Dental Contract Reform
Sharing Experiences from Prototyping

60 Seconds with: Bhavin Patel, Associate, Woodford Dental Care – Blend B prototype practice

What was it about the current UDA contract that prompted your practice into wanting to become a prototype/what did you dislike about the current contract?
We've always been a practice looking forwards and wanting to be involved with any changes to help shape and implement the future of NHS dentistry. We agree the changing face of NHS dentistry must utilise the skill set of the whole team. The current contract has many flaws that we all know about with perverse incentives. It, being target driven, also left a restricted feeling where we believe we are unable to provide the highest level of care.

How is the way of working different to you under the prototype arrangements?
It's a shift in mindset being free from targets and allowing much more time for explanations, education and prevention. Utilising this to being able to give our patients all their options and really allowing them to understand why simple changes are important for their long term health.

How do you feel your patients feel about the changes? How have they responded?
At first it was difficult, it's all about re-educating them and also equally importantly, the team. You're overhauling and altering previous experiences and expectations. However, over time they have adapted and understand the pathway approach. They've learnt to appreciate and value the enhanced level and detail of care it's allowed us to provide, which is tailored to each individual.

How do you feel your stress/anxiety levels have changed under the prototype way of working? Why?
Much reduced stress and anxiety with no pressures of targets and time to spend with patients being satisfied that you've covered all your duties of care (i.e.

History/examination/diagnostics/diagnoses/options/consent/plan) and involved patients with their care.

Do you have any suggestions for improvements to the programme?
I do hope there won't be any huge adjustments when it rolls out and shifting back to a predominantly target driven contract. Guidance and training of how best to implement into general practice would be helpful for providers and associates alike. We have been lucky as we adapted very quickly and efficiently with zoning our books to ensure every appointment type is catered for and hence each has its own waiting times so the book doesn't get clogged up with one modality and you're providing care to the best of your capacity and ability to deliver the contract.

Stephen Wright: Principle, Thornhedge Dental Practice, Blend B prototype practice

When we joined the dental contract reform programme in September 2011 it felt like a new beginning. The pilot contract followed on from Jimmy Steele's report and we were going to provide oral health assessments for our patients which would lead us to develop a treatment plan and management for those patients in order to improve patient outcomes.

The emphasis was on the oral health assessment which proved to be a long process, initially taking us at least 30 minutes on each patient. The computer systems proved rather difficult in the early days as the programs required a lot of clicks to get through. This resulted in the appointment book becoming very full and led to difficulties trying to fit in appointments for treatments. Patients started to complain and indeed leaving the practice.

We were reassured by the DCR team that patient numbers may reduce in the short term but would re-establish once things had settled down. As time went by and the computer system improved we were able to reduce our times to 20 minutes for an oral health assessment and our capitation list started to increase, albeit rather slowly. All through this process the feedback from those that we treated was good

and the new system was well received by the patients and things started to settle down at the practice.

Then there was an announcement that the Pilot contracts were to be replaced by Prototype contracts and we were allocated a Blend B contract. We were given our capitation and activity targets which we were expected to deliver and there were now to be financial penalties if we did not deliver. At the time we had a capitation list of about 2200 patients per full time equivalent dentist but our target was 2600 patients and 135 band 3 treatments.

The band 3 treatments were achievable but the increase of 400 patients for each dentist was a big ask as we had noted that the new patients coming in mostly had high treatment needs. We had a big decision to make. Our choice was either return to a UDA contract or to accept the Prototype contract. I looked at why we started in the Contract Reform Process and reminded myself that I did not want to return to a UDA contract and that previously we had always achieved our UDA activity and had never had to pay clawback.

An action plan was developed and we looked at recalling anybody who had not been to the practice for 36 months. We also advertised with a local newspaper. The most effective method however was putting a banner across the front wall of the practice saying “Register Your Baby Now”. Allowing this increased access caused us to be very busy and we decided that to add another dentist to achieve the targets would give the DCR team the thought that these targets are easily achievable. I wanted to know if this system could replace the UDA contract on a like for like manpower basis.

If we were to fail then it would prove that this prototype had big problem. Currently we are just over our capitation target and are trying to stabilize the periodontal condition of many patients who have attended in the last few years.

I would say that we have worked harder in the last few years than before we entered the Pilot process in order to increase our list size, but we are hoping that once our patients’ oral care starts to improve then things will settle down.

I am glad that we persisted with the reform and did not return to a UDA contract.

Simon Flaherty: Principle, Alverna House Dental Practice, Blend B prototype practice

As a Dentist and practice owner of a four-surgery practice in St Helens, Merseyside; I was initially sceptical about the new NHS capitation-based dental contract which had particular emphasis on prevention. However, 30 months on, it has undoubtedly won me over.

In February 2016, we started as one of thirty Wave 3 prototype practices, following on the heels of sixty others as part of a piloting process.

Like many of my colleagues, I initially had some anxieties around the proposed payment system, with three funding components based on capitation and activity with an unknown quality measure. A lot of practice owners were not interested because of the threat of a fall in income without the opportunity to increase it, but I was intrigued as to what exactly it involved.

I attended two 'introduction to prototype' meetings and it became clear to me that the key principle in the contract was patient need rather than activity. The prototype challenged the practice to deliver just two thirds of the Band 3 Activity from the previous year whilst maintaining the same patients numbers from the previous financial year. Whilst officials would use the information to assess the quality payment, the Dental Quality Outcomes Framework would not form part of the payments in the first year.

I particularly disliked the current UDA payment system, specifically I felt that when a contract is based 100% on activity, it becomes difficult to maintain the same level of income if you improve the health of your patients. In other words, the contract disincentivises preventative patient care, which seems morally and ethically difficult to comprehend. I recall days spent checking the UDAs up to 3 times a day, finding it very difficult to hit the target perfectly at the end of the year.

Satisfied with the prototype conditions with the potential to improve prevention and overall patient care; without an increased threat to the practice income were key reasons for taking on this opportunity. Considering both the new clinical pathway and contract together, doing more preventative work especially with those who need it the most, will mean less activity down the line. This is a positive for patients whilst

also reducing the amount of drilling and filling dentists have to do, an incentive for all.

The dentists can also use the skill mix of the practice team more effectively. For example, if a patient is low risk of caries, cancer and tooth wear but is high risk of gum disease they have an annual check-up with a dentist but every three months they can be treated by a dental therapist only. This frees up dentist time for more assessments and advanced work. Due to the reduced emphasis on numbers, there is also benefit for commissioners as it increases access and reduces overall dental disease in patients.

One key challenge I have identified is the constant need to address practice consistency in various scenarios. It's important to have monthly dentist meetings, as well as staff meetings. However, it is easier to schedule monthly performer/ therapist meetings being off the activity treadmill.

One further difficulty is issues with IT which I have no doubt can be ironed out in time. Other challenges that we have encountered include duplicated patients, associate agreements and remuneration, therapist fees and foundation training funding.

In an ideal scenario there would be no activity element in the payment structure with payment for quality and capitation. However, I appreciate politically this may not be possible.

Patient satisfaction is high following an initial dip relating to the number of available appointments. In particular, patients acknowledge the extra time spent preventing deterioration in oral health. The dentist's priority is back where it should be - treating the patient as a patient, and not seeing them as a unit of activity. And most importantly it is less stressful for the practice team in general.

Overall my conclusion is very positive and as it has an emphasis on access and on improving the dental health of the population, I hope this contract will be considered carefully by commissioners.