Dental contract reform: the prototypes

In a nutshell
The ‘new’ 2006 primary dental care contract is not fit for purpose. It has been roundly criticised by two governments, a Health Select Committee, the Chief Dental Officer, dentists and the British Dental Association (BDA).

The Steele Report emphasised the profession’s goal should be to move away from dental activity towards oral health and stressed the need for health outcomes.

Elements of a reformed contract were piloted in 2011. The findings of these pilots were published in 2014. The pilots were based on registration, capitation and quality with care being provided using a preventive care pathway. The pathway approach was popular with patients and dentists but resulted initially in a decrease in access.

Prototypes
The Department of Health (DH) invited dentists to take part in “prototypes” in 2015. The key difference between pilots and prototypes was the addition of “activity” as a target. The DH has proposed two types of prototype and moved away from the previous pilots which tested registration and capitation with 10% of contract value on quality. The prototypes blends are as follows:

**Blend A**
- Capitation
- Activity
- Quality

**Blend B**
- Capitation
- Activity
- Quality

When?
The closing date for application has passed. Regulations have been amended and prototypes will start from autumn 2015. Realistically the earliest roll out of contract reform is April 2018.

“Quality”
The measures of quality have also been changed. They are still 10% of contract value but now include

- Clinical outcomes (decayed teeth, BPE, bleeding points)
- Prevention (fluoride application and complying with ‘Delivering Better Oral Health’ DBOH)
- NICE recall guidelines (calculated from the risk status algorithm in the software)
- Patient safety (medical history)
- Patient experience
- Data quality and timeliness

Capitation
For current pilots, patients will count towards a practices registered list if they have received an oral health assessment or review in the previous three years or have not entered another practice’s capitated list.

“Activity” - UDAs
The activity component will be counted as UDAs. There is no UDA allocation for “urgent” courses of treatment other than to patients from other practices.
What has been learnt from the Pilots?
In February 2014, the DH published its second evidence and learning report which includes the following findings:

- Dentists and patients enjoy the new way of working with its emphasis on prevention and more time spent with the patient.
- There has been a net reduction in risk of disease of 2 - 4 per cent. This is promising in such a short time scale (to measure improvement of disease levels).
- Practices that have delegated treatments effectively via ‘skill mix’ have experienced the smallest changes to their list size. Use of dental nurses with enhanced skills in prevention and other DCPs has been popular.

What is the BDA's view?
We believe UDAs are bad for patients and bad for dentists. We continue to push for progress towards contract reform and discussions with the DH, led by the General Dental Practice Committee (GDPC), continue in earnest. Our focus is to ensure fair and equitable arrangements for dentists based around capitation. A higher proportion of capitation would minimise perverse incentives and reward dentists for improvement in oral health. In a society where disease levels are falling radically, capitation has major advantages over ‘fee per item’ or UDA systems.

Capitation
Capitation for the prototypes will not be based on national values but will be based on a percentage of the contract value depending on the blend. Government does intend to move to a system based on national values in the future.

Flexing
In the prototypes, if a practice does not meet their expected level of activity they may, with commissioner approval, over deliver on their patient numbers. Only in exceptional circumstances and with commissioner approval can a practice over deliver on activity if they are under-delivering on expected patient numbers.

What does it mean for me?
- There will be no “big bang” as happened in 2006 however the exact method of rolling the reformed contract out is unknown.
- The most successful “Blend” will form the basis of the reformed contract.
- Likely measures of success are access and patient charge revenue.
- The BDA will be developing guidance on how to adjust to new ways of working.

Practice owners
The prototypes require an up-to-date clinical I.T. system in practice. IT costs include hardware, software, contract support and broadband. The new prototypes allow for a risk (or loss) of up to 20%. Thus the risk is greater than with the pilots.

Associates
We have two model associate agreements for pilot sites and are developing new agreements for the prototypes. Associate feedback is to retain self-employed status and we have tried to retain this.

Prototype practices are advised to contact the BDA to discuss relevant issues.
Please contact Nicola Hawkey at nicola.hawkey@bda.org

You can find out more about the our views on reform at www.bda.org/prototypes