appreciate I write from a personal perspective and you and your staff see the larger view but request you consider my views.

You can contact me at [redacted]. Thank you for your help with this matter, I look forward to your response.

Yours sincerely,

[redacted]

Respondent type: Local Professional Network

Dental Contract Reformation Notes

The following notes were collected during a Meeting of the [redacted] Local Dental Network on 16 July 2014.

1. What are your views on the philosophy of a need and risk – based, preventative approach to care?

Salaried services reported that they already operate a service with emphasis on prevention. The new pilot has helped reinforce these messages to our patients which they like and agree with. The social history element also provides a means to discuss diet and tooth brushing and to find out more about their patients. They have had issues when dentists feel uncomfortable to override the care path way to suit their patients and have had meetings to discuss this. It was to be noted that the current system is not a decision making IT system but a decision supporting system (and this should not take away clinical independence).

There have been on-going IT issues as the service is still awaiting version 3. The current system is very time consuming especially when the Medical and Social History can't be fully ascertained and therefore a Pathway is not generated. Many of the patients are RED (the current system operates a RAG rating Red, Amber, Green), and it is difficult to treat special care patients following the pathways in the pilot. Salaried services also report concerns over on going monitoring.

Significant challenges were also identified with patients attending for urgent care, this required lots of paperwork to start the pathway, and however other group members advised that changes had been made to V3. Special care patients (for example patients with Autism) also needed longer appointments and again the paperwork took up lots of time.

The two additional practices felt that the philosophy works well. Oral health educators are available in larger practices, skill mix is bigger in larger practices (so they tend to benefit more), smaller practices found the pilot to be a learning curve, more time needed to be spent on patient care, but that there are also concerns from patients that waiting times are now longer to see their GDP.

Access had become a big issue due to preventative care, patient charge revenue was dropping and patients were leaving as some felt that they were unable to secure appointments. Worries around changing the pathway approach on the system, GDPs were working more hours, (but not being remunerated) and some patients were also disengaging. However there are further challenges around space and staffing costs there is a need for change, but some people are against this.

2. Do you think the areas of clinical effectiveness, patient experience and safety are the right ones for the DQOF?

Salaries Service felt that is was too early to gauge. Patient Experience was already monitored, but it was felt that being monitored on oral health - DQOF for patients with special needs cannot be measured in the same way as general practice

Monitoring not an issue, but you need to take into account the types of patients (and why they are in RED) . Special care patients present unique challenges and can't always fully engage in the pathway or prevention. There will be difficulties in demonstrating improvement by moving from RED to Green.

In addition to this, other GDPs felt that the scoring was correct and the areas were correct, there was difficulty with the validity of the data (securing accurate data), this needs to be carried out against matched patient's exams; however there were a lot fewer patients to match against as the way the current pilot is run. Currently patients are asked to return in two years well this is currently not possible as the pilot ends March 31.

The current metrics should not prevent vulnerable/hard to reach groups from getting access. There should be flex around shared care, homeless and transient populations have complex oral health issues.

In addition to the comments above the following were also suggested:

The principles for measurement must be:

Appropriate metrics that offer and demonstrate fairness of measurement and value in terms of evidencing benefits in a balanced way across the processes, pathway and show outcomes

Not huge in number but a reasonable set of easily collectable metrics so that it does not create a cottage industry of data collection and performance reporting

Agreed with the clinicians, contract holders, commissioners and wider stakeholders so that the whole dental system understands the validity of the metrics and 'buy in' to them as they can see the benefits of their application

Not such that they create new or re-enforce perverse incentives that disadvantage patients, dental teams or contract holders

3. What percentage of contract value do you think should be used from DQOF?

The principles for remuneration must:

Incentivise practices/clinicians to maximise application of the oral health pathway and optimise the quality of care and health outcomes that will result.

Not dis-incentivise practices/clinicians from ‘seeing and treating’ irregular practice attenders, those patients who choose not to follow the oral health pathway or urgent ‘in hours’ care provision for unsolicited patients who are not regarded as ‘expected practice patients’

It is important any reformed contract allows for flexibility in funding for shared care arrangements between specialists and primary care services to enable delivery of care for people with special needs close to their homes. Some care is possible to do from a consultant’s prescription but is not cost effective under a primary care contract. This could prevent some patients having to travel to a secondary care unit at expense to them, in order to have simple care provided by specialist which does not make sense for either patients, practitioners or the tax payer.

Be fair to all contractors so that the payment system does not result in pro-active practices/practitioners being disadvantaged financially or otherwise by trying to adopt best clinical practice

Remove existing and not introduce new ‘perverse incentives’ that results in financial drivers being considered ahead of patient experience/outcome

It was also felt that flexibility is a must, groups will be disadvantaged otherwise, “dental re-cluses” will be formed.

Effective monitoring could be achieved by re-introducing Dental Reference Officers; this would give assurance regarding appropriate levels and quality of treatment in any new contract system.

Under a ‘ blended contract’ it was felt that all routine restorative care and prevention should be included in the capitation element and activity should only be monitored on advanced restorative care such as molar endodontics, and items of treatment that involve laboratory work.

Organisations that responded to the Engagement Exercise

Federation of London Local Dental Committees
British Endodontic Society
Faculty of Dental Surgery, Royal College of Surgeons of England
British Dental Association (BDA)
Oasis Dental Care
Guy's & St Thomas' NHS Foundation Trust - Dental Directorate Management Team
British Dental Industry Association
NHS England, Cheshire, Warrington & Wirral Areas - Dental Local Professional Network
NHS Business Services Authority
Denplan Ltd
The Royal College of Surgeons of Edinburgh, Dental Faculty
NHS Fife
NHS Protect
BNSSSG Dental LPN
mydentist
HEI
Committee of Postgraduate Dental Deans & Directors (UK) (COPDEND)
Northumberland Tyne and Wear Local Dental Network
Dental LPN in South Yorkshire and Bassetlaw
Cumbria Local Dental Network
Coventry LDC
General Dental Council
Faculty of General Dental Practice at the Royal College of Surgeons
Tees LDC
North Yorkshire and the Humber LDN
Wirral Local Dental Committee

There were responses from 26 named organisations (as above), 33 responses from unnamed organisations and a 124 responses from individuals.

Appendix 2

Glossary

BDA	British Dental Association
BL	Bleeding
BPE	Basic Periodontal Examination
NHS BSA	Business Services Authority
CDS	Community Dental Service
CQC	Care Quality Commission
DBOH	Delivering Better Oral Health
DCP	Dental Care Professional
DH	Department of Health
DMFT	Decayed, Missing, Filled Teeth
DQOF	Dental Quality and Outcomes Framework
DRO	Dental Reference Officer
DRS	Dental Reference Service
EDDN	Extended Duty Dental Nurse
FD	Foundation Dentist
GDC	General Dental Council
IC	Interim Care
LDC	Local Dental Committee
LPN	Local Professional Network
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
PHE	Public Health England
PI	Plaque Index
RAG	Red Amber Green
UDA	Unit of Dental Activity