Dental Contract Reform
Prototype Evaluation
Engagement Events

Introduction and overview
Thank You!
Support for change

• The reform of the current dental contract to increase dental access and improve oral health is a well-established aim of this and successive Governments.
2017 Renewed commitment

• It was repeated as a 2017 manifesto commitment

THE CONSERVATIVE AND UNIONIST PARTY MANIFESTO 2017

“We will support NHS dentistry to improve coverage and reform contracts so that we pay for better outcomes, particularly for deprived children.”
Prototypes – Where we are

• Running from early 2016
• Are continuing to test the prevention focussed clinical patient pathway
• Are continuing to be measured against clinical and patient indicators in the Dental Quality and Outcomes Framework
• Are testing two blends of remuneration. The majority of remuneration in both blends are for capitated ongoing and preventative care
• The current regulations that underpin the prototype programme is due to expire on 31 March 2018
What happens next

• Agreement has been given to amend regulations which would allow the prototypes to run until 31 March 2020
• Clinical pathway has proved itself
• Not pre-empting the results of the autumn evaluation
• From a mid year to end of year position the data is encouraging
• More testing is needed…
• Report is being developed and this is your opportunity to input into the report
High level timeline for reform

2017/18
Development and evaluation

- Full Evaluation (after first full year of prototyping)
- Prototype Regulations Amended (1 April 2018 - 31 March 2020)

2018/19
Continued prototyping/learning and development

- Continued prototyping/Consideration of recruiting further practices
- Second year evaluation
- Continued developments on underpinning workstreams
- Decisions on 2019/2020

2019/2020 and beyond…
Dental Contract Reform
Evaluation Engagement Events

Introduction to evaluation report
Introduction to the report on prototypes after one year

• 4th report
• Follows structure set out by the evaluation working group
• Is a development of the interim report
• Introduces new information and updates on data trends included in the interim report
• Addresses some of the issues and questions raised at the interim report workshops in January 2017
• Opportunity to help finalise this report
Evaluation – Prototype scheme

• Evaluation and Learning Sub Group:
  – Chaired by Eric Rooney, Deputy CDO
  – A range of representatives

• Key themes
  – Improvements in oral health
  – Quality and appropriateness of care
  – Sustainability for roll out
  – Access and accessibility
  – Value for money
Evaluation questions

• A list of questions were generated from feedback about the next steps for contract reform –
  – How do prototype practices compare to UDA ones with respect to oral health, such as DMF?
  – Have the treatment patterns in prototypes changed in desired/undesired ways?
  – How many new patients have had an OHA since joining? Is appropriate change in interval sustained over time?
  – Are patients being taken out of the Pathway? Are outcomes better for those that follow the pathway?
  – Do bigger practices fare better?
  – What is the impact of DCR on PCR?
Dental Contract Reform
Evaluation Engagement
Events

Oral health, the clinical pathway and quality (DQOF)
Oral health and the clinical pathway
Oral health and clinical pathway - High level questions

• Has the oral health risk profile of the practice population changed over time?
• How is risk distributed across the 4 clinical domains and what is the profile for caries and perio over time?
• What proportion of patients have an Oral Health Assessment?
• How does the planned recall relate to the RAG rating?
• Are there relationships between RAG rating and deprivation, and RAG rating, Capitation and Activity performance?
• What's your view on the time required for OHAs and OHRs?
Oral health – Overall RAG rating over time for adults from wave 1 and 2 practices.
Oral health – RAG caries rating over time for adults from wave 1 and 2 practices
Oral health – RAG periodontal rating over time for adults from wave 1 and 2 practices.
Oral health - Adult RAG proportions in each clinical domain

<table>
<thead>
<tr>
<th>Domain</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
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</thead>
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<tr>
<td>Soft Tissue</td>
<td>84.5</td>
<td>15.3</td>
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<td>0.4</td>
<td>0.4</td>
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<tr>
<td>Caries</td>
<td>47.3</td>
<td>37.9</td>
<td>14.4</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
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<tr>
<td>Perio</td>
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</tbody>
</table>

Legend:
- Purple: Missing
- Light Green: Green
- Yellow: Amber
- Red: Red
### Oral health - Adult RAG combinations

<table>
<thead>
<tr>
<th>RAG Caries</th>
<th>RAG Soft Tissue</th>
<th>RAG Periodontal</th>
<th>RAG Tooth Surface Loss</th>
<th>Percentage of Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>July-Dec 2014 (N = 66,664)</td>
</tr>
<tr>
<td>Green</td>
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<td>Amber</td>
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<td>Amber</td>
<td>Green</td>
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<td>Green</td>
<td>Green</td>
<td>6.5</td>
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<td>Green</td>
<td>Amber</td>
<td>Amber</td>
<td>5.5</td>
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<tr>
<td>Green</td>
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<td>Green</td>
<td>Amber</td>
<td>3.7</td>
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<td>Green</td>
<td>Green</td>
<td>Red</td>
<td>Green</td>
<td>3.6</td>
</tr>
<tr>
<td>Red</td>
<td>Green</td>
<td>Amber</td>
<td>Green</td>
<td>3.4</td>
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<td>Red</td>
<td>Green</td>
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<td>Green</td>
<td>Green</td>
<td>Amber</td>
<td>3.1</td>
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<tr>
<td>Green</td>
<td>Green</td>
<td>Amber</td>
<td>Amber</td>
<td>3.0</td>
</tr>
<tr>
<td>Green</td>
<td>Amber</td>
<td>Amber</td>
<td>Green</td>
<td>2.7</td>
</tr>
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<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>Green</td>
<td>2.5</td>
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<td>Red</td>
<td>Green</td>
<td>Green</td>
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<td>2.3</td>
</tr>
<tr>
<td>Amber</td>
<td>Green</td>
<td>Red</td>
<td>Amber</td>
<td>2.0</td>
</tr>
<tr>
<td>Red</td>
<td>Green</td>
<td>Amber</td>
<td>Amber</td>
<td>1.9</td>
</tr>
<tr>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>1.7</td>
</tr>
<tr>
<td>Red</td>
<td>Green</td>
<td>Red</td>
<td>Green</td>
<td>1.3</td>
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<td>Red</td>
<td>Amber</td>
<td>Amber</td>
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<td>1.2</td>
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<td>Red</td>
<td>Amber</td>
<td>Amber</td>
<td>Amber</td>
<td>1.1</td>
</tr>
<tr>
<td>Amber</td>
<td>Amber</td>
<td>Red</td>
<td>Green</td>
<td>1.0</td>
</tr>
<tr>
<td>Red</td>
<td>Green</td>
<td>Green</td>
<td>Amber</td>
<td>1.0</td>
</tr>
<tr>
<td>Green</td>
<td>Green</td>
<td>Red</td>
<td>Amber</td>
<td>0.8</td>
</tr>
</tbody>
</table>
Oral health - Patients with a red rating

Patients have an overall RAG rating of red when one or more of their individual RAG ratings is red. As can be seen in Figure 1, most patients classified as red overall are only red on one of the four RAG ratings. Of patients who are classified as red overall, 87.1% of adults and 99.2% of children have only one red rating. As a proportion of the total cohort sample, 3.6% of adults and 0.1% of children have more than one red rating.

Figure 1. Percentage of patients with each overall RAG rating by adults and children
Clinical pathway - Adult planned recall

- Red Adults
- Amber Adults
- Green Adults

Month:
- 1:
- 2:
- 3:
- 4:
- 5:
- 6:
- 7:
- 8:
- 9:
- 10:
- 11:
- 12:
- 13:
- 14:
- 15:
- 16:
- 17:
- 18:
- 19:
- 20:
- 21:
- 22:
- 23:
- 24:

Red Adults:
- Month 9: 41.6%
- Month 12: 86.3%
- Month 13: 50.2%
- Month 14: 56.2%

Amber Adults:
- Month 6: 5.0%
- Month 7: 5.7%
- Month 12: 26.3%
- Month 13: 1.5%

Green Adults:
- Month 24: 26.3%
Oral health – Overall RAG rating over time for children from wave 1 and 2 practices.
Oral health – RAG caries rating over time for children from wave 1 and 2 practices.
Oral health – RAG periodontal rating over time for children from wave 1 and 2 practices.
Oral health - Children RAG proportions in each clinical domain

<table>
<thead>
<tr>
<th>Clinical Domain</th>
<th>Missing</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft Tissue</td>
<td>97.3%</td>
<td>2.0%</td>
<td>0.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Caries</td>
<td>37.3%</td>
<td>51.0%</td>
<td>11.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>TSL</td>
<td>67.3%</td>
<td>17.4%</td>
<td>15.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Perio</td>
<td>83.7%</td>
<td>2.1%</td>
<td>14.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Oral health - Children RAG combinations

Table 3. Combinations of RAG ratings among two samples of child patients

<table>
<thead>
<tr>
<th>RAG Caries</th>
<th>RAG Soft Tissue</th>
<th>RAG Periodontal</th>
<th>RAG Tooth Surface Loss</th>
<th>Percentage of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>July-Dec 2014 (N = 24,534)</td>
</tr>
<tr>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>29.3</td>
</tr>
<tr>
<td>Amber</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>17.8</td>
</tr>
<tr>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>Missing</td>
<td>12.6</td>
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<td>Green</td>
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<td>6.3</td>
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<tr>
<td>Amber</td>
<td>Green</td>
<td>Amber</td>
<td>Green</td>
<td>5.9</td>
</tr>
<tr>
<td>Amber</td>
<td>Green</td>
<td>Green</td>
<td>Amber</td>
<td>5.6</td>
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<tr>
<td>Red</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>4.9</td>
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<tr>
<td>Amber</td>
<td>Green</td>
<td>Amber</td>
<td>Amber</td>
<td>3.5</td>
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<tr>
<td>Amber</td>
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<td>Green</td>
<td>Missing</td>
<td>2.7</td>
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<tr>
<td>Red</td>
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<td>Green</td>
<td>Amber</td>
<td>1.8</td>
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<td>1.8</td>
</tr>
<tr>
<td>Red</td>
<td>Green</td>
<td>Amber</td>
<td>Green</td>
<td>1.5</td>
</tr>
<tr>
<td>Red</td>
<td>Green</td>
<td>Amber</td>
<td>Amber</td>
<td>1.3</td>
</tr>
<tr>
<td>Red</td>
<td>Green</td>
<td>Green</td>
<td>Missing</td>
<td>1.2</td>
</tr>
<tr>
<td>Green</td>
<td>Green</td>
<td>Missing</td>
<td>Green</td>
<td>0.1</td>
</tr>
<tr>
<td>Amber</td>
<td>Green</td>
<td>Missing</td>
<td>Green</td>
<td>0.0</td>
</tr>
<tr>
<td>Green</td>
<td>Green</td>
<td>Missing</td>
<td>Missing</td>
<td>0.1</td>
</tr>
<tr>
<td>Missing</td>
<td>Green</td>
<td>Missing</td>
<td>Missing</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Note. These categories account for approximately 96% of patients in the first sample and 95% of patients in the second sample. The first 13 categories account for around 95% within the 2014 sample.
Clinical pathway - Children planned recall

- Red Children
- Amber Children
- Green Children

Month

%
Clinical pathway - Percentage of all patients having an OHA/R

- Adult
- Child

Had OHA/R | No OHA/R
Oral health – Relationship to deprivation

Deprivation and the relationship with the proportion of red or green patients by wave and blend
Oral health – Relationship to access

Capitation performance and the relationship with the proportion of red or green patients by wave and blend
Oral health – Relationship to activity

Prototype activity performance and the relationship with the proportion of red or green patients by wave and blend
Clinical pathway - Practice survey results
Appropriateness of time for OHA (20 minutes)

Wave 1 and 2
- Much too long: 3%
- Slightly too long: 21%
- Right length of time: 35%
- Slightly too short: 30%
- Much too short: 10%

Wave 3
- Much too long: 3%
- Slightly too long: 5%
- Right length of time: 95%
- Slightly too short: 89%
- Much too short: 11%
Clinical pathway - Practice survey results
Appropriateness of time for OHR (15 minutes)

Wave 1 and 2
- Jan-17
  - Much too long: 2%
  - Slightly too long: 7%
  - Right length of time: 48%
  - Slightly too short: 34%
  - Much too short: 8%

- Aug-17
  - Much too long: 8%
  - Slightly too long: 8%
  - Right length of time: 34%
  - Slightly too short: 40%
  - Much too short: 12%

Wave 3
- Jan-17
  - Much too long: 0%
  - Slightly too long: 10%
  - Right length of time: 78%
  - Slightly too short: 59%
  - Much too short: 41%

- Aug-17
  - Much too long: 11%
  - Slightly too long: 11%
  - Right length of time: 59%
  - Slightly too short: 41%
  - Much too short: 41%
Quality - High level questions

• Quality
  – Has the clinical pathway and remuneration model supported quality and appropriateness of care?
  – How will the Dental Quality and Outcome Framework (DQOF) indicators be used to further support practices in delivering good quality care?
Quality - Measuring quality

• The Dental Quality and Outcomes Framework (DQOF) has been defined and developed over the course of the Dental Contract Reform programme

• There are 15 indicators across four domains:
  – Clinical Effectiveness
  – Patient Experience
  – Patient Safety
  – Data Quality

• Performance in 2016/17 against the indicators has now been reported to prototype practices
Quality - Embedding reporting and improving quality

- We have heard the feedback on the reports and recognise that they can be improved
- Rather than link these metrics to payment mechanisms, we want to support the profession in using them to share best practice and drive up quality
- A reference group will work to:
  - refine the reports to be most useful to practices and the programme
  - develop a road-map for bringing together the best aspects from both these measures and those used in UDA practices to provide a consistent and comparable framework
Quality – 2016/17 Prototype DQOF performance

Percentage of practices achieving maximum, reduced or no points against each indicator

Clinical Effectiveness outcome indicators
- OI01
- OI02
- OI03
- OI04
- OI05

Patient Experience
- PE01
- PE02
- PE03
- PE04
- PE05
- PE06
- PE07

Patient Safety
- SA01

Data Quality
- DQ01
- DQ02

Legend:
- Maximum points
- Reduced points
- No points
Decayed teeth (dt) for patients aged under 6 years old – improved or maintained

Decayed teeth (DT) for patients aged 6 years old to 18 years old – improved or maintained

Decayed teeth (DT) for patients aged 19 years old and over – improved or maintained

Basic periodontal examination (BPE) score for patients aged 19 years old and over – improved or maintained

Number of sextant bleeding sites for patients aged 19 years old and over – improved or maintained
Quality - Patient experience indicators

- Patients reporting that they are able to speak & eat comfortably
- Patients satisfied with the cleanliness of the dental practice
- Patients satisfied with the helpfulness of practice staff
- Patients reporting that they felt sufficiently involved in decisions about their care
- Patients who would recommend the dental practice to a friend
- Patients reporting satisfaction with NHS dentistry received
- Patients satisfied with the time to get an appointment
Quality - Patient safety and data quality indicators

- Recording an up-to-date medical history at each oral health assessment/review
- Appointment transmissions received within seven calendar days
- FP17 submissions received within two months of completion of course of treatment

- Some of these results may be impacted by software issues, and potentially outside the direct control of practices
Workshop questions and discussions

- Sense check the data:
  - Was the data provided as you expected?
  - What data was a surprise?
- Does this raise further questions for you that the programme needs to consider?
- What question should we have asked?
- What suggestions do you have to answer these questions?

The discussions and a key message to be captured on both oral health and quality
Dental Contract Reform
Evaluation Engagement
Events

Sustainability for rollout
Sustainability - High level questions

– How is skill mix changing
– Why has skill mix not worked in some practices
– How do survey responses differ by job role
– Is there a relationship between size of practice and the ability to meet contractual requirements?
Sustainability – Skill mix has changed to deliver pathway (for prototyping)

Wave 1 and 2
- Strongly agree: 32%, 11%
- Agree: 44%, 44%
- Neither agree nor disagree: 9%, 12%
- Disagree: 14%, 18%
- Strongly disagree: 3%, 18%

Wave 3
- Strongly agree: 11%, 14%
- Agree: 14%, 18%
- Neither agree nor disagree: 18%, 18%
- Disagree: 32%
- Strongly disagree: 14%
Sustainability – Skill mix change would be an advantage/disadvantage

Wave 1 and 2

<table>
<thead>
<tr>
<th>Category</th>
<th>Jan-17</th>
<th>Aug-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial advantage</td>
<td>43%</td>
<td>42%</td>
</tr>
<tr>
<td>Slight advantage</td>
<td>33%</td>
<td>26%</td>
</tr>
<tr>
<td>No difference</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>Slight disadvantage</td>
<td>9%</td>
<td>18%</td>
</tr>
<tr>
<td>Substantial disadvantage</td>
<td>7%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Wave 3

<table>
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<tr>
<th>Category</th>
<th>Jan-17</th>
<th>Aug-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial advantage</td>
<td>33%</td>
<td>22%</td>
</tr>
<tr>
<td>Slight advantage</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>No difference</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>Slight disadvantage</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Substantial disadvantage</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>Don't know</td>
<td>7%</td>
<td>5%</td>
</tr>
</tbody>
</table>
Sustainability – Skill mix has reverted back (wave 1 and 2 practices)

Wave 1 and 2

- Strongly agree: Jan-17 9%, Aug-17 8%
- Agree: Jan-17 25%, Aug-17 18%
- Neither agree nor disagree: Jan-17 21%, Aug-17 20%
- Disagree: Jan-17 39%, Aug-17 28%
- Strongly disagree: Jan-17 13%, Aug-17 18%
Sustainability - Which staff members deliver interim care (IC) appointments?

Answered: 25  Skipped: 0

- Nurse
- Hygienist
- Therapist
- Dentist
- Other (please specify)
Sustainability - Staff mix

[Graph showing the staff mix with different categories and percentages.]
Sustainability – Time spent on delivering NHS care

Average total booked hours spent delivering NHS care

Hours

Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
Sustainability – Reported additional hours

- Average additional hours reported
- % of responses reporting a change in opening hours

- April 2016: 0%
- May 2016: 2%
- June 2016: 4%
- July 2016: 6%
- August 2016: 8%
- September 2016: 10%
- October 2016: 12%
- November 2016: 10%
- December 2016: 8%
- January 2017: 6%
- February 2017: 4%
- March 2017: 2%

Graph showing the trend from April 2016 to March 2017.
Sustainability - When are extra hours provided?
Sustainability - Achievement vs size of practice (based on NHS patient list size)

<table>
<thead>
<tr>
<th>Contract achievement</th>
<th>NHS Patient list size &gt;10k</th>
<th>NHS Patient list size 5-10k</th>
<th>NHS Patient list size &lt;5k</th>
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</thead>
<tbody>
<tr>
<td>above 100%</td>
<td>43%</td>
<td>42%</td>
<td>28%</td>
</tr>
<tr>
<td>96%-100%</td>
<td>22%</td>
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<td>50%</td>
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<tr>
<td>90%-96%</td>
<td>9%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>below 90%</td>
<td>26%</td>
<td>18%</td>
<td>11%</td>
</tr>
</tbody>
</table>
Sustainability – Stress (personal) compared to under UDA system

**Wave 1 and 2**
- Much better: 6% (Jan-17), 10% (Aug-17)
- Slightly better: 21% (Jan-17), 13% (Aug-17)
- No difference: 18% (Jan-17), 16% (Aug-17)
- Slightly worse: 18% (Jan-17), 13% (Aug-17)
- Much worse: 49% (Jan-17), 37% (Aug-17)

**Wave 3**
- Much better: 55% (Jan-17), 33% (Aug-17)
- Slightly better: 22% (Jan-17), 14% (Aug-17)
- No difference: 18% (Jan-17), 18% (Aug-17)
- Slightly worse: 22% (Jan-17), 14% (Aug-17)
- Much worse: 22% (Jan-17), 22% (Aug-17)
Sustainability – Stress (practice) compared to under UDA system

Wave 1 and 2

- Much better: 6% (Jan-17), 7% (Aug-17)
- Slightly better: 14% (Jan-17), 18% (Aug-17)
- No difference: 19% (Jan-17), 15% (Aug-17)
- Slightly worse: 23% (Jan-17), 13% (Aug-17)
- Much worse: 38% (Jan-17), 46% (Aug-17)

Wave 3

- Much better: 22% (Jan-17), 41% (Aug-17)
- Slightly better: 27% (Jan-17), 33% (Aug-17)
- No difference: 9% (Jan-17), 22% (Aug-17)
- Slightly worse: 23% (Jan-17), 22% (Aug-17)
- Much worse: 22% (Jan-17), 22% (Aug-17)
Sustainability – How well are practices managing under prototype scheme

Wave 1 and 2

- Very well: 15% (Jan-17), 15% (Aug-17)
- Well: 29% (Jan-17), 31% (Aug-17)
- Neither well nor poorly: 28% (Jan-17), 27% (Aug-17)
- Poorly: 13% (Jan-17), 23% (Aug-17)
- Very poorly: 11% (Jan-17)

Wave 3

- Very well: 22% (Jan-17), 41% (Aug-17)
- Well: 67% (Jan-17), 50% (Aug-17)
- Neither well nor poorly: 9% (Jan-17), 0% (Aug-17)
- Poorly: 11% (Jan-17), 0% (Aug-17)
- Very poorly: 0% (Jan-17), 0% (Aug-17)
Sustainability – The blended contract is better than existing UDA system

**Wave 1 and 2**

- Strongly agree: Jan-17 - 20%, Aug-17 - 16%
- Agree: Jan-17 - 32%, Aug-17 - 18%
- Neither agree nor disagree: Jan-17 - 18%, Aug-17 - 18%
- Disagree: Jan-17 - 11%, Aug-17 - 23%
- Strongly disagree: Jan-17 - 29%, Aug-17 - 18%

**Wave 3**

- Strongly agree: Jan-17 - 44%, Aug-17 - 27%
- Agree: Jan-17 - 33%, Aug-17 - 36%
- Neither agree nor disagree: Jan-17 - 11%, Aug-17 - 11%
- Disagree: Jan-17 - 5%, Aug-17 - 9%
- Strongly disagree: Jan-17 - 5%, Aug-17 - 11%
Workshop questions and discussions

• Sense check the data:
  – Was the data provided as you expected?
  – What data was a surprise?
• Does this raise further questions for you that the programme needs to consider?
• What question should we have asked?
• What suggestions do you have to answer these questions?

The discussions and a key message to be captured on sustainability
Dental Contract Reform Evaluation Engagement Events

Access and accessibility and contract delivery,
Dental Contract Reform Evaluation Engagement Events

Access and accessibility
High level questions

• Access and accessibility
  – Can practices provide care to the same number of patients?
  – Are patients able to get an appointment (both new patients and existing patients)?
Access - Timeline by wave

Change in capitated patient numbers from start of pilot/prototype (at March 2017)

- Wave 3 practices
- Wave 2 practices
- Wave 1 practices
Access - Timeline by blend and wave

Percentage of capitated patients by blend and wave, from pilot/prototype start (March 2017 data)
Access – Relationship with RAG status of practice population

<< patient lists size declined 2016-2017  
>> patient list size increased 2016-2017 >>
### Accessibility

<table>
<thead>
<tr>
<th></th>
<th>% of patients responding that they were quite or very satisfied with NHS dentistry received (PE.06)</th>
<th>% of patients responding that the length of time it took to get an appointment was as soon as was necessary (PE.07)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015/16</td>
<td>2016/17</td>
</tr>
<tr>
<td>Wave 1</td>
<td>97.0%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Wave 2</td>
<td>97.5%</td>
<td>97.0%</td>
</tr>
<tr>
<td>Wave 3</td>
<td>97.5%</td>
<td>97.4%</td>
</tr>
<tr>
<td>Total</td>
<td>97.2%</td>
<td></td>
</tr>
<tr>
<td>Current UDA practices</td>
<td></td>
<td>95.7%</td>
</tr>
</tbody>
</table>
Dental Contract Reform
Evaluation Engagement
Events

Contract delivery
High level questions

• Contract Delivery (value for money)
  – What proportion of practices achieved their contract?
  – Is there a relationship between contract values and the ability to meet their contract?
## Contract delivery – Average achievement by blend

<table>
<thead>
<tr>
<th>Blend</th>
<th>At Nov 2016</th>
<th>At Year-end 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>92.6%</td>
<td>95.8%</td>
</tr>
<tr>
<td>B</td>
<td>96.4%</td>
<td>99.2%</td>
</tr>
<tr>
<td>All practices</td>
<td>94.5%</td>
<td>97.4%</td>
</tr>
</tbody>
</table>
### Contract delivery - Performance improvement by wave

<table>
<thead>
<tr>
<th>Wave</th>
<th>&gt;96%</th>
<th>90-96%</th>
<th>&lt;90%</th>
<th>&gt;96%</th>
<th>90-96%</th>
<th>&lt;90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>39%</td>
<td>22%</td>
<td>39%</td>
<td>68%</td>
<td>7%</td>
<td>24%</td>
</tr>
<tr>
<td>2</td>
<td>35%</td>
<td>41%</td>
<td>24%</td>
<td>76%</td>
<td>6%</td>
<td>18%</td>
</tr>
<tr>
<td>3</td>
<td>67%</td>
<td>24%</td>
<td>10%</td>
<td>76%</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>All</td>
<td>46%</td>
<td>27%</td>
<td>28%</td>
<td>72%</td>
<td>9%</td>
<td>19%</td>
</tr>
</tbody>
</table>
Contract delivery – Use of exchange mechanism

<table>
<thead>
<tr>
<th>% of Expected Minimum Activity (EMA) achieved</th>
<th>Achieved &gt;100% Contractor’s Expected Capitated Patients (CECP)</th>
<th>Achieved &lt;100% Contractor’s Expected Capitated Patients (CECP)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% or more</td>
<td>15</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Capped at 100%</td>
<td></td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Less than 100%</td>
<td>27</td>
<td>18</td>
<td>45</td>
</tr>
<tr>
<td>Grand Total</td>
<td>42</td>
<td>37</td>
<td>79</td>
</tr>
</tbody>
</table>
Contract delivery – Achievement by blend

- % of Blend A practices
  - >100%: 33%
  - 96%-100%: 35%
  - 90%-96%: 8%
  - <90%: 25%

- % of Blend B practices
  - >100%: 46%
  - 96%-100%: 31%
  - 90%-96%: 10%
  - <90%: 13%
Contract delivery – Achievement by wave

- **% of Wave 1**: 34% (>100%), 34% (96%-100%), 24% (90%-96%), 7% (<90%)
- **% of Wave 2**: 41% (>100%), 35% (96%-100%), 18% (90%-96%), 6% (<90%)
- **% of Wave 3**: 48% (>100%), 29% (96%-100%), 14% (90%-96%), 10% (<90%)
Contract delivery – Achievement by blend and wave

- % of wave 1, blend A: 33%
- % of wave 1, blend B: 33%
- % of wave 2, blend A: 43%
- % of wave 2, blend B: 35%
- % of wave 3, blend A: 43%
- % of wave 3, blend B: 35%

- % of wave 1, blend A: 11%
- % of wave 1, blend B: 4%
- % of wave 2, blend A: 17%
- % of wave 2, blend B: 0%
- % of wave 3, blend A: 17%
- % of wave 3, blend B: 0%

- % of wave 1, blend A: 0%
- % of wave 1, blend B: 0%
- % of wave 2, blend A: 18%
- % of wave 2, blend B: 0%
- % of wave 3, blend A: 18%
- % of wave 3, blend B: 0%

- % of wave 1, blend A: 22%
- % of wave 1, blend B: 17%
- % of wave 2, blend A: 45%
- % of wave 2, blend B: 0%
- % of wave 3, blend A: 45%
- % of wave 3, blend B: 0%

- % of wave 1, blend A: 33%
- % of wave 1, blend B: 0%
- % of wave 2, blend A: 45%
- % of wave 2, blend B: 0%
- % of wave 3, blend A: 45%
- % of wave 3, blend B: 0%

- % of wave 1, blend A: 11%
- % of wave 1, blend B: 0%
- % of wave 2, blend A: 18%
- % of wave 2, blend B: 0%
- % of wave 3, blend A: 18%
- % of wave 3, blend B: 0%

- % of wave 1, blend A: 0%
- % of wave 1, blend B: 0%
- % of wave 2, blend A: 17%
- % of wave 2, blend B: 0%
- % of wave 3, blend A: 17%
- % of wave 3, blend B: 0%

- % of wave 1, blend A: 27%
- % of wave 1, blend B: 9%
- % of wave 2, blend A: 18%
- % of wave 2, blend B: 0%
- % of wave 3, blend A: 18%
- % of wave 3, blend B: 0%

- % of wave 1, blend A: 30%
- % of wave 1, blend B: 20%
- % of wave 2, blend A: 0%
- % of wave 2, blend B: 0%
- % of wave 3, blend A: 0%
- % of wave 3, blend B: 0%
Contract delivery - Contract value against expected capitated patients 2016/17

Although total contract values are not explicitly based on capitated patient numbers, there is a natural relationship, albeit with variation either side of the trend line.
Workshop questions and discussions

- Sense check the data:
  - Was the data provided as you expected?
  - What data was a surprise?
- Does this raise further questions for you that the programme needs to consider?
- What question should we have asked?
- What suggestions do you have to answer these questions?

The discussions and a key message to be captured on both access and accessibility and contract delivery
Dental Contract Reform
Evaluation Engagement
Events

Next steps for evaluation and programme
Dental Contract Reform
Evaluation Engagement Events

Key messages from five evaluation engagement events
Dental Contract Reform Evaluation Engagement Events

Leeds, 20 September 2017
Key messages from facilitated discussions

Table allocation
- Table 1 (Associates and DCPs)
- Table 2 (Business and practice managers)
- Table 3 (Business and practice managers)
- Table 4 (Principals and corporate providers)
- Table 5 (Principals and corporate providers)
Key messages from facilitated discussions

Improvements in oral health

1. In a full capitation/activity system there is concern that oral health may worsen due to the expected increase in waiting times.

2. Information captured on medical social history forms does not always reflect what is happening in patients mouth.

3. The group would like more refined data ie blend A/B and existing/new patients to allow us to see the trends in terms of RAG ratings for caries and perio (adult/child).

4. The group were surprised that there hasn’t been improvements in oral health. Very disappointed. Too coarse a measure as this should have been improving.

5. Pathway is effective in providing consistency. However, can BPE difference be due to who is taking it? This might explain changes.
Key messages from facilitated discussions

Quality and appropriateness of care

1. There is a concern that performance against each of the DQOF indicators will worsen over time.

2. Patients' expectations are different regarding what they feel as acceptable time for waiting for an appointment. It doesn’t break down what type of appointment patients are waiting for.

3. It would be ideal if we could target the patient satisfaction question regarding appointment times to gain a better understanding if patients have been given an appointment for OHA/OHR and treatments separately within a reasonable NHS timeframe.

4. Principle of collecting the DQOF is a good idea – the data needs to run in the background for a long time before making any meaningful conclusions from it.

5. Regular reporting of DQOF by practice and performer benchmarked against other practices.
Key messages from facilitated discussions

Sustainability for roll out

1. Has any thought been given to looking at the impact of the remuneration mechanism of associates on the use of skill mix?
2. Costs running a practice under prototype arrangements have significantly increased.
3. Skill mix is important and advantageous but it comes at a cost and so impacts a practices profitability.
4. This is based on historical data which is flawed as it does not take into consideration changes in practice since 2011 ie CQC requirements, HTM0105 and note taking.
5. The group question the value of the survey results based on less than complete responses.
Key messages from facilitated discussions

Access and accessibility

1. The drive for new patients effects the access to treatment for existing patients.
2. Focus being placed on increasing patient access could effect delivery of effective patient care.
3. The data (slide 75) shows that contract value per head clearly impacts on practices ability to deliver.
4. Don’t think waiting for treatment is acceptable for patients.
5. As patients have moved through the system the amount of time being spent on prevention is less as its more re-enforcing with existing patients so access now increasing
Key messages from facilitated discussions

Contract delivery

1. Will consideration be given to establish a common £ per patient or UDA or both, across the country?

2. If measures are set for contract delivery these need to be sustainable and achievable for all practices.

3. What did Wave 3 do differently which enabled them to deliver their contracts more successfully?

4. Put whichever figure you want but it is costing the practice more – all practices have put in more resources to deliver their contracts.

5. Can questions be asked about whether profitability has changed worse or better might help identify whether sustainable long term?
Dental Contract Reform Evaluation Engagement Events

Leeds, 21 September 2017
Key messages from facilitated discussions

Table allocation

– Table 1 (Associates and DCPs)
– Table 2 (Business and practice managers)
– Table 3 (Business and practice managers)
– Table 4 (Principals and corporate providers)
– Table 5 (Principals and corporate providers)
Key messages from facilitated discussions

Improvements in oral health

1. How does the impact of prototyping in oral health gain compare with the oral health improvement of UDA practices over the same period?

2. Expecting patients to take responsibility of their own oral health is extremely difficult and takes an awful lot of time and effort.

3. RAG status is too broad. Incremental stepped measure would be a better way to motivate patients.

4. We feel that the current system does not support care to high needs patients

5. Provide a breakdown of new patients vs existing patients for indicators (oral health) to show effectiveness of the pathway.
Key messages from facilitated discussions

Quality and appropriateness of care

1. Targets need to be more realistic in order to be able to provide a quality service

2. What is the sample of patients used for DQOF data?

3. Patient satisfaction question is too subjective. If the question was “were you offered an appointment within a specific time frame eg 0-6 weeks” this would provide a better reflection.

4. We want to keep DQOF measure and develop it, and lose the activity measure.

5. Practices achieved DQOF measures despite not being directly paid for it.
Key messages from facilitated discussions

Sustainability for roll out

1. Don’t underestimate the impact of stress levels on associate dentists choosing to leave the profession.
2. To make this work, practices need to invest time and resources and money.
3. Is the stress within the system due to the financial penalties of the prototype system particularly for practices that were former pilots?
4. Need to design a contract that promotes the use of skill mix.
5. How do we get a clear financial picture of sustainability of prototypes?
Key messages from facilitated discussions

Access and accessibility

1. The prototype contract is an access contract not a prevention contract.
2. There is not an issue in patients accessing an NHS dentist, it is the length of time they may have to wait for an appointment.
3. Introducing prototyping with a step change (ie % of patients onto capitation in first year) would be helpful.
4. The focus on increase in access instead of increase in quality is worrying.
5. Remove activity and focus on capitation and quality.
Key messages from facilitated discussions

Contract delivery

1. Are you convinced that the calculation mechanism for establishing the contract value fully reflects the practice workload taking on new patients

2. Setting individual targets helps to deliver contract activity

3. Learn from previous experience of pilots and prototypes to ensure new practices entering prototype system are better prepared to manage the system effectively

4. Need a sensitive weighted capitation system to make this work

5. Contract delivery needs to be considered over a rolling 3 – 5 year period
Dental Contract Reform
Evaluation Engagement
Events

Birmingham, 22 September 2017
Key messages from facilitated discussions

Table allocation
– Table 1 (Associates and DCPs)
– Table 2 (Business and practice managers)
– Table 3 (Principals and corporate providers)
– Table 4 (Principals and corporate providers)
Key messages from facilitated discussions

Improvements in oral health

1. It is crucial for patients to be informed and educated about the oral health benefits of the pathway approach in a national campaign.

2. What other treatments are red patients having during that period? How the care pathway approach is communicated to patients is key.

3. Give dentists the confidence to use the software as guidance tool. Be confident when overriding.

4. Is the 24 month recall appropriate? Overrides are the norm not the exception.
Key messages from facilitated discussions

Quality and appropriateness of care

1. Quality can only really be assured by actually examining patient and record cards.

2. Patient expectations are all different. What appointments are they waiting for?

3. Validity and reliability of data for perio?!

4. Provide information at each performer level to increase quality discussions at team meetings and individual appraisals.
Key messages from facilitated discussions

Sustainability for roll out

1. Will practice funding be ring-fenced to cover the period of time it takes to ‘convert’ all patients onto the clinical pathway?

2. Lessons learned from Wave 1 and 2 have been shared with Wave 3 and this has made a huge difference in being able to manage their contracts. Please do the same (and listen) for whatever comes next.

3. Capacity and variability of skill mix is a big challenge.

4. Does the prototype system encourage dentists to stay within the NHS system?
Key messages from facilitated discussions

Access and accessibility

1. It would be good to be able to charge patients a band 1 fee for a failed appointment, due to the impact it has on access.

2. No issues with patients accessing NHS dentistry. The issue is with appointment availability.

3. How are wave 3's delivering the pathway in comparison to wave 1 and 2 as they haven't seen the fall in access - need to know.

4. The programme needs to focus on wave 3 data over a further 12 month period in order to determine roll-out (waves 1 and 2 are not reflective of new dentists joining due to consequences of piloting).
Key messages from facilitated discussions

Contract delivery

1. Has the selection process for wave 3 practices invalidated the data?
2. The whole clinical team need to understand how the contract value is achieved.
3. Effective and efficient management of time is essential with individual performer expectations agreed.
4. Programme to consider the effect on business profitability for prototype practices.
Dental Contract Reform Evaluation Engagement Events

London, 26 September 2017
Key messages from facilitated discussions

Table allocation
– Table 1 (Business and practice managers)
– Table 2 (Principals and corporate providers)
– Table 3 (Associates, Principals and corporate providers)
Key messages from facilitated discussions

Improvements in oral health

1. Not cost effective to treat high need perio patients without greater funding.

2. Can data be produced that compares individual patient NHS appointment time to increases in oral health improvement?

3. The group were surprised that there was such a high number of 24 month recalls and questioned how many of these had been seen for an IC.
Key messages from facilitated discussions

Quality and appropriateness of care

1. Patients are confused by patient questionnaire and sometimes ask the practice to complete for them which defeats the purpose

2. The patient experience questions are not objective enough.

3. The prototypes may be more highly motivated than UDA practices and therefore the clinical indicators are good.
Key messages from facilitated discussions

Sustainability for roll out

1. Skill mix is advantageous but is not appropriate for all practices.

2. Skill mix used heavily in practice can restrict access as patients still need to be examined by a dentist.

3. Prototypes have meant there is less emphasis on skill mix which has been compounded by the difficulty to find and/or access training for OHE’s.
Key messages from facilitated discussions

Access and accessibility

1. It is a difficult balancing act to be able to provide access to patients, provide necessary treatment and meet contract measures.

2. Focusing on access could have an impact on the quality of care provided.

3. Blend B better suits delivering access as practices are not focused simply on activity.
Contract delivery

1. The profession needs to be fully aware of the prototype system at the start and good quality management is key to delivering contract measures.

2. Contract delivery at the end of 16-17 was achieved but at a substantial cost to practices.

3. High need areas where patients require more intervention are better with Blend B. It is important that lessons from Wave 3 are used to inform a roll out.
Dental Contract Reform Evaluation Engagement Events

London, 27 September
Key messages from facilitated discussions

Table allocation
– Table 1 (Business and practice managers)
– Table 2 (Principals and corporate provider)
– Table 3 (Associates, Principals and corporate provider)
– Table 4 (Principals and corporate provider)
Key messages from facilitated discussions

Improvements in oral health

1. We would have expected perio data to reflect the higher levels of deprivation that practices are experiencing.

2. Evident that some practices are making this work and others are struggling. What are the reasons – such as demographics etc.

3. High level position is disappointing. Need to do some more detailed analysis on cohorts of patients to see if there is movement between red, amber and green.

4. Changes from wave 1 pilot to prototype phase with change in focus has diminished some of the gains being made.
Key messages from facilitated discussions

Quality and appropriateness of care

1. Surprised that the percentage of patients satisfied with time for appointment is as high as it is.
2. Difficulty in taking a complex disease like perio and providing meaningful data. Calibration/training would be the way forward.
3. Don’t think it is beneficial to link payments to quality. Do need to think carefully about indicators included.
4. Quality is improving, ask patients relevant questions and monitor clinical activity (DRO).
Key messages from facilitated discussions

Sustainability for roll out

1. Skill mix could be advantageous but it is dependent on significant and adequate training and support (clinical) for DCPs must be in place.

2. Pressure on the appointment books is a key factor to the increase in stress levels.

3. Skill mix provides excellent value for the NHS but additional cost to the practice.

4. Need to ensure that calculation for determining contractual figures are more appropriate and robust.
Key messages from facilitated discussions

Access and accessibility

1. Zoning appointment book to provide range of appointments is key to offering access to all patients.

2. Remuneration for patient numbers should be related to explicit patient need determined by more exact measures e.g. DMFT social deprivation as well as usual elements over an extended period of time (e.g. 2 years)

3. Length of capitated period should be looked at, is 3 years right?

4. Every practice has had to invest in additional resources to maintain access levels.
Key messages from facilitated discussions

Contract delivery

1. It is imperative that the whole team understand the system if contract measures are to be achieved.

2. Associate remuneration and contract monitoring is extremely difficult – clinically this works but at what cost?

3. How red is red? Does this impact on contract delivery (the RAG status measure is not sensitive enough).

4. Do we know what additional resources practices have had to invest in order to “achieve” their contracts? Is there a correlation between additional investment and achievement?
Next steps for evaluation report

• Feedback from the evaluation engagement events to be incorporated into the evaluation report
• Report will go through governance process
• Report published
Next steps for programme

• Regulations come into force 1 December 2017
• Regulations will support a further two years of prototyping
• Evaluation report will inform the detailed approach to 2018/19
• Going forward is a decision for the practice and the programme
• Taking on more practices is under consideration
Dental Contract Reform Evaluation Engagement Events