

**Guidance to support dental
contract management
arrangements for the 2020/21-
year-end reconciliation**

Contents

1. Introduction	2
2. Covid-19	3
3. Principles for reconciling year end activity	4
3.1 1 April 2020 to 7 June 2020	4
3.2 8 June 2020 to 19 July 2020	4
3.3 20 July 2020 to 31 December 2020	5
3.4 1 January – 31 March 2021	7
3.4.1 Activity requirements for 1 January – 31 March 2021 - UDA contracts	8
3.4.2 Activity requirements for 1 January – 31 March 2021 - UOA contracts	10
3.4.3 Adjustment to reflect reduced variable costs	13
3.4.4 Practice expectations	14
3.5 Urgent Dental Centres (UDC)	15
4. 2020/21 Year End	18
4.1 Practice expectations – UDA activity	19
4.2 Practice expectations – UOA activity	24
5. Carry Forwards	27
6. Exceptional circumstances	28
7. Annual declaration	30
8. Dental foundation trainees	32
9. Community Dental Services	33
10. Any Qualified Provider (AQP) contracts	35
11. Abatement reconciliation principles	37
12. PPE Reimbursement Scheme	38
Appendix A: PPE Reimbursement Scheme timescales UDA/UOA Providers .	41
Appendix B: Issue 3 Preparedness letter for primary dental care	42
Appendix C: Issue 4 Preparedness letter for primary dental care	50
Appendix D: Urgent dental letter	56
Appendix E: Issue 5 Preparedness letter for primary dental care	58

1. Introduction

The Covid-19 pandemic has had a significant impact on dental services and commissioning in the 2020/21 financial and contract year. Temporary operational and contractual arrangements were put in place in order to meet emergency and urgent dental care needs and to provide assurance and financial stability to the dental profession during the pandemic.

The document describes the expectations, requirements, and financial arrangements for dental contractors. This includes the minimum activity levels and measurements for the contract year, the year end reconciliation process for 2020/21, and abatement process.

The guidance is applicable to dental commissioners, contractors, and the wider dental community in England. Dental services operating under contract to the NHS in Northern Ireland, Scotland and Wales should refer to guidance and Standard Operating Procedures (SOPs) produced by the governing bodies and regulators in their devolved administration.

Covid-19 information and communication around dental practice can be accessed through the [NHSE & NHSI \(NHSE & NHSI\) website](https://www.england.nhs.uk)¹. This includes a Transition to Recovery SOP for dental practices, a separate Urgent Dental Care SOP, and a series of preparedness letters for primary dental care. The information will be updated in response to regulatory, clinical or operational changes due to the Covid-19 response.

¹ <https://www.england.nhs.uk>

2. Covid-19

The novel coronavirus SARS-CoV-2 and the associated disease Covid-19 was first identified in December 2019 in China. Transmitted between people through respiratory droplets, the World Health Organization (WHO) declared the outbreak of Covid-19 a pandemic on 11 March 2020.

In the UK, the spread of the virus escalated rapidly in March and reached its initial peak in April. Emergency measures were introduced with the aim of slowing the spread of the virus, including the closure of all but essential services, limiting the movement of people and the introduction of social distancing. In recent months, several areas, towns and cities have been put under local or regional lockdown in order to curb the spread of the virus.

The Covid-19 response presented huge challenges for everyone involved in planning and providing dental care in England. The dental commissioning teams at NHSE & NHSI worked in collaboration with the Chief Dental Officer, NHS Business Services Authority, 7 Regional teams, the BDA and wider dental profession to provide guidelines, frameworks, and systems in a rapidly evolving setting.

Following the announcement of the UK-wide lockdown, several changes were introduced to the delivery and operation of dental services in England on 25 March 2020. All routine, non-urgent primary dental care provision was deferred or stopped, dental practices were directed to establish a telephone triage system for patients, and NHS regions were tasked with establishing local urgent dental care services.

Practices were able to reopen from 8 June providing patient care on a remote and/or face to face basis, subject to capacity, availability of the workforce and supply and fit testing of personal protective equipment (PPE). All practices were expected to be open by 20 July 2020.

3. Principles for reconciling year end activity

The following details how activity undertaken in 2020/21 will be processed for the year end reconciliation process and applies to General Dental Services (GDS) contracts and Personal Dental Services (PDS) agreements.

3.1 1 April 2020 to 7 June 2020

Temporary contract arrangements were in place that facilitated monthly payments in 2020/21 to all practices, equal to 1/12th of their Negotiated Annual Contract Value (NACV), less any patient charge revenue (PCR) collected. As per dental preparedness letter 5, dated 13 July 2020, there will be a 16.75% abatement to the total contract value across this period, see section 11. Abatement reconciliation principles.

All practices, except for those designated as Urgent Care Centres (UDCs), were closed from 25 March 2020 until reopening on the 8th June. Whilst closed to face to face care, practices were unable to deliver Units of Dental Activity (UDAs)/Units of Orthodontic Activity (UOAs) against their contract.

During the closure period, practices were expected to provide remote advice and triage for patients in active treatment and record this activity via the e-triage form in Compass.

For year-end reconciliation, contractors who have met the above conditions will have their overall activity credited, up to a maximum of 25%². This is discussed further in section 4 Year End Outcomes. The dental preparedness letter published on 25 March can be found in [appendix B](#).

3.2 8 June 2020 to 19 July 2020

Resumption of dental services for all face to face care, where practices assessed that they had the necessary infection prevention and control (IPC) and personal protective equipment (PPE) requirements in place.

² This is calculated by 100%/12 months to give 8.33% per month, 3 months gives a total of 25%

Practices risk assessed staff, patients and care delivery and established the appropriate PPE, IPC and social distancing and separation measures to ensure the safety of patients and dental teams. The urgent dental letter published on 28 May 2020 can be found in [appendix D](#).

3.3 20 July 2020 to 31 December 2020

Holding contract arrangements were in place that facilitated monthly payments in 2020/21 to all practices, equal to 1/12th of their NACV, less any PCR collected.

From 8th June practices were expected to reopen, with all being open on 20 July, providing patient care on a remote and face to face basis, subject to capacity, capability, availability of the workforce, supply of PPE, fit testing, and local public health guidance. The expectation was that practices would be delivering the equivalent of at least 20% of historic patient care volumes. Practices not delivering 20% patient care volumes would be deemed to be non-compliant.

Practices were expected to adhere to contractual hours with reasonable staffing levels for NHS services in place and perform the highest possible levels of activity. No undue priority was to be given to private activity over NHS activity. In addition, any practice that had significantly increased private practice provision at a rate that exceeded that for NHS provision may be deemed to be non-compliant. Practices were to continue to pay all staff, including associates, non-clinical and others, at previous levels. Full details of the expectations can be found in the dental preparedness letter published on 13 July 2020, [appendix E](#).

Guidance was issued by the NHS Business Service Authority (BSA) Provider Assurance team regarding how to determine historic levels of activity from the monthly pay statements available in Compass. The guidance is available in the how to guides page on the [NHS BSA website](#)³.

The percentage will be calculated for this period based on the number of patient care activities (E triage forms and FP17's/FP17O's) undertaken which

³ <https://www.nhsbsa.nhs.uk/compass/guidance-and-tutorials>

should be at least 20% of the number of FP17's/FP17O's reported during the same period last year.

For year-end reconciliation the level of activity across the six months will need to be 20% or greater in order to achieve a credit of up to 50%⁴. This credit will be applied during the reconciliation process. This is discussed further in section 4 Year End Outcomes.

Throughout this document it is assumed that providers have achieved all the requirements for the period 20 July to 31 December. The contractual requirements were:

- Maintenance of the eTriage system for recording of telephone/remote consultations.
- FP17 data to be transmitted from all practices to evaluate treatment interventions at a practice level and patient outcomes.
- Submission of declaration around equivalence of NHS service offer and private service offer. This will include a statement of relative volumes of private activity and NHS activity for specified treatments.
- Submission of declaration over continued staff engagement and payment to staff, please see section 2.3 of dental preparedness letter 5, dated 13 July 2020.

Where any of the above arrangements or requirements have not been met, the providers will revert to usual contractual arrangements. Further information around how these will be implemented will follow.

NHS England and NHS Improvement are in the process of establishing a procedure to identify and understand why providers have not achieved the 20% patient volumes. Further information will follow shortly.

⁴ This is of one months expected full activity and is calculated by 100%/12 months to give 8.33% per month, 6 months gives a total of 50%

3.4 1 January – 31 March 2021

Contractual arrangements and general principles from 1st January to 31st March 2021, include:

- Practices must be open on a face to face basis, providing access for urgent care, care which was delayed during the initial phase of lockdown, and prioritise routine care for patients who are considered at highest risk of oral disease in line with the SOP;
- Care may be delivered face to face, or through remote consultation where clinically appropriate;
- Continuation of e-triage/remote consultation forms to support the assurance that:
 - 1 Patients of the highest need are prioritised first;
 - 2 Provide reassurance to patients who are seeking routine examination or treatment, thus freeing capacity to see urgent/high needs patients;
- Submission of FP17's or FP17O's for face to face treatments provided;
- Continuation of the submission of a monthly workforce return; and
- For this period, GDS contracts and PDS agreement holders will continue to be paid monthly payments of 1/12th of their NACV, less any PCR collected. There will also be a 16.75% adjustment to reflect variable costs not incurred due to the reduced patient care activity will be applied to all contracts that have achieved 80% or greater at year end, see section 3.4.3 Adjustment to reflect reduced variable costs.

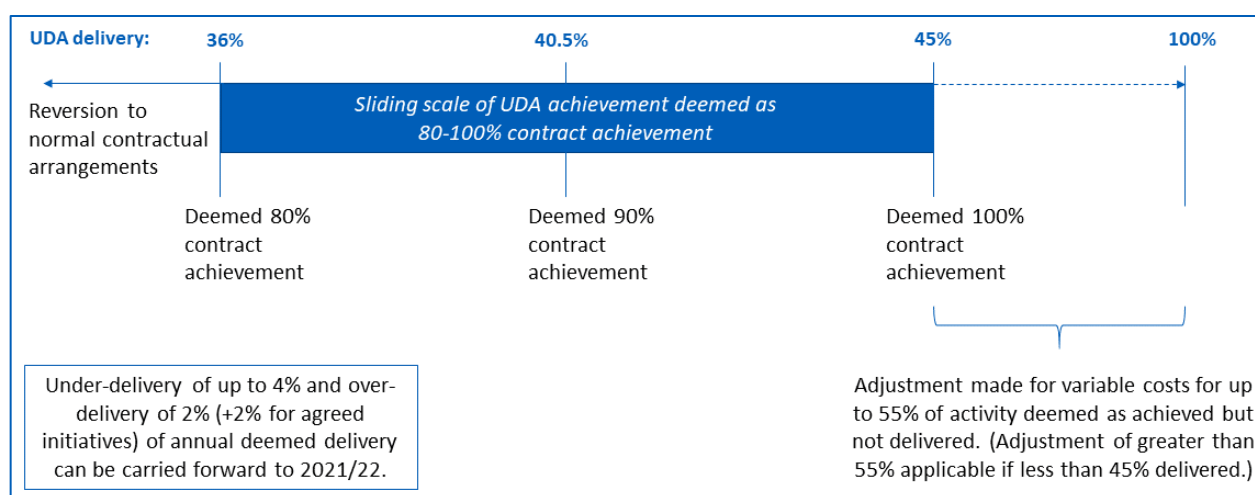
The above conditions, and those set out in section 3.4.4, apply to all GDS contracts and PDS agreements that provide mandatory, advanced mandatory (including domiciliary, sedation, public health and orthodontic services). Community Dental Services and Any Qualifying Providers PDS agreements are covered in Section 8 and 9.

3.4.1 Activity requirements for 1 January – 31 March 2021 - UDA contracts

From the 1 January 2021 activity measurement will revert to pre-Covid contractual metrics, UDA/COT⁵ measurement, with practices working towards delivering reduced activity levels for the remainder of the contract year, with a requirement to deliver a minimum 45% of contractual monthly activity between January and March.

Figure 1 summaries the arrangements for this period.

Figure 1



The 45% of contracted activity between January and March is calculated by:

- Calculating 3 months (25%) of the annual contracted UDAs, for example a contract with a 12,000 UDAs is multiplied by 0.25 to give 3 months pro rata activity of 3,000 UDAs
- Next calculate 45% of this 3-month figure by multiplying 3,000 UDAs by 0.45 to give a target of 1,350 UDAs to be achieved between January to March.

Where contractors deliver 45% of activity in January to March:

⁵ Courses of treatment completed from 1st January onwards and submitted within the 60 day rule.

- This will be deemed to be equivalent to 100% of usual contract activity in this period for year-end clawback calculations.
- Any activity over 45% counts as normal amount of UDAs, not the 100/45 times usual UDAs used to calculate deemed annual activity for the period January to March. Over-performance is carried over to 21/22 within usual limits. For example, 48% activity in January to March for a contract with 12,000 UDAs equates to 3,090 UDAs. This figure is added to the deemed activity of 9,000 UDAs for April to December (12,090 UDAs) and divided by the NACV (12,000). This equals 100.8%, which results in 0.8% over-performance carried over.

Where contractors deliver at least 80% of this 45% cumulative activity in January to March (i.e. at least 36% of contracted activity for this period) but under 45%:

- This will be deemed to be equivalent to the percentage of 45% of usual activity in this period and is calculated by 100/45 multiplied by actual activity delivered in this 3 month period⁶. For example, a contract with 12,000 UDAs has a pro rata 3 month target of 3000 UDAs, if 36% of this target is achieved (1,080 UDAs)⁷ then the deemed activity is calculated by 100/45 multiplied by 1,080 UDAs to give 2,400 UDAs for this period. This figure is added to the 75% of credited activity for April to December (9,000 UDAs⁸) to give a total of 11,400 UDAs. This as a percentage of 12,000 UDAs gives an annual achievement of 95% resulting in a 5% clawback.

Where contractors deliver less than 80% of this 45% cumulative activity in January to March (i.e. less than 36% of contracted activity for this period):

- Contractors will be deemed to have delivered only the actual activity delivered in the months January to March plus any deemed activity for the months April to December (75%⁹) where conditions in place at that time were met. For example, a contract with 12,000 UDAs has a pro

⁶ This calculation produces deemed activity

⁷ 3000 UDAs / 100 multiplied by 36% is 1,080 UDAs delivered between Jan to Mar

⁸ 12,000 UDAs / 100 multiplied by 75 = 9,000 UDAs – The 75% credit is applied assuming all conditions for April to December have been met

⁹ 100%/12 months to give 8.33% per month, 9 months is 75%

rata 3 month target of 3,000 UDAs if 35% of this target is achieved (1,050 UDAs) then this figure is added to the 75% of credited activity for April to December (9,000 UDAs) to give a total of 10,050 UDAs. This as a percentage of 12,000 UDAs gives an annual achievement of 83.8% resulting in a 16.2% clawback.

Carry forward guidance can be found in section 4 2020/21 Year End and also Section 5 Carry Forwards.

Table 1 outlines the monthly activity levels from January to March as a percentage of the annual contractual activity that will be expected to have been delivered. It also highlights the deemed activity for the period April to December, subject to contractors having met the conditions above.

Table 1

	Delivering e-triage			Expected minimum 20% patient volumes, including e-triage and FP17						UDA delivery		
Month	Apr 20	May 20	Jun 20	Jul 20*	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
% of annual activity	25%			50%						25%		
Activity delivered	e-triage	e-triage	e-triage	20% or above	20% or above	20% or above	20% or above	20% or above	20% or above	45%	45%	45%

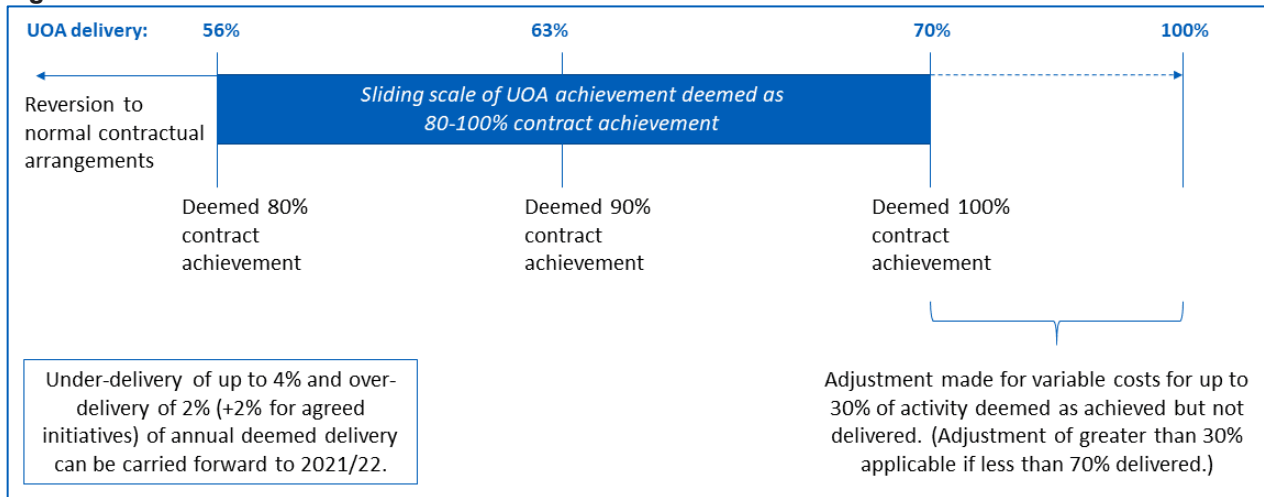
* From 20 July onwards

3.4.2 Activity requirements for 1 January – 31 March 2021 - UOA contracts

For UOA activity, the principles described in the document also apply to UOAs with the exception that providers are expected to achieve 70% between January and March.

Figure 2 summaries the arrangements for this period.

Figure 2



The 70% of contracted activity between January and March is calculated by:

- Calculating 25% (3 months) of the annual contracted UOAs, for example a contract with a 12,000 UOAs is multiplied by 0.25 to give 3 months pro rata activity of 3,000 UOAs
- Next calculate 70% of this 3month figure by multiplying 3,000 UOAs by 0.70 to give a target of 2,100 UOAs to be achieved between January to March.

Where contractors deliver 70% of activity in January to March:

- This will be deemed to be equivalent to 100% of usual contract activity in this period for year-end clawback calculations.
- Any activity over 70% counts as normal amount of UOAs, not the 100/70 times usual UOAs used to calculate deemed annual activity for the period January to March. Over-performance is carried over to 21/22 within usual limits. For example, 75% activity in January to March for a contract with 12,000 UOAs equates to 3,150 UOAs. This figure is added to the deemed activity of 9,000 UOAs for April to December (12,150 UOAs) and divided by the NACV (12,000). This equals 101.3%, which results in 1.3% over-performance carried over.

Where contractors deliver at least 80% of this 70% cumulative activity in January to March (i.e. at least 56% of contracted activity for this period) but under 70%:

- This will be deemed to be equivalent to this percentage of 70% of usual activity in this period and is calculated by $100\%/70\%$ multiplied by actual activity delivered in this 3 month period¹⁰. For example, a contract with 12,000 UOAs has a pro rata 3 month target of 3,000 UOAs, if 56% of this target is achieved (1,680 UOAs)¹¹ then the scaled up deemed activity is calculated by $100\%/70\%$ multiplied by 1,680 UOAs to give 2,400 UOAs for this period. This figure is added to the 75% of credited activity for April to December (9000 UOAs¹²) to give a total of 11,400 UOAs. This as a percentage of 12,000 UOAs gives an annual achievement of 95% resulting in a 5% clawback.

Where contractors deliver less than 80% of this 70% cumulative activity in January to March (i.e. less than 56% of contracted activity for this period):

- Contractors will be deemed to have delivered only the actual activity delivered in the months January to March plus any deemed activity for the months April to December (75%) where conditions in place at that time were met. For example, a contract with 12,000 UOAs has a pro rata 3 month target of 3000 UOAs if 55% of this target is achieved (1,650 UOAs) then this figure is added to the 75% of credited activity for April to December (9,000 UOAs) to give a total of 10,650 UOAs. This as a percentage of 12,000 UOAs gives an annual achievement of 88.75% resulting in a 11.25% clawback.

Table 2 outlines the monthly activity levels from January to March as a percentage of the annual contractual activity that will be expected to have been delivered. It also highlights the deemed activity for the period April to December, subject to contractors having met the conditions above.

¹⁰ This calculation produces deemed activity

¹¹ 3000 UOAs / 100 multiplied by 56% is 1680 UOAs delivered between Jan to Mar

¹² 12,000UOAs / 100 multiplied by 75 = 9,000 UOAs – The 75% credit is applied assuming all conditions for April to December have been met

Table 2

	Delivering e-triage			Expected minimum 20% patient volumes, including e-triage and FP17O						UOA delivery		
Month	Apr 20	May 20	Jun 20	Jul 20*	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
% of annual activity	25%			50%						25%		
Activity delivered	e-triage	e-triage	e-triage	20% or above	20% or above	20% or above	20% or above	20% or above	20% or above	70%	70%	70%

* From 20 July onwards

3.4.3 Adjustment to reflect reduced variable costs

A 16.75% adjustment to reflect variable costs not incurred due to the reduced patient care activity will be applied to all contracts that have achieved 80% or greater at year end. The adjustment will be based on undelivered activity between January 2021 to March 2021 and calculated as follows:

- Providers who achieve **45%** or greater between 1 January and 31 March 21 will be subject to an adjustment of 16.75% of the NACV to reflect variable costs not incurred due to the reduced patient care activity. This is applied to any undelivered activity between 1 January to 31 March¹³ (Undelivered activity = Total contracted UDA (Jan-Mar) – Actual UDA activity (Jan-Mar)).

For example, a provider has an annual contract of 12,000 UDAs at a value of £25/UDA¹⁴ and achieved 45% at year end. The total contracted UDAs for Jan-Mar equates to 3,000 UDAs. 1,350 UDAs were delivered in total for this period (actual UDA activity). The undelivered activity would be 3,000 UDAs minus 1,350 UDAs which equals 1,650 UDAs. A 16.75% cost adjustment will be applied to the 1,650 UDAs to give 16.75% x 1,650 UDAs x £25 = £6,909.38.

- Providers who achieve **36% to 44.99%** between 1 January and 31 March 21 will be subject to an adjustment of 16.75% of the NACV to reflect variable costs not incurred due to the reduced patient care

¹³ ie the 55% of activity that has not been delivered during this period

¹⁴ This is an example figure to illustrate the workings out

activity. This is applied to any undelivered activity minus clawback¹⁵ between 1 January to 31 March (Undelivered activity = Total contracted UDA (Jan-Mar) – Actual UDA activity (Jan-Mar)). This ensures that the variable costs adjustment is not applied to the portion of activity that is subject to clawback. Any UDA/UOAs carried forward will be excluded from the 16.75% adjustment.

For example, a provider has an annual contract of 12,000 UDAs at a value of £25/UDA and achieved 36% at year end (clawback of 5%¹⁶). The total contracted UDAs for Jan-Mar equates to 3,000 UDAs. 1,080 UDAs were delivered in total for this period (actual UDA activity). The undelivered activity would be 3,000 UDAs minus 1,080 UDAs which equals 1,920 UDAs.

Next the number of UDAs that clawback is calculated against is worked out – 5% of 12,000 UDAs to give 600 UDAs. This figure is subtracted from the undelivered activity and gives a figure of 1,320 UDAs. A 16.75% cost adjustment will be applied to the 1,320 UDAs to give $16.75\% \times 1,320 \text{ UDAs} \times £25 = £5,527.5$, in addition to any other clawback for deemed under-delivery of activity

- For providers achieving **less than 36%** (i.e. less than 80% of deemed annual contracted activity) no additional adjustment will be made as this will be incorporated into the year end claw back.

3.4.4 Practice expectations

Practices are expected to work towards delivering reduced activity targets with the following conditions in place, along with those mentioned in section 3.4. Any breach of those conditions will result in the application of the usual contractual arrangements and claw back, instead of any waiver of claw back rights:

¹⁵ This is to ensure that - Where clawback and a variable cost adjustment applies the variable cost adjustment will not be applied to any portion of the activity that is subject to clawback

¹⁶ Assuming all requirements for April to December were also met

- A commitment to maximise safe throughput in the spirit of meeting as many prioritised needs as possible;
- A commitment by practices to remain open and to prioritise care for patients who are considered at highest risk of oral disease in line with the prevailing dental SOP and guidance;
- A commitment to utilise NHS Funding to the full for the provision of NHS services and ensure full compliance to clause 59 of GDS/PDS contract agreements
- A commitment to continue preventative work (such as confirmation via the FP17 data that best practice prevention advice has been given to patients) and to target their efforts in a way that they judge will reduce health inequalities (for example agreeing to see irregular attenders in addition to usual patients). This will be auditable by local teams with an expectation that practices will be able to provide evidence of their efforts;
- Practices will prioritise all known and unknown patients to the practice who require urgent dental care if contacted directly or via 111 services
- An expectation that all contractual premises remain open unless otherwise agreed via the regional commissioner
- A commitment to complete and keep under review all staff risk assessments
- A commitment not to seek any duplicate or superfluous funding from the NHS or other Government sources – including furlough or additional sick or parental leave pay that was not used to pay for cover;

3.5 Urgent Dental Centres (UDC)

There are currently more than 600 UDCs in operation across England. Established with minimal preparation through effective partnership working between NHSE & NHSI, NHS trusts and providers, UDCs provide urgent and

emergency dental care via referrals from NHS 111. UDCs played a particularly critical role during the April to June closure period, ensuring that patients across England had access to face to face treatments at time of need. They continued to provide vital additional capacity for treatments as practices were reopening and will ensure that urgent dental care needs are met in the event of further national, regional or local lockdowns.

UDC contractors are expected to meet the contractual requirements and activity targets set out above.

Specific circumstances associated with UDCs could adversely affect their ability to meet their activity target. This may include a lack of referrals and a higher than average level of complex cases. Should a UDC contractor be unable to meet the activity target, they can apply for an exceptional adjustment to their delivery levels at year end reconciliation. This applies for the period they were operating as a UDC.

The following conditions need to be met for the application to be considered. The contractor:

- (i) has not been able to deliver activity to meet the adjusted target of 45% of usual activity (corresponding to 100% of contractual activity in 2020/21) and
- (ii) the actual level of activity delivered was lower than it would have been were they not acting as a UDC and
- (iii) they can demonstrate this to their commissioner.

At year end reconciliation, UDC contractors who delivered less than 45% of usual activity and wish to apply for an adjustment will need to provide evidence to their commissioner. They should demonstrate the level of activity they believe they would have delivered during this period had they operated as a general practice with an adjusted activity target. This may be based on FP17/FP17O data from recent years and their previous performance against activity targets.

The commissioner should consider the evidence carefully before reaching a decision. They can choose to adjust the contractor's delivery, up to the level

the contractor can demonstrate they would have delivered during that period. The adjustment can be set to a maximum of 104% of usual activity for the period they were a UDC. Should the adjustment result in delivery below 45%, financial claw back will apply in accordance with the below year end reconciliation outcomes.

The 16.75% adjustment for variable costs not incurred during the period 1 January to 31 March 2021 will be applied to all UDC providers, as is for other contractors. This will be based on actual delivery, not the commissioner agreed adjusted figure or deemed delivery, in accordance with the arrangements outlined in section 3.4.2.

4. 2020/21 Year End

The following describes the 2020/21 year end financial reconciliation outcomes and claw back arrangements.

NHSE & NHSI will waive claw back (apart from where it relates to variable costs not incurred) in relation to deemed delivery of activity subject to delivery of the following:

- For any period during April to December where the conditions detailed within our letters of the 25 March 2020, 28 May 2020 and 13 July 2020 were met
- Minimum of 45% activity of the contractor's UDA/COT target, minimum 70% for UOA/COT target, delivered between 1 January 2021 and 31 March 2021
- Completion of the annual declaration in full

For contractors that have delivered more than 45% activity in this period, over-performance of up to 2% (4% may be allowed in specific, agreed circumstances) can be carried forward and reduce the contractual requirement in 21/22. Once the 45% target has been reached, the UDA/UOAs delivered will be counted as standard contractual UDA/UOAs, not the 100/45 deemed delivery calculation.

Contracts that are deemed to have delivered at least 96% and less than 100% of their annual activity will have their outstanding activity up to 100% carried forward.

Where clawback or carry-over applies there will not also be an additional adjustment for variable costs for any activity that is clawed back in full or required to be carried over in full.

4.1 Practice expectations – UDA activity

The possible outcomes for the year end reconciliation are as follows:

Provider achieves 45% between 1 January 21 and 31 March 21, (for the purposes of 2020/21 year end this is deemed to be the equivalent to 100%), plus provided e-triage from April to June and completed 20% patient care activities from July to December and has met all associated conditions.

- There will be no claw back based on activity levels, provider will be deemed to have delivered 100% of their contracted annual activity
- A 16.75% adjustment to reflect variable costs not incurred due to the reduced patient care activity will be applied in place of the usual clawback.

Worked example:

Practice A

Non-UDC with a contract to deliver 13,000 UDAs annually at £25/UDA. The practice carried out remote triage consultations, focusing on advice, analgesia and antibiotics (AAA) to all patients making contact from April to June. The practice re-opened on 8 June for face-to-face consultations and remote triage. From July they were carrying out on average 30% of usual contractual activity. They aim to increase this to 46% in January and plan to gradually increase to 50% activity during the remainder of 20/21.

At the end of March 2021, the practice will have delivered 48.0% of contracted activity in the period January to March and met the conditions for the period April to December. This equates to 100.8% deemed annual contract activity. 0.8% over-delivery will be carried forward to 2021/22. An adjustment of £7,075 will be applied for variable costs not incurred.

Table 3

Month	Delivering e-triage			Expected minimum 20% patient volumes, including e-triage and FP17						UDA delivery*		
	Apr 20	May 20	Jun 20	Jul 20**	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
% of annual activity	25%			50%						25%		
20/21 monthly targets				216.6 patient care activity volumes						487.4 UDAs		
Activity delivered	e-triage	e-triage	e-triage	90	314	357	325	347	347	498	520	542
% activity delivered in month				25%	29%	33%	30%	32%	32%	46%	48%	50%

* UDAs: 13,000 annually / 1,083 monthly. Adjusted monthly UDA target: 487

** From 20 July onwards. Calculation adjusted to this timeframe

Adjustment calculation

Total contracted UDA (Jan-Mar) – Actual UDA activity (Jan-Mar) = Undelivered activity:

3,249 – 1,560 = 1,689

Undelivered activity * 16.75%: 1,689 * 16.75% = 283 UDAs

Adjustment value: 283 * £25 = £7,075

Provider achieves 36% to 44.99% between 1 January 21 and 31 March 21

Plus provided e-triage from April to June and completed 20% patient care activities from July to December.

- Claw back will be based on the annual deemed level of activity.
- Deemed activity between 96%-99.99% will be carried forward to 21/22.
- A 16.75% adjustment to reflect variable costs not incurred due to the reduced patient care activity will be applied to any actual activity that was not delivered and is not being clawed back.

Worked examples:

Practice B

Non-UDC with a contract to deliver 27,000 UDAs annually. The practice carried out remote triage consultations and AAA to patients during the April to June closure period. The practice opened for face-to-face consultations in late

June, operating at 22% of usual contractual activity. They aim to increase their activity to 38% in January and 42% from February onwards.

At the end of March 2021, the practice will have delivered 39.7% of contracted activity in the period January to March. This equates to 97.0% deemed annual contract activity. As the practice failed to meet the target of 45% activity but otherwise met the conditions, a 3.0% under-delivery will be carried forward to 21/22. An adjustment of £13,663 will be applied for variable costs not incurred, in relation to any activity that was not delivered and is not being clawed back.

Table 4

Month	Delivering e-triage			Expected minimum 20% patient volumes, including e-triage and FP17						UDA delivery*		
	Apr 20	May 20	Jun 20	Jul 20**	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
% of annual activity	25%			50%						25%		
20/21 monthly targets				450 patient care activity volumes						1,012.5 UDAs		
Activity delivered	e-triage	e-triage	e-triage	165	540	518	563	585	585	855	878	945
% activity delivered in month				22%	24%	23%	25%	26%	26%	38%	39%	42%

* UDAs: 27,000 annually / 2,250 monthly. Adjusted monthly UDA target: 1,012.5

** From 20 July onwards. Calculation adjusted to this timeframe

Adjustment calculation

Total contracted UDA (Jan-Mar) – Actual UDA activity (Jan-Mar) = Undelivered activity:
6,750 – 2,678 = 4,073

Under-delivery carried forward * 16.75% = Adjustment for under-delivery carried forward:
(3.0% * 27,000) * 16.75% = 135.7

(Undelivered activity * 16.75%) – Adjustment for under-delivery carried forward = Adjustment:
(4,073 * 16.75%) – 135.7 = 546.5

Adjustment value: 546.5 * £25 = £13,663

Practice C

UDC with a contract to deliver 28,000 UDAs annually at £25/UDA. The practice was set up as a UDC in April, carrying out urgent treatments at 25% of usual activity levels. They increased their activity to 30% in October and aim to deliver 40% of activity from January onwards.

At the end of March 2021, the practice will have delivered 40.0% of contracted activity in the period January to March. The practice submitted evidence to the

commissioner, successfully demonstrating that their activity levels were affected by them operating as a UDC. Their adjusted activity level was set at 45%. This equates to 100.0% deemed annual contract activity. No claw back will be applied to the total contract value at year end reconciliation. An adjustment of £17,529 will be applied for variable costs not incurred, in relation to any activity that was not delivered and is not being clawed back.

Table 5

Month	Delivering urgent treatment			Expected minimum 20% patient volumes, including e-triage and FP17						UDA delivery*		
	Apr 20	May 20	Jun 20	Jul 20**	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
% of annual activity	25%			50%						25%		
20/21 monthly targets				466.6 patient activity volumes						1,049.9 UDAs		
Activity delivered				607	630	630	700	723	747	788	1,013	1,013
% activity delivered in month				26%	27%	27%	30%	31%	32%	35%	45%	45%

* UDAs: 28,000 annually / 2,333 monthly. Adjusted monthly UDA target: 1,049.9

** From 20 July onwards

Adjustment calculation

Total contracted UDA (Jan-Mar) – Actual UDA activity (Jan-Mar) = Undelivered activity:

7,000 – 2,814 = 4,186

Undelivered activity * 16.75% = Adjustment: 4,186 * 16.75% = 701.2

Adjustment value: 701.2 * £25 = £17,530

Provider achieves 35.99% or less between 1 January and 31 March 21

plus provided e-triage from April to June and completed 20% patient care activities from July to December.

- Claw back will be based on the annual deemed level of activity
- A provider will be deemed to have delivered only the actual activity delivered in months January to March plus any deemed activity for the months of April to December

Worked example:

Practice D

Non-UDC with a contract to deliver 21,000 UDAs annually. The practice started carrying out remote triage consultations and AAA to patients in April. They opened for face-to-face consultations in July, operating at 20% of usual contractual activity. They are aiming to increase their capacity to 30% from January onwards.

At the end of March 2021, the practice will have delivered 30.0% of contracted activity in the period January to March. This equates to 82.5% deemed annual contract activity. This results in a 17.5% claw back, applied at year end reconciliation.

Table 6

Month	Delivering e-triage			Expected minimum 20% patient volumes, including e-triage and FP17						UDA delivery*		
	Apr 20	May 20	Jun 20	Jul 20**	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
% of annual activity	25%			50%						25%		
20/21 monthly targets				350 patient care activity volumes						787.5 UDAs		
Activity delivered	e-triage	e-triage	e-triage	117	350	350	350	385	368	525	525	525
% activity delivered in month				20%	20%	20%	20%	22%	21%	30%	30%	30%

* UDAs: 21,000 annually / 1,750 monthly. Adjusted monthly UDA target: 787.5

** From 20 July onwards

Claw back calculation

Deemed activity Apr-Dec + Activity achieved Jan-Mar = Deemed annual contract activity:

15,750 + 1,575 = 17,325

Deemed annual contract activity as % of contract: 17,325 / 21,000 = 82.5%

100% - 82.5% = 17.5% claw back

4.2 Practice expectations – UOA activity

The possible outcomes for the year end reconciliation are as follows:

Provider achieves 70% between 1 January 21 and 31 March 21, (for the purposes of 2020/21 year end this is deemed to be the equivalent to 100%), plus provided e-triage from April to June and completed 20% patient care activities from July to December.

- There will be no claw back, provider will be deemed to have delivered 100% of their contracted annual activity
- A 16.75% adjustment to reflect variable costs not incurred due to the reduced patient care activity will be applied in place of full clawback.

Provider achieves 56% to 69.99% between 1 January and 31 March 21 Plus provided e-triage from April to June and completed 20 % patient care activities from July to December.

- Claw back will be based on the annual deemed level of activity.
- A 16.75% adjustment to reflect variable costs not incurred due to the reduced patient care activity will be applied to any deemed activity that was not delivered and is not being clawed back.

Provider achieves 55.99% or less between 1 January and 31 March 21 Plus provided e-triage from April to June and completed 20% patient care activities from July to December.

- Claw back will be based on the annual deemed level of activity. A provider will be deemed to have delivered only the actual activity delivered in months January to March plus any deemed activity for the months of April to December

Worked examples:

Practice E

Non-UDC practice with a contract to deliver 8,500 UOAs annually. The practice delivered remote consultations to patients between April and June. They opened for face to face consultations in July, delivering 20% of usual activity levels. The practice increased their activity to 25% in September and they aim to work towards carrying out 70% of usual activity by March.

At the end of March 2021, the practice will have delivered 67.6% of contracted activity in the period January to March. This equates to 99.1% deemed annual contract activity. 0.9% under-performance will be carried forward to 2021/22. An adjustment of £2,876 will be applied for variable costs not incurred, in relation to any activity that was not delivered and is not being clawed back.

Table 7

Month	Delivering e-triage			Expected minimum 20% patient volumes, including e-triage and FP17O						UOA delivery*		
	Apr 20	May 20	Jun 20	Jul 20**	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
% of annual activity	25%			50%						25%		
20/21 monthly targets				141.6 patient care activity volumes						496 UOAs		
Activity delivered	e-triage	e-triage	e-triage	47	156	156	163	156	191	467	474	496
% activity delivered in month				20%	22%	22%	23%	22%	27%	66%	67%	70%

* UOAs: 8,500 annually / 708 monthly. Adjusted monthly UOA target: 495

** From 20 July onwards

Adjustment calculation

Total contracted UOA (Jan-Mar) – Actual UOA activity (Jan-Mar) = Undelivered activity:
2,125 – 1,437 = 688

Under-delivery carried forward * 16.75% = Adjustment for under-delivery carried forward:
(0.9% * 8,500) * 16.75% = 12.8

(Undelivered activity * 16.75%) – Adjustment for under-delivery carried forward = Adjustment:
(688 * 16.75%) – 12.8 = 102.4

Adjustment value: 102.4 * £25 = £2,560

Practice F

Orthodontic practice with a contract to deliver 19,000 UOAs annually. The practice delivered remote consultations to patients between April and June. They opened for face to face consultations in July, delivering 5% of usual activity levels. The practice increased their activity to 15% in September and 40% from October. They aim to work towards carrying out 65% of usual activity by March.

At the end of March 2021, the practice will have delivered 52.0% of contracted activity in the period January to March. This equates to 88.0% deemed annual contract activity. As a result, the practice will have a 12% claw back applied at year end reconciliation.

Table 8

Month	Delivering e-triage			Expected minimum 20% patient volumes, including e-triage and FP17O						UOA delivery*		
	Apr 20	May 20	Jun 20	Jul 20**	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
% of annual activity	25%			50%						25%		
20/21 monthly targets				316.6 patient care activity volumes						1,108.1 UOAs		
Activity delivered	e-triage	e-triage	e-triage	26	142	238	633	697	712	744	792	934
% activity delivered in month				5%	9%	15%	40%	44%	45%	47%	50%	59%

* UOAs: 19,000 annually / 1,583 monthly. Adjusted monthly UOA target: 1,108.1

** From 20 July onwards

Claw back calculation

Deemed activity Apr-Dec + Activity achieved Jan-Mar = Deemed annual contract activity:

14,250 + 2,470 = 16,720

Deemed annual contract activity as % of contract: 16,720 / 19,000 = 88.0%

100% - 88.0% = 12% claw back

5. Carry Forwards

2019/20:

- Contractor over and under performance from 19/20 will have been reconciled as part of the year end process.
- For providers that have a carry forward of either over or under-delivered activity from 2019/20, there are two options available:
- Commissioners can reserve the right to transfer over or under delivered activity from 2019/20 into a future year, i.e. 2021/22; subject to a local negotiation/agreement with the contractor.
- Alternatively, over and under performance from 2019/20 can be added to the expected delivery for 2020/21, with the activity delivered for the remainder of the contract year, January to March 2021.

2020/21:

- Contracts that are deemed to have delivered at least 96% and less than 100% of their deemed annual activity will have their outstanding activity up to 100% carried forward.
- For contractors that have delivered more than 45% activity between 1 January to 31 March, over-performance of up to 2% (4% may be allowed in specific, agreed circumstances) can be carried forward and reduce the contractual requirement in 21/22. Once the 45% target has been reached, the UDA/UOAs delivered will be counted as standard contractual UDA/UOAs, not the 100/45 deemed delivery calculation.

6. Exceptional circumstances

In accordance with the Policy Book for Primary Dental Services there may be instances in which a contractor is unable to fulfil its requirements to deliver the annual contractual activity. In addition to these, the Covid context and response may result in specific circumstances affecting contractors. These cases will be considered on an individual basis and could include a decision by the Commissioner to waive its rights to recover any portion of the financial claw back.

The following could be considered exceptional circumstances for the Covid pandemic. This list is not exhaustive:

- Covid-19 outbreak forcing the practice to close, as advised by NHS Test and Trace or a local public health team;
- Staff shortages due to individual members of staff being advised to self-isolate or shield;
- Covid-19 causing disruption to supply chains (PPE, consumables, materials); and
- Delays caused by implementing Covid-19 specific infection prevention and control guidance where contractors had plans that were disrupted by supplier issues.

Contractors are advised to bring any Covid specific exceptional circumstances to the attention of the Commissioner at the earliest possible opportunity. However, Commissioners would only approve these as exceptional circumstances where they have endured and have precluded the ability for contractors to make up the shortfall in the months preceding or following the exceptional circumstances.

Providers are encouraged to liaise with commissioners early if they feel that any contractual conditions are not being met, and to work with the commissioner to improve compliance in order to improve access and reduce the likelihood of clawback being necessary.

The established process outlined in chapter 17 of the [Policy Book for Primary Dental Services](#)¹⁷ should be followed in these circumstances.

¹⁷ <https://www.england.nhs.uk/wp-content/uploads/2018/04/policy-book-for-dental-services.pdf>

7. Annual declaration

As part of the year end reconciliation process, contractors will be required to complete and submit an annual declaration via Compass. In order to fully meet the year end reconciliation obligations, the declaration and associated documentation must be submitted in full, as well having met the activity targets and contractual requirements set out in chapter 3.

The declaration covers the following:

- Completion of workforce risk assessments;
- Completion of the monthly workforce return and retention of the workforce;
- Declaration that payments during the 2020/21 contract year, have been made to the practice workforce during from April to December 2020;
- Declaration of proportion of NHS and Private turnover;
- Declaration of surgery opening hours and availability of NHS services;
- Practice has an NHS nhs.net email address that is active;
- Practice has not received any duplicate or superfluous funding from the NHS or other Government sources – including furlough or additional sick or parental leave pay that was not used to pay for cover;
- Have ensured that face to face urgent dental care is available for regular and none regular attenders via direct contact or referral via 111;
- Have reviewed any interrupted patient care pathways and restarted these where appropriate to do so; and
- Have ensured that patients who normally attend the practice are prioritised for care in terms of their risk.

NHS Business Services Authority (BSA) will manage this process as part of the National Dental Contract Management year end delivery reconciliation.

The form will be available in Compass ahead of the year end reconciliation process. Further information will follow in this regard.

8. Dental foundation trainees

Current funding streams for dental foundation trainees are expected to fully cover the trainee's salary costs, compensate trainers for time and business/capital costs, and for supervising trainees. Business costs include pay and non-pay costs.

There is an expectation that trainees will deliver around 1,875 UDA's per annum, performance varies for each trainee. Service costs do not attract superannuation.

For the avoidance of doubt, activity undertaken by dental foundation trainees from 1 January 2021 to 31 March 2021, and submitted within the 60-day rule, will count towards delivery of the trainer's mandatory services contract from 1 January 2021 to 31 March 2021.

9. Community Dental Services

Community Dental Services (CDS) provide dental services to patients who are unable to be seen on the High Street due to having complex health needs and/or being medically compromised. CDS services often provide bolt on services such as epidemiology, oral health promotion, GA and paediatric services.

PDS agreements are the preferred contracting mechanism for CDS commissioning. They enable local commissioning arrangements and the inclusion of key performance indicators (KPIs) to support delivery of care to this vulnerable patient population. KPIs may include patient numbers, complexity of patients seen, and waiting times for assessment and treatment.

While UDAs are the activity metric for PDS agreements, this is not necessarily suited to delivery of care for patients who fall under the remit of a CDS, and to ensure services operate within the parameters of the regulations, a notional number of UDAs are established.

Current holding arrangements, as set out in the letter of preparedness apply to CDS unless alternative arrangements have been agreed as part of the local response to Covid. An example of those arrangements would be re deployment of the CDS workforce, or operating as an Urgent Dental Care (UDC) hub.

The local population health need, historic commissioning arrangements, ability to restore and recover services, and market forces, will vary widely across the seven Regions in England. We are therefore proposing each Region manages CDS commissioning arrangements on a local basis from 1st January to 31st March 2021. The national team will collect data on local commissioning arrangements agreed for 20/21, further information to follow.

January to March 2021 arrangements

Revised UDA and KPI targets and any potential clawback should be agreed and communicated with the CDS contractor.

Guiding principles for commissioners are set out as follows:

1. Local commissioners will work with their CDS providers to ensure that any contractual targets and KPIs take account of the provider's circumstances during the current pandemic;
2. The targets should reflect the importance of maximising access for this population and be reasonable and reflect the challenges involved in providing dental services for people with complex health needs
3. These circumstances will include such things as fallow time, responsibilities for providing general anaesthetic, redeployment of staff to support other areas of the NHS, vulnerability of CDS patients, the need for social distancing within clinics and the fact that the CDS is a referral service whose patients usually have a high level of dental need;
4. CDS services treat the most vulnerable members of society and there is a need to ensure the stability of services;
5. Maintaining regular contact with CDS providers so problems can be prevented at an early stage and the providers feel supported;
6. The UDA target would not be expected to exceed the agreed target for GDS and PDS contractors for the same period;
7. Commissioning teams should also agree a set of criteria for clawback for CDS contractors at year end reconciliation. This would be expected to include a cost adjustment for variable costs not incurred for undelivered activity. If Regions implement a cost adjustment, this can be based on the criteria set for GDS contractors;
8. The arrangements for CDS providers for the January to March 2021 period should be clearly documented, including the rationale and principles used for determining the contractual targets and/or KPI's and any potential clawback; and
9. Dental leads should ensure local governance procedures are followed to include sign off by responsible Officers.

10. Any Qualified Provider (AQP) contracts

Any qualifying provider (AQP) services provide tier 2 and 3 dental services to patients, who are unable to receive care in a mandatory service dental setting, and their care can be provided locally due to local commissioning arrangements.

AQP contracts include Intermediate Minor Oral Surgery (IMOS), endodontic and periodontal treatment, prosthodontics, and restorative dentistry.

PDS agreements are the preferred contracting mechanism for AQP commissioning. They enable local commissioning arrangements and the inclusion of key performance indicators (KPIs) to support delivery of care.

While UDAs are the activity metric for PDS agreements, this is not necessarily suited to delivery of care for patients who fall under the remit of an AQP contracting arrangement, to ensure services operate within the parameters of the regulations, a notional number of UDAs are established.

Current holding arrangements, as set out in the letter of preparedness apply to AQP unless alternative arrangements have been agreed as part of the local response to Covid. An example of those arrangements would be re deployment of the AQP workforce or operating as a UDC hub.

The local population health need, historic commissioning arrangements, ability to restore and recover services, and market forces, will vary widely across the seven Regions in England. We are therefore proposing each Region manages AQP commissioning arrangements on a local basis from 1st January to 31st March 2021. The national team will collect data on local commissioning arrangements agreed for 20/21, further information to follow.

January to March 2021 arrangements

Revised UDA and KPI targets and any potential clawback should be agreed and communicated with the AQP contractor.

Guiding principles for commissioners are set out as follows:

1. Local commissioners will work with their AQP providers to ensure that any contractual targets and KPIs take account of the need to maximise access for patients as well as provider's circumstances during the current pandemic;
2. These circumstances will include such things as fallow time, responsibilities for providing courses of treatment and general anaesthetic, redeployment of staff to support other areas of the NHS, vulnerability of AQP patients, the need for social distancing within clinics and the fact that the AQP arrangements are a referral service whose patients usually have a high level of dental need;
3. AQP services treat the most complex cases and there is a need to ensure the stability of services;
4. Maintaining regular contact with AQP providers so problems can be prevented at an early stage and the providers feel supported;
5. The targets should be reasonable and reflect the challenges involved in providing dental services for people with complex dental needs;
6. The UDA target should be agreed locally and will be dependent on local market forces;
7. Commissioning teams should also agree a set of criteria for clawback for AQP contractors at year end reconciliation. This would be expected to include a cost adjustment for variable costs not incurred for undelivered activity. If Regions implement a cost adjustment, this can be based on the criteria set for GDS contractors;
8. The arrangements for AQP providers for the January to March 2021 period should be clearly documented, including the rationale and principles used for determining the contractual targets and/or KPI's and any potential clawback; and
9. Dental leads should ensure local governance procedures are followed to include sign off by responsible Officers.

11. Abatement reconciliation principles

As stated in Issue 5, Preparedness letter for primary dental care – 13 July 2020¹⁸, all non-UDC practices will have a 16.75% abatement applied to the total contract value for the period 1st April – 7th June 2020. The abatement was agreed in recognition of the reduction in consumable costs associated with significantly reduced and altered service delivery.

Abatements will not apply to UDC practices for the period that they are operational. For any period where the practice was not operating as a UDC they will be subject to the 16.75% contract abatement as outlined above. Assurance of UDC activity will be gained via workforce returns, e-triage forms and FP17's/FP17O's submitted to NHS BSA.

Further information will be shared once the amended Dental Standard Financial Entitlement (SFE) directions have been laid in parliament.

¹⁸ https://www.england.nhs.uk/wp-content/uploads/2018/04/policy-book-for-dental-services.pdf/sites/52/2020/03/C0603-Dental-preparedness-letter_July-2020.pdf

12. PPE Reimbursement Scheme

Eligible health and social care providers can order PPE through the PPE portal to meet the increased need that has arisen as a result of the Covid-19 pandemic. Operated by the Department of Health and Social Care (DHSC), the PPE portal went live for dental practices on 29 September.

Dental practices should now be obtaining their Covid-19 PPE free of charge through the PPE portal.

A process has been agreed by the DSHC to [reimburse dental practices for PPE](#)¹⁹ procured and paid for between 27 February 2020 and 31 December 2020.

Reimbursement process

Dental practices will be able to claim for PPE purchased between 27 February 2020 and 31 December 2020 for use in the delivery of NHS dental services. See appendix A for full timescales.

From July – December practices received 100% of contract value, with no adjustment made for variable costs not incurred, in order to account for the increased PPE costs that practices were incurring for activity delivered. This will have covered the increased costs for the majority of practices. Therefore, the following criteria applies:

- Contractors that have delivered over 45% of their contracted activity between 8 June 2020 and 31 December 2020 should submit a claim for their PPE costs. For UCD practices this period is 27 February 2020 to 31 December 2020.
- Contractors that have delivered less than 45% of their contracted activity between 8 June 2020 and 31 December 2020 should not need to claim for reimbursement as the cost is offset by undelivered activity.

¹⁹ <https://www.gov.uk/government/publications/ppe-reimbursement-for-non-hospital-providers/covid-19-ppe-reimbursement-for-non-hospital-providers>

- Contractors that have delivered less than 45% activity but believe they have incurred legitimate PPE costs, over the threshold set out, should submit a claim. This will be considered an exceptional claim.

Dental practices should submit their claims via COMPASS, administered by the NHS Business Services Authority. The PPE Reimbursement Scheme is due to go live on Saturday 2 January 2021.

The thresholds for standard claims are based on modelling to benchmark valid monthly costs that practices would have incurred for medical grade PPE as outlined in IPC guidance. Information on how to complete a claim will be provided via the NHS BSA COMPASS portal prior to the scheme going live on 2 January 2021.

NHSE & NHSI
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

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Appendix A: PPE Reimbursement Scheme timescales UDA/UOA Providers

	Delivering e-triage – UDCs Open			Expected minimum 20% patient activity						UDA/UOA delivery		
Month	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Activity delivered	e-triage	e-triage	e-triage	20% or above	20% or above	20% or above	20% or above	20% or above	20% or above	45% UDA 70% UOA	45% UDA 70% UOA	45% UDA 70% UOA
Activity credit	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	25%		
PPE source	LRF delivery to UDCs	LRF delivery to UDCs	LRF delivery to UDCs/wholesalers	Wholesalers	Wholesalers, PPE portal for emergency use		Wholesalers, PPE portal for COVID use			PPE Portal		
PPE paid for in the contract	None – costs abated (apart from for UDCs)	None – cost abated (apart from for UDCs)	From 8 June the majority of PPE costs incorporated in the contract. Practices received full contract value in order to cover increased PPE costs, even though activity lower than normal.	The majority of PPE costs incorporated in the contract. Practices received full contract value in order to cover increased PPE costs, even though activity lower than normal.						Non-COVID PPE costs covered within contract for actual delivered activity		
PPE costs paid for by reimbursement	Some UDCs may have incurred additional costs			Costs for the minority of practices delivering over 45% activity, where the existing contract value may therefore be insufficient to cover costs.						Not required if all PPE available via the portal at 100% modelled demand		

Note: PPE provision and reimbursement policy is DHSC led.

Appendix B: Issue 3 Preparedness letter for primary dental care

Publications approval reference: 001559

25 March 2020

This is the third of a series of regular updates to general dental practices and community dental services regarding the emerging COVID-19 situation. An electronic copy of this letter, and all other relevant guidance from NHS England and NHS Improvement can be found here:

www.england.nhs.uk/coronavirus/primary-care/.

Dear colleagues

Thank you again for your continued work to prepare for and handle the COVID-19 pandemic. We are grateful for the commitment and effort that is going into providing care for patients and for your forbearance as we seek to provide clarity in a fast-moving situation.

Since the publication of our last letter on the morning of 20 March, the Prime Minister announced later that afternoon further social distancing measures to slow down the spread of COVID-19. On 22 March a further announcement included the introduction of “shielding” our most at risk members of the population and then, on 23 March, a further set of restrictions on daily activity to contain the spread of the virus were introduced.

The emphasis has now shifted away from the delivery of routine care while minimising infection risk to a requirement to stop all non-urgent activity in line with the changes to people’s everyday lives that the Prime Minister has signalled. This is the time for a collaborative, collective and concerted effort to re-direct our talents and to help support our fellow NHS primary care colleagues when they are at their most stretched. Your skills, your time and your commitment can and will make a difference to our national effort.

In light of these most recent public health control measures and in recognition of the difficulties that practices are facing including continuing concerns about staff safety, we are making a number of immediate changes to the delivery and operation of our dental services.

A. Changes to Primary Dental Care services

(General Dental Practices and Community Dental Services)

- 1. All routine, non-urgent dental care** including orthodontics should be stopped and deferred until advised otherwise.
- 2.** All practices should establish (independently or by collaboration with others) a remote **urgent care service**, providing telephone triage for their patients with urgent needs during usual working hours, and whenever possible treating with:
 - Advice
 - Analgesia
 - Antimicrobial means where appropriate
- 3.** If the patient's condition cannot be managed by these means, then they will need to be referred to the appropriate part of their **Local Urgent Dental Care system**. These new arrangements will involve providers working with defined groups of patients to manage urgent dental care needs only, with appropriate separation arrangements in place to manage patient status and professional safety. These will be established via NHSE/I regions to manage urgent care dental needs in the specific groups of patients. The service model is described in section D, "Developing local Urgent Dental Care systems" below.

Some practices and community dental services may need to become designated providers of urgent dental care as part of these Local Urgent Dental Care systems during the COVID-19 pandemic. This will be determined and agreed with each practice as part of the regionally-organised system.
- 4.** All community outreach activities such as oral health improvement programmes (e.g. Starting Well, routine non-urgent work in care homes) and dental surveys should be stopped until advised otherwise.
- 5.** In order to provide accurate information to the public we are asking that all dental practices:
 - Update their messaging and websites;

- Contact their regional commissioner should practice availability hours alter as a result of staffing levels; and
- Inform the commissioner of these changes and the arrangements for cover. Your regional commissioner will then inform the Directory of Services (DOS) lead so that 111 are up to date with the correct information.

B. Contracts and funding

1. 2019-20 contract reconciliation

We recognise that in most years dental activity is usually higher during the month of March and that this year the majority of contractors may have been impacted because of COVID-19. We can confirm that year end reconciliation will therefore operate in the following manner:

- For the purposes of calculating year end contract delivery, we will consider the year to be March 2019 – February 2020, and we will apply March 2019 data instead of March 2020;
- For contracts delivering above 96% over this period we will then operate normal year end reconciliation with the ability to carry forward activity to 2020; and
- For contracts delivering below 96% over this period we will enter into normal clawback position up to 100% of total contract value (TCV).

2. 2020-21 contracts: cashflow and reconciliation

We will take immediate steps to revise the operation of the 2020-21 contract to reflect service disruption due to COVID19 for practices who are participating as required in the COVID response. The approach will aim to achieve the following:

- Maintaining cash flow to provide immediate stability and certainty for dental practices;
- Protecting the availability of staff to provide essential services during the response period to COVID-19;

- Actively enabling staff time that is no longer required for routine dental activity to be diverted to support service areas with additional activity pressures due to COVID-19;
- Maintaining business stability to allow a rapid return to pre-incident activity levels and service model once the temporary changes cease; and
- Fairly recompensing practices for costs incurred.

We will therefore take the following steps:

Cashflow

We will continue to make monthly payments in 2020-21 to all practices that are equal to 1/12th of their current annual contract value.

Contract value and reconciliation

We will progress our work with the BDA to finalise an approach to contract value and reconciliation in 2020-21 that takes account of the following principles:

- Contract delivery and year end payment for the period of the COVID-19 response should be assumed to have been maintained at a level that allows continued employment of staff (despite reduced actual activity);
- In return for this certainty, this will be conditional upon practices being required to offer all available staff capacity to other areas as outlined in section C, "Workforce" below;
- A requirement on practices to ensure that all staff including associates, non-clinical and others continue to be paid at previous levels;
- An agreed and fair reduction for any variable costs associated with service delivery (e.g. in recognition of reduced consumable costs) will be applied to all contract values;
- These arrangements will operate over a fixed number of months with an agreed end date; and

- Practices benefiting from continued NHS funding will not be eligible to seek any wider government assistance to small businesses which could be duplicative.

We anticipate that this approach gives certainty over both the immediate cashflow for practices and the longer-term ability to maintain income and contribute to the COVID-19 response across the NHS.

C. Workforce

We recognise the impact that self-isolation and social distancing is having on the dental workforce. We also realise that the changes to primary dental care outlined above will mean that there is freed capacity within a highly skilled workforce, and we appreciate the offers that have come in from the profession to contribute to the wider COVID-19 response. This will now be a condition of the approach set out in this letter.

As well as providing remote support to patients who contact your own practice / service with dental problems, we would like to direct the freed-up workforce capacity to support:

- Urgent dental care services being set up in the NHS regions (see below).
- NHS colleagues working in wider primary care
- NHS colleagues working in the acute COVID-19 response
- Local authority and voluntary services COVID-19 response.

As part of the funding support, the NHS expects that dental practices will fully support the redeployment of professionals and staff working in general dental services to support the wider NHS response, as is happening across the rest of the NHS. In particular, we ask staff contact details are made available immediately and for practices actively to support any national or local calls for help. This will include helping to staff the new Nightingale Hospital that is being established in London and other similar facilities that may be established over the coming weeks. You will receive a further communication on this on Wednesday 25 March.

D. Developing local Urgent Dental Care systems

Across every NHS region we require rapid coordination of the development of robust and safe services through the creation of local Urgent Dental Care systems across a range of sites to provide care for urgent and emergency dental problems.

These systems should be established to meet the distinct needs of the following groups within the population with urgent dental care needs:

1. Patients who are possible or confirmed COVID-19 patients – including patients with symptoms, or those living in their household
2. Patients who are shielded – those who are at most significant risk from COVID-19
3. Patients who are vulnerable / at increased risk from COVID-19
4. Patients who do not fit one of the above categories

Each local Urgent Dental Care system will involve provision at a number of sites in a way that allows appropriate separation and treatment of patients in the categories above.

The range of conditions provided for by local UDC systems are likely to include, but are not limited to:

- Life threatening emergencies, e.g. airway restriction or breathing/swallowing difficulties due to facial swelling
- Trauma including facial/oral laceration and/or dentoalveolar injuries, for example avulsion of a permanent tooth
- Oro-facial swelling that is significant and worsening
- Post-extraction bleeding that the patient is not able to control with local measures
- Dental conditions that have resulted in acute and severe systemic illness

- Severe dental and facial pain: that is, pain that cannot be controlled by the patient following self-help advice
- Fractured teeth or tooth with pulpal exposure
- Dental and soft tissue infections without a systemic effect
- Oro-dental conditions that are likely to exacerbate systemic medical conditions

Each patient should be assessed and managed on their own merit, taking into account the patient's best interests, professional judgement, local UDC arrangements and the prioritisation of the most urgent care needs.

Local Dental Networks, Commissioners and Local Dental Committees should work together with local Dental Public Health colleagues to define and implement a system that meets the principles set out above to meet the dental needs of their local populations and to appropriately support staff to provide services safely.

The exact mechanisms, facilities and approaches will need to reflect existing local arrangements in way that that can be flexed. It will also require the development of some specific and bespoke arrangements, especially for the suspected and confirmed COVID-19 patients, and for those who are being shielded.

The flexibility around operation of the contract outlined above enables staffing for each local Urgent Dental Care system to draw flexibly on a wide range of professional groups including general dental practice staff, community dentists, hospital dentists and academic dentists in a way that best fits local circumstances.

E. Personal Protective Equipment (PPE)

We recognise that the issue of staff safety and confidence in PPE guidance is very important for staff engaged in direct patient care. A number of professional bodies have issued their own guidance over the weekend. We will continue to be led by the emerging evidence and are currently seeking urgent updated advice through our NHS Infection Prevention Control (IPC)

colleagues and Public Health England. We will implement their guidance throughout our urgent dental care services.

Dental public health colleagues are being trained to fit test FFP3 masks and they will be available in regions to carry out this function.

Conclusion

We appreciate that these are significant changes that will have major implications on your personal and professional lives and will bring about new ways of working locally and nationally. We know that the profession are calling for further guidance and we are fully committed to working openly and constructively to rapidly update and clarify guidance as the position evolves.

We are grateful for your patience and understanding as we work with dental teams across the country as quickly as possible to keep you and your patients safe and supported, to produce information and guidance, and to listen to your concerns and suggestions as the situation progresses.

Thank you again for your commitment and engagement as part of this unprecedented national effort.

With very best wishes

Sara Hurley, Chief Dental Officer England

Matt Neligan, Director of Primary Care and System Transformation

Appendix C: Issue 4 Preparedness letter for primary dental care

Publications approval reference: 001559

15 April 2020

Dear colleague

This is the fourth of a series of regular updates to general dental practices and community dental services regarding the COVID-19 situation. A copy of this letter, and all other relevant guidance from NHS England and NHS Improvement, can be found here:

www.england.nhs.uk/coronavirus/primary-care/

We also send out a daily primary care bulletin, which you can sign up for here: <https://www.england.nhs.uk/email-bulletins/primary-care-bulletin/>

Thank you for your ongoing support in providing remote triaging and advice services and, in some situations, providing urgent clinical care where appropriate. Many of you have also contributed through your local dental networks and local dental committees, along with Public Health England (PHE) and NHS England and NHS Improvement regional commissioning colleagues, to design and plan local urgent dental care (UDC) systems at pace. We are grateful for your continued professionalism in these unprecedented times along with your offers of support for the wider COVID-19 response.

Thank you for joining the webinar on Friday 3 April. In total 10,400 people joined and we received around 3,200 questions and comments. We will publish the answers to the common issues and have addressed a number of these in this letter. Alongside we have published the latest iteration of the standard operating procedure (SOP) for dental care during the COVID-19 response.

Below we summarise current arrangements in place in relation to:

- operation of urgent dental care systems
- availability of personal protective equipment (PPE)
- redeployment and volunteering
- contracts and financial arrangements.

Operation of urgent dental care systems

We have today published alongside this letter the SOP for dental care for UDC systems in the context of coronavirus (COVID-19).

The SOP sets out more detail on the principles for the operation of UDC systems. In summary, each UDC system should deliver:

a clear local message for the public that routine dental care is not available during this delay phase of the COVID-19 pandemic and advise them what to do if they have a dental emergency

a remote consultation and triage service whose outcomes are

- advice analgesia, antimicrobials where appropriate (AAA); or
- referral, when absolutely necessary and treatment cannot be delayed, to a designated UDC site for a face-to-face consultation and treatment.

Any referral should specifically identify those patients who are shielded (individuals at the highest risk of severe illness from COVID-19 who are advised to shield themselves and stay at home for 12 weeks) and patients at increased risk, to inform the route for referral in line with local protocols.

a face-to-face consultation and treatment service using a range of providers and locations supported with appropriate PPE for the clinical procedures (AGP, non-AGP) to be carried out at the site.

Aerosol generating procedures (AGP) should be avoided unless absolutely necessary.

As we are now in the sustained transmission phase of COVID-19, we need to consider that all patients may potentially have the virus. Therefore, for all patients attending any face-to-face consultation and treatment at any UDC site, it is important that there is adequate separation either physically or by spacing appointments to ensure that risk of potential contamination is reduced.

Significant efforts should be made to ensure that shielded patients (defined in guidance) in particular are separated from other patient groups. These should be aligned with local systems and protocols to support shielded patients.

We recognise that since our letter of 25 March, as regions have been developing their UDC systems, it has been necessary for some practices and clinicians to see an urgent patient face to face with appropriate PPE when other (AAA) measures have failed or are not appropriate. In the absence of an NHS-designated UDC service, a dental practice may undertake non-AGP face-to-face dental assessment and care with Level 2 PPE. This has been recognised by the CQC and GDC as an appropriate response in the best interests of the patient. As UDC systems become operational, individual practices, unless they are identified by regions as part of the system in a region, should not see patients face to face unless there is no UDC system provision available. Any face-to-face treatment must be delivered in line with the guidance set out in the SOP.

Personal protective equipment

This letter clarifies the latest position around guidance for use and supply of PPE.

PPE guidance

We appreciate there is understandable concern in the dental community regarding the risks of COVID-19 infection. The safety of all dental professionals and patients during the delivery of dental care during this pandemic is a key priority.

A review of PPE in all settings has been undertaken across the four UK health protection organisations, supported by a rapid review of the existing and emerging evidence of the modes of spread of COVID-19.

Public Health England's guidance last updated on 12 April 2020 is applicable to all settings, including dental settings, and can be found [here](#).

The SOP for dental care for UDC systems clarifies what this means for dentistry, including:

the specific PPE to be used for aerosol generating procedures (AGPs) and non-AGPs; and

following consultation with the Deans of the Royal Colleges, FGDP UK, representatives of specialist dental societies and based on PHE's guidance, a clarification of AGP and non-AGP dental procedures.

PPE supply

Only UDCs need PPE as all routine face-to-face work has been suspended. PHE have coordinated delivery of two weeks' worth of PPE to sites delivering urgent dental care to support immediate supply levels. In addition PHE has facilitated local fit-testing training for FFP3 masks where requested, although this can also be done by any appropriately trained personnel from other local sources.

The DHSC COVID-19 PPE Plan published on 10 April 2020 sets out the latest guidance and arrangements for distribution and future supply of PPE. NHS England and NHS Improvement regional teams (EPRR leads working with dental commissioning leads) should support providers of urgent dental care to access PPE for expected numbers of patients through the following routes in priority order:

1. **Usual wholesale suppliers** and distributors of PPE.
2. **Local Resilience Forums** (LRFs) who have been and continue to be provided with priority drops of PPE.
3. The **National Supply Disruption Response** (NSDR) system. This operates a 24/7 helpline for providers who have an urgent requirement (eg require stock in less than 72 hours) for PPE, which they have been unable to secure through their business as usual channels.

Redeployment and volunteering

Over the past 10 days, there has been an unprecedented number of volunteers from the dental workforce who have indicated a willingness to be redeployed to help within the wider healthcare settings during the COVID-19 crisis. Over 15,000 members of the dental workforce have responded, which

is a phenomenal response and speaks volumes about the care and compassion of our colleagues and profession.

The information gathered has been passed onto regional hubs so that each region can tap into this reserve as appropriate to the specific needs of their area and based on the ever-changing picture in each region. There will be a need for local processes to ensure deployment in a rapid manner, while maintaining the required governance.

Full guidance on principles and practical arrangements for redeployment of the dental workforce to support the COVID-19 response is here.

Contracts and financial arrangements

Following our letter of 25 March, we have received requests for clarification over various elements of the contractual and financial arrangements that it set out. We continue to work with the BDA to ensure that the measures we have developed are fair and reasonable and are applied in a way that supports practices to play their full part in the emerging service model.

We have been asked for further clarification in the following areas.

Practices providing private and NHS services

We have received several queries from dental contractors whose practice income is split between NHS and private revenue. We can confirm that the application of the principles outlined in the 25 March letter for practices benefiting from continued NHS funding are intended to apply to NHS income only. Contract holders wishing to claim against additional government support schemes should ensure this is in relation to their proportion of private revenue only.

In line with the methodology of determining private and NHS income used for business rates reimbursements, contractors are advised to use the proportion of gross income that relates to GDS/PDS contract value as NHS revenue, the balance being private share. Those contractors who claim business rates reimbursements will have this data readily available.

We expect that as part of the 2020/21 reconciliation process, practices will be expected to declare that they have not applied for any duplicative government funding and provide evidence of the proportions of NHS/private income used in any applications for additional support.

Dental practices that do not perform NHS activity can access wider government support in the same way as any other private business.

2019/20 contract reconciliation and clawback

A number of practices have queried the application of the March 2019-February 2020 activity period for the purposes of calculating 2019/20 contract reconciliation. This is a particular issue where activity levels in March 2020 had been anticipated to be higher than March 2019, or where the practice had opened after 1 March 2019. In recognition of these circumstances, practices

may agree with their commissioner to use the following activity from the Compass system as the basis for 2019/20 contract reconciliation:

1. 11 months April 2019 to February 2020
plus
2. in agreement with commissioners, an additional month that may be one of:
 - March 2019 (default)
 - March 2020 or
 - average UDA delivery over an appropriate three-month period in 2019/20 agreed with their commissioner.

Any clawback repayments relating to contract year 2019/20 may be payable over the financial year, with full balance payable by 31 March 2021.

Patient charges

Queries have arisen about when to apply patient charges in the following circumstances:

- telephone triage – there is no regulatory framework to claim for activity or apply patient charges for a patient contact/triage via telephone; providers undertaking telephone triage are advised to keep a manual record of patients triaged by telephone, with the view that this data collection will help support and inform development of contract management arrangements for 2020/21
- urgent treatments provided within UDC systems should adhere to the current regulatory framework for FP17 submission and applying patient charges.

Redeploying staff

The expectation is that in return for providing a fixed period of income stability, practices are able to provide continuity of employment for staff. They will therefore be able to make reasonable efforts to support staff to redeploy to support the wider COVID-19 response, including in local UDC systems, Nightingale hospitals and wider parts of the NHS as highlighted above. If staff are unable to be redeployed due to ill health/self-isolation, being in a shielded household, a medically vulnerable group or with caring responsibilities for a family member, the NHS would of course not expect them to be available to provide frontline clinical care. Practices will be expected to demonstrate they have made every reasonable effort to offer staff appropriate opportunities to support the wider effort.

The NHS 111 team is planning for increased levels of dental activity within NHS 111 telephony and online as a consequence of the service changes that we have made. Work is underway to identify how dental resources (dentists and dental nurses) could be used to help manage this surge, and this

therefore presents another option for the redeployment (where applicable) of a proportion of the workforce into a national remote environment.

Next steps

Thank you for your ongoing commitment to the response. We will continue to work with you to refine and develop solutions, address your concerns and secure safe and appropriate services for patients in these challenging circumstances.

With very best wishes

Sara Hurley, Chief Dental Officer England

Matt Neligan, Director of Primary Care and System Transformation

Appendix D: Urgent dental letter

28 May 2020

Dear colleagues

RESUMPTION OF DENTAL SERVICES IN ENGLAND

Thank you for your contribution through the peak pandemic period and your continued commitment to supporting the national response.

On 25 March 2020 we wrote to NHS dental practices setting out immediate changes to services due to the overriding need to limit transmission of COVID-19. These included:

- deferring routine, non-urgent dental care including orthodontics
- establishing remote urgent care services, providing telephone triage for patients with urgent needs and
- setting up networks of urgent dental care (UDC) sites for face-to-face care where clinically necessary.

We are incredibly grateful to the clinicians and professionals who have risen to this challenge in providing remote services and in rapidly establishing over 550 urgent dental care sites from existing practices, acute and community facilities across the country to meet patients' urgent dental care needs.

This letter now sets out next steps for delivery of NHS dental services in England, as the NHS moves into the second phase of the COVID-19 response.

Resumption of services

The goal for patients and professionals is to resume the safe and effective provision of the full range of care in all practices, as rapidly as practicable.

Working with the British Dental Association, wider professional representative groups and the dental industry, we have consensus on the commencement of reopening services.

We support the full resumption of routine dental care, in a way that is safe, operationally deliverable and allows dental practices flexibility to do what is best for patients and their teams. Central to this is the acknowledged clinical judgement of practitioners and their ability to risk manage the delivery of dental care, as service provision is re-commenced.

In developing this approach, we recognise:

- clear safety standards, including personal protective equipment (PPE) and infection prevention and control (IPC) protocols are required to safely deliver dental care, as recommended by Public Health England (PHE)

- that given the dual impacts of IPC requirements and changed patient behaviour during the pandemic, previous operating volumes will inevitably phase back in
- that remote consultations will continue as part of a practice's revised operating model

Today, we are asking that **all dental practices commence opening from Monday 8 June for all face to face care**, where practices assess that they have the necessary IPC and PPE requirements in place.

Our advice is that the sequencing and scheduling of patients for treatment as services resume should take into account:

- the urgency of needs
- the particular unmet needs of vulnerable groups
- available capacity to undertake activity

Progression to resumption of the full range of routine dental care will be risk-managed by the individual practice and can include aerosol-generating procedures (AGPs), subject to following the necessary IPC and PPE requirements. Dental practices should also take steps to risk assess their workforce and take commensurate actions.

There also remains a need to be able to respond to any local or national re-imposition of public health measures should they arise.

NHS England and NHS Improvement regional teams will work with local providers to agree which UDC sites remain operational and for what period. This will include support for the provision of AGP during the early stages of resumption of services and assist with any local dental access issues.

Financial and contractual arrangements

Initially we will maintain the current temporary contract arrangements to make monthly payments in 2020-21 to all practices that are equal to 1/12th of their current annual contract value, subject to abatement for lower costs. We continue to work with the BDA on the mechanisms for the full 2020-21 contract year with the intention of reintroducing a link to delivery of activity and outcomes.

A number of dentists have been asking if the advice to NHS dental providers also applies to the private dental sector. We recommend a single approach to the safe and effective resumption of dental care.

Thank you for your commitment and understanding of the complex challenges we have collectively navigated in meeting the COVID-19 public health requirements, maintaining safety and access to care for patients, and the safety of the dental workforce. Your co-operation throughout this difficult period continues to be recognised and appreciated.

Sara Hurley, Chief Dental Officer

Matt Neligan, Director of Primary Care and System Transformation

Appendix E: Issue 5 Preparedness letter for primary dental care

Publications approval reference: 001559

13 July 2020

Dear colleague

This is the fifth in a series of regular updates to general dental practices and community dental services regarding the emerging COVID-19 situation. An electronic copy of this letter and all our other relevant guidance can be found here: www.england.nhs.uk/coronavirus/primary-care/.

We also send out a regular primary care bulletin, which you can sign up for here: www.england.nhs.uk/email-bulletins/primary-care-bulletin/.

With the gradual resumption of face-to-face dental care in practices across England, we want to reiterate our gratitude for the ongoing commitment to quality care.

In light of the emerging evidence and recommendations for Infection prevention and Control, we continue to review the risk management measures for dental practices and will keep you informed of any developments. However, the potential for localised and regional resurgence of COVID-19 will endure. To this end, regions will retain their urgent dental care capability, and practices should be prepared to comply with any localised public health measures and restrictions.

Regional directors and public health leads will provide the necessary direction and practices are reminded to remain connected with their regional teams.

Resumption of dental services

As detailed in our letter of 28 May, restrictions around the provision of face-to-face care were lifted for primary care dental services on 8 June.

Practices need to risk assess staff, patients and care delivery and establish the appropriate PPE, IPC and social distancing and separation measures to ensure the safety of patients and dental teams, but we ask that this is done as quickly as possible.

In recognition of the above, we remind all dental practices to keep their local commissioners informed of service status and opening hours (see existing guidance, Appendix 4: Informing the public and commissioners of service status, p25-26).

1.1 Patient management

The patient pathway for dental care should consist of two broad stages – remote management and face-to-face management – for both urgent and routine care. It is important to retain the initial remote stage, particularly to

identify possible/confirmed COVID-19 cases (and household contacts), patients who are shielding, and patients at increased risk, to ensure safe care in an appropriate setting. This stage also helps to prevent inappropriate attendance, support appointment planning, and maintain social distancing and patient separation.

Once remote risk assessment and dental triage are complete, the professional judgement of the clinician will determine whether the patient continues to be managed remotely or face to face. Any face-to-face care required should be arranged at a dental service/care setting which is appropriate and suitably equipped for the patient's care requirements (eg service with Level 3 PPE available for aerosol generating procedures (AGPs); domiciliary setting/site with appropriate separation measures for patients who are shielded; designated UDC provider site for patients with COVID-19).

1.2 Guidance and standard operating procedures

The following guidance and SOPs are available to support dental teams:

- Transition to recovery **SOP** supports dental teams through the transition from restarting face-to-face care to the full resumption of dental care services.
- Urgent dental care **SOP** provides guidance for urgent dental care delivery in all primary care dental settings (general dental practices and community dental services), as well as designated UDC provider sites, as part of local UDC systems.

2. Financial and contractual arrangements for dental services in England

On 25 March 2020 NHS England and NHS Improvement wrote to dental practices detailing immediate steps to revise the operation of the 2020/21 contract that reflected service disruption due to COVID-19 for practices participating as required in the COVID-19 response. We also committed to work with the British Dental Association to agree a fair reduction for any variable costs associated with service delivery (e.g. in recognition of reduced consumable costs) will be applied to all contract values.

This letter sets out the detail of the abatement and contractual handling for non-urgent dental care centres (UDC) and UDC practices.

2.1 Contractual arrangements: 1 April to 7 June

A. Non UDC practices

As all service provision has been delivered remotely it is recognised that consumable (laboratory and materials) and other variable costs in practices will be lower over this period. In light of this, we have agreed with the BDA that it would be appropriate to apply a **16.75% abatement** to the total contract value across the period 1 April 2020 – 7 June 2020. This will be enacted through reconciliation over the period to 31 March 2021.

B. UDC practices

We remain grateful to those practices that have opened their premises and mobilised UDC centres. This has been an essential part of the national effort to manage the impact of the pandemic and to provide urgent and emergency care. We recognise that practices will have incurred additional cost burdens for items such as consumables, resource and administration. Given this impact, we have agreed with the BDA that it would be appropriate to apply **no abatement** to UDC practices for the period that they are operational. For any period of time where the practice was not operating as a UDC they will be subject to the 16.75% contract abatement as outlined above. We will gain assurance of UDC activity via workforce returns, transmitted activity to NHSBSA and eTriage.

2.2 Contractual arrangements 8 June onwards

From 8 June all practices have been able to resume provision of face-to-face services in a way that is safe, operationally deliverable and allows flexibility to do what is best for patients and their teams.

We are maintaining the UDC centres as they provide a critical service, in particular for provision of AGPs, where appropriate, and for resilience within the system in the event of regional or localised outbreaks.

From 20 July 2020 we expect that all practices should have been able to mobilise for face to face interventions. We recognise that capacity is constrained and that it may not be possible to deliver historical unit of dental activity (UDA) activity levels during this period, but we expect practices to be making all possible, proactive efforts to be delivering as comprehensive a service as possible, with particular regard to need which has not been met during phase one of the incident and any health inequalities issues which have emerged locally.

We are working with the BDA and profession to establish an appropriate mechanism for the measurement of activity, patient outcomes and quality of care provision while services are affected by the pandemic. The contractual arrangements need to appropriately take account of the increasing activity levels, the constrained capacity due to infection prevention and control guidance and the increased costs of PPE.

In advance of this agreement we propose to operate the following arrangements:

- From 8 June we have moved to a 0% abatement for all contracts.
- For UDC practices this will apply automatically from 8 June.
- For non UDC practices this is conditional on specific assurance that individual practices are open for face-to-face interventions, are adhering to contractual hours with reasonable staffing levels for NHS services in place and are performing the highest possible levels of activity, with no undue priority being given to private activity over NHS activity.

- Accordingly, any practice not delivering the equivalent of at least 20% of usual volumes of patient care activity will be deemed to be non-compliant with the above criteria.
- In addition any practice that has significantly increased private practice provision at a rate that exceeds that for NHS provision while we provide this funding stability may be deemed to be non-compliant with the above criteria. We will seek specific assurance from contract holders on this matter and in the event of any subsequent concerns may then carry out a spot check to provide assurance.
- Where this assurance is not received, we will revert to operating pre-existing contract arrangements from 20 July.

This is a temporary holding arrangement that recognises reduced variable costs that are offset by additional PPE costs. We are working to rapidly complete work with the BDA and the profession to have established the new mechanism for the measurement of activity, patient outcomes and quality of care provision.

Contractual requirements will be:

- maintenance of the eTriage system for recording of telephone/remote consultations
- FP17 data to be transmitted from all practices to evaluate treatment interventions at a practice level and patient outcomes.
- Submission of declaration around equivalence of NHS service offer and private service offer. This will include a statement of relative volumes of private activity and NHS activity for specified treatments.
- Submission of declaration over continued staff engagement (see section 2.3 below)

In the event of a second phase or regional lockdown, we would seek to shift affected contracts back to the operating model utilised within the period 1 April 2020 to 7 June 2020.

The above conditions apply to all General Dental Service contracts and Personal Dental Service contracts that provide mandatory, advanced mandatory and prototype activity.

2.3 Further assurance

The principles behind the arrangements introduced in the letter of 25 March were to provide a fixed period of income stability, that allowed practices to provide continuity of employment for staff and to cover fixed costs relating to the NHS proportion of their business.

This rapidly established a mechanism whereby practices were able to address their costs for the NHS proportions of business as follows:

Expenditure area	Principles and purpose
Staffing	Preserve income; maintain payments to staff (employed and associates) that provided income stability for individuals and that enabled redeployment to other parts of the COVID response.
Other fixed costs (e.g. facilities, fixed business overheads)	Preserve income; maintain ability to meet essential and unavoidable business costs
Variable costs (e.g. consumables, lab fees)	Reduced income through abatement; reflecting commensurate reduced expenditure

The agreement to provide this stability of income was linked to a requirement on practices to ensure that all staff, including associates, non-clinical and others, continue to be paid at previous levels. This continues to be an essential requirement as we move forward and ensure that all practices are playing their part in delivering services as part of the resumption of routine dentistry across the country.

We are therefore requiring all practices to provide assurance over their continued contracting with and employment of staff, and to confirm that through the temporary funding arrangements they have not gained any windfall profits arising from the continued NHS funding being made available to support staff and essential business overheads.

We will implement a simple assurance mechanism via the newly implemented workforce data collection with a signed declaration of adherence from each practice. This will be an explicit condition of the funding stability provided above.

3. PPE and fit testing

3.1 Respirator fit testing

Plans are in place to train fit testers from the dental sector across NHS regions, who will each fit test colleagues in local practices. This is a collaborative arrangement between:

- our regions and their Local Dental Networks which, working with the local profession, will identify those to be trained
- Health Education England (HEE) regions which will identify venues and organise bookings for courses working with Respiratory Protective Assessment Ltd (RPA) which will provide the trainer
- Public Health England which has funded RPA to support the COVID-19 response and specifically support these courses.

Once trained, fit testers will be provided with a fit testing kit to enable them to begin testing in their region. We are arranging for fit testers to be engaged under an honorary agreement for these activities, which will cover any liabilities arising through that agreement.

For further details on local arrangements, please contact your local regional dental team. Details of regional contacts are in this letter.

RPA also has helpful information on its website.

3.2 Dental care provision PPE and IPC requirement

PPE and IPC requirements for dental settings remain as described in Appendix 1 of the Transition to recovery SOP, and referring to Table 4 in the IPC guidance.

4. Workforce issues

4.1 Risk assessments

All primary care organisations remain legally responsible for securing appropriate occupational health assessments (including staff risk assessments) for their employees, including those at-risk and vulnerable groups within their workforce. Further information on risk assessment is available:

- NHS Employers: risk assessments for staff
- Faculty of Occupational Medicine: risk reduction framework for NHS staff at risk of COVID-19 infection

4.2 Impact of COVID-19 on dental training

HEE aims to minimise the impact on progression of dentists currently in training while ensuring patient safety, and to continue with dental foundation training (DFT), dental core training (DCT) and specialty training (ST) recruitments with as little disruption to usual start dates as possible.

More information on this can be found on the HEE website, under 'Information for dental trainees'.

Dental foundation training: Recruitment to 2020/21 DFT was undertaken in November 2019 and is complete; new trainees will begin training on 1 September 2020 as planned. Clinical training for 2019/20 dental foundation trainees has been disrupted. Work is underway to minimise the impact and enable foundation dentists to progress to the next stage of their careers.

Dental core and specialty training: DCT and ST recruitment is underway through evidence-based self-assessment. The HEE website outlines how it is dealing with progression.

Due to postponement of the college examinations required for trainees to evidence completion of the curriculum, extensions to training are required.

Thank you for your continued contribution to the national response which has not gone unrecognised.

With very best wishes

Sara Hurley, Chief Dental Officer England

Matt Neligan, Director of Primary Care and System Transformation