
CONTRAC
REFORM

# Paint drying or contract reform: which comes first?

By Martin Woodrow,
Director of Member Services, BDA

Since 2015, the Department of Health has been prototype testing two remuneration models for a reformed NHS dental contract in England. The prototype process is expected to continue now until March 2020 probably with a small number of practices joining the programme in 2018/19. This article describes where we are in the process, the issues we have with the prototypes and some changes we would like to be made.

## Government objectives

The Department of Health's stated aim for contract reform is 'to improve access, quality and appropriateness of care and improve oral health, within the current cost envelope, in a way that is financially sustainable for dentists'. The BDA's objectives are to develop a more appropriate payment system (including the removal of Units of Dental Activity (UDAs)), improve oral health and improve dentists' working lives.

## Prototypes – current issues

There are now just under 80 prototype practices that have been testing two remuneration models:

- Blend A pays for Band 1 level care via capitation payments and more complex Bands 2 and 3 treatment via UDAs
- Blend B pays for Bands 1 and 2 under capitation and Band 3 via UDAs.

Both use the preventive clinical care pathway that has been tested since 2011.

The Department's interim evaluation report showed that practices that were not former pilots have been doing generally better than former pilots (who had to catch up on patient numbers lost during the piloting process).

The evaluation reinforces the fact that any rollout will be undertaken by practices new to the process so these non-pilot 'wave 3' practices arguably give a better feel for what a rollout would look like.

We want to see contract reform succeed but have the following issues with the prototypes:

- Patient numbers can be very difficult to maintain
- UDA targets can be difficult to meet at the same time as maintaining patient numbers
- Retaining associates can be difficult
- To maintain patient numbers, new patients often have to be taken on who can require a lot of treatment
- There may be a shortage of available new patients in some areas
- Having to extend working hours or recruit new staff increases practice costs.

## The present context

The BDA has evidence of widespread shortages of associates prepared to work in NHS general

dental practice, stressed and over-burdened NHS practitioners and a service that is in crisis. The BDA remains supportive of contract reform as the current system is not fit for purpose. But that change cannot be at any cost, and change must not make the situation worse. The Department of Health and NHS England must be more flexible and creative to ensure that a reformed contract helps to solve current difficulties and doesn't make things worse.

### *Access*

It would be beneficial if the Department could rethink what they mean by access to care. In September there was a Parliamentary Adjournment Debate on access to NHS dentistry and Opposition MPs had been extensively briefed by the BDA. During the debate, the Minister with responsibility for dentistry, Steve Brine, said: 'The prototypes are being evaluated against a number of success criteria, but let me be clear that they will have to prove that they can increase dental access before we consider rolling them out as a new dental contract.'

Evidence suggests that it will be difficult to increase dental access using the current prototype model and current definition of access, unless practices themselves pay for increases in staff time and facilities. Such an approach will not be sustainable for dentists. There are two main ways of addressing NHS access:

- → Increase Government investment in NHS dentistry
- → Develop an alternative measure for access for use in the prototypes.

We would welcome a more imaginative approach to access. For example, the number of patients registered for and receiving NHS care seems an accepted approach to access. Lifelong NHS registration seems to be working in Scotland. Using an approach along these lines would mean that patients wouldn't fall off a practice's capitation list unless they died or attended another practice. A system like this would give practices more time to serve the needs of their population without losing financially.

### *Remuneration*

The BDA position is that capitation payments should be weighted to reflect treatment need. We believe that the remuneration system needs to recognise the amount of time spent delivering care for particular patients. A Dental Reference Officer system should be reinstated to demonstrate that appropriate care is being provided. This could be paid for out of the money previously used for seniority payments.

We believe that Blend B prototypes seem to be working better than Blend A, so current Blend A prototypes should have the option to change to Blend B if they wish. We would like to see more practices taken on as Blend B prototypes in 2018/19 to enable further testing in a wider variety of practices.

> 'Evidence suggests that it will be difficult to increase dental access using the current prototype model and current definition of access.'

### Long overdue

Although wider roll-out seems far away the Department and NHS England need to start negotiating with the BDA soon. The profession can't wait around forever for change to come – it's already long overdue.

Although Len D'Cruz, Practice owner of Woodford Dental Care, a six surgery practice in North east London, has managed to maintain a solid patient base throughout the pilots and the prototypes, he believes both are fraught with problems.

'We have actively zoned our appointment books from the outset. We calculated how many oral health assessments we needed to do per dentist per day and put this into the book. For us it was 7-8 OHAs per dentists per day. We then built out the appointment book to accommodate urgent treatment slots and treatment time. We since have altered the zones now to prioritise Band 3 treatments since as a Blend B prototype we get measured on our Band 3 activity. This has the effect of reducing Band 2 time and therefore increases the waiting time for patients to have just B2 treatments. This is not really fair for patients, causes some grumbling at reception but is a pragmatic solution to how we are measured

'Running two treadmills of UDAs and capitation numbers is very time consuming exercise particularly since we have 7 dentists. This is more challenging since the system allows for taking on more patients and offsetting this using an exchange calculation to reduce the number of annual UDAs you have to achieve. This means constant monitoring to make in-month adjustments throughout the financial year. In our case we achieved 107% of our capitation target and consequently only had to meet about 85% of the UDAs we were contracted to do at the start of the year.

'We over performed last financial year and we did not get paid so we will be ensuring we don't do that again! This has meant however that as of December, we have run out of Band 3 UDAs till April 2018. This adds to the general chaos of the system and patient's treatment having to be delayed. This creates a feeling of mistrust amongst our patients who think either we lack the organisational skill to run the practice or we are trying to push them into having private treatment. Neither is true.'

Az Hyder Clinical Director, Burgess Hyder Dental Group, believes there is no end in sight to the issues relating to the prototypes.

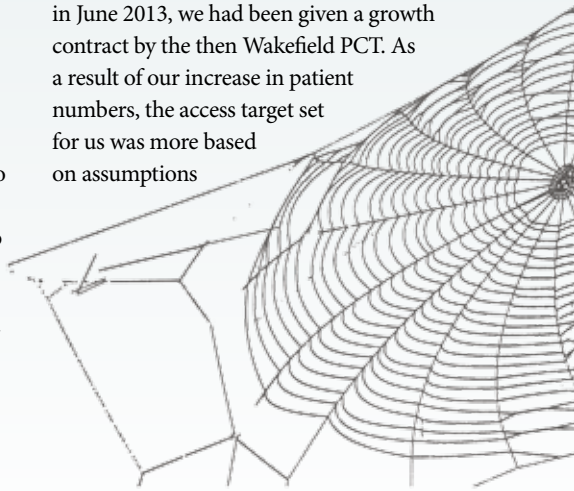
'There is a huge issue relating to the fine balancing act of capturing new patients and activity based measures to treat these patients', Az said. 'The current system does not reward a practitioner for working in a high needs area. The patients in these areas do not regularly attend and do not lend themselves to capitation, but at the same time are costly to treat due to multiple restorations.'

Joe Hendron, Principal at St Michaels Dental Practice, also has a number of issues with contract reform as it stands.

'Practices who have had a stable patient base and a low turnover of Performers will have an access target which is more easily achieved. A practice which is more volatile where patients often attend for urgent and single courses of treatment and do not return for regular recalls and/or where there is a high turnover of Associates will find maintaining access targets more challenging.

'The access target is set unilaterally by the contract reform team, apparently using historical records provided by NHS Business Service Authority and it can be very difficult for a practice to understand the justification of the numbers set. When we moved from pilot to prototype in 2015, there was a reconfiguration of the access targets and every practice I have spoken to have had their targets increased further as a result.

'In our case, prior to embarking on the Pilot in June 2013, we had been given a growth contract by the then Wakefield PCT. As a result of our increase in patient numbers, the access target set for us was more based on assumptions



than fact and we frankly did not know any better at the time. We assumed a certain trust that the contract reform team and NHS BSA knew what they were doing and the figures must have been appropriate. However, when we set about the access targets we found that they were impossible to achieve with the current workforce.

'However, as some patients signed up for continuing care and returned for regular recalls, others only wanted urgent or single short course of treatment often ending with FTAs. When it came to the pilot, patients are registered on the dental list for three years and if they had not been seen again in that time, drop off that list. We started to suffer as the new irregular patients were dropping off, we had to replace them with often, more irregular new patients and the idea of trying to achieve the plateau level whereby we could tread water was becoming less attainable.'

## The same old brand new

One underlying issue everyone has with the contract is the promise of a new dawn tainted by the paint of the past.

Units of dental activity have underpinned the demise of the ill-fated contract that will soon be 12 years old. So why do they appear in the proposed contract reform?

Len said: 'The return of the UDAs has been the most depressing and disappointing aspect of the whole process. Whilst I accept in principle that activity needs to be measured, the UDA is not the way to do it. It bears no relation to the complexity of the treatment provided, the individual needs of the patient or the time taken to provide the care as well as preventive advice that is needed to ensure that the intervention provided is looked after. The unit value of the UDA varies so much across the country that after 11 years they have no relationship with the demographics of a practice population.

> 'Frankly I am puzzled that we are still seeing UDAs as part of the prototypes. Az said. 'It seems that the Department of Health are refusing to remove UDAs as a currency.'

'A pure capitation scheme is something we worked with in our practice in the pilots and I believe we delivered good care, in a timely manner with all the prevention it needed to put patients' on the right path to looking after themselves. Capitation leaves the dentist with the decisions on how care for their patients should be achieved without the artificial targets of UDAs hanging over their heads. Patients are not a means to an end to achieve UDA targets. They are human beings with oral health issues that need to be cared for with an entitlement to have those needs ethically managed in their best interests.'

'Frankly I am puzzled that we are still seeing UDAs as part of the prototypes', Az said. 'It seems that the Department of Health are refusing to remove UDAs as a currency. As long as this continues any type of commissioning will be flawed and inequalities will not be addressed because dentists will not want to work in high needs area.'

Joe agrees that their appearance in any conversation surrounding contract reform is puzzling.

'Everyone is asking it but no-one can answer it', he said. 'When the Department of Health decided to re-introduce activity, they did not have the imagination to call it by any other name.

'The initial aim of the reforms was to produce a dental contract with prevention at its core. How can you care for people giving the prevention message alongside the current thinking of minimal intervention when you have an activity target hanging over your head? The concept is a complete contradiction. Of course, treatment intervention is necessary but the CRT seem to think that this is the only way of measuring activity. They refuse to recognise that the time and effort taken to provide the message of prevention is in itself activity.

'Simply put, the CRT and NHS England do not trust dentists. If they cannot see widgets for fillings, extractions and dentures, they think we are sitting looking out the window drinking coffee like in the advert a few years ago or God forbid, on the golf course.

'DH and NHS England will remain in the dark ages of drill and fill dentistry and are unwilling and refuse to take the leap of faith required to produce a dental contract which is of its time, which will improve our patients' oral health and which is fulfilling for the clinicians who deliver that care.'

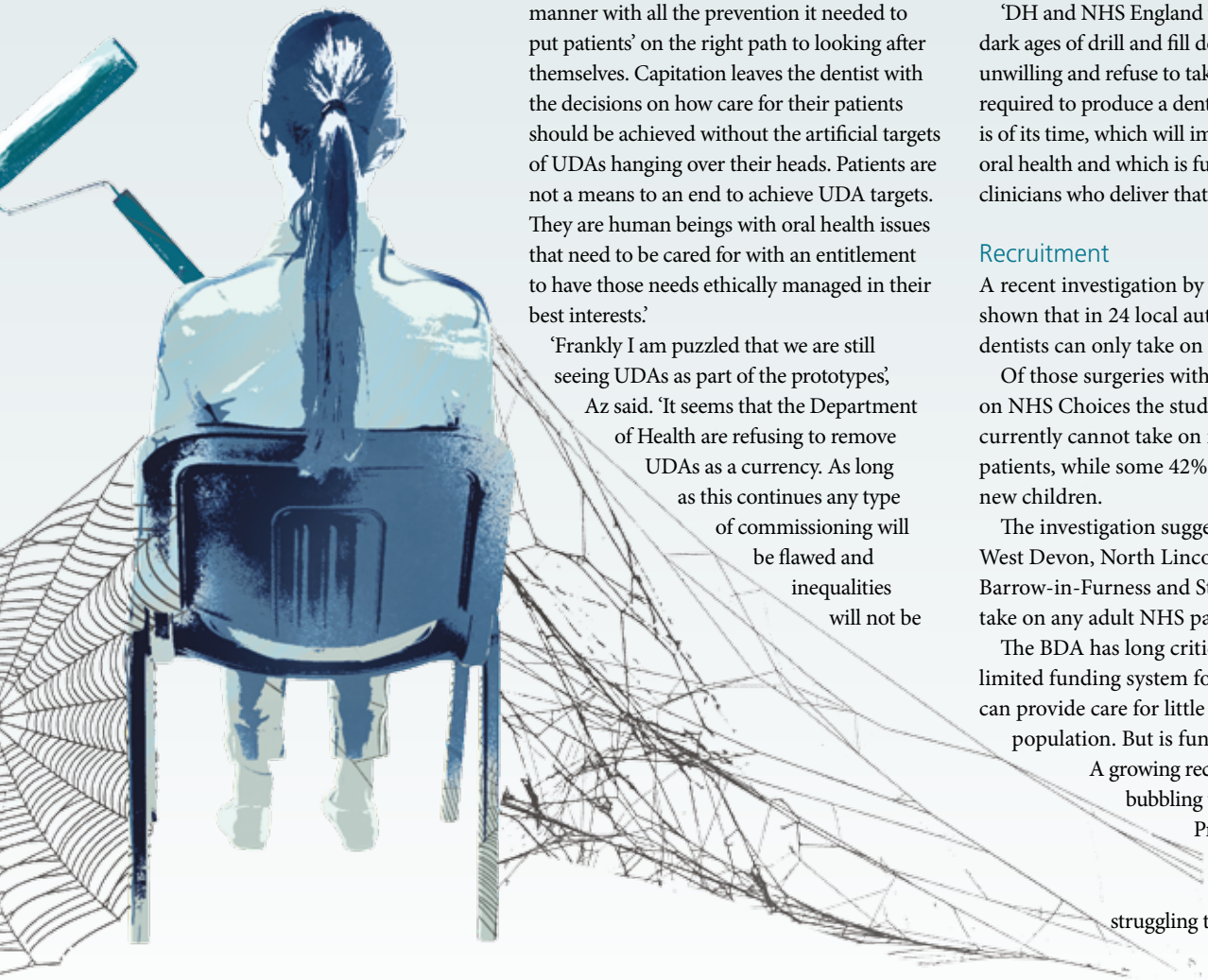
## Recruitment

A recent investigation by *The Times*[1] has shown that in 24 local authorities in England dentists can only take on private patients.

Of those surgeries with information on NHS Choices the study found 49% currently cannot take on new adult NHS patients, while some 42% are unable to see new children.

The investigation suggests areas including West Devon, North Lincolnshire, Gosport, Barrow-in-Furness and Stafford are unable to take on any adult NHS patients at all.

The BDA has long criticised the cost-limited funding system for dentistry that can provide care for little over half the population. But is funding the only issue? A growing recruitment crisis is bubbling under the surface. Practices across the country – including corporates – are struggling to recruit dentists.



However the CDO for England, Dr Sara Hurley, has long insisted the future of the workforce lies with dental care professionals. So the question is, how does the prototype reflect their skillset?

'There is no doubt that DCPs have a vital role to play in the future delivery of dental care', Joe said. 'They can provide the time and the skills in specific areas of periodontal health and children's dentistry amongst other disciplines allowing general dental practitioners to spend time on the advanced needs of our patients.

'But there are things that have to change first and it must be a gradual process – what may be good in Rugby or Leatherhead may not be appropriate for Wakefield or Keighley. Not every practice has the physical space to accommodate DCPs or the resources to support them either and it is a fine balance knowing how many dentists or DCPs you need and when you need them.

> 'The numbers and statistics suggest progress, but the reality of the situation is very different. Those running and making the change aren't moving at all.'

'The patient has to accept the change and this cannot be forced on them. Patients are still used to attending their dentist for all their treatment needs and they have built up a level of trust over the years. They don't necessarily want to be farmed out to what they might consider, a less experienced clinician, with whom they have to build up that rapport again.

'The regulations must change to allow DCPs to open a course of treatment on the NHS.'

While Joe thinks it's about a fine balance, Az believes a change would be beneficial.

'A move to utilising dental care professionals is a huge move forwards. Currently, no treatment credit can be allocated to a therapist without prior endorsement by a dentist. Is that the most efficient service for patients?

'Therapists and their services do not lend themselves to commissioning under the NHS. True oral health and disease prevention pathways, together with ICM courses, get no credit under the present system. I am very keen for this to happen.'

According to Len, cost prohibits their value being fully utilised.

'Yes, dental care professionals are valuable members of the team, but their support is limited in a reformed contract even if their scope of practice with the GDC is extended. This is primarily because of cost.

'Therapists cost more than hygienists but only slightly less than associate dentists on an hourly basis. They have a narrower scope of practice than associates, cannot perform examinations on the NHS and are often not as quick and efficient as dentists.

'On the other hand, dental nurses do have a significant part to play in contract reform as they are well placed to provide and deliver prevention in accordance with Delivering Better Oral Health to a wide range of the practice population. Encouraging dental nurses to pursue further training such as Prevention in Practice and other certificated post-qualification courses is certainly the way forward to developing the wider team. Hygienists are an essential part of the prevention agenda but again on the basis of cost, certainly in the south of England, their services are often only provided to patients under private contract. This is because the hourly rate demanded by hygienists makes offering their services on the NHS uneconomical.'

## An honest mistake

It's not inconceivable that the use of dental care professionals will continue to evolve over time. The current system may allow for that. What it also allows for is 50 shades of grey.

For example, ethical considerations around the desire to take on high-needs patients versus the cost to do so is a dilemma opened up by contract reform. As it stands, the system does not provide what Az described as 'an honest day's pay for an honest day's work' with its continued insistence on UDAs.

So will patient numbers create ethical and moral dilemmas for practitioners moving forwards?

Joe said: 'I feel that the number of patients we have to see is too high and this is why we struggle with the access targets, providing timely treatment and struggling to get any prevention message out.

The Oral Health Assessment has been the victim of its own success. For years prior to pilot we were putting appropriate patients on 12-month recall as recommended. These were patients who had excellent oral health or who simply were not engaging and anything more regular was a waste of resources.

The Assessment resulted in setting recall periods of 3, 6, 9, 12 or 24 month recalls for ICM or Oral Health Review. Long-term patients with periodontal problems and who smoked started to engage with the process who were otherwise on 12-month recall. They did not like the idea of being classed in the 'red category', undertook their intensive periodontal treatment and are now being maintained every 3 months.

'Children previously on 6-month recall with caries risk are to be seen every 3 months for fluoride varnish and very soon our books became clogged. Currently, routine treatment for a restoration will usually be seen in 4 months – a simple DO may well then require endodontic treatment – how is this reform?

'Therefore, to free up the books, prevention messages are abrupt if at all. Three month ICMs are now 6 months; 6 month recall are now 12 months. I no longer have the space for our nurses to provide fluoride varnish applications. It's just not working.'

According to Len, the most significant issue facing practitioners operating in a system weighted heavily towards capitation is the lack of financial incentive to provide extensive or expensive treatment.

'For those within the prototypes this is a well-recognised issue, and whilst it would be easy to say dentists should not succumb to the perverse incentives of such a system, it is human nature.

'One can only imagine how HR departments the world over, in every sector of business and industry, think of more and more innovative ways to increase production in their workforce. The other problem that is created by the dependence of your NHS income on patient numbers is that it creates direct competition with other local practices for those patients. This would make sense if the money followed the patients so that the more popular a practice the more patients they get and the more contract value they attract. It is the natural way of high street competition. It appears however this is not the commissioning model NHS England are planning on following.'

Perhaps the situation surrounding contract reform can be likened to running a marathon on a treadmill. The numbers and statistics suggest progress, but the reality of the situation is very different. Those running and making the change aren't moving at all. Time is ticking to deliver effective change. Practitioners are tired of waiting for change, and with no end in sight, for many time will expire. ◆

## References

1. The Times. News article: Millions denied an NHS dentist. 30 November 2017. Available online at: www.thetimes.co.uk/article/millions-denied-an-nhs-dentist-xfhbgzlz0 (Accessed December 2017).