NHS Dental Services -
Dental Contract Reform (DCR)
handbook
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Foreword

NHS England is currently ensuring that the longer term commissioning of dental services fits with NHS England’s Five Year Forward View. The forward view is not about structures and institutions but describes a broad consensus on why the NHS needs to change and sets the direction for the future. It builds on the principles of prevention, achieving better value and outcomes, meeting need and delivering patient centred care within a supportive system.

It is now widely recognised that the NHS needs transformational change to services, in order to deliver better outcomes for patients, promote health and ensure that we commission effectively.

NHS Business Services Authority (NHSBSA) published in early 2017 a document entitled ‘Managing dental services – a guide for commissioners, practices and dentists in England’, which provides commissioners with general contract management advice, including clinical and financial aspects and, advice about management of practices for both commissioners and contract holders.

This additional handbook has been developed specifically for the prototype practices that form part of the dental contract reform (DCR) programme and is intended to be of interest to both commissioners and contract holders. There will be elements included in both documents that are generic. However this handbook has been written to take account of the differences that have been introduced with the system of reform and so it is important to reference this guide in respect of prototype practices.
Introduction

The DCR programme is testing new contract models that focus on disease prevention; supporting patients on a care pathway to secure improved oral health whilst ensuring that access to dental health services for the population served is maintained or improved. The contract models are also testing alternative methods to remunerate dental practices, in line with the clinical philosophy of new ways of working.

To support commissioners and practices in understanding the contract management for prototyping, this online resource entitled ‘Managing prototype dental services – guide for commissioners, practices and dentists in England’ has been developed.

This handbook has been split into three sections:

- Contract management including performance and remuneration
- Prototype clinical guidance
- Managing a prototype practice

Maintaining and increasing access to NHS dentistry is a key objective for NHS England. Access to dental services is a priority enshrined in the NHS Constitution. The DCR programme aims to help deliver appropriate dental care to populations. Effective contract management is a key lever for change. Well managed contracts by both commissioners and contractors deliver value for money and the potential to treat the greatest number of people. Poorly managed contracts may result in money that could have been spent providing more effective treatment or treating more patients being wasted.

A contract management guide has already been published which covers general dental practices operating under the 2006 contract reform where over 90% of funding of NHS dentistry is committed in existing contracts. This guide focuses on contract management for prototype practices. It covers what commissioners need to do, highlighting where the central team needs to be involved so that the impact of any contractual changes can be monitored for learning and evaluation purposes.

Contract management must be focused on quality as well as productivity.

Cooperation between dental and finance teams is essential to monitor spending against dental budgets; to manage under-delivery, appropriate treatment patterns and recall and treatment intervals.

This handbook helps commissioners and contract managers to assess current processes, identify where change is required and take clear, practical steps to address the changes that are necessary.

The handbook is designed to help commissioners engage with prototype practices about effective delivery of NHS dental services. It aims to support a consistent approach across England.
This handbook supports contractors in understanding the care pathway and associated processes linked to providing dental care to patients in the prototype programme. The practice management section will help them to understand the issues in relation to managing a prototype practice.

**Resources**

The table below refers to a number of resources which you may find helpful in undertaking effective prototype contract management.

<table>
<thead>
<tr>
<th>Internal expertise:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental contract reform programme team mailbox <a href="mailto:dentalcontractreform@pcc.nhs.uk">dentalcontractreform@pcc.nhs.uk</a></td>
</tr>
<tr>
<td>NHS England central primary care operations team mailbox <a href="mailto:england.primarycareop@nhs.net">england.primarycareop@nhs.net</a></td>
</tr>
<tr>
<td>NHS England local office’s commissioning and contracting team</td>
</tr>
<tr>
<td>Clinical advice via clinical adviser or other appropriate clinical support identified through the medical directorate</td>
</tr>
<tr>
<td>Finance team</td>
</tr>
<tr>
<td>Internal audit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External support:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Business Services Authority (NHSBSA) <a href="https://www.nhsbsa.nhs.uk/nhs-dental-services">https://www.nhsbsa.nhs.uk/nhs-dental-services</a></td>
</tr>
<tr>
<td>NHSBSA dental services – clinical services (contacted via NHSBSA helpdesk or clinical adviser contact) <a href="https://www.nhsbsa.nhs.uk/clinical-services">https://www.nhsbsa.nhs.uk/clinical-services</a></td>
</tr>
<tr>
<td>NHSBSA dental services Compass system reports and guidance: <a href="https://www.nhsbsa.nhs.uk/compass">https://www.nhsbsa.nhs.uk/compass</a></td>
</tr>
<tr>
<td>PCC advisers: <a href="http://www.pcc-cic.org.uk">www.pcc-cic.org.uk</a></td>
</tr>
<tr>
<td>External audit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulatory, statutory and policy documents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICE clinical guidance on recalls <a href="http://www.nice.org.uk/guidance/cg19">www.nice.org.uk/guidance/cg19</a></td>
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</tbody>
</table>
- The National Health Service (Dental Services) (Prototype Agreements) Directions [www.legislation.gov.uk/id/uksi/2016/298](www.legislation.gov.uk/id/uksi/2016/298)
- Prototype exit guidelines [www.pcc-cic.org.uk/article/contract-management](www.pcc-cic.org.uk/article/contract-management)

Information available on contract data:

- Compass reports [https://www.nhsbsa.nhs.uk/compass](https://www.nhsbsa.nhs.uk/compass)
- GDS and PDS Dental assurance framework tier 1 and 2 reports [www.nhsbsa.nhs.uk/5335.aspx](www.nhsbsa.nhs.uk/5335.aspx)

Templates

- Prototype contract variation documentation: [www.pcc-](www.pcc-)


Medical and social history forms [www.pcc-cic.org.uk/article/making-it-work-clinically](http://www.pcc-cic.org.uk/article/making-it-work-clinically)


PDRP Form [www.pcc-cic.org.uk/sites/default/files/articles/attachments/pr_prototype_20160401_v3.pdf](http://www.pcc-cic.org.uk/sites/default/files/articles/attachments/pr_prototype_20160401_v3.pdf)

Fair processing notice [www.pcc-cic.org.uk/sites/default/files/articles/attachments/151208_dental_prototypes_fair_processing_notice_final_v1_0.pdf](http://www.pcc-cic.org.uk/sites/default/files/articles/attachments/151208_dental_prototypes_fair_processing_notice_final_v1_0.pdf)

Bulk transfer guidance [www.pcc-cic.org.uk/sites/default/files/articles/attachments/dcrp_bulk_patient_transfer_between_performers_user_guide_final_v1_0.pdf](http://www.pcc-cic.org.uk/sites/default/files/articles/attachments/dcrp_bulk_patient_transfer_between_performers_user_guide_final_v1_0.pdf)


Patient eligibility to exemption or remission from charges [www.nhs.uk/chq/Pages/1786.aspx?CategoryID=74](http://www.nhs.uk/chq/Pages/1786.aspx?CategoryID=74)

GDC standards [www.gdc-uk.org/Newsandpublications/Publications/Publications/Standards%20for%20the%20Dental%20Team.pdf](http://www.gdc-uk.org/Newsandpublications/Publications/Publications/Standards%20for%20the%20Dental%20Team.pdf)

Patient information leaflet order [www.nhsforms.co.uk](http://www.nhsforms.co.uk)

Xerox enquiries email [nhs.print@nhs.net](mailto:nhs.print@nhs.net)

Primary Care Support England portal and registration [www.pcse.england.nhs.uk](http://www.pcse.england.nhs.uk)

Primary Care Support England support [PCSE.enquiries@nhs.net](mailto:PCSE.enquiries@nhs.net)


Section 1: Contract management

Commissioners have a responsibility to assure themselves about the availability, quality and value of the dental services that they commission, this includes all services regardless of where they are provided or how they are contracted for.

The focus of this handbook is primary care dental services that are provided for under the dental contract reform (DCR) programme and therefore will cover the management of general dental services (GDS) contracts and personal dental services (PDS) agreements delivering mandatory dental services in the DCR programme.

For many local offices the number of prototype practices has varied but their contract management should be considered alongside the other contracts held by a local office.

To support the local commissioning teams during the period of reform, the DCR programme has provided the main support to both commissioners and the prototype practices. This has included provision of training, advice and support in relation to the care pathway approach and the management reports in relation to the prototype practices.

This section contains information that is of particular relevance to commissioners.

Prototype contracts

NHS England remains signatories to, and commissioners of contracts held by prototype practices. A contract variation notice (known as a prototype agreement variation) is agreed and signed between NHS England local office and their prototype practices and enables practices to participate in the DCR programme.

Making and varying a prototype agreement

Prototype agreements can only be entered into with the approval of the Secretary of State for Health. This also applies to any later variations of that agreement. The prototype agreement requires commissioners to obtain the Secretary of State’s approval for any variations to the prototype contract. This includes:

- Changes to contract values (either up or down)
- Allocation of growth monies (i.e. temporary increase in contract value)
- Duration of prototype agreement.

Managing under/over-delivery of units of dental activity (UDAs) in the pre-prototype period

Stayed UDAs is the term used in the prototype agreement scheme Statement of Financial Entitlements (the prototype SFE) to describe the carry forward of any under/over-delivery of UDAs that existed at the time the prototype went live. This means the UDAs are suspended for the life of the prototype.
Where practices under/over-delivered in the full financial year prior to the commencement of a prototype agreement, commissioners had the option to include these UDAs as stayed for the duration of the DCR programme.

When a prototype contract is agreed part way through a financial year, the final UDA delivery position for the year will be unknown. Therefore, where the commissioner has reason to believe that there will be a significant under/over-delivery of UDAs during the months prior to the prototype going live (in financial year), the commissioner can either put in a temporary figure based on forecast performance which will then be finalised on year end data or do a retrospective adjustment to the variation document once the final year end position is known.

The number of stayed UDAs are recorded in the contract variation notice (please note this should not be the total contracted number of UDAs only the stayed level).

**Working with contractors**

With the formation of NHS England in 2013 there has been a changing landscape, which has resulted in coverage of a larger geographical patch and numbers of contracts that are being managed by commissioning teams.

NHS England has a requirement to inform contractors of key messages and contractors need to inform commissioners of the local pressures that may affect the delivery of commissioned services.

To this end, the relationships forged with individual contractors and also with Local Dental Committees (LDC’s), Healthwatch, with Local Dental Networks (LDNs) and other strategic organisations are important. Contractors should be assured that commissioners will respond when matters arise that require response or intervention. To support the management of dental contracts the NHS Business Services Authority (NHS BSA) has introduced a new contract management reporting and financial payments system, known as Compass. Commissioners are expected to support their dental practices to ensure they are able to access this system, so that contractors as well as the commissioners are able to monitor delivery of contracts and that contractors take a more active role in ensuring that they deliver their expected requirements over the course of the year.
Contract assurance

Dental Assurance Framework for prototypes (prototype DAF)

To support commissioners, the DCR programme and NHS England have published a DAF specifically for prototype practices. The framework looks at four key areas that provide a high level of assurance in relation to the quality of services that are delivered. These are:

- Delivery
- Patient safety
- Patient experience
- Quality and clinical effectiveness

Within the four areas outlined above there are individual indicators to focus on:

- Delivery: overall performance as a combined percentage of delivery against capitation (expected capitated patient numbers) and activity (expected minimum activity)
- Patient safety: underlying GDS and PDS requirements to provide premises, facilities and equipment that are suitable for delivery of services and appropriate Care Quality Commission (CQC) registration.
- Patient experience: patient reported experiences including the dental quality and outcomes framework (DQOF) indicators on patient experience and other sources of information such as complaints and locally held information.
- Quality indicators: current DQOF clinical measures (outlined below) plus further development of indicators planned.

The current prototype DAF focusses on delivery of contract obligations. The indicators to support the other areas as listed above will be developed over time.

A link to the prototype DAF can be found in the resources section.

Dental quality and outcomes framework

The DQOF framework allows prototype practices to be monitored against achievement of indicators and to potentially be remunerated for this achievement. The indicators within the DQOF are relevant to commissioners to help assure them of the quality of service and outcomes for patients. The DQOF is made up of four domains:

- Patient safety
- Clinical effectiveness
- Patient experience
- Data quality

The details under each of the indicators are:
- Patient safety: recording of an up to date medical history at each oral health assessment (OHA)
- Clinical effectiveness: decayed teeth levels in children under the age of 6, 6-18 years old and 19 year old and over are maintained or improved; basic periodontal examination (BPE) score for over 19 year olds is maintained or improved and number of sextant bleeding sites for over 19 year olds is maintained or reduced. Data points are between OHA and oral health review (OHR)
- Patient experience: patients who report they are: able to speak and eat comfortably; satisfied with cleanliness of practice; satisfied with helpfulness of practice staff; felt sufficiently involved in decisions about their care; who would recommend the practice to a friend; satisfied with NHS dentistry received and satisfied with time to get an appointment
- Data quality: timeliness of both appointment transmissions and FP17 submissions.

However it is clear that the indicators in the prototype DAF and DQOF themselves cannot provide absolute assurance of quality. Commissioners should have regard to a number of other information sources available to them when reviewing dental contracts within their locality.

Further information on the financial adjustments linked to DQOF can be found in the prototype remuneration section.

A link to the DQOF can be found in the resources section.

**The priorities**

As part of the history of contract management and through the assurance process there are many areas that dental commissioners may focus on, however nationally there are areas of priority to ensure optimal access for all patients and provision of a high quality service within the DCR programme.

This section focuses on the following areas:

- Reducing contract under-performance
- Managing for appropriate recall patterns within the care pathway approach
- Providing preventive focused dental care
- Managing appropriate treatment patterns

Under prototype arrangements contractors have both an expected capitated list size to maintain and an expected minimum activity level to deliver. Practices working in the prototype arrangements are expected to follow a care pathway approach that prioritises preventive care and treatment with appropriate assessment, interim care and review appointments. For details of the care pathway please see the clinical section. When looking at performance of a contract it is important to review all aspects otherwise the commissioners may see the number of inappropriate recall/treatments reduce but the level of under-performance rise.
Under-performance of contract delivery

Why it is important to address under-performance?

Since the introduction of the GDS contract and PDS agreements in 2006, there has been a consistent under-performance of contracted activity. Historically this under-performance was handled differently by commissioners across the country, some took no action whilst others rebased contracts in order to release funding to commission new services or to bolster existing services for a limited period.

It remains a key priority under quality, improvement, productivity and performance (QIPP) for commissioners to manage performance of contracts within the prototype agreements. It is important that commissioners are able to show they can meet the requirements of not only provision of dental access but also value for money.

Contractors need to understand what commissioners expect of them in performance terms, and what the consequences of under-performance might be. Commissioners should also have regard to the adverse events that contractors may face that impact performance and consider these in a proportionate and consistent manner in line with their operating policies. Examples of adverse events could be physical damage to premises or death or sudden illness of a significant performer.

Commissioners should be encouraging their contractors to self-monitor their contracted performance levels through regular use of prototype reports available on Compass and other support tools such as the modelling tool so they can ensure that they meet their contractual obligations throughout the year. Where contractors know they are underperforming on their contract they should contact their commissioning team to make them aware of this and should proactively put forward improvement plans to assure the commissioning team that they are addressing the issue and resolving any potential shortfall.

There may be a requirement for commissioners to put in place short term contract changes to reflect the issues practices face. Commissioners may reduce the expected patient list and activity levels during the current financial year with a return to full level the following contractual year. However, the commissioner should also ensure that there is adequate provision for the needs of their population and consider how they are able to recommission the activity non-recurrently during the financial year. This action may depend on the timing of the approach by the contractor, as it may not be reasonable to make these amendments in the last quarter of the financial year.

What the legislation says

The National Health Service (Dental Services) (Prototype Agreements) Directions 2015 require that overall capitation and activity performance is established (as detailed in the prototype SFE). Under-performance which is greater than 4% is considered a breach of contract and the ultimate consequence of a breach of contract is that it can be terminated. If the commissioner is considering issuing a breach notice or termination of the contract then they should manage these in line
with chapter 7 of the NHS England policy book for primary dental services. Commissioners will need to seek the permission of the Secretary of State via the DCR programme team, in line with the contract variation document.

NHS England’s financial recovery and reconciliation policy states that commissioners must manage this level of under-performance by recovering the full financial repayment by the contractor in the next financial year. Ideally, monies should be recovered as early as possible within that year to allow commissioners to maximise the potential to commission non-recurrent provision of services for their patient population.

Where an under-performance is less than 4%, then the financial value of the under-performance should be carried forward into the following year or be allowed to be paid back in full if the contractor wishes to. For further details on managing year end processes please see the remuneration section within this handbook. The principles of the financial recovery and reconciliation policy are adopted for financial recovery for practices in the DCR programme; however, commissioners need to be aware that any carry forward is a financial value.

**Approach**

To tackle under-performance successfully, commissioners should consider the following approach:

- Make full use of the NHSBSA’s Compass system, e-reporting reports and the modelling tool, so they have all the necessary information relating to the contracts they manage to enable them to prioritise their efforts appropriately throughout the year
- Commissioners should work with the DCR programme team, when necessary, to understand performance reports and implications of under-performance
- Ensure their contractors are aware of the functionality within Compass and e-reports and supporting tools to allow them to self-manage their own contracts, especially in relation to delivery patterns and working with the commissioner
- Follow the policies for the yearend process that provide opportunities to manage under-performance in year and recover funding in respect of any under-performance, which then may be used to support service delivery elsewhere in-year
- Work informally with contractors at the mid-year point (there is no formal mid-year review process within the prototype agreements) and throughout the year to help practices understand their position
- Use the prototype dental assurance framework to review the quality of services provided when reviewing contract delivery
- Implement a robust process of contract management. The key tasks above are not intended to be an exhaustive list and should be read in conjunction with all relevant policies where matters relate to the underlying GDS contract or PDS agreement.
Useful report and modelling tool

Figure 1: Capitation remuneration report

This overview report, available in pdf format on Compass provides a summary of the actual patient numbers on the capitated patient list against the expected capitated patient numbers for current year and the prototype UDAs delivered against the expected minimum activity level for current year.

The report is updated monthly and available on Compass, usually by the end of the full first week of the calendar month.
**2016-17 Capitation remuneration report - Prototype 100YYYY - September 2016**

**Provider name or company name** Practice XXXX

**Prototype reference number** 100YYYY

**Start date for prototype** 01/01/2016

**Prototype Blend** A

**Actual Annual Prototype Value - Capitation Element (AAPV-C)** £340,000

**Actual Annual Prototype Value - Activity Element (AAPV-A)** £225,000

**Actual Annual Prototype Value (AAPV = AAPV-C + AAPV-A)** £565,000

Transitional allowance figure above is provisional. The allowance will be confirmed following end of year reconciliation in June once all the FP17 forms and appointment data transmissions have been processed.

**Capitated patient list - patients seen in 36 months**

<table>
<thead>
<tr>
<th>Month</th>
<th>36-month actual capitated patient numbers</th>
<th>New joiners needed per remaining month</th>
<th>New joiners needed plus imminent lapsed</th>
<th>% of expected patient numbers currently delivering</th>
<th>% of expected patient numbers currently delivering including transitional allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-16</td>
<td>6,520</td>
<td>40</td>
<td>93%</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>May-16</td>
<td>6,560</td>
<td>37</td>
<td>94%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Jun-16</td>
<td>6,590</td>
<td>34</td>
<td>94%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Jul-16</td>
<td>6,620</td>
<td>32</td>
<td>95%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Aug-16</td>
<td>6,640</td>
<td>30</td>
<td>95%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Sep-16</td>
<td>6,720</td>
<td>23</td>
<td>96%</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>Oct-16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov-16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec-16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Feb-17</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Mar-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Activity - Prototype UDAs delivered**

<table>
<thead>
<tr>
<th>Month</th>
<th>Prototype UDAs carried out in month</th>
<th>Prototype UDAs cumulative total</th>
<th>Expected Prototype UDAs achieved</th>
<th>% of expected Prototype UDAs achieved</th>
<th>RAG Green: 100% or more, Amber 90% - 100%, Red less than 90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-16</td>
<td>580</td>
<td>580</td>
<td>625</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>May-16</td>
<td>590</td>
<td>1,170</td>
<td>1,250</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>Jun-16</td>
<td>596</td>
<td>1,766</td>
<td>1,875</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>Jul-16</td>
<td>540</td>
<td>2,306</td>
<td>2,500</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Aug-16</td>
<td>610</td>
<td>2,916</td>
<td>3,125</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Sep-16</td>
<td>235</td>
<td>3,151</td>
<td>3,750</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>Oct-16</td>
<td>437</td>
<td>3,588</td>
<td>4,375</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>Nov-16</td>
<td>5,000</td>
<td>5,170</td>
<td>5,625</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Dec-16</td>
<td>6,250</td>
<td>5,925</td>
<td>6,250</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Jan-17</td>
<td>6,875</td>
<td>6,525</td>
<td>7,500</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Feb-17</td>
<td>7,500</td>
<td>7,500</td>
<td>7,500</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Mar-17</td>
<td>7,500</td>
<td>7,500</td>
<td>7,500</td>
<td>100%</td>
<td></td>
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</tbody>
</table>

These UDA figures are used for assessing Prototypes - see guidance.

**Total UDAs delivered - Scheduled activity vs. activity completed in month**

<table>
<thead>
<tr>
<th>Month</th>
<th>Total scheduled UDAs</th>
<th>Total UDAs completed in month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-16</td>
<td>924</td>
<td>1,450</td>
</tr>
<tr>
<td>May-16</td>
<td>1,396</td>
<td>1,520</td>
</tr>
<tr>
<td>Jun-16</td>
<td>1,410</td>
<td>1,490</td>
</tr>
<tr>
<td>Jul-16</td>
<td>1,310</td>
<td>1,525</td>
</tr>
<tr>
<td>Aug-16</td>
<td>1,416</td>
<td>1,287</td>
</tr>
<tr>
<td>Sep-16</td>
<td>1,423</td>
<td>800</td>
</tr>
<tr>
<td>Oct-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov-16</td>
<td></td>
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<td>Dec-16</td>
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</tr>
<tr>
<td>Feb-17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar-17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These UDA figures are for information only - see guidance.

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**2016-17 delivery requirements**

| Contractor's Expected Capitated Population | 7,000 |
| 2016-17 transitional allowance (provisional) | 100 |
| Required patients at March 2017 (minus transitional allowance) | 6,900 |
| Expected Minimum Activity | 7,500 |
| Activity and Capitation Performance Tolerance | no limit |
| Contract Value Carried Forward - Previous Year | TBC |

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*These tables and figures are for information only.*

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*These tables and figures are for information only.*
The monthly reports do not show the likely combined position at year end. A modelling tool has been developed to allow commissioners and practices to forecast the likely combined year end position based on the predicted percentage achievement against capitated list and activity. Commissioners and practices are able to input current achievement against capitated list and activity (as taken from the capitation remuneration report) which will provide them with their forecast position at year end.

Commissioners and contractors can use the modelling tool to look at various scenarios which will help contractors plan to achieve their contractual obligations.

Full instructions on how to use this are available on the first tab of the interactive modelling tool.

A link to the tool is available in the resources section.
### Practice Information (from capitation remuneration report)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Annual Prototype Value (AAPV)</td>
<td>£1,265,000.00</td>
</tr>
<tr>
<td>Capitation element (AAPV-C)</td>
<td>£775,000.00</td>
</tr>
<tr>
<td>Activity element (AAPV-A)</td>
<td>£480,000.00</td>
</tr>
<tr>
<td>Expected patient list (CECP)</td>
<td>12,000</td>
</tr>
<tr>
<td>16-17 transitional allowance</td>
<td>100</td>
</tr>
<tr>
<td>Expected Capitated Population</td>
<td>11,900</td>
</tr>
<tr>
<td>Expected Minimum Activity (EMA)</td>
<td>£54,000</td>
</tr>
<tr>
<td>Contract value c/fwd - previous year (£)</td>
<td>£0.00</td>
</tr>
</tbody>
</table>

### Estimated year-end delivery (practice’s own figures)

<table>
<thead>
<tr>
<th>Category</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient numbers</td>
<td>11,500</td>
</tr>
<tr>
<td>UDAs</td>
<td>54,000</td>
</tr>
</tbody>
</table>

### Step 1 - Year end delivery percentage for capitation and activity

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation</td>
<td>96.64%</td>
</tr>
<tr>
<td>Activity</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

### Step 2 - Apply rules for adjustments for activity and capitation delivery (exchange mechanism)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation</td>
<td>96.64%</td>
</tr>
<tr>
<td>Activity</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

### Step 3 - Combine the year end achievement for capitation and activity

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation</td>
<td>£748,949.58</td>
</tr>
<tr>
<td>Activity</td>
<td>£480,000.00</td>
</tr>
<tr>
<td>Total</td>
<td>£1,228,949.58</td>
</tr>
<tr>
<td>% total</td>
<td>97.92%</td>
</tr>
</tbody>
</table>

### Step 4 - Apply carry forward from previous year

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carry forward from previous year</td>
<td>£0.00</td>
</tr>
<tr>
<td>% total</td>
<td>97.92%</td>
</tr>
</tbody>
</table>

### Step 4a - Additional calculation if initial Y/E position is less than 90% (SFE 4.6 - CAAML)

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>£1,228,949.58</td>
</tr>
<tr>
<td>% total</td>
<td>97.92%</td>
</tr>
</tbody>
</table>

### Step 5 - Calculate the final position and carry forward (if applicable) for next year

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial year-end value</td>
<td>£26,050.42</td>
</tr>
<tr>
<td>Initial year-end percentage</td>
<td>2.08%</td>
</tr>
</tbody>
</table>

### Step 5a - Apply tolerances to carry forward figures

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final year-end value</td>
<td>Under-performance</td>
</tr>
<tr>
<td>Final year-end percentage</td>
<td>2.08%</td>
</tr>
</tbody>
</table>

For every 100 UDAs below your expected minimum activity level (EMA) 13.76 extra patients are required to achieve the same financial value.
Contractual processes

Figure 3: Contractual flow chart

The flow chart below shows the appropriate action to take to manage underperformance where delivery concerns have been identified through in year monitoring and year end processes.
Regulatory and contractual processes

The prototype directions state that any variation to the prototype agreement has to be agreed by the Secretary of State. Currently commissioners work with the DCR programme team when issuing any contractual changes to the agreement.

Contractual changes not relating to the prototype agreement such as variation notices should follow the principles that are set out in the dental policy handbook.

Commissioners should inform the DCR programme of the action they are taking in case of any unforeseen consequences to the prototype arrangements.

Commissioners considering taking contractual action against the prototype agreement should contact the DCR programme to discuss the matter, before taking any action.

When action is taken, it is important to keep a clear record of each step, what happened, when, why, who was involved, so that the commissioner is in a position to show that they have acted reasonably throughout and in accordance with the relevant regulations.

It is also recommended that any important communications (such as remedial or breach notices) are either hand delivered to the practice and a written receipt obtained or sent by registered post (not recorded delivery as this does not prove the document has been received).

The table below outlines the objectives, key tasks and timescales commissioners need to consider when addressing under-performance issues with contracts.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>To reduce under-performance of contracted activity to within 4% of contracted levels</td>
<td>Appropriate and improved patient access to a high quality service maximised through local delivery of contracts.</td>
</tr>
<tr>
<td>To ensure expected capitation patient lists are maintained or improved. Over achievement of capitated patient lists can offset activity delivery below the expected minimum level</td>
<td></td>
</tr>
<tr>
<td>To ensure under-performance is managed appropriately to achieve the aims of improving access and ensuring value for money</td>
<td></td>
</tr>
<tr>
<td>Key tasks to complete</td>
<td>When</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Read and understand NHS England’s commissioning policies including the DAF to undertake the required tasks of contract management appropriately</td>
<td>As required</td>
</tr>
<tr>
<td>Use relevant reports including capitation remuneration/prototype DAF/DQOF to identify under-performance</td>
<td>Quarterly or more frequent as appropriate</td>
</tr>
<tr>
<td>Review delivery against contract at any visit undertaken at practices</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Manage end of year process in line with the commissioner policies</td>
<td>June onwards</td>
</tr>
<tr>
<td>Negotiate contract changes such as a rebasing of contracted levels (mandatory services only) at year end or at any other time ensuring DCR programme team is informed of intention to negotiate, to gain secretary of state approval and allow the DCR programme to support the recalculation of the expected patient list and minimum activity levels in line with the new contract value.</td>
<td>As appropriate</td>
</tr>
<tr>
<td>Consider use of non-recurrent funding to commission additional in year provision to support delivery of commissioning aims. This may be delivery of services to an additional population or provided in innovative ways such as prevention or care pathway approaches to improve access to services. The DCR programme team need to be informed to gain secretary of state approval and allow the DCR programme to recalculate expected patient list and minimum activity levels in line with the new contract value.</td>
<td>As appropriate</td>
</tr>
<tr>
<td>Maintain regular communication with practices throughout the contract period to remind them of requirements and share examples of best practice</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
Managing contracts for appropriate recall patterns, preventive approach and treatment patterns.

The principles of a reformed system include:

- A system which maintains or improves patient access to NHS dentistry
- A system which improves oral health by a clinical approach focused on thorough assessment and prevention as well as treatment, and which supports a pathway approach to care
- Measurement and remuneration for quality of care that supports continuing care with a focus on prevention as well as treatment/activity.

Commissioners are responsible for commissioning appropriate dental access for their population. A way in which commissioners can help deliver this is by ensuring patients are seen at appropriate recall and treatment intervals. The use of the care pathway approach within practices should support the patient and clinical behaviour change to improve appropriate recall and treatment intervals.

Early recall

Historically, patients have been encouraged to attend their dentist every six months and those patients with a high level of motivation have come to expect this. These patients typically have better oral health and attend for reassurance. In order to make certain that access to NHS primary care dental services is maintained or improved for the wider population, dentists need to ensure that all patients attend based on their oral health needs and not their demands. This will free up the dentist’s time to see more patients and potentially improve the oral health of the wider population.

The Independent Review into NHS Dentistry in England conducted by Professor Jimmy Steele in 2009 included concerns about patients being recalled more frequently than would seem justified.

Commissioners need to be aware that a key principle of the care pathway approach is that patients may be seen for an interim care (IC) appointment for preventive treatment and advice. These appointments may be scheduled at different time intervals, for example three or six months after the oral health assessment or review appointment. The need for these appointments is determined at the clinical discretion of the dentist, including the time interval for these appointments. However, these appointments do not need to be provided by a dentist, they can be provided by utilisation of clinical skill mix. IC appointments are captured on FP17s as a Band 1 course of treatment and therefore traditional monitoring reports will not capture the detail and should be used with caution.

Re-attendance

National data shows that frequent re-attendance for dental treatment is occurring for patients being treated under all banded courses of treatment. Multiple courses of treatment undertaken within a few weeks should be a relatively rare occurrence and
under the care pathway approach commissioners would be interested where the re-attendance is not for the preventive interim care appointments. Band 2 and Band 3 courses of treatment following in quick succession may be an indicator of a poor quality service where poor diagnosis and treatment planning leads to inappropriate clinical care.

There will however be exceptions where a successive banded course of treatment may be given for example if trauma or damage to a filling has occurred.

**Continuation**

Where a high number of patients are being seen as a continuation of their original course of treatment (within two months of completion of the original course of treatment) it may also indicate issues with the diagnosis and treatment.

**Splitting courses of treatment**

The GDS and PDS Regulations do not formally define splitting courses of treatment but the term is generally used to describe the deliberate intention not to deliver all necessary treatment in a single course of treatment.

**What the GDS and PDS Regulations say**

Under the care pathway approach, patients will have suggested recall periods based on their dental needs under the four domains (see clinical section for detail on these domains).

Patients may also have IC appointments for preventive actions. These intervals will be dependent on the dental need of the patient and will be suggested based on clinical algorithms.

Clinicians have the ability based on their clinical judgement to override these recommended periods; either lengthening or shortening these intervals. Commissioners should be satisfied that any override of the suggested intervals is based on clinical need not patient demand. Commissioners may wish to undertake a record review to look for evidence of informed discussion with the patient for the reasons for amending a recall or interim care period. Commissioners should consider use of clinical advisers (the DCR programme or their own), potential practice visits and support from NHSBSA if they have concerns.

Under the GDS and PDS regulations it is a contractual obligation for contractors to work within current National Institute for Clinical Excellence (NICE) guidelines. They both state that the contractor shall provide services under the contract in accordance with any relevant guidance that is issued by NICE, in particular the guidance entitled Dental recall - recall interval between routine dental examinations. NICE guidelines were used in the development of the care pathway matrices. Further detail on the matrices is included in the clinical guide section of this handbook.
The actual interval should be assessed by the dentist based on a patient’s oral health need. This may be up to 24 months but can be as frequent as three months, if clinically appropriate.

Alongside the care pathway and NICE guidelines, Delivering Better Oral Health version 3 (DBOH), also supports clinical decision making and formed part of the basis of the clinical matrices in both recall intervals but also preventive actions. DBOH was developed to be a practical tool for practitioners to be able to work with specific patient groups or dental conditions, which set best practice guidelines including recall intervals and appropriate interventions.

**Patient communication and record keeping**

The dentist should discuss the recommended recall interval with the patient and record this and the patient’s agreement/disagreement with it, in the clinical record. The patient may be given a self-care plan (not to be confused with treatment plan as required under the regulations for any Band 2 or 3 course of treatment) as part of the pathway approach.

The recall interval should be captured on the self-care plan and the FP17. Where there is a clinical decision to alter the recommended recall interval within the pathway this discussion and reason should be noted in the clinical notes. For some patients it may be appropriate to extend the recall intervals in increments away from six months to the appropriate recall interval but these should be relatively rare and decided on a case by case basis.

**Impact on access and efficiency**

If the pathway and NICE recall guidance is not being implemented appropriately then there may be implications for access to NHS dentistry. If patients with better oral health are seen at intervals shorter than their dental need suggests, practices could struggle to have capacity within their appointment books to see new patients and to provide timely treatment and preventive advice to patients with a higher dental need.

**What commissioners should do**

Areas that commissioners may wish to focus are:

- Children aged between 3 and 18 classified overall as green who attend for an oral health review before 12 months
- Adults (aged over 18) classified overall as green who attend for an oral health review before 24 months
- Patients classified overall as amber with no interim care appointments
- Average Band 3 to Band 3 rates.

This does not mean, however, that other areas of concern should be ignored in discussions with practices.
Commissioners should look at other combinations such as a Band 2 treatment quickly followed by a Band 3 course of treatment, as commissioners would not normally expect two courses of treatment within three months.

**What should the commissioner expect to see?**

The table below looks at what should normally be delivered under each appointment type and treatment band together with possible reasons for repeat attendances within relatively short time intervals.

It should be emphasised that it is a requirement under the regulations that when any banded course of treatment is provided (with the exception of a Band 1A interim care appointment and a Band 1 urgent) the patient should receive an examination and assessment and be offered all proper and necessary dental care and treatment required at that time.

<table>
<thead>
<tr>
<th>What should be delivered</th>
<th>Reasons for frequent re-attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral health assessment/review</td>
<td>Where a patient attends for repeated Band 1 courses of treatment it may be justified based on an assessment of their individual need or risk of dental disease. It may be appropriate for these patients to be seen at an interim care appointment</td>
</tr>
<tr>
<td>The oral health assessment/review will consist of as a minimum Band 1 treatments defined in Schedule 1 of the NHS (Dental Charges) Regulations 2005</td>
<td>Practices should not see patients for an oral health assessment (minimum of a Band 1) sooner than the recall period, the minimum period between OHA and OHR varies depending on risk and age of patients (see matrices). There may be rare occasions where due to changes in clinical need they have an earlier review period</td>
</tr>
<tr>
<td>These treatments relate to diagnosis, preventive advice and interventions, treatment planning and maintenance and includes such items as:</td>
<td>For example, some patients may have physical difficulty in maintaining a satisfactory standard of oral hygiene, or may suffer from medical conditions that increase their risk of developing dental disease, or their dental need changes such as a broken filling.</td>
</tr>
<tr>
<td>- Clinical examination</td>
<td>This should only apply to treatment intervals of three months or more. Patients who are seen for a review less than two months after the previous assessment are outside of the pathway and NICE</td>
</tr>
<tr>
<td>- Radiographs</td>
<td></td>
</tr>
<tr>
<td>- Surface application of primary preventive interventions</td>
<td></td>
</tr>
<tr>
<td>- Dietary and oral hygiene advice</td>
<td></td>
</tr>
<tr>
<td>- Scaling and polishing.</td>
<td></td>
</tr>
<tr>
<td>As part of the initial oral health assessment the patient may also require a Band 2 or exceptionally a Band 3 course of treatment.</td>
<td></td>
</tr>
</tbody>
</table>
Interim care appointment

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1A</strong> Preventive treatment and advice appointment are defined in regulations as:</td>
<td>If it is clinically appropriate to do so patients may be bought in for an interim care appointment between the oral health assessment and review. The time between interim care appointments will vary depending on the underlying diagnosis and the purpose of the interim care appointment. Generally interim care appointments could be between 3 and 6 months after initial assessment and treatment (if necessary).</td>
</tr>
<tr>
<td>(a) the giving of specific advice in relation to diet, hygiene, personal habits and oral health in respect of a person to enable that person to be aware and to be able to take steps to prevent dental and oral disease</td>
<td></td>
</tr>
<tr>
<td>(b) the giving of instructions on techniques and practice required by a person in relation to their dental hygiene to enable that person to improve their dental health and prevent oral disease</td>
<td></td>
</tr>
<tr>
<td>(c) checking a person’s compliance in relation to the self-care plan proposed at the oral health assessment or oral health review;</td>
<td></td>
</tr>
<tr>
<td>(d) the provision of a prescription for high fluoride toothpaste or mouth rinse if considered required (when delivered together with one or more of (a), (b), (c), (e), (f) or (g))</td>
<td></td>
</tr>
<tr>
<td>(e) the surface application of primary preventive measures such as topical fluoride varnish applications and fissure sealants, if required and necessary</td>
<td></td>
</tr>
<tr>
<td>(f) scaling and polishing if,</td>
<td></td>
</tr>
</tbody>
</table>
required

(g) follow up root surface debridement if required.

<table>
<thead>
<tr>
<th>Band 2 course of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>As identified at an oral health assessment/review a Band 2 course of treatment may be required. These include all treatment available under a Band 1 course of treatment and those treatments defined in Schedule 2 of the NHS (Dental Charges) Regulations 2005. These treatments include for example, non-surgical treatment of periodontal disease, permanent fillings, root treatments, extractions and additions to existing dentures. An FP17DC or equivalent should be provided to the patient for any Band 2 course of treatment and a copy should be available as part of the clinical record.</td>
</tr>
<tr>
<td>There will be occasions where a patient returns within a short period of time after an oral health assessment/review or an interim care appointment for a Band 2 course of treatment for perfectly valid reasons, e.g. a problem with tooth/teeth that could not have been identified during the previous course of treatment. Possible examples might be where a filling has fractured or been lost or where an acute apical abscess arises. It is also possible that a Band 1 urgent course of treatment may be followed by a Band 2 course but should be a rare occurrence and not a method of claiming where the majority of patients have an urgent course of treatment followed by a banded course of treatment. Dental practices may be following approved or appropriate care pathways such as prevention or periodontal pathways, which may show up in data sets as more frequent re-attendance patterns within the practice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Band 3 course of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>As identified at an oral health assessment/review a Band 3 course of treatment may be required. Band 3 courses of treatment include the provision of appliances defined in Schedule 3 of the NHS (Dental Charges) Regulations 2005. Appliances provided under schedule 3 include the provision of porcelain veneers, gold inlays, crowns, bridges and dentures. Where a Band 3 course of</td>
</tr>
<tr>
<td>There may be a small number of occasions where a patient returns for a Band 3 course of treatment within a relatively short period of time e.g. as for Band 2 a problem with teeth that could not have been identified during the previous course of treatment. A possible example might be the fracture of a crown following an episode of trauma, requiring replacement.</td>
</tr>
</tbody>
</table>
treatment is provided an FP17DC or equivalent should be provided to the patient and a copy should be available as part of the clinical record.

Information available

Under prototype arrangements there are a number of specific reports relating to capitation and activity performance. Reports are being developed to support commissioners to understand the quality of the service that is being delivered which will include reports to support the prototype DAF, DQOF reports and a vital sign report.

Commissioners can use the existing reports to help them understand the delivery pattern within prototype practices but these should be used with caution as the clinical delivery under prototype arrangements is different to delivery under GDS and PDS arrangements.

Prototype practices currently supply two sources of data as part of their arrangements the standard FP17 form and dental practice management system data (DPMS) known as appointment data. Both sets of data include information on clinical treatment provided. The appointment data provides an additional data set such as overall RAG status and IC treatments. Currently e-reporting only supports data sets which can be captured from the FP17 forms and commissioners do not yet have access to information on the wider clinical data set, especially the practice populations RAG status or IC recommendations.

Specifically, the following reports provide relevant information:

- DQOF report
- Dental assurance framework tier 1 report – commissioner and contract specific
- Dental assurance framework tier 2 report – contract specific
- E- reporting templates
  - Exception data report which looks particularly at contracts with the following exceptions:
    - High re-attendances within three months
    - High re-attendances within three to nine months
    - Multiple courses of treatment
- Quarterly re-attendance report

With this information commissioners will be able to review data using specialist support including the DCR programme team, the local office clinical advisers and clinical advisers from NHSBSA to ask specific questions of the prototype practices. This approach will help them understand if a preventive approach is being followed, that appropriate recall patterns are being implemented and that appropriate care is being delivered to patients.
**Information sharing and discussion with contractors**

Where concerns arise, the commissioner should give the contractor the opportunity to explain their position regarding interpretation of the data. The contractor’s response should be reviewed by the commissioner. Where concerns remain or there is a lack of response (such as number of triggers/level of re-attendance) this should be addressed at a review meeting with the contractor.

Where a contractor is being asked to explain a particular pattern of clinical activity, reference should be made to the specific clinical records being reviewed. It is strongly recommended that a clinical adviser, such as the dental practice adviser or the clinical advisers at the NHSBSA are involved in the discussions to provide the commissioner with clinical insight.

It is likely that with most contractors a discussion of their data with clinical input would be sufficient to agree a resolution to any concerns that have been identified. Commissioners may want to agree an action plan with the contractor that outlines SMART (specific, measurable, attainable, relevant and time-bound) actions to be undertaken by the contractor and any commissioner support that is agreed. The action plan should include review dates.

However, if no agreement is reached with the contractor, the commissioner may want to ask for further clinical support from their dental practice adviser or the NHSBSA clinical services to undertake a full clinical review or advice on other monitoring that may be appropriate.

It is important to note that it is a contractual requirement to provide (and retain a copy of) a treatment plan in the form of an FP17DC (or equivalent) for patients undergoing Band 2 and Band 3 courses of treatment, and where the patient requests one and for any banded course where private treatment is also provided e.g. with a hygienist.

If the result of any investigation supports the commissioners concerns and no agreement is reached after these checks have been carried out, commissioners may want to formalise their management of the process for that contractor through the issue of an informal dispute resolution, remedial or breach notice as appropriate and where appropriate seeking approval of secretary of state via the DCR programme team.

Finally, it is important to point out that at all stages of their processes for addressing recall issues, if commissioners become aware of any serious patient safety issues or material financial risks to the commissioner then the process for managing such cases should be followed as defined in the NHS England policy book for primary dental services.
Prototype remuneration system

Overview

The prototype agreement is based on a blended remuneration system where a practice’s contract value is split between:

- A capitation element, for which the practice is expected to have a minimum number of capitated patients on their list
- An activity element, for which the practice is expected to deliver a minimum level of activity.

In addition, there is the provision for a quality remuneration adjustment based on performance against DQOF. The DCR programme confirmed in December 2015 that the first time any financial adjustment will be applied for DQOF is likely to be 2017-18. No financial adjustments will be applied for DQOF performance before this point in time. However DQOF performance is reported in shadow form and reports available on Compass.

There are two blends of remuneration being tested in the prototype system:

- Blend A: Where capitation is used as the basis of remuneration for oral health reviews and preventative care (currently Band 1 associated care) and activity payments are used for all treatment (current Band 2 and Band 3 associated care)
- Blend B: Where capitation is used as the basis of remuneration for oral health reviews, preventative care and routine treatment (current Band 1 and Band 2 associated care) and activity payments are used for more complex treatment (current Band 3 associated care)

Financial management of the budget associated with prototype practices

Commissioners are responsible for commissioning all dental services and the budget from which these services are commissioned, whether that is in secondary care or primary care; and at the various levels of patient complexity outlined in the commissioning dental specialities guides. Whilst it is important that the commissioner has an understanding of financial management across the whole dental system, this guide focuses on the element of the primary care budget (GDS and PDS) applicable to practices operating under the prototype arrangements as part of the DCR programme.

Commissioners should manage this budget in accordance with the standing financial instructions (SFI), and policies and procedures adopted by the commissioner, thus ensuring that all financial transactions are carried out appropriately in order to achieve probity, accuracy, economy, efficiency and effectiveness.

There are a number of key tasks and responsibilities that need to be undertaken to ensure appropriate management and reporting of dental expenditure. To ensure the appropriate financial management of dental resources the commissioner will need to:
• Have a clear understanding of how the prototype practices operate
• Have appropriate systems in place to monitor the current and future financial commitments
• Develop internal working relationships to ensure that finance and dental teams have a joint approach for monitoring and assessing dental expenditure associated with prototypes
• Monitor and review patient charge revenue (PCR) taking into consideration the different system that the prototype practices are operating under

**Establishing the prototype agreement**

**Calculation of prototype contract values and delivery requirements**

A practice’s contract value does not change upon entry into prototype arrangements. The DCR programme team, working with local commissioners, calculates the split of the contract value between capitation (patient numbers) and activity. Historic delivery is used to calculate this split and the expected delivery requirements. This is based on the full financial year prior to a practice entering the prototype arrangements, and is described as the baseline year.

There is an agreed process for calculating prototype contract values and delivery requirements. The background finance schedule sets out the calculations for each prototype practice, as detailed in figure 4.
Figure 4: Example background finance schedule

Prototype Finance Schedule (Blend A)

Provider name or company name: The Dental Practice
Prototype blend: A
Prototype reference number: 14000
Baseline year: 2014-15
NHS England local office: NHS England

<table>
<thead>
<tr>
<th>Table 1 - Summary information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiated Annual Prototype Value (NAPV)</td>
</tr>
<tr>
<td>Actual Annual Prototype Value (AAPV)</td>
</tr>
<tr>
<td>Actual Annual Prototype Value – Blend A – Capitation Element (AAPVA-C)</td>
</tr>
<tr>
<td>Baseline EMA (Expected Minimum Activity Level)</td>
</tr>
<tr>
<td>Baseline CECP (Contractor’s Expected Capitated Population)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2 - Calculation of baseline CECP (Contractor’s Expected Capitated Population) and capitation element of contract value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline prototype capitated patient numbers</td>
</tr>
<tr>
<td>Adjusting for changes in delivered and commissioned UDA</td>
</tr>
<tr>
<td>Baseline expected patient numbers (CECP)</td>
</tr>
<tr>
<td>Contract value associated with capitation (AAPV-C)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3 - Calculation of baseline EMA (Expected Minimum Activity Level) and activity element of contract value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitated patients</td>
</tr>
<tr>
<td>Band 1s</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Baseline UDA delivery</td>
</tr>
<tr>
<td>Band UDA delivery</td>
</tr>
<tr>
<td>Adjusted blend UDA delivery</td>
</tr>
<tr>
<td>Adjusted blend UDA delivery</td>
</tr>
<tr>
<td>Activity percentage for prototype blend: 42.5%</td>
</tr>
<tr>
<td>Commissioned UDA 2015-16: 15,295</td>
</tr>
</tbody>
</table>

<p>| Non-Capitated patients |</p>
<table>
<thead>
<tr>
<th>Band 1s</th>
<th>Band 2s</th>
<th>Band 3s</th>
<th>Band 1 urgents</th>
<th>Charge exempt CoTs</th>
<th>Band 1 urgents</th>
<th>Charge exempt CoTs</th>
<th>Band 2s &amp; Band 3s on referral</th>
<th>Total UDAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline UDA delivery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Band UDA delivery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adjusted blend UDA delivery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

| Baseline EMA (Commissioned UDA x Activity percentage for prototype blend) | £165,631 |
| Contract value associated with activity (AAPV-A) | £165,631 |

Actual Annual Prototype Value – Blend A – Capitation Element (AAPVA-C)
Actual Annual Prototype Value – Blend A – Activity Element (AAPVA-A)
Negotiated Annual Prototype Value (NAPV)
Process for calculating prototype contract values and delivery requirements

The total contract value (TCV) is broken down to identify the value for each service element provided within a contract, which may include:

- General dentistry
- Orthodontics
- Sedation
- Domiciliary
- Minor oral surgery

The general dentistry element of the contract value is then split between:

- A capitation element, for which the practice will be expected to have a minimum number of capitated patients on their list at year end
- An activity element, for which the practice will be expected to deliver a minimum level of activity by year end.

This split of the general dentistry element of the contract value is based on the calculated delivery requirements for capitation and activity.

The calculation of baseline expected capitated population (CECP) or capitated patient list is established by counting the number of patients seen by a practice in the preceding three year period on the last day of the baseline year. Capitated patient numbers are based on actual patient numbers and counted using the prototype rules, which will exclude any patients last seen by the foundation dentist (FD).

Further information on the prototype rules for capitation can be found in the managing a prototype practice section of this handbook. This number is then adjusted to reflect any changes in delivered and commissioned UDAs in the previous financial years to identify the impact on patient numbers.

The expected minimum activity level (EMA) is based on activity delivered in the baseline year counting the relevant UDAs for the prototype arrangements:

- Blend A: For Band 2 courses of treatment counting two out of the three UDAs, and for Band 3 courses of treatment counting eleven out of the twelve UDAs
- For Blend B: For Band 3 courses of treatment counting nine out of the twelve UDAs.
- For both blends UDA activity associated with Band 1 urgent, charge exempt courses of treatment and referral courses of treatment delivered to non-capitated patients are also counted.

An adjustment is then applied to these treatment volumes to recognise the additional time being spent on prevention following the pathway observed in the pilots. Expected activity levels are reduced by 20% for Band 2 (applicable for blend A only) and 30% for Band 3 (applicable for blend A and B). The activity level set is a minimum level. All prototype practices are expected to deliver all necessary care to
each capitated patient. If more treatment than the minimum level is required, practices are expected to deliver this within their overall contract value. Once the delivery requirements for both capitation and activity have been established this information is used to determine the split of the general dentistry element of the contract value. The value of the activity element is calculated first using the activity percentage for prototype blend and applying this percentage to the general dentistry element of the contract value.

Example, using the detail from figure 4:

Contract value associated with general dentistry (AAPV) x activity percentage for prototype blend = contract value associated with activity

£390,000.00 x 42.4695% (42.5%) = £165,631.18

The balancing value is then attributed to the capitation element

Example, using the detail from figure 4:

Contract value associated with general dentistry (AAPV) – contract value associated with activity (AAPV-A) = value of capitation element of contract value

£390,000 – £165,631.18 = £224,368.82

**Figure 5: Flowchart showing how the contract value for prototypes is identified**

![Flowchart showing how the contract value for prototypes is identified](image-url)
Contract payments and reviews

Payments to contractors

Payments to contractors operating under the prototype arrangements are undertaken by NHSBSA who acts as the paymaster on behalf of the commissioner. These payments are made in accordance with the prototype SFE.

Prototype practices continue to be paid 1/12th of their annual contract value, net of appropriate adjustments. Key information entered in the online payment system, Compass, is used to calculate and make the monthly payments to contractors alongside the dataset submitted by dentists on the FP17 form.

It is therefore essential that the data entered into the Compass system is accurate and up-to-date.

All practices operating under the prototype scheme must be identified on Compass. This is done by selecting the “pilot” tag which appears below the contract type field in the contract details screen.

Figure 6: Example of “pilot” tag under the contract details screen on Compass

Where a practice’s contract value contains additional services such as sedation, domiciliary or orthodontics the values of these individual elements should be separately identified in Compass using the service lines along with the associated activity expected for each element, for example:

<table>
<thead>
<tr>
<th>Service</th>
<th>Value</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>General dentistry</td>
<td>£500,000</td>
<td>20,000 UDAs *</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>£150,000</td>
<td>2,300 UOAs</td>
</tr>
<tr>
<td>Sedation</td>
<td>£50,000</td>
<td>500 courses of treatment</td>
</tr>
</tbody>
</table>

* The UDAs recorded on Compass should be the agreed commissioned UDAs in the underlying GDS contract / PDS agreement, not the prototype UDAs.

There is no facility for commissioners to split the general dentistry element between the value associated with capitation and the value associated with activity on the Compass system. This detail is held on record in the prototype contract variation, and updated on an annual basis. Commissioners should check that the sum of these two elements equal the general dentistry service line on Compass.

All transactions undertaken on Compass should be appropriately authorised, with a clear audit trail detailing amendments and alterations. Each commissioner will have their own process for deciding who uses the system and the administrative organisation of its use.
Commissioners should ensure there is a local process for agreeing any additional payments to contractors, which should involve input from their finance team.

There is a bespoke section on the NHSBSA website which includes support guides and interactive how to guides for Compass. Advice is available via the NHSBSA “Ask us” facility. Advice is also available from the DCR programme team on finance issues relating to prototype practices.

**Debt management**

There are a number of situations where a debt can occur and money will need to be recovered from prototype practices. These may include:

- Where a contractor has a monthly schedule showing a negative value due to an adjustment, for example, financial recovery for an overpayment
- The contract may have closed and the practice sent in FP17 claims after the closed date resulting in no allocation for NHSBSA to take the patients charges from, and
- The monthly deductions may be more than the contractor has received in payments that month.

Where money is owed by a contractor there are a number of mechanisms for this money to be recovered:

- **Automatic recovery:** Within the Compass system there is a debt management facility, which will automatically commence a debt recovery process where a contract is in debt. This is referred to as auto netting. Where there is one contract number associated with a provider ID, the system will continue to attempt to recover the money owed each month, until the debt is cleared. Commissioners need to be aware that this automatic process may result in a contract receiving no monthly payment, depending on the level of debt and the monthly payment due. If there is more than one contract number associated with a provider ID, the system will recover the money owed from any of the open contract numbers if there is not enough money available to recover the debt from the original contract number that the money is owed against. There is the option to switch off the auto netting process.

- **Repayment plan:** This will need to specify how many months the debt will be repaid over and the contract number(s) that the debt amount will be deducted from. The repayment plan should be agreed in writing between the commissioner and the contractor. When agreeing a repayment plan the commissioner will need to take into consideration patient charges, superannuation, levies and other standard deductions to ensure there is enough money in the scheduled monthly payment to cover the planned monthly repayment amount. This is to minimise the financial risk and to ensure that the contractor does not end up with a negative payment, which creates further debt. The maximum length of a repayment plan is the end of the financial year (March) except in exceptional circumstances.
• One off payment: A contractor may choose to make a one off payment to repay any monies owed. Alternatively the commissioner and contractor may agree to a mix of a one off payment and repayment plan.

The preferred repayment mechanism for any debt is an adjustment via the payment system. The commissioner can however agree to a BACS transfer. In such instances the payment should be made into NHSBSA’s bank account. Bank account details should be confirmed with NHSBSA prior to payment.

Payments should not be receipted directly into the bank account of the commissioner. This is so that the debt can be appropriately accounted for and any adjustments required around superannuation contributions actioned. If however, this situation occurs it is essential that NHSBSA is informed immediately and arrangements made to pay the funds over to NHSBSA.

In instances where a contract has already closed and there is no option through the auto netting process to recover the money owed from an alternative open contract number associated with the provider ID then the commissioner will need to follow up the debt and arrange for this to be collected.

There are a number of measures that the commissioner can ensure take place to minimise the level of debt in the first place, particularly where a provider has only one contract number and no opportunity to recover debt from alternative open contracts through the auto netting option:

• Ensure that Compass is kept up to date. Once it is known that a contract is closing, undertake the appropriate steps within the system to record this information. The help guides and interactive section on the Compass section of the NHSBSA website provide details of this process. The commissioner has a legal duty to provide an end of contract reconciliation as soon as reasonably practicable, and in any event no later than four months after the termination of the contract.

• The commissioner has the option to retain payment prior to contract closure, which is one way to help reduce the risk of negative schedules or debts on closed contracts. Negative schedules can occur due to receipt after contract closure of the FP17s submitted for work that was performed under the contract before it closed, and the associated patient charges have still to be recovered. It could also relate to arrangements for financial recovery of under-performance once the performance information for the contract has been finalised. Once the final PCR and any underperformance repayments have been processed, any retained final payment can be released with either a final net sum due to the contractor or a residual debt, which will then need to be recovered.

• Regular submissions of FP17s ensure that PCR is collected on a timely basis. Where contractors retain forms and submit in batches even within the allowable two month period, this increases the risk that there is an insufficient level of baseline payment to offset the PCR income against. This will therefore leave the contract with a negative position. Details of suspended and negative payments
are included in the monthly contract payment report which is available through the reporting section on Compass.

**Employers’ superannuation contribution costs**

The NHS Pension Scheme Regulations 2015 set out the arrangements for the NHS pension scheme. Membership is subject to employee contributions being paid by dentists and employer contributions paid by their employing authority. These arrangements do not change for dentists working under a prototype agreement.

For the purpose of superannuation the commissioner is the employing authority and is therefore liable for paying the employers’ superannuation contributions in respect of pensionable earnings of providers and performers where they are members of the NHS pension scheme.

The NHSBSA undertakes the collection process on behalf of the commissioner as defined in the administrative provisions in the prototype SFE. Further details of the superannuation process are set out in part 3, section 9 of the prototype SFE.

Every month NHSBSA calculates the employers’ and employees’ superannuation contributions from the estimated net pensionable earnings (NPE) or net pensionable earnings equivalent (NPEE) entered onto Compass. It is therefore essential that these figures are kept up to date to ensure accurate payment of pension contributions.

The NPE/NPEE of the practice cannot exceed 43.9% of the gross contract value. However, the NPE/NPEE of individual performers will not necessarily equate to the total of 43.9% of their gross allocation. The NPE/NPEE should reflect the salary of the performer after deducting practice expenses such as lab fees and hygienist bills etc. The NPE/NPEE should exclude maternity, paternity and sick pay. The estimate is supplied to commissioners by contractors and should be updated each time a performer leaves or joins the practice. NHSBSA has a contract allocation form (CAF) available on its website to calculate NPE/NPEE values. A link to this form can be found in the resources section. This figure is then updated onto the Compass system. The process for arriving at a performer’s NPE/NPEE is determined at practice level and any formula can be used.

The Compass system will have the facility where contractors can update the NPE/NPEE of performers at the practice. Any updates will need to be authorised by the commissioner. Commissioners and contractors will be informed when this ability is made live on the system.

The employees’ superannuation contributions are deducted from the monthly pay of the provider and are shown on the pay statement alongside the employer’s contributions. The individual performer receives a monthly superannuation statement which clearly shows the amounts deducted for employee’s contributions as well as the amount to be paid by the commissioner for employers’ contributions.

At the end of each financial year, as part of the annual reconciliation report (ARR) process contractors are required to provide the actual NPE/NPEE for all performers.
during the financial year to 31 March. This is done by completing the ARR online via the Compass system, and has to be completed by 30 June. Each performer will also be required to confirm the NPE/NPEE figure. Guidance is issued each year by NHSBSA to support this process.

In order to budget for the likely expenditure associated with employers’ superannuation costs there are a number of key considerations:

- When budgeting for superannuation costs, the maximum employers’ superannuation liability should not exceed 14.3% of 43.9% of contract values;
- Employer contributions are collected from the commissioner by NHSBSA every month. Once the ARR process is completed at year end NHSBSA will collect any arrears or repay overpaid contributions
- Be aware that contractors must provide net pensionable earnings for each performer on the contract. For performers not part of the pension scheme a net pensionable earnings equivalent (NPEE) should be entered. This ensures any residue of the 43.9% for performers who are not superannuable is not being ‘given’ to other performers on the contract to artificially uplift their pensions, thereby adding additional costs for the commissioner. It is illegal for a NHS dentist (or any other scheme member) to credit themselves for NHS pension purposes, with NHS income from another colleague even if that colleague has opted out of the NHS pension scheme.
- Ensure that contractors inform the commissioner every time someone leaves or joins the contract so that the NPE/NPEE is updated within Compass. Commissioners will have standard forms to collect this information
- To note that a performer trading as a limited company cannot be in the NHS pension scheme. This came into force from 7 November 2011
- Make sure every contractor completes the ARR. It is a requirement of the NHS pension scheme and the provider’s contract that this is completed by 30 June each year.

Mid-year

The prototype directions remove the obligation for a formal mid-year process for those practices operating under a prototype agreement.

Therefore commissioners should not apply the process set out in the dental policy document under chapter 1 - financial recovery and reconciliation, for those practices operating under a prototype agreement.

Year-end

At year-end a prototype practice will be reviewed to assess whether:

- Capitated patient numbers are above or below the expected level
- Prototype activity is above or below the expected minimum level

The value of these year-end positions are calculated and combined to see what the actual remuneration should have been for the year.
The remuneration system for prototypes allows an exchange mechanism between prototype activity and capitated patient numbers. This means that practices can over-deliver on capitated patient numbers to compensate for any under-delivery against activity. There is no limit applied to this exchange mechanism under the prototype arrangements. There are also a number of rule sets for managing prototype activity:

- If capitated patient numbers are less than or equal to 100% of expected numbers, then any adjustment relating to activity delivery will be capped at 100%
  - e.g. if patient numbers are 97% of the expected levels, then the activity delivery counted will be no more than 100% of the activity levels.
- If capitated patient numbers are more than 100% of the expected level, then any adjustment relating to activity delivery will be capped at the same percentage as the achieved level for patient numbers
  - e.g. if patient numbers are 101% of the expected level, then the activity delivery counted can be no more than the patient number percentage level i.e. 101%.

There is a year-end modelling tool available for practices to use which can be used by commissioners and practices to assess the combined year-end position taking into consideration delivery on expected capitated patient numbers and expected prototype activity.

A link to this tool can be found in the resources section.

Contractors have two months after a course of treatment is completed to ensure that the necessary paperwork is submitted to NHSBSA. Therefore, year-end calculations cannot be undertaken until the two month period beyond 31 March has lapsed. NHSBSA and the DCR programme prepare the individual calculations for each prototype practice on behalf of NHS England.

Please note the standard year-end reports based on the UDA system continue to be generated for prototype practices. These reports should not be used for the basis of year-end adjustments by the commissioner, and no definitive action on year-end should be taken until the calculations have been received from NHSBSA and the DCR programme.

Where a prototype agreement contains specified services, eg orthodontics, sedation, domiciliary services the year-end calculations described above will not cover these elements of the contract value; only the delivery of capitated patient numbers and prototype activity. Therefore the commissioner must undertake the year-end assessment of delivery against these elements of the contract and apply any necessary adjustments.

The overall principles set out in section 11 of the policy book for primary dental services covering financial recovery and reconciliation remains applicable for prototype agreements. However there are differences in the calculations to determine the final year-end position and any associated financial adjustment or carry forward.
For prototype agreements:

- Where the combined delivery percentage of capitated patient numbers and prototype activity is less than 96% the commissioner will recover the full value of this under-delivery eg if a practice delivers a combined delivery percentage of 94% then 6% of the value of the capitation and activity element of the contract value (known as the AAPV) will be recovered.

- Where the combined delivery percentage of capitated patient numbers and prototype activity is less than 90%, the maximum financial recovery that can be applied is 10%, eg if a practice delivers a combined delivery percentage of 88% then the maximum financial recovery will be 10% of the AAPV.

- Where the combined delivery percentage of capitated patient numbers and prototype activity is between 96% and 100% no financial adjustment is made, but the value of this under-delivery is carried forward to the next financial year. Under the prototype arrangements this under-delivery is carried forward as a financial value rather than activity and/or patient numbers. Section 11 of the policy book for primary dental services states that there should be no financial adjustment made, and a carry forward applied. However, a contractor may prefer not to carry forward the value of any under-delivery and choose instead to pay NHS England the value of this under-delivery. This would be at the discretion of the contractor and commissioner to agree, and in such instances the DCR programme team should be informed.

- Where the combined delivery percentage of capitated patient numbers and prototype activity is above 100%, the prototype directions state that the commissioner may allow a tolerance of up to 2% per year (therefore a maximum of 102% of the value of the AAPV). The commissioner has the flexibility to either pay for the over-delivery or carry forward to the following financial year as a credit. The DCR programme team should be advised on how over-delivery is managed. Under the prototype arrangements this over-delivery is carried forward, if applicable, as a financial value rather than activity and/or capitated patient numbers.

There is no facility in the Compass system to record the carry forward value at the present time. Therefore this figure is recorded in the prototype variation notice and also annotated in the monthly capitation remuneration report.

**Adverse events**

Where there is a provision in underlying GDS contract and PDS agreement for a force majeure a provider can claim for relief subject to a number of criteria and conditions.

Chapter 9 of the NHS England policy book for primary dental services sets out the process to be followed when dealing with these adverse events. It states that contractors are required under the terms of their contracts to promptly notify the commissioner of a force majeure event, detailing the cause or event, what service
provision is being delayed or prevented and what action(s) within their power they are taking in order to comply with the terms of the contract as fully and promptly as possible. Chapter 9 also provides the calculation of dental relief, which is the term used to describe the calculation of the total units of activity that the contractor was delayed or prevented from providing because of the adverse event.

The calculation of dental relief where deemed appropriate is undertaken after all the year-end data has been produced and it is the responsibility of the contract holder to submit an application.

Any application from a prototype practice for dental relief received from a prototype practice should be discussed with the DCR programme team so that the calculation of dental relief is reflected in line with the prototype delivery measurements.

**Exiting prototype arrangements**

Where the decision has been taken, by either party for the practice to exit prototype arrangements, the commissioner, following guidance set out by the DCR programme will need to undertake a number of practical steps before the practice revert to their underlying GDS contract or PDS agreement.

A link to this guidance can be found in the resources section.

If the commissioner wishes to give notice to a practice to exit the prototype arrangements they must first discuss their intentions with the DCR programme. No action should be taken before this.

- **Timing of exit date:** This should be agreed between the practice and commissioner, and it is recommended that the return to the standard GDS / PDS contractual arrangement takes place on the 1st of the month.

- **Contract value and activity:** Practices will return to their underlying contractual arrangements on the same terms and conditions as they had prior to entering prototype arrangements, i.e. with the same contract value and UDA requirement. If the practice exits prototype arrangements at any point other than 1 April, as with any other mid-year contract start, commissioners will need to agree the delivery requirement with the provider for the remainder of the financial year.

- **Updates to Compass:** Following a practice’s exit from prototype arrangements, commissioners should update the following:
  - Contracted UDAs should be entered on a pro-rata basis for the remainder of the financial year (if applicable).
  - Stayed UDAs should be entered as a carry forward.
  - The ‘pilot’ flag included within the contract details section removed.

In accordance with the prototype SFE, when a practice exits prototype arrangements, adjustments for capitation, activity and DQOF (when applicable) will be made on a pro rata basis. Paragraph 4.1 of the prototype SFE states that adjustments will be calculated in month 15 regardless of when the practice leaves the prototype arrangements.
In line with the standard year-end calculations for prototype practices the DCR programme will undertake the calculations required, and once finalised these will be provided to the commissioner to inform the practice of any financial adjustments that are required following their exit from prototype arrangements.

Where a practice exits the prototype arrangements during the financial year the commissioner will also need to assess UDA delivery for the period of the financial year that the practice operated under the UDA system. In accordance with GDS/PDS regulations UDA allocation is based on the completion date of treatment. Therefore, commissioners should ensure they download the appropriate reports via Compass to assess delivery for this period. Further details on the reports to use can be requested from NHSBSA.

For practices that exit mid-year, two calculations will be undertaken to establish the overall year-end position; one on the basis of prototype delivery which will be undertaken by the DCR programme team and shared with the commissioner and one on UDA delivery which will be undertaken by the commissioner. The commissioner is responsible for providing both elements of the year end calculation to the practice. Commissioners should ensure that practices are fully aware of this when exit arrangements are discussed.

**Dental assurance framework for prototypes**

The DAF for prototypes sets out the process for commissioners to follow to assure them that contract holders are on course to meet the obligations under their prototype agreement. Commissioners may wish to work with finance teams when reviewing individual contracts, and may require members from both teams may take part in contract review visits, if appropriate.

**Internal financial planning and reporting**

**Internal working relations**

Effective financial management of the dental budget will include the costs associated with prototype practice, and require a close working relationship between the dental and finance teams. Regular liaison is essential, and may include discussions on:

- The finance team regularly produce budget statements for all areas of expenditure and income which include internal budget reports, expenditure year to date, and forecast year-end positions. The dental team will need to input into this process to ensure that all planned expenditure is accurately accounted for. In addition, to ensure that the dental team is fully aware of their financial position when making decisions around planning and developing services. The finance team should be involved in supporting dental teams to assess the affordability and value for money of contracts, in particular when commissioning new activity or contracts
- Contract data within Compass: The accuracy of the Compass system is essential to ensure that correct and timely payments are made to dentists. If this system is not kept up to date then the commissioner is at risk of making inaccurate and
untimely payments which will create further work and expense to recover this money at a later stage if appropriate, as well as making monthly reports inaccurate. An example of this would be where a contract is due to close, and the closed date has not been entered into the appropriate field within Compass in sufficient time to allow any adjustments to be made to monthly payments.

Internal reporting

As part of the monthly finance reporting process, the finance team will produce budget statements for each service area, and it is important that this information is shared with the dental commissioning team and the designated budget manager. These reports should be reviewed regularly to ensure that they accurately reflect the current position, and that forecasted expenditure includes all known service developments. Reporting timetables will be agreed at the beginning of year, to include scheduled time for discussion between the budget manager and finance. It is also important to ensure that financial matters concerning dental services are reported regularly through the appropriate management structures, which should include details of known and planned expenditure for dental services.

It is important that the commissioner provides regular financial performance reports to update management teams on the year to date positions and provide the latest forecast on full year performance.

The standard reports prepared by NHSBSA will include the prototype practice’s position from their underlying GDS contract/PDS agreement. Therefore any overall reporting of year to date positions and forecasts prepared using this data, should ensure that the activity and performance for these practices are removed. A separate reporting line should be included to cover the prototype practice’s position based on the delivery requirements set out in the prototype agreement.

Patient charge revenue (PCR)

The banded patient charges levied under the prototype scheme are the same as the UDA system. The prototype directions provide for an additional band of treatment under the prototype scheme. This is known as an interim care course of treatment. This course of treatment covers the additional advice and preventative treatment which is planned at the oral health assessment or oral health review. This is known as Band 1A and the charge to the patient is the same as a standard Band 1 course of treatment.

The charge for each band of treatment is updated each year effective from 1 April. It should be possible for expected levels of PCR to be assessed and reviewed using previous years patterns and known service changes and also taking into consideration the different profile of patient charge revenue for prototype agreements.

There are a number of variables that will affect the level of PCR collected:

- The expected capitated patient numbers and prototype activity
• Actual capitated patient numbers on the practice list and the prototype UDAs delivered
• The proportion of charge-paying and exempt patients treated and
• The number of charge-exempt treatments given to patients who would normally pay charges such as denture repairs.

With respect to an individual contractor, where PCR is less than expected, there are a number of recommended points of discussion between the commissioner and the contractor:

• Timely submission of FP17s: Contractors are required to submit FP17 forms (or electronic equivalent) within two months of the date of completion of a course of treatment. Without this data, the NHSBSA cannot make PCR deductions from the contractor’s monthly payments or credit the contractor with prototype UDAs. This also affects the ability for commissioners to be able to make accurate forecasts of full-year PCR, and understand levels of delivery.
• Patient mix: There may be an expected reason for changes in the underlying patient mix, e.g. an expansion in the service provided by the practice and a deliberate attempt to target increased capacity at areas of greater deprivation. Economic influences may also affect the number of charge paying patients coming forward for treatment. If, however, there is a significant and unexpected reduction in the underlying patient mix, the commissioner should establish the reasons for this with the contractor.

Commissioners should also discuss any concerns regarding patient charge revenue associated with prototype practices with the DCR programme.

**Year-end accruals**

Due to the nature of dental reporting, there will always be a time lag in the figures reported for patient charge revenue. Therefore, commissioners can choose to make monthly accruals to reflect this within the monthly finance reports. NHSBSA has produced a template under e-reporting, which calculates the impact of this time lag and the indicative PCR accrual which can be applied in the monthly budget statements. This template is called time lag, and can be run as often as required. An example is shown below:

**Figure 7: Time lag report**

<table>
<thead>
<tr>
<th>Total UDA</th>
<th>In month</th>
<th>1 month</th>
<th>2 month</th>
<th>3 month</th>
<th>Time lag</th>
<th>Average patient charge</th>
<th>Indicative PCR Accrual</th>
</tr>
</thead>
<tbody>
<tr>
<td>22,550</td>
<td>18.4 %</td>
<td>68.1 %</td>
<td>10.0 %</td>
<td>3.6 %</td>
<td>98.8 %</td>
<td>£205,982</td>
<td>£203,421</td>
</tr>
</tbody>
</table>

Finance teams will need to ensure that appropriate accruals are made for patient charge revenue in the year-end accounts. This figure estimates the PCR that relates to the activity delivered before 31 March and reported between 1 April and 31 May each year.
Where prototype practices have combined year-end delivery percentage which is between 96% and 100% the value of this under-delivery is carried forward to the next financial year. The finance team will need to ensure that the appropriate adjustments are made in financial reporting to account for the fact that this delivery will be paid for in one financial year and delivered in the next financial year.

As part of this process the finance team need to ensure that any PCR accruals made are reversed once actual PCR receipts are made, to ensure an accurate position is reported for PCR.

**Contract changes**

For prototype practices any planned changes to the contract should be discussed with the DCR programme team prior to changes being made. The DCR programme team will support the commissioner and finance teams in calculating the delivery requirements following the contract change for the prototype arrangements.

It is important that any changes take into consideration the impact on the dental budget as a whole, such as impact on superannuation costs, SFE payments and impact on PCR collection.

- **PDS to GDS transfers:** A contractor with a PDS agreement has the right to transfer to a GDS contract providing they provide mandatory services, even if they are operating under prototype arrangements. The dental policy handbook has a section which covers managing a PDS contractor's right to a GDS contract, which sets out the process to be followed. The commissioner has the right to consider and negotiate the average value of the UDAs, and it may be beneficial to include the finance team with the calculations to support this negotiation. Any changes made to the underlying UDA value would need to then be discussed with the DCR programme team to translate these changes to the prototype delivery requirements. Any transfers would also need to be reflected in the longer term financial planning as a GDS contract is not time limited.

- **Non-recurrent funding:** The commissioner has the discretion to commission non-recurrent activity in any financial year which may be funded according to local priorities and circumstances. When deciding to award non-recurrent growth practices operating under prototype arrangements should be assessed against the same selection criteria as UDA practices.

- **Recurrent funding:** It is essential that the finance team is involved in any decision about the commissioning of new or extended services. When deciding to award non-recurrent growth practices operating under prototype arrangements should be assessed against the same selection criteria as UDA practices. When identifying the total funding available it is important that it is not just cost of the contract value that is budgeted for. Consideration will need to be made for costs such as superannuation, SFE payments and likely PCR revenue.

**Cost recharge to from NHSBSA to NHS England**

As stated previously, NHSBSA acts as the paymaster on behalf of the commissioner and makes all monthly contract payments. The detail of what is paid to each contract is based on the entries made onto the Compass system, which is adjusted to reflect
the value of PCR that has been reported as collected by each contract. The total net cost is then recharged to the commissioner and the value will reconcile back to the detail contained in the payment and recharge report produced by NHSBSA. The costs associated with the prototype practices continue to be included in this overall recharge.

This report is supported by the detailed contract payment report, which sets out the contracts against which payments have been made.

**Monitoring prototype budgets within the total dental budget**

In order to effectively monitor dental spend, commissioners will need to ensure that there is an appropriate plan/budget in place to be able to routinely monitor the level of spend against the whole of the dental budget, including prototype practices. The key components that should formulate the dental budget include:

- Gross cost of contract values * agreed with the dentists, and
- Anticipated levels of PCR.

* The gross value of practices operating under a prototype agreement does not change upon entry to the prototype arrangements.

The commissioner will also need to account for the following costs as part of the overall dental budget:

- **Superannuation**: Section 4 of the GDS/PDS SFE provides details of how the employers’ superannuation costs are calculated and paid. There should be information on the estimated net pensionable earnings for each dentist who is a member of the NHS pension scheme. For budgeting purposes the maximum liability for superannuation costs will be 14.3% of 43.9% of their gross contract values

- **Cost of out of hours services**: Commissioners are responsible for the provision of these services for their population. There may be more than one provider across an area and these services will vary depending on local needs. The appropriate cost/recharge should be included within the overall dental budget

- **Seniority payments**: These are payments made in respect of individual dental performers who meet the eligibility criteria listed within the SFE under Section 6, which is broadly based on the individual reaching the age of 55 before 1 April 2011. Due to the eligibility criteria this will be a decreasing cost for the dental budget over time as the number of dentists eligible for this payment will decrease. Local workforce information may be available to assess these costs over time

- **Payments for maternity, paternity and adoption leave**: Contractors are entitled to payments in respect of maternity, paternity or adoption leave taken by a dental performer provided the eligibility criteria are satisfied. Changes introduced from April 2017 reintroduce a ceiling to the payments dental providers can claim in respect of a performer taking parental leave. Where this payment is required, the contractor is required to make an application to NHSBSA on the application for
personal payment under the statement of financial entitlements form. Contractors are only eligible for this payment under the SFE if they are claimed within three months of the date on which they could first have fallen due (paragraph 11.13)

- Long term sickness leave: A contract holder is entitled to receive sickness leave payments in respect of a dentist performer that it employs or engages in respect of a complete week of sickness absence, subject to the eligibility criteria set out in section 9 of the SFE. Changes introduced from April 2017 reintroduce a ceiling to the payments dental providers can claim in respect of a performer taking parental leave. Applications for these payments are also managed by NHSBSA. Contractors are only eligible for this payment under the Prototype Scheme SFE if they are claimed within three months of the date on which they could first have fallen due (paragraph 11.13)

- Non-domestic rates: A contractor may be able to claim reimbursement of the non-domestic rates payable in relation to any premises where services are provided under its contract. Broadly speaking the contractor needs to have formal rights in the property which can be inherited which is why it is referred to as the hereditament in the SFE. The eligibility criteria is set out in Section 10 and where these conditions are met then the contract holder must make an application to NHSBSA on the application for personal payment under the statement of financial entitlements form. The proportion of the non-domestic rates to be reimbursed will depend on the proportion of total gross income that relates to the NHS contract. The detail of this calculation is included within the SFE. NHSBSA may request from documentary evidence to accurately demonstrate the proportion of income between private and NHS. The contractor must comply with this request within three months, and

- Funding for FDs: Health Education England hold the budget to fund FD placements. This is specifically to fund approved placements within dental practices. Funding covers the salary and on-costs of employing the trainee, provides payment to the performer who is providing the training and a payment to the contract holder to cover service costs, and commissioners should ensure that there is a full cost recharge process in place. Section 7 of the SFE provides details of the payments and conditions in relation to these payments.

Appropriate planning and monitoring of these costs will ensure that the commissioners can accurately monitor and manage spend within resources available.

The table below provides commissioners with a summary of the objectives, key tasks and timescales:
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>To have a clear understanding of how the remuneration system operates for prototype agreements</td>
<td>Appropriate use of the dental budget to maximise access to and quality of NHS dental services</td>
</tr>
<tr>
<td>To have a clear understanding of the components of the dental budget</td>
<td></td>
</tr>
<tr>
<td>To have systems in place to reconcile the dental budget against committed resources</td>
<td></td>
</tr>
<tr>
<td>Comply with standing financial instructions</td>
<td></td>
</tr>
<tr>
<td>Appropriate management of patient charge revenue</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key tasks to complete</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contract payments and reviews</strong>&lt;br&gt;Paid by contractor</td>
<td>Monthly</td>
</tr>
<tr>
<td>Ensure that the Compass system is kept up-to-date and accurately reflects the total value of each contract, and the elements contained within the overall contract value</td>
<td>Ad-hoc</td>
</tr>
<tr>
<td>Ensure that additional payments are appropriately authorised, with input from the finance team</td>
<td>Annually (after 30 June)</td>
</tr>
<tr>
<td><strong>End of year</strong>&lt;br&gt;In line with the prototype SFE to assess the end of year position of each prototype practice, and calculate the value of under-delivery which may be reclaimed from the contractor</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Assurance Process</strong>&lt;br&gt;Ensure that there is appropriate finance input to inform the dental assurance process for prototype practices</td>
<td>As required</td>
</tr>
<tr>
<td><strong>Internal financial planning and reporting</strong></td>
<td></td>
</tr>
<tr>
<td>Internal working arrangements</td>
<td>On-going</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Ensure that the dental team work closely with finance colleagues, and there is finance input on financial matters associated with contract management.</td>
<td>On-going</td>
</tr>
<tr>
<td>Appropriate use of the prototype reports to monitor prototype agreements contracts.</td>
<td>On-going</td>
</tr>
<tr>
<td>Internal reporting</td>
<td>Monthly</td>
</tr>
<tr>
<td>Produce monthly statements on dental expenditure and income ensuring prototype practices are included (part of the monthly financial timetable)</td>
<td>On-going</td>
</tr>
<tr>
<td>Ensure that dental costs are accurately reflected in the primary care budget as part of the overall financial reporting structure for the commissioner.</td>
<td>On-going</td>
</tr>
<tr>
<td>Monitoring of dental spend and management of patient charge revenue (PCR)</td>
<td>On-going</td>
</tr>
<tr>
<td>Ensure that monthly payments to providers are accurate.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Monitor collection of PCR, taking into account previous year’s trends and known changes to contracts.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Ensure robust forecasting of dental expenditure and PCR, reflecting known service changes and future expenditure plans.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Ensure finance and DCR programme team input into any contract changes such as contract negotiations for new activity or contracts relating to prototype practices.</td>
<td>As required</td>
</tr>
<tr>
<td>Cost recharge from NHSBSA</td>
<td>Monthly</td>
</tr>
<tr>
<td>Ensure that the monthly recharge from NHSBSA is reconciled to local budgets. The payment and recharge summary report produced by NHSBSA can also be used in this process.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Accruals</td>
<td>Year-end</td>
</tr>
<tr>
<td>Calculation of monthly PCR accruals as part of the monthly reporting process.</td>
<td>Year-end</td>
</tr>
<tr>
<td>Ensure that PCR is appropriately accounted for at year-end within the annual accounting process.</td>
<td>Year-end</td>
</tr>
</tbody>
</table>
Section 2: Prototype clinical guidance

Overview

This section has been produced primarily for dental practices, but it contains useful information for commissioners of dental services.

Under the prototype scheme, practices adopt a care pathway approach for patients, with an emphasis on prevention rather than treatment.

Practices operating under the prototype scheme must continue to deliver high quality care to patients but simultaneously patients are helped to accept responsibility for improving and or maintaining their own oral health.

Dental practice software systems for prototype practices have been updated to reflect the requirements of the care pathway.

Regulations and legislation

Practices participating in the dental contract reform programme (DCR programme) need to understand their NHS contract and the associated regulations which underpin it.

The relevant legislation that applies is:

- The National Health Service (General Dental Services Contracts) Regulations 2005
- The National Health Service (Personal Dental Services Agreements) Regulations 2005
- The National Health Service (Dental Charges) Regulations 2005

As well as the legislation listed above, contractors operating under the prototype arrangements must also be aware of the associated regulations that have been developed for this, which are:

- The National Health Service (Dental Services) (Prototype Agreements) Directions 2015
- Prototype Agreement Scheme Statement of Financial Entitlements
- Prototype Agreement Scheme Statement of Financial Entitlements (Amendment) Directions 2016

A link to the regulations can be found in the resources section.
What can be provided through the NHS

All treatment that is, in the dentist’s opinion, clinically necessary to protect and maintain good oral health is available through the NHS. This means the NHS provides any treatment needed to keep the mouth, teeth and periodontal tissues healthy and free of pain.

NHS dental treatment does not include cosmetic treatments that are not clinically necessary, such as teeth whitening and the provision of spare appliances. The provision of sports guards is specifically precluded by the National Health Service (Dental Charges) Regulations 2005, Schedule 3 (p).

The treatment provided through the NHS does not change under the prototype arrangements.

Care pathway under the prototype arrangements

Figure 8: The basic structure of the care pathway.

Steps in the primary care pathway

The care pathway begins with a comprehensive assessment and full examination of the patient’s oral health.

Specific information from the assessment as well as information from the patient’s medical and social history forms is used to assign risk in four clinical areas:
- Dental caries (tooth decay)
- Periodontal disease (gum disease)
- Tooth surface loss (worn down teeth)
- Conditions affecting the soft tissues of the mouth e.g. mouth cancer.

The matrices which have been developed in line with Delivering Better Oral Health: An evidence based toolkit for prevention. The prototype clinical software systems are set to function on the basis of clinical findings and patient information provided. The system enables clinicians to indicate if a patient is non-compliant in one or more of the four clinical domains (caries, periodontal disease, tooth surface loss and soft tissues). An example could be a dentate patient for who a basic periodontal examination (BPE) cannot be completed. By selecting non-compliant in this domain it will not prompt the need to enter a BPE score but will still be used by the matrices within the prototype software.

Information collected for each of these four domains will identify the areas of risk and next steps for the patients.

Using the information gathered during the assessment and examination, the care pathway guides clinicians to provide patients with a preventive care plan indicating their risk using a red, amber and green (RAG) traffic light system. The care plan provides a useful tool for communication with patients and assists the clinician in the transfer of responsibility for self-care. It includes:

- Individually tailored advice to patients on their oral health status and the preventive actions they need to take to improve their own oral health
- Information about the preventive actions recommended by the clinician for example fluoride varnish applications every three months, referred to as interim care (IC)
- Suggested timing for the next oral health review (recall interval).

The RAG risk assessment is as follows:

- Red: red risk status is allocated if there is a red clinical factor that cannot be modified by patient factors (social history information)
- Amber: amber risk status is allocated if there is an amber clinical factor or a green clinical factor with a co-existing patient factor which increases risk eg a patient with no caries would still be classed as amber if poor plaque control
- Green: green risk status is allocated if there are green clinical factors and no patient factors which would increase risk.
The risk status and associated actions are suggested based on the information that has been entered by the clinician. This may be amended at the clinician’s discretion.

For each of the four clinical domains, the matrices within the software combines the disease and/or clinical factors relating to a particular patient with the patient’s modifying factors to produce a RAG score:

- Disease/clinical factors + patient factors = RAG score

It is important to remember that clinical factors take precedence to patient factors, when suggesting a RAG score with one exception (see asterisk* in table above). This single exception is in the soft tissue domain where presence of lesion in a high risk site triggers a red RAG.
For example at an oral health assessment, a patient is assessed as:

- green in tooth surface loss and soft tissue domains
- red in periodontal domain
- amber in caries domain

The RAG score (and recommended recall intervals) default to the highest need. The patient’s RAG score is therefore red.

Certain elements of the pathway/domains are optional to allow clinicians to omit those that are inappropriate in particular circumstances. For example it makes no sense to complete the periodontal or caries risk assessment for edentulous patients, however clinicians must record any item considered clinically necessary.

This may apply to the following:

- Urgent patients (less detailed assessment is required)
- Edentulous patients
- Risk screening for children aged <3
- Referrals
- Domiciliary patients
- Orthodontic screening

**The domain matrices**

The following tables explain how the matrices work in relation to the four clinical domains when comparing the modifying factors with associated risks.
### Figure 11: Caries domain

<table>
<thead>
<tr>
<th>Modifying factors</th>
<th>Risk</th>
<th>Interim care (IC)</th>
<th>Oral health review (OHR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High sugar and high frequency sugar in diet</td>
<td><strong>Green</strong> = Free of caries</td>
<td>For all children aged 3+ ≤ 18 years consider need to apply fluoride varnish 2-4 times yearly in accordance to Delivering Better Oral Health (DBOH)</td>
<td>For children: 3-12 months</td>
</tr>
<tr>
<td>Unsatisfactory plaque control</td>
<td><strong>Green</strong> = Arrested caries (1 or more teeth)</td>
<td>For amber and red adults consider the need for an IC</td>
<td>For adults: 12-24 months</td>
</tr>
<tr>
<td>Sibling with caries (child patient)</td>
<td><strong>Amber</strong> = Early caries (1 or more teeth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of previous caries (&lt;16 years)</td>
<td><strong>Red</strong> = Caries (1 or more teeth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History active caries last 2 years (adult)</td>
<td>Note: Where modifying factors are present with a green clinical factor (free of caries or arrested caries) risk status moves to amber</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence orthodontic appliance (7-18years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not use fluoride toothpaste</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Figure 12: Periodontal domain

<table>
<thead>
<tr>
<th>Modifying factors</th>
<th>Risk</th>
<th>Interim care (IC)</th>
<th>Oral health review (OHR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td><strong>Green</strong> = No sextant BPE 2 or more except lower anterior sextant</td>
<td>No ICs recommended, but consider 3-6 month appointments for amber and red patients</td>
<td>12-24 months</td>
</tr>
<tr>
<td>Plaque control unsatisfactory</td>
<td><strong>Amber</strong> = 1 or more sextant with BPE 2 (excluding lower anterior sextant) or 1 sextant BPE 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoker</td>
<td><strong>Red</strong> = 1 or more BPE of 4, or 2 or more BPE 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ortho appliance (7-18 years old)</td>
<td>Note: If green clinical risk but any modifying factor present excluding age then risk moves to amber</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Figure 13: Soft tissue domain

<table>
<thead>
<tr>
<th>Modifying factors</th>
<th>Risk</th>
<th>Interim care (IC)</th>
<th>Oral health review (OHR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk site (lateral border tongue or FOM)</td>
<td><strong>Green</strong> = no lesion present</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Amber</strong> = lesion present</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Red</strong> = lesion requiring referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol above safe limit (&gt;14 units weekly women and &gt;21 units weekly men)</td>
<td>Notes: 1. If the clinical risk is green and any modifying factors are present then risk becomes amber 2. If the clinical risk is amber and lesion is in a high risk site (eg lateral border of tongue or floor of mouth), this is a case where a modifying factor does change risk status to red</td>
<td>No ICs recommended</td>
<td>12-24 months depending on patient’s age</td>
</tr>
<tr>
<td>Tobacco or smokeless tobacco use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Figure 14: Tooth surface loss domain

<table>
<thead>
<tr>
<th>Modifying factors</th>
<th>Risk</th>
<th>Interim care (IC)</th>
<th>Oral health review (OHR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsatisfactory tooth brushing technique</td>
<td><strong>Green</strong> = Tooth wear normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parafunction</td>
<td><strong>Amber</strong> = Tooth wear moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastric reflux / eating disorder</td>
<td><strong>Red</strong> = Tooth wear excessive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fizzy / acidic diet</td>
<td>Note: Any modifying factor for a green clinical risk moves the risk to amber</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No ICs recommended</td>
<td>12-24 months depending on patient’s age</td>
</tr>
</tbody>
</table>
Care pathway appointment types

Oral health assessment

An oral health assessment (OHA) is the entry point for the patient into the care pathway. Its purpose is to identify the level of clinical need and risk for each patient, and to assess any treatment required.

Based on the clinical examination plus patient’s responses to specific questions about their medical and social history, the software supporting the care pathway will produce a RAG score for each patient.

As part of the assessment/examination the clinician is required to collect the following information:

- Full dental chart including
  - Number of teeth with carious lesions
  - Existing restorations
  - Number of filled, missing, decayed teeth (DMFT/dmft)
- Dental attendance pattern
- BPE, plaque levels and bleeding
- Assessment of soft tissue
- Assessment of non-carious tooth surface loss
- Analysis of the patient’s risk from future disease
- Medical and social history for the patient

The DCR programme has designed medical and social history templates to support the pathway and therefore clinicians may wish to add other questions to help in their approach. Certain data items required to operate the risk assessment are mandatory such as elements of the medical and social history.

The mandatory questions are:

<table>
<thead>
<tr>
<th>Medical history form</th>
<th>Social history form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Use of fluoride toothpaste</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>Diet risk factors (carbonated drinks, sugar snacks etc)</td>
</tr>
<tr>
<td>Gastro-oesophageal or acid reflux</td>
<td>Sibling caries risk (children)</td>
</tr>
<tr>
<td></td>
<td>Smoking/alcohol consumption</td>
</tr>
</tbody>
</table>

A link to examples of the medical and social history forms can be found in the resources section.
Once all the information has been entered into the software system, it is then used to provide patients with a personalised self-care plan which summaries the result of their OHA. The self-care plan enables patients to see clearly why they are in a particular risk category and also flags up any risk behaviours that need to be addressed.

The self-care plan is broken down into four sections:

- Section one provides an overall RAG score for the patient based on their assessment
- Section two provides patients with information on what actions they can take in order to improve their oral health
- Section three provides clinical actions and advice that can be given to patients
- Section four provides information on the next appointment for the patient.
Figure 15: Example self-care plan

Your dental self-care plan

1. ASSESSMENT OF YOUR ORAL HEALTH TODAY

YOUR TOOTH DECAY
- None
- Risk of new decay
- Decay present

YOUR GUM HEALTH
- Healthy
- Need better cleaning by you
- Need treatment by us and better cleaning by you

WHAT ELSE?
- Smoking
- Alcohol
- Soft tissues
- Tooth wear

2. WHAT YOU CAN DO TO ACHIEVE GREAT ORAL HEALTH

Diet
- Keep foods and drinks containing sugar for mealtimes only
- Cut back on sugary drinks or snacks – have none before bed

Toothbrushing
- Brush twice a day: last thing at night and again in the morning
- Parents should help young children
- Spit out afterwards – do not rinse with lots of water

Fluoride
- Use an adult toothpaste with a fluoride concentration of at least 1350 ppm
- Use the toothpaste / rinse / tablets we have recommended

Technique
- We are happy to show you the best way to brush
- Use tape or brushes to remove the plaque between teeth

Tobacco
- Stop smoking or chewing tobacco as this increases your risk from gum disease and oral cancer
- We are happy to give you details of services to help you stop

Alcohol
- Reduce your drinking to safe limits – we can give details of services to help with this

Attendance
- Keeping appointments with us allows us to catch problems early.

3. WHAT WE CAN DO TO HELP PREVENT ORAL DISEASE - Today we have discussed the following:

GENERAL CARE
- Diet – In particular:
  - Effective cleaning to remove plaque
  - Benefits of adult fluoride toothpaste

WHERE WE FOUND GUM DISEASE we recommend:
- Using a toothpaste with active ingredient triclosan or stannous fluoride
- Using a brush with long and short bristles
- Using an electric brush which rotates
- Using a mouthwash called chlorhexidine as a temporary measure
- Using a small headed brush

WHERE WE FOUND DECAY we recommend:
- Fluoride tablets
- Daily fluoride rinse
- Twice daily fluoride toothpaste
- Fluoride varnish application

WHERE REQUIRED
- Tobacco advice
- Alcohol advice
- Tooth wear advice

4. YOUR NEXT VISIT

PREVENTION
- Fluoride varnish application in 8 months
- Advice and support to get the best from toothbrushing
- Advice on diet
- Fluoride varnish

TREATMENT
- Fissure fillings
- More complex restoration of teeth
- Gum treatment – cleaning
- Provision or repair of dentures
- Extraction of teeth
- Other

Your next visit is with the hygienist/nurse/dentist on [date] [time], and will cost £

And then you will need to visit in: 3 months 6 months 12 months 18 months Other (please state)
**Patient communication**

Explaining the RAG status to patients helps them to understand their oral health and through discussion the clinician can encourage them to take responsibility for their own oral health. It also enables the dental team to explain specific preventive interventions they can provide or that the patient can undertake themselves. The preventive actions and codes are generated by the matrices to three different areas:

- Preventive actions for the dental team, for example advice about tobacco and signposting to smoking cessation services
- Preventive actions for patient, for example comply with tobacco smoking cessation advice
- Guidance for clinicians, for example to consider referral for advanced care

Advice on appropriate dental team and patient actions can be found in delivering better oral health, which contains a chapter on helping patients to change their behaviour. A link to the toolkit can be found in the resources section.

If there is any treatment identified at the OHA where possible this should be completed at the OHA appointment.

If the OHA includes a single treatment appointment, this is the completion of the initial CoT and the FP17 is submitted.

There are some patients for example those with learning disabilities or challenging behaviour where it may be very difficult or even impossible to complete a full OHA. If this is the case it is important to record the reasons in the patient’s clinical record as well as ticking the patient “non-compliant” box for the relevant domains.

Whilst the number of non-compliant patient’s will vary depending on the demographics of the practice it would not normally be expected that there would be a significant number of patients that showed as non-compliant for one or more domains.

A patient’s risk status may be amended at any time without having to repeat the full OHA. This may be appropriate where a recent medical diagnosis of diabetes changes a patient’s risk status for periodontal disease.

**Oral health review (OHR)**

The OHR is a refresh or update of the original OHA and will trigger the start of a new care pathway. The OHR is planned according to the patient’s need and risk and acts as a review of the patients care pathway. The recall should be in line with the recommended NICE recall periods. Original information collected during the initial OHA will be pre-populated by the software at the OHR stage in order to save time having to re-enter this information.

As with the OHA if any treatment is identified at the OHR, where possible this should be completed at the OHR appointment.
Treatment appointments

Treatment appointments are appointments used to treat any problems identified at the OHA/OHR, which could not be completed at these appointments. They form part of the same CoT as the original OHA/OHR, and may span more than one additional appointment.

Once the CoT has been completed the FP17 can be submitted.

Interim care (IC)

Interim care (IC) is a concept that is unique to the DCR programme. If, at the OHA/OHR, it is identified that interim care is required, suggested intervals will be provided based on the risk matrices. It is possible to review this interval if considered appropriate by the clinician.

IC appointments are used to provide specific treatment, which has been specified in regulation 12A of the NHS Charges Regulations (charges in respect of primary dental services provided under a Prototype Agreement or a Capitation and Quality Scheme 2 Agreement) as:

a) The giving of specific advice in relation to diet, hygiene, personal habits and oral health in respect of a person to enable that person to be aware and to be able to take steps to prevent dental and oral disease
b) The giving of instructions on techniques and practice required by a person in relation to their dental hygiene to enable that person to improve their dental health and prevent oral disease
c) Checking a person’s compliance in relation to the self-care plan proposed at the oral health assessment or oral health review
d) The provision of a prescription for high fluoride toothpaste or mouth rinse if considered required (when delivered together with one or more of (a), (b), (c), (e), (f) or (g));
e) The surface application of primary preventive measures such as topical fluoride varnish applications, and fissure sealants if required and necessary
f) Scaling and polishing, if required
g) Follow up root surface debridement if required.

Patients receiving treatments in categories (a – d) are seen as advice only and do not attract a patient charge for these treatments.

Patient receiving treatments in categories (e – g) attract a Band1A patient charge.

An IC course of treatment is not intended as a further check-up and unlike any other banded CoT there is no regulatory requirement for a dentist to do an examination. Therefore this appointment can be provided by any clinician with the appropriate skill set and it is un-necessary (and inefficient) for a dentist to do a full examination of the patients mouth – doing a full examination negates the point of the comprehensive need and risk assessment that is undertaken during the OHA. The clinician may however, particularly for periodontal cases, compare findings at the OHA with the patient’s progress at their IC appointment.
An interim care appointment is also a separate CoT in its own right and is about prevention and reinforcement of oral health advice NOT active treatment. It is defined in the prototype regulations as:

“The additional advice and preventative treatment proposed for a patient in an interim care plan at a patient’s oral health assessment or oral health review, known as an interim care course of treatment...is to be provided by the participant as a new course of treatment.”

As there is no regulatory requirement for an examination, IC appointments may be delivered by either a registered dental care professional (DCP) eg hygienist, therapist, extended duty dental nurse or a dentist. Under the prototype scheme this course of treatment can be opened and closed by a DCP as there is no need to include an examination or assessment for these appointments.

The patients RAG status guides the clinician to the appropriate IC interval. The dentist may determine a shorter or longer IC interval based on their clinical discretion. Generally patients marked as green (and therefore orally fit) should not receive an interim care appointment.
General information

Prototype leaflets and forms

For practices operating under the prototype arrangements there is a dedicated practice record form – patient declaration (PRDP) that must be used. This form must be completed by the patient in order to give consent to treatment.

The DCR programme is collecting data from practices which include information of any private treatment delivered to patients on the practice capitation list that may be given as an alternative to NHS care. In order to make sure that patients are aware of this, the DCR programme has designed a fair processing notice, (also known as a privacy notice) which informs patients that basic details regarding any private treatment may be shared with NHSBSA, and in an anonymised form, with the Department of Health.

Both of the above documents are specific to prototyping arrangements and it is a requirement that practices operating under the prototype scheme adheres to the requirement to use them.

All other forms, such as the FP17, are unchanged.

Additional information can be found in the managing a prototype practice section.

National Institute for Health and Care Excellence (NICE) recall guidance

Under NHS regulations all dentists are expected to deliver care to patients in accordance with NICE guidance. Practices operating under the prototype scheme are expected to adhere to these regulations.

NICE has published guidance on dental recall intervals and for adult patients it recommends that they should be recalled between three months and two years and the recommended interval for children is between three and 12 months. The actual interval should be assessed by the dentist based on the patient’s needs.

Dentists should discuss the recommended recall interval with the patient and record this interval, and the patient’s agreement/disagreement with it, in the clinical record. The recommended interval should also be recorded on the form FP17.

Completion of the FP17 claim form

The standard FP17 rules for completion and return of information on courses of treatment apply in the prototypes. To minimise the risk of late FP17 submissions, it is recommended that they are sent daily to NHSBSA after being approved.
Completion of the FP17DC treatment plan

The GDS and PDS regulations state that a contractor is required to issue a written form FP17DC to patients who are accepted for treatment under Band 2, Band 3 or if providing any part of the treatment under private contract, or where the patient requests one. An electronic equivalent version of the form FP17DC is an acceptable alternative.

Treatment on referral and completion of the FP17RN referral notice

The referral notice must be completed when patients are referred to another provider who holds either an additional or advanced mandatory services referral contract and for referral to specialist care. The form is not required for referral for orthodontic services.

All sections of the FP17RN would be completed by the referring practice.

Additional services contracts cover treatment on referral for sedation, domiciliary and orthodontics (where UOAs apply). When a patient is referred for additional services, all of the patient's treatment is carried out as two separate courses of treatment and therefore two patient charges where a patient charge is applicable.

The patient's main dentist carries out the treatment they have proposed (excluding that to be provided on referral) and charges the patient for it. The dentist will receive the appropriate number of UDAs/UOAs for the treatment completed. The paper FP17 or the electronic FP17 (referred to as an EDI claim is completed in the usual way and no additional boxes need to be crossed.

The second dentist, who is providing treatment on referral under additional services, completes the treatment required and charges the patient separately for this course. The second dentist will receive the appropriate number of UDAs/UOAs for the treatment provided. For domiciliary and sedation services, the FP17/EDI claim will require entries in part 6 indicating 'treatment on referral' and which service has been provided where applicable. There are no equivalent boxes to complete for orthodontic claims which are made on form FP17O.

Advanced mandatory services contracts cover other types of treatment provided on referral that are not included under additional services. These contracts are usually for endodontics, surgical dentistry and periodontics. When a patient is referred for advanced mandatory services, all of the patient's treatment is effectively carried out as one course of treatment for patient charge purposes.

The patient's main dentist refers a patient to another dentist, each dentist will be credited with UDAs associated with the treatment they provided. The collection of patient charges will remain unchanged and it is the responsibility of the referring dentist to collect any patient charge. This charge will be based on the treatment band for the entire course of treatment. The treatment band should be entered into box G 'referral for advanced mandatory services' on the FP17.
The dentist providing the treatment on referral under advanced mandatory services claims the UDAs appropriate to the treatment provided. No charge is levied as the patient has already paid for the full course of treatment. The dentist providing treatment on referral under advanced mandatory services submits an FP17 or EDI claim and will need to cross 'treatment on referral' in part 6 to ensure that no patient charge is deducted.

This will not trigger capitation.

**Incomplete courses of treatment**

For any incomplete treatment claim, the dentist must have started the treatment to claim the prototype UDAs and not just planned the treatment. For example where the dentist prepares a tooth for a crown or records impressions for a denture, but the crown or denture are not fitted, they can claim Band 3 incomplete and claim the prototype UDAs.

**Free repairs and replacements**

Certain restorations can be repaired or replaced at no charge to the patient in the 12 month period commencing on the date the restoration was provided.

These restorations are:

- Fillings
- Root fillings
- Inlays
- Porcelain veneers
- Crowns

Repeated free repairs and replacements of the same restoration in a tooth may indicate poor treatment planning or inadequate quality of treatment. Although the patient does not pay for free repairs and replacements there is a cost to the NHS.
Urgent treatments

Contractors are expected to deliver urgent courses of treatment in line with GDS and PDS regulations.

Under prototype arrangements an urgent course of treatment does not trigger capitation.

Requirements for a course of treatment/splitting courses of treatment

The GDS and PDS regulations do not formally define splitting courses of treatment but the term is generally used to describe the deliberate intention not to deliver all necessary treatment in a single course of treatment.

Once an OHA has been undertaken a dentist is required to provide all necessary treatment that has been identified for the patient within the appropriate banded course of treatment. Where treatment options are available these should be agreed with the patient

If a dentist is repeatedly splitting treatment across several courses of treatment, this will be identified in the activity monitoring reports from NHSBSA.

Mixing of services provided under the contract with private services

Where patients elect to have a mix of NHS and private treatment, the contractor should discuss all treatment options with the patient.

Patients do have a choice to opt for treatment to be provided to them on a private basis however they must be provided with all the relevant information in order to make an informed decision.

When discussing treatment with a patient the dentist must not mislead the patient about the treatment options or the quality available on the NHS. They may wish to discuss alternative private care which a patient can consider.

A treatment plan outlining the care being delivered must be provided to the patient with the clear indication of whether this is being provided under the NHS, privately or as a mixture of the two.

Regulation 11

Regulation 11 is the treatment band that applies to replacement NHS dental appliances, when the original was lost or broken, due to an act or omission by a patient. This also applies to stolen appliances. Both the original and the replacement appliances must be provided under the NHS for Regulation 11 to apply.
A Regulation 11 doesn't apply to the two month continuation rule regardless of the time lapsed since the course of treatment has been completed, it would still be considered as a Regulation 11 course of treatment.

**Patient charges and activity**

- The patient will pay 30% of the Band 3 (per appliance) charge even if they do not normally pay (30% will always be rounded down to the nearest ten pence if there is an odd pence).

- Prototype UDAs are awarded for replacement general appliances.

- UOAs are not awarded for replacement orthodontic appliances. The orthodontist keeps the patient charge instead.
Section 3: Managing a prototype practice

Overview

Managing a prototype practice requires an understanding of the care pathway philosophy, the remuneration system and the practice’s contractual obligations as specified in the contract variation that underpins the prototyping arrangements in place for practices delivering services under general dental service contract (GDS) and personal dental service agreements (PDS) contracts. Please refer to relevant sections of this handbook for detailed information about each.

Compass

Compass is a web based system that helps contractors manage their contract.

Compass gives providers and performers:

- Visibility of contract information
- Visibility of financial information
- Visibility of the progress of claims as they are being processed
- Increased visibility of pension information
- Access to bespoke prototype reports

The system provides contractors with the functionality and information to help monitor the delivery contract expectations and enables contractors to take a more active role in ensuring they are able to deliver expected performance over the course of the year.

Accessing compass

It is important that all providers and performers activate and use their Compass accounts. If anyone in the practice hasn’t activated their account they should be encouraged to do so.

Advice is available from NHSBSA’s Dental Services helpdesk by sending an email to nhsbsa.dentalservices@nhsbsa.nhs.uk or by ringing 0300 330 1348

Where to get help on Compass

How to … guides are available on the NHSBSA website.

A link to the NHSBSA website can be found in the resources section

Submitting data

There are two information flows which must be transmitted by prototype practices:

- The FP17 returns
• Dental practice management system data (DPMS) which is required as a condition of prototyping. The DPMS data is also referred to as appointment data.

There is no relationship between these two data streams, they are independent transmissions. Therefore a schedule indicating that the FP17s have been successfully transmitted does not mean that DPMS data relating to appointments in those courses of treatment has also been received and vice versa.

The practice must check the separate data transactions frequently and thoroughly to ensure that both sets of information have been successfully sent and received. This will ensure the practice is contractually compliant.

The timeliness of DPMS transmissions and FP17 submissions is measured within DQOF and practices will be able to view their monthly performance via the online Compass reporting system operated by NHSBSA.

**FP17 returns**

In line with paragraph 38 of the NHS General Dental Services Regulations and paragraph 39 of the NHS Personal Dental Services Regulations the standard FP17 rules for completion and return of information on courses of treatment (CoTs) apply in the case of prototypes. This means that if FP17s are submitted outside the required two month timeframe any prototype units of dental activity (prototype UDAs) associated with the CoT will not be counted, nor will the late FP17 trigger or retrigger capitation. Patient charge revenue (PCR) deemed to have been collected by the practice, will still be deducted from the monthly payment made to the contractor. However, this rule does not apply to incomplete courses of treatment, where the patient failed to return.

Failure to return an FP17 within the required timescale will result in direct financial consequences for the practice as it does in the UDA system. In the case of prototypes, both activity and capitation elements of the contract will be affected.

To minimise the risk of late FP17 submissions, it is recommended that they are sent daily to NHSBSA after being approved by the contractor. Submission reports should be viewed and reconciled monthly to ensure the data captured and recorded provides an accurate reflection of the services delivered.

**Dental practice management system data**

Appointment data is collected for prototype practices and this is referred to as dental practice management system data. The data reported against individual appointments will include the type of appointment, e.g. oral health assessment (OHA), oral health review (OHR) or treatment appointment. All will contain basic information, including the identity of the contractor and performer, patient details, appointment date, duration of treatment, details date of acceptance and/or date of completion of treatment or how far the course of treatment is progressed.

In the case of OHA/OHR appointments, details of the assessment are required including details of current problems; a summary of the patient’s charting identifying
the number of decayed, missing and filled teeth, plaque control and the red/amber/green (RAG) status for the four clinical domains:

- Dental caries (tooth decay)
- Periodontal disease (gum disease)
- Tooth surface loss (worn down teeth)
- Conditions affecting the soft tissues of the mouth e.g. mouth cancer

In the case of treatment appointments, the additional data will include what treatments have been provided at a particular appointment, whether the treatment provided is NHS, private or mixed. The detail required is at the same level as the FP17 clinical dataset, for example the number of crowns provided or whether a scale and polish has been undertaken.

All completed appointments must be reported to NHSBSA within seven days of completion but practices are strongly advised to establish a routine of daily transmissions and avoid a back log building up. A delay in submitting data can quickly become unmanageable particularly if any transmissions are rejected and need to be re-sent. A daily routine will also help maintain the accuracy of the practice list size.

The process for transmitting the DPMS data is different for each of the software systems that are supporting the DCR programme. Guidance provided by the software supplier will give details of the process that should be followed.

It is likely that approval of transmissions will be required before they are sent; failure to approve may result in the information not being transmitted.

The following applies to all software systems:

- Appointments are transmitted to NHSBSA as a batch. A batch can be a single appointment or multiples (for example all appointments completed that day)
- Information already transmitted can be corrected, if required. This does not mean the whole batch has to be resubmitted just the appointment containing the changed information
- Daily transmissions are strongly recommended

The DPMS data is vital to prototype evaluation. Any significant failure to return DPMS data within the seven day window set out in The National Health Service (Dental Services) (Prototype Agreements) Directions 2015 is grounds for the commissioner to issue a remedial breach notice and to consider exiting the practice from the prototype scheme. If the practice experiences problems keeping up with returns, the commissioner, the software provider, NHSBSA and the DCR programme team should be alerted as soon as possible.

**Interim care (IC)**

An IC CoT (Band 1A) is unique to the prototype schemes and reported in the same way as data from any other prototype CoT or appointment.
Most IC CoTs will be a single appointment but as with any other CoT they can include as many appointments as required to complete the treatment.

The patient charge, Band1A, is collected where applicable in the same way as other patient charges.

**Capitation triggers**

Capitation is triggered by the receipt of an FP17 in respect of the following courses of treatment:

- Band1
- Band1A (IC)
- Band 2
- Band 3

A late filed FP17 will not trigger (or reset) capitation for a patient.

Capitation is not triggered by Band 1 Urgent CoTs or any CoTs carried out on referral.

DPMS data for an oral health assessment or review (OHA/R) triggers capitation in advance of an FP17 being received, which ensures contractors have up to date capitation information. If no FP17 is then submitted, the DPMS capitation data for that patient is discounted at year-end.

**Transition to prototyping - open courses of treatment**

In the case of practices entering the prototyping system it is important to note that there is no close down of open courses of treatment on transition to prototyping. Courses of treatment that are open when practices become a prototype continue as normal over the transition period. When treatments are completed, the FP17 is sent to NHSBSA ensuring the UDAs delivered are counted towards fulfilment of the contract. However, in the case of these particular courses of treatment, the DPMS data will not trigger capitation because the OHA will have happened prior to the start date of prototyping. However the FP17 data will ensure the patient is counted in the capitation list subject to prototype rules noted above.

**Transmission errors**

**FP17 errors**

All FP17s received by the NHSBSA undergo a validation process where error messages are produced when mandatory data has not been transmitted or has been transmitted incorrectly. In this case the data has been rejected by the NHSBSA system, and must therefore be corrected and re-transmitted.

Below is a list of the top ten reasons for claims being rejected from processing.
<table>
<thead>
<tr>
<th>Error code</th>
<th>Error message</th>
</tr>
</thead>
<tbody>
<tr>
<td>501</td>
<td>Invalid contract number or performer</td>
</tr>
<tr>
<td>103</td>
<td>Invalid date of acceptance or completion</td>
</tr>
<tr>
<td>401</td>
<td>Claims overlaps / duplicates and existing claim for the same patient, the same contract or performer</td>
</tr>
<tr>
<td>109</td>
<td>Remission or exemption box error</td>
</tr>
<tr>
<td>101</td>
<td>Invalid patient’s details</td>
</tr>
<tr>
<td>856</td>
<td>No significant treatment found on the claim</td>
</tr>
<tr>
<td>505</td>
<td>Claim dates are outside of the contract dates of performer’s tenure with that contract</td>
</tr>
<tr>
<td>128</td>
<td>Inappropriate quantity associated with treatment code</td>
</tr>
<tr>
<td>113</td>
<td>Quantity or tooth notation following treatment is incomplete or incorrect</td>
</tr>
<tr>
<td>860</td>
<td>Incomplete treatment band not consistent with band claimed</td>
</tr>
</tbody>
</table>

**DPMS errors**

Similar to the FP17 data, appointment data also has a validation process that will reject incorrect transmissions, which must also be corrected and retransmitted. In the event of a transmission error or problem that cannot be resolved, the practice should contact the software supplier for help and advice. Each supplier has support arrangements in place.

**Accessing reports on Compass**

Bespoke reports are available for prototype practices through Compass on a monthly basis.

To view these reports the practice will need to logon to Compass using normal Compass login details.

A link to information about Compass and on how to find reports can be found in the resources section.

The prototype reports are designed to provide information to the contractor about how the practice is performing against the prototype delivery requirements. It is recognised that some reports will be of interest to individual performers, and a number of these reports are now available directly to performers via their own personal Compass login.

Eight reports are available on Compass to help manage the practice principally in pdf format but in some instances the report are also available in excel. This allows practices to sort and filter the information. A summary of each report is set out in the table below:
| Capitation remuneration report | This report provides a summary of the actual patient numbers on the capitated patient list against the expected patient numbers and the prototype UDAs delivered against the expected minimum activity level. |
| Capitation and activity report – performer level | This report provides a performer level breakdown of the number of capitated patients and the number of prototype UDAs delivered during the month, as reported on the capitation remuneration report. Performers have access to their own information from this report, which is available via their Compass login. |
| Capitated patient list – details | This report contains the name and personal details of each patient on the capitated patient list, the name and performer number of the performer who last saw the patient at the most recent capitation trigger event and, the time left until the patient lapses. A full explanation of capitation triggers can be found above. Patients are listed in the order of the time left on the practice's capitated patient list until they are lapsed. A red/amber/green flag indicating how imminently the patient will lapse and the immediacy with which attention should be paid to making contact with the patient. Excel provides the facility to sort and filter the data. Performers have access to their own information from this report, which is available via their Compass login. |
| Capitated patient list – summary by performer | This report provides a summary of the total number of patients included in the practice's capitated patient list at the end of each month, by performer. This report will be updated every month throughout the financial year. |
| Imminent lapsers – details | This report is a sub-set of the main capitated patient list and provides the personal details of patients who are due to lapse within six months from the date of the report. |
| Imminent lapsers – summary by performer | This report summarises the total number of patients due to lapse within one month, on to three months, three to six months by performer. |
| Leavers and joiners – details | This report lists the patients that have left the practice in the latest reporting month. The report provides the transfer date for the patient, which is the date the |
patient left the capitated patient list. The reasons for this may be because the patient lapsed or became a capitated patient at another practice or was last seen by a foundation dentist trainee for continuing care. It also lists the patients who have joined the practice in the latest reporting month.

**Leavers and joiners – summary**

The report is a summary of the number of joiners and leavers and provides the net increase in capitated patients at the practice for each month of the financial year to date and the totals for that period. It also shows the number of joiners and leavers for the financial year to date by performer.

**Frequency of reports**

Prototype reports are produced on a monthly basis to facilitate regular review and management of a prototype practice’s delivery against expected levels.

The reports are published in the month after the schedule close, for example May’s reports will be available in early June.

The cut-off date for appointment transmissions is the 22nd of each month, and the FP17 data cut off is in line with the NHSBSA scheduling dates, usually around the middle of the month. A link to the list of FP17 transmission schedule cut-off dates can be found in the resources section.

**Prototype practice year-end modelling tool**

The remuneration models for the prototype contracts are different to those of the UDA and pilot systems, reflecting the changes currently being tested. It may be difficult for a prototype practice to estimate the likely fulfilment of its contractual obligations at year-end because the arrangements for prototype remuneration are different to what practices are used to.

To assist, a modelling tool has been developed to help prototype practices forecast their year-end position at any point in the year based on their own estimated year-end figures, enabling timely decision making about any actions that may be required to meet their contractual requirements. For example, whether to implement skill mix, review appointment and recall patterns or opening hours. It should also help practices take into account holidays or extended periods of leave such as sickness, maternity or paternity leave when planning the delivery of the service.

A link to the modelling tool can be found in the resources section.

Practices can populate the green boxes with the data from the capitation remuneration report (available on Compass) and the tool will automatically calculate the current year-end position. There are guidance notes contained within the first tab of the tool.
The data entry field for capitated patient numbers and prototype UDAs within the tool may be varied by the practice to determine the impact of an increase or decrease in the number of patients seen or, prototype activity delivered. Under the prototype system, a shortfall in prototype UDAs may be offset if the practice sees more patients and so at its simplest, the tool allows the contract holder in this scenario to calculate the number of additional patients required to be seen in that financial period or additional prototype UDAs delivered if combination of both is needed.

**Dental assurance framework (DAF) for prototypes**

The dental contract reform DCR programme team and NHS England have jointly drafted a DAF to reflect the system of working for prototype practices. The purpose of the framework is to create a standardised approach to assurance taking into account performance across the four domains, which are delivery, patient safety, patient experience and quality/clinical effectiveness to provide commissioners with an informed view of contract delivery.

A link to the prototype DAF can be found in the resources section.

**Appointment book management top tips**

Managing the appointment book to maintain access to services can be challenging for any practice, but working in a new system can complicate this further.

The appointment book management top tips handbook has been produced to help prototype practices manage their appointments. It is a collection of useful hints and tips shared with the DCR programme by a range of former pilot practice contractors.

The hints and tips are divided into three areas; structure, managing patient flow and practice administration. Not all sections will be applicable to all practices.

A link to the appointment book management top tips can be found in the resources section.
Prototype Leaflets and Forms

The following documents are specific to prototyping arrangements and it is a requirement that prototype practices use them.

| **Appointmenet book management top tips** | Managing the appointment book to maintain access to services can be challenging for any practice, but working in a new system can complicate this further.

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The hints and tips are divided into three areas; structure, managing patient flow and practice administration. Not all sections will be applicable to all practices.

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|---|---|
| **NHS dental prototypes: patient information leaflet** | The prototype patient information leaflet which sets out the care patients can expect under the prototype arrangements and provides information on the relevant NHS charges effective from 1 April each year and the standard patient information leaflet entitled “NHS dental services in England” which provides details about NHS dental services in England should be given to all patients. The prototype patient information leaflet replaces the pilot patient information leaflet “Oral Health Assessment: NHS Dental Pilot Leaflet.”

A link to a copy of the leaflet and information about how to place an order can be found in the resources section. |
| **Prototype practice record form – patient declaration (PRDP)** | Practice record form – patient declaration (PRDP) is the form the patient must complete giving consent to treatment.

There is a dedicated PRDP form that prototype practices must use. A link to a copy of the form can be found in the resource section.

The PRDP form has been revised to reflect changes in universal credit exemptions that came into effect on 1 April 2016. |
| **Fair processing notice (also known as a privacy notice)** | The DCR programme is collecting data, for evidence and learning purposes, on private treatment delivered to all patients who are on the practice capitation list held by the |
NHSBSA, as an alternative to NHS care. The fair processing notice makes patients aware that basic details of their private treatment (the fact that a treatment was delivered) may be shared with the NHSBSA and, in anonymised form, with the Department of Health and NHS England. All patients including those who have had NHS care from the practice in the previous three years should be handed a copy of the fair processing notice that the DCR programme has produced.

A link to a copy of the fair processing notice can be found in the resources section.

Ordering process

Please note there are different processes depending on which leaflet is being ordered:

Patient information leaflets

These leaflets can be ordered online and Xerox’s registration process must be followed:

- The registration form, entitled Xerox registration template can be downloaded
- It should then be completed and submitted electronically
- Once registered, Xerox will enable access to the online ordering portal

A link to the online form can be found in the resources section.

PRDP and fair processing notice

The PRDP forms and the fair processing notice are supplied by Primary Care Support England (PCSE). These leaflets can be ordered online and PCSE’s registration process must be followed.

- Register with the PCSE portal Prototype. Practices will have received a letter by post advising them how to register to use the PCSE portal. The letter has a unique identifier at the top of the page which is required for successful registration. If the practice does not have the unique ID number they can email to request one. The subject heading of the email should state ‘portal unique identifier needed’ and the body of the email should contain name of the sender, the practice name, practice address and the organisation code which is the same as the practice’s location ID
- Once registered order a supply of PRDP forms and the fair processing notice by visiting the PCSE portal.

A link to the PCSE portal and email address can be found in the resources section.
bulk transfers

In order to provide accurate performer level reports for practices, patients need to be allocated, where possible, to the correct performer. The process referred to as “bulk transfers” allows contractors to transfer a whole capitation list from one performer to another within the practice as and when a performer leaves or goes on long term sick/maternity/paternity leave. It is currently only possible to transfer a whole list.

Patients that are seen by a foundation dentist (FD) are excluded from the capitation count. Patients therefore can be transferred from the list of one FD to another as and when they leave the practice without any impact on the calculation of capitation payments.

Please note that it is not possible to transfer patients from one FD to a performer as they can only be included on a performer’s list when he/she provides treatment for the patient and submits an oral health assessment/review appointment, a Band 1, 2 or 3 non referral course of treatment or an interim care course of treatment.

To ensure there is adequate time for a bulk transfer to take place, practices should ensure the request is submitted at least 10 working days before the end of the month by clicking the link at the bottom of the page “transfer request form”

A link to the NHSBSA site to make a bulk transfer can be found in the resources section.

Claiming for Prototype Statement of Financial Entitlement (SFE) items

Claims for parental, sickness and non-domestic rates pay will be processed by NHSBSA on behalf of NHS England in line with the eligibility criteria in the prototype SFE.

Contractors can claim for additional payment items in respect of their performers’ long term sickness leave payments and parental leave (maternity, paternity and adoptive leave). Contractors can also claim for reimbursement for non-domestic rates that meet the criteria specified in the prototype SFE.

In order to claim for these additional payment items contractors must complete the claim form application for personal payment under the prototype SFE.

A link to the claim form can be found in the resources section.

It is important to note that any performer, who has registered themselves as a limited company performer, isn't entitled to claim prototype SFE payments.

Incorporated performers are specifically not allowed to join the NHS pension scheme and, as they are a corporation providing subcontracted services to a contracted contractor, they are not considered as individuals. A company isn't entitled to other benefits offered to individual dentists under the prototype SFE including maternity, paternity, sickness etc.
Self-employed individual contractors can apply for self-employed sickness or maternity benefits under the national government scheme.

**Parental leave and long term sickness**

In April 2017, changes to parental (maternity, paternity and adoption) and long term sickness leave arrangements will come into effect underpinned by amendment directions to the SFE. These changes will reintroduce a ceiling to the payments dental providers can claim in respect of a performer taking parental or sickness leave.

Where a claim is made in respect of a performer who is entitled to claim statutory maternity allowance (SMA), as a self-employed individual, an equivalent amount should be deducted from the amount claimed.

**Non domestic rates**

Contractors are entitled to reclaim non domestic rates paid for premises where services are provided under an NHS contract where they are responsible for paying those rates.

In order to claim payment for non-domestic rates contractors must complete the Application for Personal Payment under the prototype SFE form available on the NHSBSA website.

All claims must be submitted with the appropriate evidence of NHS / private treatment ratios as detailed on the form.

NHS BSA carry out post payment verification of claims for non-domestic rates. Where the evidence does not support the ratio that has been declared the reimbursement will be recovered proportionately.

A link to the prototype SFE can be found in the resources section.

**Annual reconciliations returns**

All contractors and performers are required by law to confirm net pensionable earnings for the previous financial year by 30 June each year. This is referred to as the annual reconciliation process and these figures are used to provide NHS pensions with the actual net pensionable earnings of each scheme member in order to calculate accurate pension records. Contractors and performers who are members of the NHS pension scheme are required to confirm that the estimate of their NPE is correct.

Contractors and performers will complete their declaration online using Compass.

A link to the NHSBSA’s guidance on annual reconciliation returns can be found in the resources section.
NHSBSA carry out a number of checks following the end of year superannuation reconciliation process to determine whether the UDA’s attributed to performers for the year appear to be in line with the net pensionable earnings declared.

The timetable for the process is:

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 April</td>
<td>The annual reconciliation reports are available in Compass</td>
</tr>
<tr>
<td>30 June</td>
<td>All annual reconciliation reports must be completed and submitted by 30 June</td>
</tr>
<tr>
<td>July</td>
<td>Any adjustments needed as a result of the declared figures will appear on the July schedules paid in August</td>
</tr>
<tr>
<td>August</td>
<td>SD86Cs giving the final position for contributions will be available in Compass from early August</td>
</tr>
</tbody>
</table>

Please note that the system of annual reconciliation of pensionable earnings is the same for prototype practices as it is for those working in the UDA system.

**Contract allocation form**

There is a form on the NHSBSA website which contractors use to notify their commissioners about how much each of their performers estimated net pensionable earnings are. This can be changed each time there is any change to the practice, the contractor, or the performer. This contract allocation form should be sent to the commissioners who will enter the figures on Compass.

A link to the form can be found in the resources section.

**Patient eligibility to exemption or remission from charges**

Patients may claim NHS dental services for free or at a reduced cost, if they entitled to do so. Patients are required to complete the reverse of FP17/PR form declaring their entitlement to free or reduced cost for NHS dental services, indicating which benefit of certificate they receive. Patients should show evidence to their dental practice to support their declaration.

Checks on claims are undertaken to confirm patients are entitled to free or reduced cost of NHS dental services. Incorrect claims will result in a penalty charge to the patient, in addition to the cost of NHS dental services.

A link to further information about free or reduced cost NHS dental services for both patients and dental practices can be found in the resources section.

Both patients and dental practices have a responsibility to ensure claims for free or reduced cost NHS dental services are correct. An estimated £60m worth of NHS dental patient charges a year are at risk from patient error or fraud. This is money that could be used on frontline NHS services.
Storage and availability of patient records

The GDC imposes a professional obligation to create records to document dental treatment that is provided to patients. This obligation is set out in standard 4.1 standards for the dental team which states: “You must make and keep contemporaneous, complete and accurate patient records”.

A link to the document produced by the GDC and published on their website can be found in the resources section.

The GDS contract requires that records are made of any treatment provided. It also specifies the length of time that records must be kept, in accordance with the contract.

The NHS contract currently requires records to be kept for two years in England.

The contractor is advised to seek guidance from his/her dental protection indemnifier on this matter as their advice is likely to be that clinical records should be kept for longer than this minimum period of two years.

There are a number of pieces of legislation that require both NHS and private practitioners to keep records. These include:

- The Consumer Protection Act 1987 under which an action could arise for a defective product
- The Medical Devices Directive (Directive 93/42/EEC), which relates to custom-made devices
- The Medicines Act 1968
- The Misuse of Drugs Regulations 2001
- Access to Health Records 1990

A link to these documents can be found in the resources section.

The Health and Social Care Act 2008 has led to the formation of the Care Quality Commission (CQC), which sets out detailed requirements for records.

What the regulations say with regard to CQC and records

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (No 2936) states that:

- The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of: an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and such other records as are appropriate in relation to
- The registered person must ensure that the records referred to in paragraph (1) (which may be in paper or electronic form) are: kept securely and can be located
promptly when required; retained for an appropriate period of time; and securely destroyed when it is appropriate to do so.

People who use services can be confident that their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.

Other records required to be kept to protect their safety and well-being are maintained and held securely, where required.

Contractors who comply with the regulations will keep accurate personalised care, treatment and support records secure and confidential for each person who uses the service:

- Keep those records for the correct amount of time
- Keep any other records the CQC asks them to in relation to the management of the regulated activity
- Store records in a secure, accessible way that allows them to be located quickly
- Securely destroy records taking into account any relevant retention schedules.

Access to records

Patients have a statutory right to see records made about their dental care under the Data Protection Act 1998 and Access to Health Records Act 1990. If a patient has died, the right to access their records passes to those who may have a claim against their estate.

Retention of records

The Data Protection Act says that a person holding sensitive personal data, which includes, dental records, should retain that information no longer than necessary. There is no definition of ‘necessary’ as this will depend on individual circumstances.

Legal obligations regarding storage of dental records

A dentist must keep records safely and securely (Data Protection Act, principle 7). Keeping them securely also requires that they are kept confidential (employed staff who have been instructed on the practices security policy are exempt). Access to the records by others must only be given if necessary, and with necessary and appropriate safeguards. The dentist is expected to make, and be able to demonstrate, an assessment of risk in deciding on appropriate security measures.

Further information

To support contractors further, the PCC website hosts online material for the dental contract reform DCR programme reflecting up to date to information to help practices operating within the prototype system which may be useful to refer to.

A link to the DCR programme webpages can be found in the resources section.