Dental handbook
A guide for commissioners, practices and dentists in England
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>5</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>Contract management</td>
<td>9</td>
</tr>
<tr>
<td>Working with providers</td>
<td>9</td>
</tr>
<tr>
<td>Dental assurance framework</td>
<td>9</td>
</tr>
<tr>
<td>The priorities</td>
<td>10</td>
</tr>
<tr>
<td>Under-delivery of mandatory services</td>
<td>10</td>
</tr>
<tr>
<td> Why it is important to address under-delivery</td>
<td>10</td>
</tr>
<tr>
<td> What the regulations say</td>
<td>11</td>
</tr>
<tr>
<td> Approach</td>
<td>12</td>
</tr>
<tr>
<td> Regulatory and contractual processes</td>
<td>18</td>
</tr>
<tr>
<td>Managing for appropriate recall and re-attendance</td>
<td>20</td>
</tr>
<tr>
<td> Early recall</td>
<td>20</td>
</tr>
<tr>
<td> Re-attendance</td>
<td>20</td>
</tr>
<tr>
<td> Continuation</td>
<td>20</td>
</tr>
<tr>
<td> Splitting courses of treatment</td>
<td>20</td>
</tr>
<tr>
<td> Assurance process</td>
<td>21</td>
</tr>
<tr>
<td> What the regulations say</td>
<td>21</td>
</tr>
<tr>
<td> Patient communication and record keeping</td>
<td>21</td>
</tr>
<tr>
<td> Impact on access and efficiency</td>
<td>22</td>
</tr>
<tr>
<td> What commissioners should do</td>
<td>22</td>
</tr>
<tr>
<td> What should the commissioner expect to see?</td>
<td>22</td>
</tr>
<tr>
<td> Data analysis</td>
<td>24</td>
</tr>
<tr>
<td> Possible actions the commissioner can take</td>
<td>38</td>
</tr>
<tr>
<td> Data analysis: questions/issues</td>
<td>38</td>
</tr>
<tr>
<td> Information sharing and discussion with contractors</td>
<td>39</td>
</tr>
<tr>
<td>Financial management</td>
<td>41</td>
</tr>
<tr>
<td>Contract payments and reviews</td>
<td>42</td>
</tr>
<tr>
<td> Payments to contractors</td>
<td>42</td>
</tr>
<tr>
<td> Debt management</td>
<td>42</td>
</tr>
<tr>
<td> Employer’s superannuation contribution costs</td>
<td>45</td>
</tr>
<tr>
<td> Mid-year</td>
<td>47</td>
</tr>
<tr>
<td> Year-end</td>
<td>47</td>
</tr>
<tr>
<td> Adverse events</td>
<td>48</td>
</tr>
<tr>
<td> Dental assurance framework</td>
<td>48</td>
</tr>
<tr>
<td> NHSBSA support</td>
<td>48</td>
</tr>
<tr>
<td>Internal financial planning and reporting</td>
<td>49</td>
</tr>
<tr>
<td> Internal working relations</td>
<td>49</td>
</tr>
<tr>
<td> Internal reporting</td>
<td>49</td>
</tr>
<tr>
<td> Monitoring of dental spend</td>
<td>50</td>
</tr>
<tr>
<td> Management of patient charge revenue (PCR)</td>
<td>51</td>
</tr>
<tr>
<td>Regulatory definitions</td>
<td>58</td>
</tr>
</tbody>
</table>
Foreword

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

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

Progress has been made in improving oral health and access to services in general. However inequality in oral health experience and inequity in access to primary and specialist care exists. NHS England has embarked on the development of commissioning guides which cover the specialties of dentistry. However, the gateway to specialist care relies on access to efficient and effective primary dental care services. Whilst there has been some improvement in general access over the past few years, commissioners need to ensure that they continue to meet their duties to commission primary care services appropriate to the needs of their populations. This means making effective use of available resources by challenging primary care providers to deliver care to those who need it most and by adopting appropriate recall intervals for those who can be seen less frequently, freeing capacity for access by new patients. Achieving improvements in access to primary care will widen access to specialist care for those who need it.

Commissioners and dentists in primary care need to work together to ensure that resources invested by the NHS in primary dental care are used in the most effective way to provide the best possible quality and quantity of care for patients; to meet need rather than serve demand. This guide has three components, which are:

- Dental contract management
- Advice to dentists
- Key practice management information.

The dental contract management section is a tool for new and existing contract/commissioning managers as well as the wider dental community. It applies only to UDA based contracts, excluding those within the dental contract reform programme and advanced mandatory and additional services.
Introduction

Maintaining and increasing access to NHS dentistry is a key objective for NHS England (hereafter known as the commissioner). Access to dental services is a priority enshrined in the NHS Constitution, but while access continues to improve, the availability of services, the value for money they provide and the oral health outcomes they deliver to local populations still often falls short.

Effective contract management is a key lever for change. Well managed contracts deliver value for money and the potential to treat the greatest number of people. Poorly managed contracts will mean that money that could be spent providing more effective treatment or treating more patients will be wasted.

While procurement of services offers limited scope for improvement, the potential for improved contract management is vast.

Today, over 90% of funding of NHS dentistry is committed in existing contracts. Year on year a number of practices fail to deliver their contracted activity.

Contract management will need to be focused on quality as well as productivity. A “getting the UDAs” approach to performance management will not on its own deliver better access, value for money or quality. Commissioners need to be clear what these payments are funding. Without robust needs assessment and clear understanding of gaps in performance, they will be unable to determine whether dentists are addressing access and health inequalities issues or simply increasing treatments of existing patients.

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

The need to deliver universal access to dentistry remains as pressing as ever. The economic climate and the public health agenda require that access is also synonymous with productivity and quality. Contract management is key to these aims. This guide helps commissioners to assess their capabilities as contract managers, to identify weaknesses in their current positions and take clear, practical steps to address them.

This guide is designed to help commissioners further engage with dentists about delivering NHS dental services more effectively. It aims to support a consistent approach across England. In particular its focus is on ensuring:

- high quality and effective NHS dental services
- maximum productivity through effective contract management, implementing the NICE guidelines, adhering to performance policies and using data effectively
- cost effective service delivery and proper use of NHS resources.
Resources
The table below refers to a number of resources which you may find helpful in undertaking effective contract management.

<table>
<thead>
<tr>
<th>Internal expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NHS England central primary care operations team mailbox: <a href="mailto:england.primarycareop@nhs.net">england.primarycareop@nhs.net</a></td>
</tr>
<tr>
<td>• NHS England local offices commissioning and contracting team: <a href="https://www.england.nhs.uk/about/regional-area-teams/">https://www.england.nhs.uk/about/regional-area-teams/</a></td>
</tr>
<tr>
<td>• Clinical advice via clinical adviser or other appropriate clinical support identified through the medical directorate</td>
</tr>
<tr>
<td>• Finance team</td>
</tr>
<tr>
<td>• Internal audit</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Regulatory, statutory and policy documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NHS England policy book for primary dental services: <a href="https://www.england.nhs.uk/dental">https://www.england.nhs.uk/dental</a></td>
</tr>
<tr>
<td>• NICE clinical guidance on recalls: <a href="http://www.nice.org.uk/guidance/cg19">www.nice.org.uk/guidance/cg19</a></td>
</tr>
</tbody>
</table>
• General Dental Services Contracts (GDS) and Personal Dental Services Agreements (PDS) regulations:
• NHS Dental Charges regulations 2005 as amended:
• Delivering better oral health (DBOH) version 3:
  https://www.gov.uk/government/publications/delivering-better-oral-health-an-
  evidence-based-toolkit-for-prevention
• NHS dental services in England, An independent review led by Professor Jimmy Steele, DH, June 2009

Information available on contract data

• Compass reports: http://www.nhsbsa.nhs.uk/5335.aspx
• E-reporting: http://www.nhsbsa.nhs.uk/5335.aspx
• Dental assurance framework tier 1 and 2 reports:
  http://www.nhsbsa.nhs.uk/5335.aspx

Templates

• GDS contract and PDS agreement model templates:
  https://www.gov.uk/government/publications/standard-general-dental-services-
  contract-and-personal-dental-services-agreement
• NHS England policy documents in policy book and dental assurance framework
• SFE claim form:
• Contract allocation form (CAF) for superannuation purposes
Contract management

Commissioners have a responsibility to assure themselves about the availability, quality and value of the dental services that they commission. This includes all services regardless of where they are provided or how they are contracted for. However, the focus of this guide is primary care dental services and therefore will only cover with the management of GDS contracts and PDS agreements delivering mandatory dental services. To support the local commissioning teams, NHS England published the Dental Assurance Framework (DAF) in relation to primary care services. The framework has looked at four key areas that provide a high level of assurance in relation to the quality of services that are delivered. These are:

- delivery
- patient safety
- patient experience
- quality and clinical effectiveness.

Working with providers

With the formation of NHS England in 2013 with the creation of four regional teams and 13 local offices, the geographical area that commissioning teams covered increased. These larger areas has meant that the ways in which commissioners have maintain relationships with contractors, including keeping in touch with providers, may have changed. However it is important that these relationships are maintained. There is still a requirement to inform contractors of key messages and that commissioners are aware of the local pressures that may affect the delivery of commissioned services. To this end, the relationships forged with individual providers and also with LDCs, Healthwatch, with LDNs and other strategic organisations are important. Providers should also be assured that commissioners will respond when matters arise that require response or intervention.

To support the management of dental contracts the NHSBSA has recently introduced its new contract management reporting and financial payments system, known as Compass. Commissioners are expected to support their dental practices to ensure they are able to access this system, so that contractors as well as the commissioners are able to monitor delivery of contracts and that contractors take a more active role in ensuring that they deliver expected activity over the course of the year.

Dental assurance framework

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

- Delivery - percentage of contracted UDA delivered
• Patient safety – CQC registration
• Patient experience – percentage of patients satisfied with dentistry received and the percentage satisfied with the wait for an appointment
• Quality indicators (UDA) – radiographs rate per 100 FP17s, fluoride varnish rate per 100 FP17s (3-16 year olds), fissure sealants rate per 100 FP17s (3-16 year olds), endodontic treatment rate per 100 FP17s, extraction rate per 100 FP17s, extractions as a percentage of extractions and endodontic treatment, inlay rate per 100 FP17s, re-attending within three months (child), re-attending within three months (adult), average band 3 to band 3 rates.

However, it is clear that the indicators alone cannot provide absolute assurance of quality. The framework also recommends that commissioners have regard to a number of other information sources available to them when reviewing dental contracts within their locality, such as exception reports, vital signs and other information received about services provided such as complaints.

The framework allows for the commissioner to prioritise their areas of concern that they would like to focus on, the overall triggers which initiate contact with a dental practice and sets out a framework for that contact.

**The priorities**

As part of the history of contract management and through the assurance process there are many areas that dental commissioners will regularly focus on, however nationally there are two areas that stand out as potential areas of priority to ensure optimal access for all patients and provision of a high quality service.

The following section in this guide focuses on these two key areas:

• reducing contract under-delivery; and
• managing for appropriate recall and treatment patterns.

Commissioners will already have made good progress in tackling contract under-delivery, so much of this part of the guide covers familiar ground. However, managing high rates of recall and atypical treatment patterns to assure a high quality service may be less familiar. It is important that this goes hand-in-hand with work on minimising under-delivery, otherwise the commissioners may see the number of inappropriate recall/treatments reduce but the level of under-delivery rises.

**Under-delivery of mandatory services**

**Why it is important to address under-delivery**
Since the introduction of the GDS contract and PDS agreement in 2006, there has been a consistent under-delivery of contracted activity. Historically this under-delivery was handled differently by commissioners across the country, some took no action whilst others rebased contracts in order to release funding to commission new services or to bolster existing services for a limited period. With the introduction of the single operating framework in 2013, commissioners now have guidance to ensure a consistent approach to contract management is taken across the country.

Under quality, improvement, productivity and performance (QIPP), it is important that commissioners are able to show they are able to meet the requirements of not only dental access but also value for money.

Contractors need to understand what commissioners expect of them in performance terms, and what the consequences of under-delivery might be. Commissioners should also have regard to the adverse events that providers may face that impact on performance and consider these in a proportionate and consistent manner for all providers in line with their operating policies.

Commissioners should be encouraging their providers to self-monitor their contracted activity levels through regular checking of the Compass system so they can ensure that they maintain their contracted activity levels throughout the year. Where they know they are underachieving on their contract, providers should contact their commissioning team to make them aware of this and should be proactively putting forward improvement plans to assure the commissioning team that they addressing the issue and resolving any shortfall.

There may be a requirement for commissioners to put in place short term contract changes to reflect the issues practices face. Commissioners may wish to do this when there are issues in recruiting performers and infrastructure damage out of the control of the contractor such as fire or flood. In circumstances such as these the commissioner may reduce the expected delivery during that financial year with a return to full level the following contractual year. However, the commissioner should also ensure that there is adequate provision for the needs of their population and can consider how they are able to recommission the non-recurrent activity during the financial year.

What the regulations say

The GDS and PDS regulations require that the level of activity to be delivered must be specified in a contract/agreement. Under-delivery of activity whether for general (UDA) activity which is greater than 4% is considered a breach of contract and the ultimate consequence of a breach of contract can be terminated. NHS England’s financial recovery and reconciliation policy states that commissioners must manage this level of under-delivery by recovering the full financial repayment (equivalent to under-delivered UDA) by the contractor in the next financial year, ideally as early as possible within that year to allow commissioners to identify the potential to commission non-recurrent provision of services for their patient population.
Approach

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

- Make full use of the NHSBSA’s Compass system and e-reports, so they have all the necessary information relating to the contracts they manage to enable them to prioritise their efforts appropriately throughout the year.
- Ensure the contractors are aware of the functionality within Compass and e-reports to self-manage their contracts, especially in relation to delivery patterns and potential for under-delivery at mid-year and year end and allow them to be proactive in working with the commissioner.
- Follow the policies regarding mid-year and year end processes that provide opportunities to manage under-delivery in year and recover funding in respect of any under-delivery, which then may be used to support service delivery in-year elsewhere.
- Use the dental assurance framework to review the quality of services provided when reviewing contract delivery.
- Implement a robust process of contract management. The key tasks above are not intended to be an exhaustive list and should be read in conjunction with all relevant policies.

Using the data reporting system to identify and manage under-delivery, commissioners can identify potential under-delivery throughout the financial year using a number of reports, including exception reports, vital signs, and contract dashboards.
Figure 1: Exception report

The exception reports are available on a quarterly basis and the exceptions to look for are low activity and no activity.

<table>
<thead>
<tr>
<th>Contract Number</th>
<th>Name or Company Name</th>
<th>Reason for Exception</th>
<th>Total FP17s</th>
<th>Late FP17s</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>Low activity</td>
<td>546.00</td>
<td>47.00</td>
<td>8.61</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>No activity</td>
<td>16,497.00</td>
<td>3,553.75</td>
<td>21.54</td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>Low activity</td>
<td>1,320.00</td>
<td>212.80</td>
<td>16.12</td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>Low activity</td>
<td>2,640.00</td>
<td>270.80</td>
<td>10.26</td>
</tr>
<tr>
<td>5</td>
<td>E</td>
<td>Adult patient mix</td>
<td>8.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>Over delivery</td>
<td>10,691.00</td>
<td>6,154.60</td>
<td>57.57</td>
</tr>
<tr>
<td>7</td>
<td>G</td>
<td>Low activity</td>
<td>34,077.00</td>
<td>5,400.30</td>
<td>15.85</td>
</tr>
<tr>
<td>8</td>
<td>H</td>
<td>Late reporting</td>
<td>5,163.00</td>
<td>412.00</td>
<td>7.98</td>
</tr>
<tr>
<td>9</td>
<td>I</td>
<td>No general clinical data</td>
<td>1,071.00 FP17s with no CDS data</td>
<td>600.00 Band 2.3 FP17s</td>
<td></td>
</tr>
</tbody>
</table>
Figure 2: Vital signs report

The vital signs report shows a schedule of monthly delivery of UDAs.
Figure 3: The contract dashboard

The dashboard currently available on e-reporting also highlights the risk of under-delivery.

Commissioners will need to prioritise the contractors they focus on and they should begin with contractors who have consistently under-delivered rather than those that have underperformed on a single or exceptional basis.
Figure 4: Consistent underperformance report

The report entitled ‘Contracts consistently underperforming’ (see below) will help differentiate between those contractors who have consistently under-delivered rather than those that have under-performed on a single or exceptional basis.

The report below provides a list of contracts that have underperformed according to the end of year figures for the identified two consecutive years.

**List of contracts underperforming in 2014-2015**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>9,641</td>
<td>6,588</td>
<td>68.3</td>
<td>162,069</td>
<td>9,641</td>
<td>5,676.00</td>
<td>58.9</td>
<td>167,803</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>2,051</td>
<td>1,952</td>
<td>95.2</td>
<td>39,142</td>
<td>2,051</td>
<td>1,959.00</td>
<td>95.5</td>
<td>40,527</td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>36,119</td>
<td>33,925</td>
<td>93.9</td>
<td>761,231</td>
<td>36,119</td>
<td>30,622.00</td>
<td>84.8</td>
<td>788,164</td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>4,321</td>
<td>3,996</td>
<td>92.5</td>
<td>98,432</td>
<td>4,321</td>
<td>4,101.80</td>
<td>94.9</td>
<td>101,915</td>
</tr>
<tr>
<td>5</td>
<td>E</td>
<td>4,064</td>
<td>3,546</td>
<td>87.3</td>
<td>75,972</td>
<td>4,064</td>
<td>3,454.70</td>
<td>85.0</td>
<td>78,660</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>6,982</td>
<td>5,616</td>
<td>80.4</td>
<td>123,341</td>
<td>6,982</td>
<td>6,080.30</td>
<td>87.1</td>
<td>127,704</td>
</tr>
<tr>
<td>7</td>
<td>G</td>
<td>635</td>
<td>397</td>
<td>62.5</td>
<td>12,236</td>
<td>635</td>
<td>381.40</td>
<td>60.1</td>
<td>12,669</td>
</tr>
<tr>
<td>8</td>
<td>H</td>
<td>11,407</td>
<td>8,637</td>
<td>75.7</td>
<td>268,761</td>
<td>11,407</td>
<td>10,053.30</td>
<td>88.1</td>
<td>278,270</td>
</tr>
</tbody>
</table>
Figure 5: Contractual flow chart
The flow chart below shows the appropriate action to take to manage underperformance.

Regulatory and contractual processes

Variations, remedial and breach notices and contract terminations are dealt with in the GDS and PDS regulations, schedule 3, part 9. The processes are outlined in the dental policy handbook.

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

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

The tables below outline the objectives, key tasks and timescales commissioners need to consider when addressing under activity issues with contracts.
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>To reduce under-delivery of contracted activity to within 4% of contracted levels</td>
<td>Appropriate and improved patient access to a high quality service maximised through local delivery of contracts</td>
</tr>
<tr>
<td>To ensure UDAs are delivered consistently across the year, achieved by periodic monitoring of contract performance and formal review at mid-year and year end</td>
<td></td>
</tr>
<tr>
<td>To ensure under-delivery is managed appropriately to achieve the aims of improving access and ensuring value for money</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key tasks to complete</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read and understand the commissioner policies including the DAF to undertake the required tasks of contract management appropriately</td>
<td>As required</td>
</tr>
<tr>
<td>Use relevant NHSBSA reports (DAF/vital signs/exception reports) to identify UDA delivery, quality indicators, and exceptions</td>
<td>Quarterly or more frequent as appropriate</td>
</tr>
<tr>
<td>Review delivery of UDAs at any visit undertaken at practices</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Manage mid-year reviews in line with the commissioner policies</td>
<td>October onwards</td>
</tr>
<tr>
<td>Manage end of year process in line with the commissioner policies</td>
<td>July onwards</td>
</tr>
<tr>
<td>Negotiate contract changes such as in year reduction of activity following mid-year review or a rebasing of contracted activity at year end or at any other time</td>
<td>As appropriate</td>
</tr>
<tr>
<td>Consider use of non-recurrent funding to commission additional in year provision to support delivery. This may be delivery of services in innovative ways such as prevention or care pathway approaches to improve access to services.</td>
<td>As appropriate</td>
</tr>
<tr>
<td>Maintain regular communication with practices throughout the contract period to remind them of requirements and best practice</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
Managing for appropriate recall and re-attendance

As part of the commissioning responsibilities, commissioners are required to maintain or improve dental access for the population. One way which commissioners can influence this is by ensuring patients are seen at appropriate recall and treatment intervals.

Early recall

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

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

Re-attendance

National data shows that frequent re-attendance for dental treatment is occurring for patients being treated under all bands. Multiple courses of treatment undertaken within a few weeks or months should be a relatively rare occurrence. Band 2 and band 3 courses of treatment following in quick succession may be an indicator of a poor quality service where poor diagnosis and treatment planning leads to inappropriate clinical care. There will however be exceptions where a successive banded treatment may be given for example if trauma or damage to a filling has occurred.

Continuation

It should also be noted that where there is a high number of patients being seen as a continuation of their original course of treatment (within two months of completion of their original course of treatment) it may also indicate issues with the diagnosis and treatment.

Splitting courses of treatment

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

Following the publication of the DAF, commissioners have been asked to review re-attendance rates as part of that process. The purpose of this section of the guide is to assist commissioners to build on and continue that work about the recall and re-attendance of patients.

It is essential that commissioners have the support of clinical input to this work from their dental adviser or otherwise identified support and through public health advice. Good clinical engagement will be an intrinsic element of supporting clinicians to change their treatment patterns to improve the quality of care they provide and for commissioners to understand the reasons for particular recall patterns.

What the regulations say

Under GDS and PDS regulations it is a contractual obligation for contractors to work within current NICE guidelines. The GDS and PDS regulations both state that the contractor shall provide services under the contract in accordance with any relevant guidance that is issued by NICE, in particular the guidance entitled ‘Dental recall – recall interval between routine dental examinations’.

For adult patients NICE recommends that they should be recalled between three months and two years dependent on their clinical needs. The recommendation for children is an interval of between three and twelve months.

The actual interval should be assessed by the dentist based on patients’ needs. This may be up to 24 months but can be as frequent as three months if it is clinically appropriate.

Alongside the NICE guidelines, Delivering Better Oral Health (DBOH), version 3, will support the clinical decision in setting the recall interval. DBOH was developed to be a practical tool for practitioners to be able to work with specific patient groups or dental conditions which set best practice guidelines including recall intervals and appropriate interventions.

The commissioner may have also agreed for practices within their region to follow evidence based interventions such as prevention courses or periodontal treatment plans or have commissioned services based on clinical need of the population and this local information should be taken into account in any communication with practices. Where these services have been commissioned, practitioners must recognise the importance of keeping accurate clinical records, with supporting evidence about recalls and interventions provided, and where possible outcomes. This will allow commissioners to evaluate and review the effectiveness and value for money of commissioned services.

Patient communication and record keeping
The dentist should discuss the recommended recall interval with the patient and record this interval, and the patient’s agreement/disagreement with it, in the clinical record. The recall should also be captured on the FP17. For some patients it may be appropriate to extend the recall intervals in increments away from six months to the appropriate recall interval.

**Impact on access and efficiency**

If NICE recall guidance is not being implemented appropriately then there may be implications for the effectiveness and quality of care being delivered to patients. In addition the impact both in terms of loss of access and efficiency may potentially be significant.

**What commissioners should do**

Analysis of the data at national levels suggests that commissioners will want to tackle the following areas initially:

- re-attending within three months (all bands of treatment) – child
- re-attending within three months (all bands of treatment) – adults
- average Band 3 to Band 3 rates.

Commissioners may also wish to consider adult patients who have had a Band 1 course of treatment with no further treatment planned and who return for a further Band 1 course of treatment within three to five months.

This does not mean, however, that other areas of concern should be ignored in discussions with practices.

Once practices have been prioritised, commissioners should look at other combinations such as a Band 2 treatment quickly followed by a Band 3 course of treatment as two courses of treatment within three months would not normally be expected.

Commissioners will need to decide what, in their particular circumstances, would improve access.

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

The table below looks at what should normally be delivered under each treatment band together with possible reasons for repeat attendances within relatively short time intervals. It should be emphasised that it is a requirement under the regulations that when any banded course of treatment is provided (with the exception of Band 1 urgent) the patient should receive an examination and assessment and be offered all proper and necessary dental care and treatment required at that time.

<table>
<thead>
<tr>
<th>What should be delivered</th>
<th>Reasons for frequent re-attendances</th>
</tr>
</thead>
</table>

Managing dental services (v1.0) 04.2017  22
## Band 1

Band 1 courses of treatment (excluding Band 1 urgent treatment) include those treatments defined in Schedule 1 of the NHS (Dental Charges) Regulations 2005

These treatments relate to diagnosis, preventive advice and interventions, treatment planning and maintenance and includes such items as:

- clinical examination;
- radiographs;
- surface application of primary preventive interventions; and
- dietary and oral hygiene advice scaling and polishing.

Where a patient attends for repeated Band 1 courses of treatment at intervals of between three and six months this may be justified based on an assessment of their individual risk of or from dental disease. This should only apply to treatment intervals of three months or more. Those under two months are outside of NICE guidelines.

For example, some patients may have physical difficulty in maintaining a satisfactory standard of oral hygiene, or may suffer from medical conditions that increase their risk of developing dental disease.

Dental practices may be following clinical pathways such as prevention or periodontal pathways as approved by the commissioner.

For most contracts this is only likely to apply to a minority of patients.

## Band 2

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Band 2 courses of treatment include those treatments defined in Schedule 2 of the NHS (Dental Charges) Regulations 2005.

These treatments include for example, non-surgical treatment of periodontal disease, permanent fillings, root treatments, extractions and additions to existing dentures. An FP17DC or equivalent should be provided to the patient for any Band 2 course of treatment and a copy should be available as part of the clinical record.

There will be occasions where a patient returns within a short period of time for a further Band 2 course of treatment for perfectly valid reasons, eg a problem with tooth/teeth that could not have been identified during the previous course of treatment. Possible examples might be where a filling has fractured or been lost or where an acute apical abscess arises.

It is also possible that a Band 1 urgent course of treatment may be followed by a Band 2 course but should be a rare occurrence and not a method of claiming where the majority of patients have an urgent course of treatment followed by a banded course of treatment.

Dental practices may be following approved or appropriate clinical pathways such as prevention or periodontal pathways, which may show up in data sets as more frequent re-attendance patterns within the practice.
### Band 3

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

### Data analysis

Commissioners routinely receive a variety of standard reports which enable them to identify exceptional contracts and to explore the detail of any particular contract about which they have concerns.

In cases where a commissioner has concerns about the volumes of courses of treatment being provided to patients, they can access details of the treatments provided to the same patient through their relevant reporting systems (Compass/e-reporting).

This information gives a chronological breakdown of the treatments provided to the same patient within a given time period. An example of how this data might look for a specific contract is given in figure 6.
## Figure 6: Example of information available on multiple courses of treatment for the same patient

<table>
<thead>
<tr>
<th>Performer Number</th>
<th>Principal Practice &amp; Correspondance Location ID</th>
<th>Patient</th>
<th>Patient Charge Band</th>
<th>Treatment Acceptance Date</th>
<th>Treatment Completion Date</th>
<th>Exemption Type</th>
<th>Type of Amendment</th>
<th>Continuation of treatment</th>
<th>Total FP17s from this contract for patient adjusted for amended FP17s</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456</td>
<td>0001</td>
<td>Peters S 11-05-1966 00:00:00 Female</td>
<td>Free - Prescription Issue</td>
<td>15/12/2008</td>
<td>15/12/2008</td>
<td>Income Support</td>
<td>Not Amended</td>
<td>N</td>
<td>7</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Peters S 11-05-1966 00:00:00 Female</td>
<td>Urgent/Occasional</td>
<td>15/12/2008</td>
<td>15/12/2008</td>
<td>Income Support</td>
<td>Not Amended</td>
<td>N</td>
<td>7</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Peters S 11-05-1966 00:00:00 Female</td>
<td>Urgent/Occasional</td>
<td>30/12/2008</td>
<td>30/12/2008</td>
<td>Income Support</td>
<td>Not Amended</td>
<td>N</td>
<td>7</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Peters S 11-05-1966 00:00:00 Female</td>
<td>Band 1</td>
<td>09/01/2009</td>
<td>09/01/2009</td>
<td>Income Support</td>
<td>Not Amended</td>
<td>Y</td>
<td>7</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Peters S 11-05-1966 00:00:00 Female</td>
<td>Band 2</td>
<td>13/02/2009</td>
<td>13/02/2009</td>
<td>Income Support</td>
<td>Not Amended</td>
<td>N</td>
<td>7</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Peters S 11-05-1966 00:00:00 Female</td>
<td>Free - Prescription Issue</td>
<td>10/03/2009</td>
<td>10/03/2009</td>
<td>Income Support</td>
<td>Not Amended</td>
<td>N</td>
<td>7</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Peters S 11-05-1966 00:00:00 Female</td>
<td>Urgent/Occasional</td>
<td>10/03/2009</td>
<td>10/03/2009</td>
<td>Income Support</td>
<td>Not Amended</td>
<td>N</td>
<td>7</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Davies J 14-07-1970 00:00:00 Female</td>
<td>Free - Prescription Issue</td>
<td>15/12/2008</td>
<td>15/12/2008</td>
<td>Tax Credit</td>
<td>Not Amended</td>
<td>N</td>
<td>6</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Davies J 14-07-1970 00:00:00 Female</td>
<td>Urgent/Occasional</td>
<td>15/12/2008</td>
<td>15/12/2008</td>
<td>Tax Credit</td>
<td>Not Amended</td>
<td>N</td>
<td>6</td>
</tr>
<tr>
<td>222222</td>
<td>0001</td>
<td>Davies J 14-07-1970 00:00:00 Female</td>
<td>Free - Prescription Issue</td>
<td>18/12/2008</td>
<td>18/12/2008</td>
<td>Tax Credit</td>
<td>Not Amended</td>
<td>N</td>
<td>6</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Davies J 14-07-1970 00:00:00 Female</td>
<td>Urgent/Occasional</td>
<td>18/12/2008</td>
<td>18/12/2008</td>
<td>Tax Credit</td>
<td>Not Amended</td>
<td>N</td>
<td>6</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Davies J 14-07-1970 00:00:00 Female</td>
<td>Free - Prescription Issue</td>
<td>25/02/2009</td>
<td>25/02/2009</td>
<td>Tax Credit</td>
<td>Not Amended</td>
<td>N</td>
<td>6</td>
</tr>
<tr>
<td>123456</td>
<td>0001</td>
<td>Davies J 14-07-1970 00:00:00 Female</td>
<td>Urgent/Occasional</td>
<td>25/02/2009</td>
<td>25/02/2009</td>
<td>Tax Credit</td>
<td>Not Amended</td>
<td>N</td>
<td>6</td>
</tr>
</tbody>
</table>

Managing dental services (v1.0) 04.2017 25
Specifically, the following reports provide relevant information:

**Figure 7: Dental assurance framework tier 1 commissioner and contract specific**

<table>
<thead>
<tr>
<th>Contract Trend Indicators</th>
<th>Oct to Dec 2011</th>
<th>Jan to March 2012</th>
<th>April to June 2012</th>
<th>July to Sept 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiographs Rate per 100 FP17s</td>
<td>10.7</td>
<td>10.6</td>
<td>8.7</td>
<td>7.3</td>
</tr>
<tr>
<td>Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Fissure Sealants Rate per 100 FP17s (3-16 yr old patients)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Endodontic Treatment Rate per 100 FP17s</td>
<td>0.9</td>
<td>0.9</td>
<td>0.4</td>
<td>0.5</td>
</tr>
<tr>
<td>Extractions Rate per 100 FP17s</td>
<td>3.9</td>
<td>4.3</td>
<td>3.7</td>
<td>2.9</td>
</tr>
<tr>
<td>% of Extractions + Endodontic Treatment - Adults</td>
<td>74.3</td>
<td>73.5</td>
<td>81.6</td>
<td>69.6</td>
</tr>
<tr>
<td>Inlay Rate per 100 FP17s</td>
<td>0.0</td>
<td>0.1</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Re-attending within 3 months - Child</td>
<td>13.6</td>
<td>12.4</td>
<td>12.6</td>
<td>13.0</td>
</tr>
<tr>
<td>Re-attending within 3 months - Adults</td>
<td>32.9</td>
<td>26.0</td>
<td>30.0</td>
<td>32.5</td>
</tr>
<tr>
<td>Average Band 3 to Band 3 Rates</td>
<td>133.4</td>
<td>146.0</td>
<td>98.5</td>
<td>56.6</td>
</tr>
<tr>
<td>% satisfied with dentistry received</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>96.8</td>
</tr>
<tr>
<td>% satisfied with wait for an appointment</td>
<td>93.8</td>
<td>91.9</td>
<td>91.2</td>
<td>90.3</td>
</tr>
</tbody>
</table>

1) Dental assurance framework tier 2 report – contract specific
2) General contract clinical data sets contained in mid-year statements
3) General contract clinical data sets contained in year end statements
4) Exception data report – looks particularly at contracts with the following exceptions:
   - High re-attendances within three months
   - High re-attendances within three to nine months
   - Free repairs/replacements
   - Urgent
   - Continuations
   - Incomplete treatment
5) Quarterly re-attendance
6) Health body vital signs at a glance report

**Figure 8: Vital signs at a glance contract report**

<table>
<thead>
<tr>
<th>QUALITY</th>
<th>Quantity</th>
<th>Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of FP17s for the same patient ID Re-attending within 3 months</td>
<td>1,760</td>
<td>15.8%</td>
</tr>
<tr>
<td>% of FP17s for the same patient ID Re-attending between 3 months and 9 months</td>
<td>6,458</td>
<td>58.1%</td>
</tr>
<tr>
<td>% of FP17s for Band 1 Urgent Courses</td>
<td>834</td>
<td>7.5%</td>
</tr>
<tr>
<td>% of FP17s Relating to Free Repair or Replacements</td>
<td>138</td>
<td>1.2%</td>
</tr>
<tr>
<td>% of FP17s Relating to Continuations</td>
<td>189</td>
<td>1.7%</td>
</tr>
<tr>
<td>% of Patients satisfied with the dentistry they have received</td>
<td>85</td>
<td>98.5%</td>
</tr>
<tr>
<td>% of Patients satisfied with the time they had to wait for an appointment</td>
<td>85</td>
<td>90.8%</td>
</tr>
</tbody>
</table>

7) Vital signs contract report*
8) Vital signs report for health body
*Year-end versions of the vital signs reports are also available.

In addition to these reports, e-reporting allows specific reports to be generated using a set of parameters as defined appropriate by commissioners. For example, a report to review re-attendances has been developed to allow commissioners to enquire specifically about the intervals between courses of treatment. These reports can be further classified by treatment band at either end of the interval and by length of interval and type of patient, for each contract. Along with these reports, a multiple FP17 report can be run on e-reporting. Scheduled claims for any practice/performer for any given period can be run by the commissioner on e-reporting.

The following screenshots illustrate what can be done with this information.

Figure 9 gives an overview of Band 3 followed by Band 3 courses of treatment relevant to the commissioner undertaken during a particular quarter.

In the example below, a total of 659 courses of treatment fell into this category, and of them there were 103 where the interval was under three months, 93 where the patient had exemption or remission from charges, nine where the patient was liable to pay full patient charge (though may not have done so because of the continuation and free repair and replacement rules), and one child. A further 108 had intervals of between three and six months, of which 96 had patients with exemption from or remission of patient charges.
Figure 9: Band 3 to Band 3 (Filtered) showing re-attendance intervals and patient charge status
Re-attendance report: Band 3 to Band 3 analysis
Range of schedule months requested from January 2015 to March 2015
Figure 10 shows all the contracts providing the Band 3 followed by Band 3 intervals in figure 1, listed in order of the number of Band 3 followed by Band 3 cases with an interval of less than three months.

The top four of these contracts have nine or more Band 3 followed by Band 3 intervals below three months, and figure 3 shows how the detail of the first of these contracts, with 14 Band 3 followed by Band 3 cases, can be explored further, showing the full distribution of intervals between Band 3 and Band 3, and the types of patient involved. For this contract, all 14 cases were for patients with exemption from or remission of patient charges.

**Figure 10: Contract Band 3 to Band 3 (only first page shown)**

Re-attendance report: Re-attendance intervals Band 3 to Band 3 by contract Range of schedule months requested from January 2015 to March 2015.
To set the work on Band 3 followed by Band 3 in context, and to provide pointers to the next area to tackle, figure 11 shows, at NHS England local office level, the distribution of intervals between other combinations, and particularly the number of intervals below three months. Band 3 after Band 2 and Band 2 after Band 2 are likely next areas for investigation by the commissioner.

**Figure 11: Contracts with Band 3 to Band 3 (filtered) showing re-attendance Intervals and patient charge status**
Re-attendance report: Band 3 to Band 3 (filtered) Individual contract analysis

**Re-attendance Report: Band 3 to Band 3 (filtered) Individual Contract Analysis**

<table>
<thead>
<tr>
<th>Contract Number</th>
<th>Patient Charge Status</th>
<th>Number of FP17s</th>
<th>Under 3 Months</th>
<th>3 to 6 Months</th>
<th>6 to 9 Months</th>
<th>9 to 12 Months</th>
<th>12 to 15 Months</th>
<th>15 to 18 Months</th>
<th>18 to 21 Months</th>
<th>21 to 24 Months</th>
<th>24 to 27 Months</th>
<th>27 months or more</th>
<th>No previous FP17</th>
</tr>
</thead>
<tbody>
<tr>
<td>927279/0001</td>
<td>Exempt</td>
<td>100</td>
<td>14</td>
<td>15</td>
<td>18</td>
<td>15</td>
<td>7</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>927279/0001</td>
<td>Non-Exempt</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>927279/0001</td>
<td>Child</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>110</strong></td>
<td><strong>14</strong></td>
<td><strong>18</strong></td>
<td><strong>18</strong></td>
<td><strong>19</strong></td>
<td><strong>7</strong></td>
<td><strong>2</strong></td>
<td><strong>5</strong></td>
<td><strong>3</strong></td>
<td><strong>5</strong></td>
<td><strong>19</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

---

**FP17s**

- a) Under 3 Months
- b) 3 to 6 Months
- c) 6 to 9 Months
- d) 9 to 12 Months
- e) 12 to 15 Months
- f) 15 to 18 Months
- g) 18 to 21 Months
- h) 21 to 24 Months
- i) 24 to 27 Months
- j) 27 months or more
- No previous Claim

---

Managing dental services (v1.0) 04.2017  30
Figure 12 gives the full distribution across different intervals. Both figures 11 and 12 are partial pictures – the full template gives every combination, for reference. The analysis of Band 3 comes first, followed by Band 2 and so on.

**Figure 12: Treatment Bands (current and previous) under three months re-attendance (only first page shown)**
Re-attendance report: Treatment bands and under three months
Range of schedule months requested from January 2015 to March 2015

<table>
<thead>
<tr>
<th>Current Patient Charge Band</th>
<th>Previous Patient Charge Band</th>
<th>Total Number of FP17s</th>
<th>Under 3 Months</th>
<th>% of FP17s for Current Band V Previous Band</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 3</td>
<td>Band 1</td>
<td>532</td>
<td>96</td>
<td>18.0%</td>
</tr>
<tr>
<td>Band 3</td>
<td>Band 1 Urgent</td>
<td>431</td>
<td>307</td>
<td>71.2%</td>
</tr>
<tr>
<td>Band 3</td>
<td>Band 2</td>
<td>879</td>
<td>207</td>
<td>23.5%</td>
</tr>
<tr>
<td>Band 3</td>
<td>Band 3</td>
<td>659</td>
<td>103</td>
<td>15.6%</td>
</tr>
<tr>
<td>Band 3</td>
<td>Charge Exempt</td>
<td>78</td>
<td>53</td>
<td>67.9%</td>
</tr>
<tr>
<td>Band 3</td>
<td>No Previous FP17/Unbanded</td>
<td>303</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Band 3</td>
<td>Other</td>
<td>30</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Band 1</td>
<td>2,167</td>
<td>273</td>
<td>12.6%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Band 1 Urgent</td>
<td>1,057</td>
<td>757</td>
<td>71.6%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Band 2</td>
<td>3,056</td>
<td>458</td>
<td>15.0%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Band 3</td>
<td>647</td>
<td>122</td>
<td>18.9%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Charge Exempt</td>
<td>172</td>
<td>108</td>
<td>62.8%</td>
</tr>
<tr>
<td>Band 2</td>
<td>No Previous FP17/Unbanded</td>
<td>1,158</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Other</td>
<td>195</td>
<td>43</td>
<td>22.1%</td>
</tr>
</tbody>
</table>
Figures 13 and 14 are dental assurance framework tier 1 reports, showing information including local office rates and comparisons, priority contracts, individual contracts quarterly rates of re-attendance and Band 3 to Band 3 treatment rates compared to NHS England local office and England rates.

**Figure 13: Dental assurance framework tier 1 report – overall rates**

<table>
<thead>
<tr>
<th>Area Rates &amp; Comparison</th>
<th>Anon LAT</th>
<th>July - Sept 2015</th>
<th>Oct to Sept 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Indicators</td>
<td>Local</td>
<td>England</td>
<td>Rank compared with all Local area teams as were</td>
</tr>
<tr>
<td>% of Contracted UDA Delivered</td>
<td>39.0</td>
<td>39.8</td>
<td></td>
</tr>
<tr>
<td><strong>Quality Indicators</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiographs Rate per 100 F1P1s</td>
<td>17.3</td>
<td>17.6</td>
<td>17.3</td>
</tr>
<tr>
<td>Fluoride Varnish Rate per 100 F1P1s (5-16 yr old patients)</td>
<td>10.9</td>
<td>18.1</td>
<td>10.9</td>
</tr>
<tr>
<td>Fissure Sealants Rate per 100 F1P1s (5-16 yr old patients)</td>
<td>0.6</td>
<td>1.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Endodontic Treatment Rate per 100 F1P1s</td>
<td>1.4</td>
<td>1.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Extractions Rate per 100 F1P1s</td>
<td>6.4</td>
<td>6.6</td>
<td>6.4</td>
</tr>
<tr>
<td>Extractions as a % of Extractions + Endodontic Treatment- Adults</td>
<td>80.0</td>
<td>78.9</td>
<td>80.0</td>
</tr>
<tr>
<td>Inlay Rate per 100 F1P1s</td>
<td>0.3</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Re-attending within 5 months - Child</td>
<td>8.5</td>
<td>8.9</td>
<td>8.5</td>
</tr>
<tr>
<td>Re-attending within 3 months - Adults</td>
<td>17.4</td>
<td>17.9</td>
<td>17.4</td>
</tr>
<tr>
<td>Average Band 3 to Band 3 Rates</td>
<td>216.4</td>
<td>216.6</td>
<td>216.4</td>
</tr>
<tr>
<td><strong>Patient Satisfaction Indicators</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% satisfied with dentistry received</td>
<td>94.2</td>
<td>93.8</td>
<td>94.2</td>
</tr>
<tr>
<td>% satisfied with wait for an appointment</td>
<td>89.4</td>
<td>89.3</td>
<td>89.4</td>
</tr>
</tbody>
</table>

*Figures 13 and 14 are dental assurance framework tier 1 reports, showing information including local office rates and comparisons, priority contracts, individual contracts quarterly rates of re-attendance and Band 3 to Band 3 treatment rates compared to NHS England local office and England rates.*

Managing dental services (v1.0) 04.2017 33
### Summary & Priority Contracts

#### Comparison with National Results

<table>
<thead>
<tr>
<th>Measures</th>
<th>Local vs National Rate</th>
<th>How defined</th>
<th>% Flagged Contracts</th>
<th>How defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Contracted UDA Delivered</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiographs Rate per 100 FP17s</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fissure Sealant Rate per 100 FP17s (3-16 yr old patients)</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontic Treatment Rate per 100 FP17s</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extractions Rate per 100 FP17s</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extractions as a % of Extractions + Endodontic Treatment - Adults</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlay Rate per 100 FP17s</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-attending within 3 months - Child</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-attending within 3 months - Adults</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Band 3 to Band 3 Rates</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% satisfied with dentistry received</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% satisfied with wait for an appointment</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Priority Contracts (by number of flags then size)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Contract</th>
<th>Name or Company Name</th>
<th>Total Flags</th>
<th>Under-delivering UDA</th>
<th>Radiograph Rate</th>
<th>Fluoride Varnish Rate</th>
<th>Fissure Sealant Rate</th>
<th>Endodontic Rate</th>
<th>Extractions Rate Low</th>
<th>Extractions Rate High</th>
<th>Extraction % Rate</th>
<th>Inlay Rate</th>
<th>Child Re-attendance Rate</th>
<th>Adult Re-attendance Rate</th>
<th>Band 3 to Band 3</th>
<th>% Satisfied Dentistry</th>
<th>% Satisfied with wait for an appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Contract 290</td>
<td>Provider 290</td>
<td>8</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>2</td>
<td>Contract 106</td>
<td>Provider 106</td>
<td>7</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3</td>
<td>Contract 139</td>
<td>Provider 139</td>
<td>6</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>4</td>
<td>Contract 5</td>
<td>Provider 5</td>
<td>6</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

#### Contracts by number of flags

<table>
<thead>
<tr>
<th>Number of Flags</th>
<th>Number of Contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>31</td>
</tr>
<tr>
<td>1</td>
<td>111</td>
</tr>
<tr>
<td>2</td>
<td>80</td>
</tr>
<tr>
<td>3</td>
<td>47</td>
</tr>
<tr>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>0</td>
</tr>
</tbody>
</table>
Figures 15 and 16 are dental assurance framework tier 2 reports, these are individual contract reports and the extract provides information in detail on the re-attendance rates by patient age, by band charge, by performer, plus Band 3 to Band 3 treatment profiles by patient charge status, re-attendance intervals, clinical data set and by performers.

The patient charge is relevant because the patient is less likely to complain about frequent re-attendances and so more compliant if they are not being charged for the cost of the treatment provided.

Figure 15: Dental assurance framework tier 2 report - contract level

<table>
<thead>
<tr>
<th>Re-attendance indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document name: Copy of Dental Assurance Framework (General) Tier 2 - Single Contract</td>
</tr>
<tr>
<td>Last Refresh Date: 15/01/2019 14:32:56</td>
</tr>
</tbody>
</table>

Patient Charge Band of Current FF17

For FF17 with a re-attendance interval within 3 months the table shows the Patient Charge Band (band and the sub-band) for that claim. A high number of false presumptions for example could be seen as mitigating factors in a high re-attendance rate. Re-attending % shows for each charge band the proportion of FF17s with an interval within 3 months.

<table>
<thead>
<tr>
<th>All FF17s</th>
<th>Child FF17s</th>
<th>Adult FF17s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge Band</td>
<td>Re-attending FF17s</td>
<td>Re-attending %</td>
</tr>
<tr>
<td>Band 1</td>
<td>101</td>
<td>14.9%</td>
</tr>
<tr>
<td>Band 2</td>
<td>278</td>
<td>21.5%</td>
</tr>
<tr>
<td>Band 3</td>
<td>120</td>
<td>28.1%</td>
</tr>
<tr>
<td>Charge exempt - Dental Repair</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Urgent</td>
<td>60</td>
<td>24.5%</td>
</tr>
<tr>
<td>Withdrawn Claim</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Patient Charge Band of last Visit

For FF17 with a re-attendance interval within 3 months shows the Patient Charge Band (band and the sub-band) for the last visit of that patient id at any contract. A high number of false presumptions for example could be seen as mitigating factors in a high re-attendance rate. Re-attending % shows for each charge band the proportion of FF17s with an interval within 3 months.

<table>
<thead>
<tr>
<th>All FF17s</th>
<th>Child FF17s</th>
<th>Adult FF17s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge Band</td>
<td>Re-attending FF17s</td>
<td>Re-attending %</td>
</tr>
<tr>
<td>Band 1</td>
<td>184</td>
<td>16.8%</td>
</tr>
<tr>
<td>Band 2</td>
<td>211</td>
<td>21.5%</td>
</tr>
<tr>
<td>Band 3</td>
<td>51</td>
<td>37.3%</td>
</tr>
<tr>
<td>Charge exempt - Dental Repair</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Free - Dental Repair</td>
<td>6</td>
<td>0.5%</td>
</tr>
<tr>
<td>Free - Prescription Issue</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Clinical Appliances</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Disability Claim</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Underserved</td>
<td>3</td>
<td>12.5%</td>
</tr>
<tr>
<td>Urgent/Decisinal</td>
<td>123</td>
<td>76.5%</td>
</tr>
</tbody>
</table>

Re-attendance Indicators

Document name: Copy of Dental Assurance Framework (General) Tier 2 - Single Contract

Last Refresh Date: 15/01/2019 14:32:56

Contract Information for contact: 11111111/001 ; xxxx Dental Clinic

Range of schedule months requested from October 2014 to December 2014

The data is now de-identified by the owners with the following reporting characteristics: "Re-attendance within 3 months - Child" and "Re-attendance within 3 months - Adults".

Please note: The data used in the assurance framework report uses the same methodology as these are used in the VHI report, however these measures are not currently available at F4 reporting or a similar level. Therefore general re-attendance measures have been used for the purposes of this report. This is the measures for the VHI model, however the difference is the measures for the VHI model. Therefore please be aware of the data.

The overall rates of re-attendance are shown below for the same period of time.

<table>
<thead>
<tr>
<th>Overall Totals</th>
<th>Patient Charge Band of Last Visit</th>
<th>Re-attendance rates for the same period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total FF17s</td>
<td>2,064</td>
<td>502</td>
</tr>
<tr>
<td>Re-attendance FF17s</td>
<td>31.2%</td>
<td>Contract %</td>
</tr>
<tr>
<td>Child FF17s</td>
<td>990</td>
<td>102</td>
</tr>
<tr>
<td>Adult FF17s</td>
<td>2,000</td>
<td>400</td>
</tr>
<tr>
<td>Adult FF17s</td>
<td>2,000</td>
<td>400</td>
</tr>
</tbody>
</table>

Patient Age

The table and chart below show the age range of patients and proportion of that age range re-attending at the same contract within 3 months. The aim is to show any differing patterns in re-attendance.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Total FF17s</th>
<th>Child FF17s</th>
<th>Adult FF17s</th>
<th>Re-attendance FF17s</th>
<th>Re-attendance FF17s</th>
<th>Contract %</th>
<th>Re-attendance FF17s</th>
<th>Re-attendance FF17s</th>
<th>Contract %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1</td>
<td>47</td>
<td>1</td>
<td>1</td>
<td>2.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 - 4</td>
<td>163</td>
<td>152</td>
<td>11</td>
<td>17.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 - 9</td>
<td>390</td>
<td>338</td>
<td>52</td>
<td>16.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 - 14</td>
<td>270</td>
<td>214</td>
<td>56</td>
<td>19.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 - 19</td>
<td>210</td>
<td>147</td>
<td>63</td>
<td>21.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 - 24</td>
<td>260</td>
<td>207</td>
<td>53</td>
<td>21.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 - 29</td>
<td>190</td>
<td>130</td>
<td>60</td>
<td>21.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 - 34</td>
<td>400</td>
<td>354</td>
<td>46</td>
<td>12.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35 - 39</td>
<td>390</td>
<td>338</td>
<td>52</td>
<td>16.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 - 44</td>
<td>270</td>
<td>214</td>
<td>56</td>
<td>19.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient age range & % re-attending same contract within 3 months

Managing dental services (v1.0) 04.2017 35
### Performer Overall Totals and Rates

A breakdown by performer (ordered by total FP17a) is included in order to ascertain whether levels are consistent for performers practising at the contract.

<table>
<thead>
<tr>
<th>Performer No.</th>
<th>Performer Name</th>
<th>All FP17s</th>
<th>Re-attending FP17s</th>
<th>Re-attending %</th>
<th>Child FP17s</th>
<th>Re-attending FP17s</th>
<th>Re-attending %</th>
<th>Adult FP17s</th>
<th>Re-attending FP17s</th>
<th>Re-attending %</th>
</tr>
</thead>
<tbody>
<tr>
<td>111111</td>
<td></td>
<td>704</td>
<td>230</td>
<td>33.1%</td>
<td>210</td>
<td>47</td>
<td>22.4%</td>
<td>504</td>
<td>178</td>
<td>35.2%</td>
</tr>
<tr>
<td>111112</td>
<td></td>
<td>700</td>
<td>150</td>
<td>21.4%</td>
<td>114</td>
<td>24</td>
<td>21.1%</td>
<td>562</td>
<td>142</td>
<td>24.9%</td>
</tr>
<tr>
<td>111113</td>
<td></td>
<td>556</td>
<td>75</td>
<td>13.9%</td>
<td>163</td>
<td>18</td>
<td>11.3%</td>
<td>375</td>
<td>57</td>
<td>15.2%</td>
</tr>
<tr>
<td>111114</td>
<td></td>
<td>440</td>
<td>60</td>
<td>13.6%</td>
<td>140</td>
<td>8</td>
<td>5.7%</td>
<td>305</td>
<td>58</td>
<td>19.3%</td>
</tr>
<tr>
<td>111115</td>
<td></td>
<td>151</td>
<td>18</td>
<td>11.9%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>140</td>
<td>15</td>
<td>12.4%</td>
</tr>
<tr>
<td>111116</td>
<td></td>
<td>25</td>
<td>3</td>
<td>12.0%</td>
<td>9</td>
<td>1</td>
<td>11.1%</td>
<td>16</td>
<td>2</td>
<td>12.5%</td>
</tr>
<tr>
<td>111117</td>
<td></td>
<td>24</td>
<td>4</td>
<td>16.7%</td>
<td>4</td>
<td>-1</td>
<td>-25.0%</td>
<td>20</td>
<td>5</td>
<td>25.0%</td>
</tr>
<tr>
<td>111118</td>
<td></td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>111119</td>
<td></td>
<td>0</td>
<td>0</td>
<td>#DIV/0</td>
<td>0</td>
<td>0</td>
<td>#DIV/0</td>
<td>0</td>
<td>0</td>
<td>#DIV/0</td>
</tr>
</tbody>
</table>
Figure 16: Dental assurance framework tier 2 report – Band 3 to Band 3

Range of schedule months requested from October 2014 to December 2014

The data is intended to show some of the over-arching indicators “Average Band 3 to Band 3 Rates”.

Average Band 3 to Band 3 Rates is the average Intervals (in days) between attendances where the current and previous charge band are both Band 3 treatments. Shorter intervals may suggest possible “pausing” of courses of treatment.

In order to win down for this indicator, FP17s where the current and previous treatment bands were both Band 3 have been excluded.

Current and Previous Treatment = Band 3
Number of FP17s = 65

Patient Charge Status

A comparison of the rate and proportion of patients who are exempt or non-exempt may be relevant, for example another exempt patients have a higher rate than non-exempt patients.

<table>
<thead>
<tr>
<th></th>
<th>FP17a</th>
<th>% FP17a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>36</td>
<td>55.3%</td>
</tr>
<tr>
<td>Exempt</td>
<td>18</td>
<td>27.7%</td>
</tr>
<tr>
<td>Non-Exempt</td>
<td>11</td>
<td>16.9%</td>
</tr>
</tbody>
</table>

Previous FP17 Location

The table below shows the patient’s previous FP17 was not. The previous FP17 location can be either at the same contract, a different contract in the same Primary Care Organisation (PCO) or a different PCO.

<table>
<thead>
<tr>
<th>Location</th>
<th>FP17a</th>
<th>% FP17a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Contract</td>
<td>65</td>
<td>84.7%</td>
</tr>
<tr>
<td>Different Contract PCO</td>
<td>23</td>
<td>32.3%</td>
</tr>
<tr>
<td>Different PCO</td>
<td>2</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Re-attendance Interval

The table below shows the period between the earliest date of acceptance and the most recent date of committor (or date of acceptance if the date of completion is not recorded) from the FP17’s scheduled in the same month or a previous schedule month.

<table>
<thead>
<tr>
<th>FP17a</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Average Band 3 to Band 3 Rates

Document name: Copy of Dental Assurance Framework (General) Tier 3 - Single Contract
Last Updated Date: 19/09/2017 14:15:58

Clinical Data Ref (CDR)

The data below shows the clinical data sets tagged by FP17s where the current and previous treatment bands were both Band 3.

FP17s within:

<table>
<thead>
<tr>
<th>Band 3 Treatments</th>
<th>FP17a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crowns</td>
<td>10</td>
</tr>
<tr>
<td>Bridges</td>
<td>1</td>
</tr>
<tr>
<td>Implants</td>
<td>20</td>
</tr>
<tr>
<td>Veneers</td>
<td>0</td>
</tr>
<tr>
<td>Lower Dentine Acryl</td>
<td>14</td>
</tr>
<tr>
<td>Upper Dentine Acryl</td>
<td>0</td>
</tr>
<tr>
<td>Upper Canines</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Band 2 Treatments</th>
<th>FP17a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extractions</td>
<td>8</td>
</tr>
<tr>
<td>Restoration</td>
<td>0</td>
</tr>
<tr>
<td>Permanent Fillings</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Band 1 &amp; Other Treatments</th>
<th>FP17a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restorative excellence</td>
<td>0</td>
</tr>
<tr>
<td>Partial Dentures</td>
<td>1</td>
</tr>
<tr>
<td>Material Fill.</td>
<td>0</td>
</tr>
<tr>
<td>Care And Pain</td>
<td>5</td>
</tr>
<tr>
<td>Other Treatment</td>
<td>2</td>
</tr>
<tr>
<td>Extraction</td>
<td>85</td>
</tr>
<tr>
<td>Radiographs</td>
<td>23</td>
</tr>
<tr>
<td>No Clinical Data</td>
<td>1</td>
</tr>
</tbody>
</table>

Performer Overall Totals and Rates

A breakdown by performer (collected by total FP17s) is included in order to ascertain whether levels are consistent for performers practicing at the contract.

<table>
<thead>
<tr>
<th>Performer No.</th>
<th>Performer Name</th>
<th>Total FP17s</th>
<th>Band 1 to Band 3</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>111111</td>
<td></td>
<td>704</td>
<td>22</td>
<td>3.2%</td>
</tr>
<tr>
<td>111112</td>
<td></td>
<td>705</td>
<td>37</td>
<td>3.9%</td>
</tr>
<tr>
<td>111113</td>
<td></td>
<td>225</td>
<td>22</td>
<td>2.2%</td>
</tr>
<tr>
<td>111114</td>
<td></td>
<td>448</td>
<td>10</td>
<td>2.2%</td>
</tr>
<tr>
<td>111115</td>
<td></td>
<td>121</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>111116</td>
<td></td>
<td>25</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>111117</td>
<td></td>
<td>24</td>
<td>4</td>
<td>16.7%</td>
</tr>
<tr>
<td>111118</td>
<td></td>
<td>1</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>111119</td>
<td></td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
</tbody>
</table>
Possible actions the commissioner can take

Commissioners should set out clearly their approach to managing for appropriate treatment and recall intervals in line with the DAF and how they will approach practices where there is a perceived issue.

Data analysis: questions/issues

The data on individual contractors should be looked at in accordance with the NHS England local office benchmarking data.

This data along with the contract manager's local knowledge and some insight into the oral health of the population will help commissioners to identify contractors they should prioritise for an assurance and contractual review.

Commissioners are able to set their own priorities within the assurance framework and it is anticipated there will be a focus on contracts with the most flags or where significant gains can be made to secure greater access to services for patients. However it is important that the smaller contracts where possible concerns are identified are not ignored as a high incidence of inappropriate recall intervals may be an indicator of clinical quality issues in any practice and may have potentially important consequences for patient care.

Commissioners may wish to consider the following questions and issues when analysing practice data.

Band 1

• Is the patient base relatively stable or are large numbers of new patients being seen? This data is available from vital signs reports and shows the change in patients seen over a 24 month period.
• Review the percentage of same patient IDs seen within three months and three to nine months (available from vital signs reports) and consider the data in line with that held for all contracts by the commissioner.
• Review the quarterly general contract clinical data set report to ascertain if there is a high proportion of Band 1 activity being delivered and if this is represented across all patient categories (exempt adults, non-exempt adults, and children). This information is also available in the new report template described in figures 9 to12.
• Consider the size of the contract and the potential number of UDAs affected.
• Do clinical records show evidence that NICE guidance on recall intervals is being applied?

Band 2

• Has the contract appeared in any exception reports?
- Review the percentage of same patient IDs seen within three months and three to nine months (available from vital signs reports) and consider against figures for the NHS England local office as a whole.
- Is there a high percentage of continuations or free repair and replacements?
- Review the year end contract report summary. Are relatively high proportions of activity being delivered by Band 2 courses of treatment? Is this across all patient categories (exempt adults, non-exempt adults, and children)? Review Band 2 clinical data set information against national averages.
- Is any other evidence of clinical concerns available from NHSBSA clinical services?
- What is the size of the contract and the potential number of UDAs affected?

**Band 3**

- Has the contract appeared in any exception reports?
- Is there a high proportion of continuations or free repair and replacements? This information is available from vital signs.
- Review the year end contract report summary. Are there any particularly high levels of provision of particular Band 3 treatments when compared with the NHS England local office as a whole (for example: veneers, inlays, crowns or incomplete treatments)?
- Review the quarterly general contract clinical data set report. Is a high proportion of activity being delivered by Band 3 courses of treatment and is this high across all or particular patient groups (exempt adults, non-exempt adults, children)?
- Are the same patients being seen within a short time period for a further Band 3 course of treatment and are many Band 3 courses of treatment completed within a very short time period?
- What is the size of the contract and the total number of UDAs affected?
- Is there any other evidence of clinical concerns available from NHSBSA clinical services reports?

**Information sharing and discussion with contractors**

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

Where a contractor is being asked to explain a particular pattern of clinical activity, reference should be made to the specific clinical records being reviewed. It is strongly recommended that a clinical adviser (such as the dental practice adviser or one of the clinical advisers within NHSBSA) is involved in the discussions to provide the commissioner with clinical insight. Examples of the types of clinical issues that may be discussed might include:
Recalls within a short time period where there is a high incidence of a particular treatment type within that Band, with only a single tooth being treated as part of any individual course of treatment ie. where a patient attends frequently for a single filling each time this would not normally be justified as a pattern of treatment across a contract and may be an indication of either inappropriate or poor quality patient care.

Recalls for Band 3 course of treatment to provide single crowns, veneers or inlays would not normally be considered appropriate where this is a pattern of treatment;

Patterns of recalls within a short time period to provide an alternative treatment. For example small single surface gold inlay provided where a direct Band 2 restoration could have been provided. The provision of fissure sealants as a primary preventive measure where activity is recorded as a sealant restoration under Band 2, rather than as a fissure sealant appropriate to Band 1.

Where new full upper and lower dentures are required, these should normally be provided together as a single course of treatment. It would therefore be considered inappropriate if there was a pattern of activity across the contract suggesting that the required lower and upper dentures were being provided as separate courses of treatment.

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

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

Where the commissioner has concerns about recall intervals and an explanation by the contractor is not sufficient, clinical record checks can be used to evidence whether NICE recall guidance is being applied effectively. Record checks can be carried out by appropriate clinical support at the request of commissioner and will include a detailed review of the claim including (but not limited to):

- quality of clinical care provided including previous disease experience
- patient risk factors
- recommended recall interval by NICE guidelines or other commissioned pathways
- administration including record keeping.

There will be variations between practices and a range of factors will need to be taken into account when reviewing compliance with NICE guidelines:
• numbers of new patients being seen within the last 24 months: low numbers coupled with high levels of short recall intervals may support the view that NICE guidelines may not be being adhered to
• age profile of the population, e.g. an aging population may require more frequent recalls for periodontal treatment or repeat restorative work
• local oral health profile.

However, none of these is likely to justify significant high levels of short recall intervals across whole contracts.

Providers who have frequent re-attendance across their contract would need to demonstrate identified clinical need and treatment plans to support this.

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

If the result of any investigation supports the commissioner’s concerns and no agreement is reached after these checks have been carried out, commissioners may want to formalise their management of the process for that contractor through the issue of an informal dispute resolution, remedial or breach notice as appropriate.

Finally, it is important to point out that at all stage of their processes for addressing recall issues, if commissioners become aware of any serious patient safety issues or material financial risks to the commissioner then the process for managing such cases should be followed as per the policy handbook.

Financial management

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

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

There are a number of key tasks and responsibilities needed to ensure appropriate and robust management and reporting of dental expenditure. To ensure the appropriate financial management of dental resources, the commissioner will need to:
• have a clear understanding of the components of the dental budget
• have appropriate systems in place to monitor the current and future financial commitments against dental funding streams
• develop internal working relationships to ensure that finance and dental teams have a joint approach for monitoring and assessing dental expenditure
• manage and optimise patient charges revenue (PCR).

**Contract payments and reviews**

**Payments to contractors**

Payments to contractors are administered by the NHS Business Services Authority (NHSBSA) who acts as the paymaster on behalf of the commissioner. These payments are made in accordance with the GDS or PDS Statement of Financial Entitlements (SFE).

Key information entered in the online payment system, Compass, is used to calculate and make the monthly payments to contractors alongside the dataset submitted by dentists on the FP17 form. It is therefore essential that the data entered into the Compass system is accurate and up-to-date.

The system also requires that all transactions undertaken are appropriately authorised, with a clear audit trail detailing amendments and alterations to the system. Each commissioner will have their own process for deciding who uses the system and the administrative organisation of its use.

Commissioners should ensure there is a local process for agreeing any additional payments to contractors, which should involve input from the finance team.

There is a bespoke section on the NHSBSA website which includes support guides and interactive how to guides for Compass. Advice is also available via the NHSBSA “Ask Us” facility.

**Debt management**

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

• The contractor may have gone into a negative schedule due to an adjustment, for example a financial recovery for an overpayment.
• The contract may have closed and the practice sent in FP17 claims after the closed date, resulting in no allocation for NHSBSA to take the patient charges from.
• The monthly deductions may be more than the contractor has received in payment that month.
Where money is owed by a contractor, there are a number of mechanisms for this money to be recovered:

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

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

- **One off payment:** A contractor may choose to make a one off payment to repay any monies owed. Alternatively the commissioner and contractor may agree to a mix of a one off payment and repayment plan.

The preferred repayment mechanism for any debt is an adjustment via the payment system.

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

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

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

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

- Regular submissions of FP17s ensure that PCR is collected on a timely basis. Where contractors retain forms and submit in batches even within the allowable two month period, this increases the risk that there is an insufficient level of baseline payment of offset the PCR income against. This will therefore leave the contract with a negative position. The level of negative payments can be reviewed using the held and negative payment summary report which is available through the reporting section on Compass. An example of this report is shown below:
**Employer’s superannuation contribution costs**

The NHS Pension Scheme Regulations 2015 set out the arrangements for the NHS Pension Scheme. Membership is subject to employee contributions being paid by dentists and employer contributions paid by their employing authority.

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

The NHSBSA undertakes the collection process on behalf of the commissioner as defined in the administrative provisions in the SFE. Further details of the superannuation process are set out in part 1, section 4 of both GDS and PDS SFEs. Every month, the NHSBSA calculates the employers’ and employees’ superannuation contribution from the estimated net pensionable earnings (NPE) entered onto Compass. It is therefore essential that these figures are kept up to date to ensure accurate payment of pension contributions.

---

**Figure 17: Negative and held payments report**

<table>
<thead>
<tr>
<th>Negative Payment Summary</th>
<th>Total</th>
<th>Sep-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Payment</td>
<td>2,793.03</td>
<td>2,793.03</td>
</tr>
<tr>
<td>Maternity/Paternity/Adoptive Leave</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Sickness</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Business Rates</td>
<td>115.44</td>
<td>115.44</td>
</tr>
<tr>
<td>VDP Service Cost</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Trainees Grant</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Trainees Salary &amp; ENIC</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Seniority</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Commissioner Specific Items</td>
<td>(8,340.14)</td>
<td>(8,340.14)</td>
</tr>
<tr>
<td>Patient Charge Revenue</td>
<td>45.60</td>
<td>45.60</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td>(3,386.07)</td>
<td>(3,386.07)</td>
</tr>
<tr>
<td><strong>Employer Pension Contribution</strong></td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Net Charge to Commissioner</strong></td>
<td>(3,386.07)</td>
<td>(3,386.07)</td>
</tr>
</tbody>
</table>

| Deductions & Additions                  |         |         |
| Collection of money on behalf of commissioner | 0.00 | 0.00 |
| Debt Recovery                           | 0.00    | 0.00    |
| Legal and compliance deductions         | (26.00) | (26.00) |
| DSD charges including Global Crossing   | 0.00    | 0.00    |
| Employees Pension Contribution          | 0.00    | 0.00    |
| **Net Payment to Dental Contract**      | (3,414.07) | (3,414.07) |
The NPE of the practice cannot exceed 43.9% of the gross contract value. However, the NPE of individual performers will not necessarily equate to the total of 43.9% of their gross allocation. The NPE should reflect the salary of the performer after deducting practice expenses such as lab fees and hygienist bills etc. The NPE should exclude maternity, paternity and sick pay. The estimate is supplied to commissioners by contractors and should be updated each time a performer leaves or joins the practices. The NHSBSA has a contract allocation form (CAF) available on its website that can be used to calculate NPE/NPEE values (see link to document in resources section). This figure is then updated onto the Compass system. The process for arriving at a performer’s NPE is determined at practice level and any formula can be used.

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

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

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

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

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

Mid-year

The dental policy document has a section entitled financial recovery and reconciliation, which sets out the process for the mid-year review.

Following the mid-year review, a commissioner may decide to withhold payments. This should be done in line with the GDS and PDS regulations, which sets out the maximum amount that may be withheld. At the end of the financial year the commissioner must ensure that any money withheld is repaid promptly, where the contractor has provided over 96% of the total contracted UDAs. However, this payment should not be made until the final year-end position is known, after 30 June.

These financial adjustments must be appropriately recorded on the Compass system.

Year-end

Contractors have two months after a course of treatment is completed to ensure that the necessary paperwork is submitted to the NHSBSA. Therefore, at the year-end position, commissioners will need to wait until the NHSBSA has completed and issued the final year-end reports, which are produced by 30 June at the latest each year. It is recommended that no definitive action should be taken about under / over delivery until this information is received.

Section 11 of the policy book for primary dental services covers financial recovery and reconciliation. It sets out the process to be followed when dealing with financial adjustments associated with delivery at year-end. A year-end reconciliation template calculator is provided as part of this policy document and provides all the calculations for year-end review.

Any financial adjustments are dependent on the final year-end delivery position:

• Where delivery of UDAs are less than 96% the commissioner will recover the full amount of any activity not delivered, e.g. if a practice delivers 94% of the annual contracted UDAs then the value of the 6% under-delivered UDAs will be recovered.
• Where delivery of UDAs are between 96% and 100% there should be no financial adjustment made, but the under-delivered UDAs carried forward to the next financial year. The NHS England financial recovery and reconciliation policy states...
that there should be no financial adjustment made, but the under-delivered UDAs are carried forward to the next financial year. However, a provider may prefer not to carry forward any under-delivered UDAs and choose instead to pay back the value of the under-delivery. This would be at the discretion of the contractor and commissioner to agree.

- Where delivery of UDAs is above 100%, unless the GDS contract or PDS agreement specifies otherwise there is no requirement for the commissioner to make a financial adjustment or carry forward in respect of over delivery. However the commissioner may allow a tolerance of up to 2% of UDAs only, per year (therefore a maximum of 102% of the contracted UDA activity). The commissioner has the flexibility to either pay for the additional activity or carry forward to the following contract year as a credit.

These should be recorded in all instances on the Compass system to ensure that appropriate adjustments to superannuation are actioned.

**Adverse events**

Where there is a provision in the GDS contract and PDS agreement for a force majeure, a provider can claim for relief subject to a number of criteria and conditions. Chapter 9 of the policy book for primary dental services sets out the process to be followed when dealing with these adverse events, and provides the calculation of dental relief, which is the term used to describe the calculation of the total units of activity that the contractor was delayed or prevented from providing because of the adverse event.

The calculation of dental relief where deemed appropriate is undertaken after all the year-end data has been produced and it is the responsibility of the contract holder to submit an application. There is no provision under the GDS contract and PDS agreement for financial compensation or dispensation but ‘carry forward’ of activity will be permitted where the commissioner agrees that dental relief can be awarded.

Any carry forward agreed should be recorded in Compass in the normal way.

**Dental assurance framework**

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

**NHSBSA support**

The NHSBSA provides a national monitoring service to NHS England where areas of significant risk are assessed through the national dataset and contracts are assessed for
their individual risk level. This work is complemented by annual exercises to challenge contracts that are deemed to be high risk.

Clinical advisers within the NHSBSA support commissioners with monitoring of primary care dental contracts to help improve performance, access, value for money and assure the quality of primary dental care. They can help identify areas of concern, provide appropriate evidence and support relating to areas such as patient safety and poor clinical performance as well as financial irregularities and regulatory concerns. Clinical advisers can review existing data, undertake targeted clinical record reviews and assessment as well as providing patient questionnaires.

**Internal financial planning and reporting**

**Internal working relations**

Effective financial management of the dental budget requires a close working relationship between the dental and finance teams. Regular liaison is essential, and may include discussions on:

- The finance team regularly produce budget statements for all areas of expenditure and income which include internal budget reports, expenditure year to date, and forecast year-end positions. The dental team will need to input into this process to ensure that all planned expenditure is accurately accounted for. In addition, to ensure that the dental team is fully aware of their financial position when making decisions around planning and developing services. The finance team should be involved in supporting dental teams to assess the affordability and value for money of contracts, in particular when commissioning new activity or contracts.

- Contract data within Compass: The accuracy of the Compass system is essential to ensure that accurate and timely payments are made to dentists. If this system is not kept up to date then the commissioner is at risk of making inaccurate and untimely payments which will create further work and expense to recover this money at a later stage if appropriate, as well as making monthly reports inaccurate. An example of this would be where a contract is due to close, and the closed date has not been entered into the appropriate field within Compass in sufficient time to allow any adjustments to be made to monthly payments.

**Internal reporting**

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

It is also important to ensure that financial matters concerning dental services are reported regularly through the appropriate management structures, which should include details of known and planned expenditure for dental services.

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

**Monitoring of dental spend**

In order to effectively monitor dental spend, commissioners will need to ensure that there is an appropriate plan/budget in place to be able to routinely monitor the level of spend against budget. This should also include the profile of expenditure to ensure accurate forecasting of dental expenditure.

The key components that should formulate the dental budget include:

- gross cost of contract values agreed with the dentists
- anticipated levels of PCR.

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

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

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

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

- **Payments for maternity, paternity and adoption leave**: contractors are entitled to payments in respect of maternity, paternity or adoption leave taken by a dental performer provided the eligibility criteria are satisfied. Section 8 of the SFE provides
details of the eligibility criteria for each category of leave and how the calculation for payment should be applied. Where this payment is required, the contractor is required to make an application to the NHSBSA on the application for personal payment under the statement of financial entitlements form. Contractors are only eligible for this payment under the SFE if they are claimed within three months of the date on which they could first have fallen due.

- **Long term sickness leave**: a contract holder is entitled to receive sickness leave payments in respect of a dentist performer that it employs or engages in respect of a complete week of sickness absence, subject to the eligibility criteria set out in section 9 of the SFE. Sickness leave payments are only payable in respect of a maximum of 22 weeks in any period of 52 weeks. The conditions and calculation of leave payment is set out in detail within section 8 of the SFE. Applications for these payments are also managed by the NHSBSA. Contractors are only eligible for this payment under the SFE if they are claimed within three months of the date on which they could first have fallen due.

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

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

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

**Management of patient charge revenue (PCR)**

The charge for each band of treatment is updated each year effective from 1 April. It should be possible for expected levels of PCR to be assessed and reviewed using previous years patterns and known service changes.
There are a number of variables that will affect the level of PCR collected:

- the number of UDAs commissioned
- the number of UDAs actually delivered
- the proportion of charge-paying and exempt patients treated
- the number of charge-exempt treatments given to patients who would normally pay charges.

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

**Zero or low activity**

Contractors are required to submit FP17 forms (or electronic equivalent) within two months of the date of completion of a course of treatment. Without this data, the NHSBSA cannot make PCR deductions from the contractor’s monthly payments or credit the contractor with UDAs. This also affects the ability for commissioners to be able to make accurate forecasts of full-year PCR, and understand levels of delivery.

Where activity is significantly below the level that would be expected at the given point in the financial year, this is likely to be picked up as part of the DAF process and commissioners should seek to establish the reasons for this. This may include forms being submitted outside of the two month window. Contractors have two months from the end of a course of treatment to submit the claim form. Where forms are not submitted within this time frame the activity will not be counted, however PCR is still deducted. This can be monitored by the range of reports available via Compass and e-reporting. Appendix A lists the reports available.

**Patient mix**

With the transition to the new contract in 2006 some dental contracts which limited access to specific patient groups (children or exempt patients) continued. However, any new procurement of dental services since that time should be unrestricted and there is a contractual requirement to accept patients for treatment without discrimination.

There may be an expected reason for changes in the underlying patient mix, e.g. an expansion in the service provided by the practice and a deliberate attempt to target increased capacity at areas of greater deprivation. Economic influences may also affect the number of charge paying patients coming forward for treatment. If, however, there is a significant and unexpected reduction in the underlying patient mix, the commissioner should establish the reasons for this with the contractor.

**Continuations**
Where treatment that had not previously been identified is required within two months of the previous course and the new treatment is at the same or lower band than the previous treatment, this is provided under continuation arrangements. It is provided free of charge to the patient. The provider will receive the UDAs for the course of treatment provided. High incidences of continuations therefore deliver lower PCR than non-continuation treatment and should be monitored closely.

**Multiple courses of treatment**

As discussed above dentists should not be providing a second course of treatment if it is to address dental problems that have been identified, or should reasonably have been identified during the first course of treatment. For instance, if a patient receives an examination and is asked to return later for a scale and polish (e.g. by a hygienist), this constitutes a single course of treatment. Similarly, if a patient receives a filling and is asked to return later to have a second filling (or other treatment) done, this constitutes a single course of treatment.

Where multiple visits are incorrectly reported as multiple courses of treatment, this will reduce the level of service provided by the contractor over the course of the year and provides poor value for money. If, in addition, multiple courses of treatment are given disproportionately to exempt patients, this will cause a PCR pressure. The section covering managing for appropriate recall and re-attendance in this guide covers this area in detail. The NHSBSA carried out activity reviews in 2014/15 and 2015/16 which focussed on courses of treatment occurring within 28 days of a previous course. This information can be used along with the information used for managing appropriate recall and re-attendances as described in earlier sections.

**Urgent courses of treatment**

Urgent treatments are allowed for within the regulations in what should be limited circumstances where a dentist judges that immediate treatment is needed to relieve severe pain or to prevent significant deterioration in the patient’s oral health. There are some reports of dentists routinely only agreeing to see new patients on the basis of an initial urgent treatment. This would be a clear misapplication of the regulations.

**Charge-free items**

Other areas that may lead to a reduction in the level of PCR collected:

- Continuations of treatment (where a course of treatment is completed but a charge-paying patient then needs further treatment within two months, at the same band or lower. The further treatment is provided at no charge to the patient (but the dentist receives the appropriate UDAs for the banded course of treatment provided).
- Charge-free repair or replacement of certain restorations.

**Accruals for PCR**
Due to the nature of dental reporting, there will always be a time lag in the figures reported for patient charge revenue. Therefore, commissioners can choose to make monthly accruals to reflect this within the monthly finance reports. The NHSBSA has produced a template under e-reporting, which calculates the impact of this time lag and the indicative PCR accrual which can be applied in the monthly budget statements. This template is called time lag, and can be run as often as required. An example is shown below:
Finance teams will need to ensure that appropriate accruals are made for patient charge revenue in the year-end accounts. This figure estimates the PCR that relates to the activity delivered before 31 March and reported between 1 April and 31 May each year.

Where contractors have delivered between 96% and 100% of their contracted activity, and the un-delivered activity is carried forward to the next financial year for delivery, the finance team will need to ensure that the appropriate adjustments are made in financial reporting to account for the fact that the activity will be paid for in one financial year and delivered in the next financial year.

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

**Contract changes**

Where contract changes are required it is advisable for commissioners to involve the finance team in any calculations around these changes. Consideration will need to be made on the impact on the dental budget as a whole, which will include superannuation costs, SFE payments and impact on PCR collection.

Commissioners may wish to use the finance team to support:

- **PDS to GDS transfers**: A contractor with a PDS agreement has the right to transfer to a GDS contract providing they provide mandatory services. The dental policy handbook has a section which covers managing a PDS contractor’s right to a GDS contract, which sets out the process to be followed. The commissioner has the right to consider and negotiate the average value of the UDAs, and it may be beneficial to include the finance team with the calculations to support this negotiation. Any transfer will need to be reflected in the longer term financial planning as a GDS contract is not time limited.

- **Rebasing of contracts**: Where a decision is taken to re-base a contract this should be appropriately reflected on Compass and accounted for within the dental budget to ensure that this accurately reflects the future financial commitments.

- **Non-recurrent funding**: The commissioner has the discretion to commission non-recurrent activity in any financial year which may be funded according to local priorities and circumstances. The finance team can support with the calculations of funding available.

- **New services**: It is essential that the finance team is involved in any decision about the commissioning of new or extended services. When identifying the total funding available it is important that it is not just cost of the contract value that is budgeted.
for. Consideration will need to be made for costs such as superannuation, SFE payments and likely PCR revenue.

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

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

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

The table below provides commissioners with a summary of the objectives, key tasks and timescales for carrying these out.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>To have a clear understanding of the components of the dental budget</td>
<td>Appropriate use of the dental budget to maximise access to and quality of NHS dental services</td>
</tr>
<tr>
<td>To have systems in place to reconcile the dental budget against committed resources</td>
<td></td>
</tr>
<tr>
<td>Comply with standing financial instructions</td>
<td></td>
</tr>
<tr>
<td>Appropriate management of patient charge revenue</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key tasks to complete</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contract payments and reviews</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Payments to contractors</strong></td>
<td></td>
</tr>
<tr>
<td>Ensure the Compass system is kept up-to-date and accurately reflects the total value of each contract, and the elements contained within the overall contract value</td>
<td>Monthly</td>
</tr>
<tr>
<td>Ensure that additional payments are appropriately authorised, with input from the finance team</td>
<td>Ad-hoc</td>
</tr>
<tr>
<td><strong>Mid-year</strong></td>
<td></td>
</tr>
<tr>
<td>Where there is a requirement to withhold payment following a mid-year review that this is undertaken in accordance with the GDS/PDS regulations</td>
<td>Following mid-year review</td>
</tr>
<tr>
<td><strong>End of year</strong></td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Frequency</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>In accordance with the policy book for primary dental services to assess the end of year position of each contract and calculate the value of under-delivery, which may be reclaimed from the contractor</td>
<td>Annually (after 30 June)</td>
</tr>
<tr>
<td><strong>Dental assurance process</strong>&lt;br&gt;Ensure that there is appropriate finance input to inform the dental assurance process for dental practices</td>
<td>As required</td>
</tr>
<tr>
<td><strong>Internal financial planning and reporting</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Internal working arrangements</strong>&lt;br&gt;Ensure that the dental team works closely with finance colleagues, and there is finance input on financial matters associated with contract management</td>
<td>On-going</td>
</tr>
<tr>
<td>Appropriate use of the Compass reports and e-reporting system to monitor contracts</td>
<td>On-going</td>
</tr>
<tr>
<td><strong>Internal reporting</strong>&lt;br&gt;Produce monthly statements on dental expenditure and income (part of the monthly financial timetable)</td>
<td>Monthly</td>
</tr>
<tr>
<td>Ensure that dental costs are accurately reflected in the primary care budget as part of the overall financial reporting structure for the commissioner.</td>
<td>On-going</td>
</tr>
<tr>
<td><strong>Monitoring of dental spend and management of patient charge revenue (PCR)</strong>&lt;br&gt;Ensure that monthly payments to providers are accurate</td>
<td>On-going</td>
</tr>
<tr>
<td>Monitor collection of PCR, taking into account previous year’s trends and known changes to contracts.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Ensure robust forecasting of dental expenditure and PCR, reflecting known service changes and future expenditure plans</td>
<td>Monthly</td>
</tr>
<tr>
<td>Ensure finance input into any contract changes such as contract negotiations for new activity or contracts</td>
<td>As required</td>
</tr>
<tr>
<td><strong>Cost recharge from the NHSBSA</strong>&lt;br&gt;Ensure that the monthly recharge from the NHSBSA is reconciled to local budgets. The payment and recharge summary report produced by the NHSBSA can also be used in this process</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
Regulatory definitions

Mandatory services

NHS (GDS contracts) Regulations 2005 require a contractor to provide mandatory services to a patient by providing to that patient a course of treatment. This is defined in regulations as meaning:

(a) an examination of a patient, an assessment of their oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment; and
(b) the provision of any planned treatment (including any treatment planned at a time other than the initial examination) to that patient,

provided by, except where expressly provided otherwise, one or more providers of primary dental services, but it does not include the provision of any orthodontic services or dental public health services.

Course of treatment

In accordance with NHS (GDS contracts) Regulations 2005, part 1, paragraph 2, a course of treatment means that where no treatment plan has to be provided in respect of a course of treatment pursuant to paragraph 7(5) of schedule 3 (treatment plans) of the regulations, all the treatment recommended to, and agreed with, the patient by the contractor at the initial examination and assessment of that patient has been provided to the patient; or where a treatment plan has to be provided to the patient pursuant to paragraph 7 of schedule 3, all the treatment specified on that plan by the contractor (or that plan as revised in accordance with paragraph 7(3) of that schedule of the regulations) has been provided to the patient.

Urgent treatment

Urgent treatment is separately defined as a course of treatment in regulations as a course of treatment that consists of one or more of the treatments listed in schedule 4 to the NHS
charges regulations (urgent treatment under Band 1 charge) that are provided to a person in circumstances where:

(a) a prompt course of treatment is provided because, in the opinion of the contractor, that person’s oral health is likely to deteriorate significantly, or the person is in severe pain by reason of his oral condition, and

(b) treatment is provided only to the extent that is necessary to prevent that significant deterioration or address that severe pain.

Completed course of treatment

Completed in relation to a course of treatment, is defined in the regulations as meaning that:

(i) where no treatment plan has to be provided in respect of a course of treatment pursuant to paragraph 7(5) of schedule 3 (treatment plans) of the regulations, all the treatment recommended to, and agreed with, the patient by the contractor at the initial examination and assessment of that patient has been provided to the patient; or

(ii) where a treatment plan has been provided to the patient pursuant to paragraph 7(5) of schedule 3 of the regulations, all the treatment specified on that plan by the contractor (or that plan as revised in accordance with paragraph 7(3) of that schedule of the regulations, has been provided to the patient;

and completed shall be construed accordingly.

Contract review cases

As part of internal training and in consideration of contractual matters, commissioners may wish to use the following scenarios to work through their approach.

While the scenarios described below are fictitious, they bear similarities to a number of real cases and describe contracts where high levels re-attendance of the same patients, within a relatively short period of time, have been identified within each treatment band. They give details of possible approaches commissioners may wish to consider when reviewing contractors’ activity.

A. Band 1

Contract: A GDS contract to provide mandatory services with a contract value of £900,000 and activity of approximately 28,000 UDAs.

Issues:
- Vital signs data shows a relatively stable patient base with only a small number of new patients being seen within a 24 month period.
• The percentage of same patient IDs seen within three months and between three and nine months are 20% and 59% respectively, and these are some of the highest figures for this commissioners.

• Around 28% of UDAs for this contract are delivered by Band 1 course of treatments. The quarterly general contract clinical data set report shows a rate of recording scale and polish in relation to Band 1 treatments of 52/100 FP17s, which is high compared to the national average of 38.8/100 and low rates of recording of primary preventive measures.

• The average number of days between Band 1 courses of treatment for this contract is 210 days.

• The clinical data set information does not show a high rate of preventive treatments being associated with Band 1 treatments.

B. Band 1

Contract: A GDS contract to provide mandatory services with a contract value of £1.1 million and activity of approximately 50,000 UDAs.

Issues:

• Vital signs data shows little change in patients seen over a 24 month period.

• The percentage of patients with the same ID seen within three months and three to nine months are 22% and 67% respectively.

• The year-end contract summary report shows that 41% of the activity for this contract arises from Band 1 course of treatments, with comparative local and national data showing this contract has a high number of Band 1 treatments across all patient categories (children, exempt adults and non-exempt adults).

• Analysis of quarterly data for adult patients re-attending for a further Band 1 course of treatments shows approximately 80% of adult patients re-attending for further band 1 course of treatment do so within 8 months.

• A clinical report had noted that while for the particular patients examined on their visit the identified recall interval appeared satisfactory, there was no evidence in the clinical records that NICE recall guidance was being applied and that written treatment plans and FP17DCs needed to be available as part of the clinical records (where required by regulations).

C. Band 2

Contract: A GDS contract to provide mandatory services, with a contract value of £1million and activity of 43,500 UDAs.

Issues:

• The contract has appeared in exception reports for late reporting.

• Vital signs data shows the percentages of patients with the same ID seen again within three months and three to nine months are 22% and 61% respectively.

• The year-end contract report summary report shows that 45% of the reported activity for the contract is delivered by Band 2 courses of treatment and that around 8% of UDAs arise from continuations. The number of fillings, root fillings and extractions are low compared to national data per 100 FP17s.
• Information from clinical reports shows concerns about the provision of very small single surface inlays for which no justification could be identified and also concerns was raised about the NHS/private interface. These concerns were supported by unsolicited information from a patient questionnaire suggesting that patients were encouraged to see the hygienist under private arrangements.
• Analysis of quarterly data for adult patients returning for a further Band 2 course of treatment shows that 84% of patients were returning for further Band 2 treatment within eight months and that 34% returned within two months for a further Band 2 course treatment. This data was based on more than 340 Band 2 courses of treatment in the quarter.

D. Band 3
Contract: A GDS contract to provide mandatory services with a contract value of £1.3 million and activity of just over 51,000 UDAs.

Issues:
• Vital signs data showed continuation of treatment to be high (7.1% compared with local average at 3.1%) and urgent treatment to be above local average at 13.5% compared with 7.6%.
• Crowns, veneers and inlays were above local averages on the year-end contract report summary report, with the provision of inlays being four times greater than the local average.
• The provision of Band 3 treatments to children was above the local average at 11/100 FP17s.
• Detailed analysis of Band 3 claim data showed a number of instances of provision of Band 3 treatments to the same patient within a short period of time, with a number of instances where charge paying patients had been treated as continuations.
• Analysis of quarterly data for adult patients attending for a further Band 3 course of treatment showed that 76% of the patients were seen again within 8 months.
• In the first instance discussion of these findings with the provider was advised, in particular the necessity for the provision of large numbers of inlays.

E. Band 3
Contract: A GDS contract to provide mandatory services, with a contract value of £225,000 and associated activity of 9200 UDAs.

Issues:
• The contract had appeared previously on exception reports in relation to treatment on continuation, incomplete treatments and low activity;
• Vital signs data showed the percentage of free repair items for this provider to be 4.2% compared to a local average of 1.7%.
• Examination of data in relation to Band 3 courses of treatment showed a number of instances where Band 3 treatments had been completed in a single day and a number of cases of multiple Band 3 treatments within a short period of time.
• Analysis of quarterly data for adult patients attending for a further Band 3 course of treatment showed that for a single quarter 88% of patients attended for a further
Band 3 course of treatment within eight months (based on 42 Band 3 courses of treatment).

- A clinical record review noted eight Band 3 course of treatment for a single patient within an 18 month period.
- Clinical notes were generally very brief, in some cases no radiographs were present to support the provision of cast restorations and in others radiographs were of poor quality.
### List of standard reports available in Compass

<table>
<thead>
<tr>
<th>Report Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 month list report</td>
<td>Electronic data transmission by treatment location</td>
</tr>
<tr>
<td>24 month patient lists</td>
<td>Electronic data transmission guidance</td>
</tr>
<tr>
<td>Antibiotics prescribing results</td>
<td>Ethnicity report guidance notes</td>
</tr>
<tr>
<td>Combined consistent under performers UDAs</td>
<td>Exception data report</td>
</tr>
<tr>
<td>Commissioner EOY rollover</td>
<td>Exception report data guidance</td>
</tr>
<tr>
<td>Commissioner EOY rollover - not processed</td>
<td>Exception report data guidance June 2010</td>
</tr>
<tr>
<td>Consistent under performance report</td>
<td>Exception report letter</td>
</tr>
<tr>
<td>Consistent under performers report</td>
<td>Exception reports guidance notes</td>
</tr>
<tr>
<td>Consistent under performers report</td>
<td>GDS-PDS general</td>
</tr>
<tr>
<td>Contract general age analysis</td>
<td>General clinical data set General contract clinical data set</td>
</tr>
<tr>
<td>Contract general data</td>
<td>Health Body vital signs at a glance report</td>
</tr>
<tr>
<td>Contract general data file description</td>
<td>Held and negative payment summary</td>
</tr>
<tr>
<td>Contract general report</td>
<td>LNB under performance</td>
</tr>
<tr>
<td>Contract payment</td>
<td>Mid-year activity</td>
</tr>
<tr>
<td>Contract payment report</td>
<td>Mid-year benchmark figures</td>
</tr>
<tr>
<td>Contract summary</td>
<td>Mid-year review of dental activity</td>
</tr>
<tr>
<td>CRS guidance</td>
<td>Mid-year review of dental activity guidance</td>
</tr>
<tr>
<td>CRS index</td>
<td>Mid-year review of dental activity sept.</td>
</tr>
<tr>
<td>Dental activity framework</td>
<td>Midyear statement</td>
</tr>
<tr>
<td>Dental assurance framework flag methodology</td>
<td>Midyear statement guidance</td>
</tr>
<tr>
<td>Dental assurance framework general contract report</td>
<td>Mid-year VDP report</td>
</tr>
<tr>
<td>Dental assurance framework general report</td>
<td>Monthly contract summary</td>
</tr>
<tr>
<td>Dental assurance framework report guidance</td>
<td>Monthly contract summary</td>
</tr>
<tr>
<td>Dental assurance framework report guidance (Wales)</td>
<td>Monthly PDS plus contract report</td>
</tr>
<tr>
<td>DPD guidance</td>
<td>Monthly report notes</td>
</tr>
<tr>
<td>Electronic data transmission by contract</td>
<td>Net pensionable earnings sample</td>
</tr>
<tr>
<td>Electronic data transmission by contract number</td>
<td>Net pensionable earnings update</td>
</tr>
<tr>
<td>Electronic data transmission by contract number notes</td>
<td>New finance LHB monthly summary</td>
</tr>
<tr>
<td>Electronic data transmission by contract number guide</td>
<td>New finance LHB payment and recharge summary</td>
</tr>
<tr>
<td>Electronic data transmission by PCT</td>
<td>New finance monthly summary</td>
</tr>
<tr>
<td>Electronic data transmission by treatment location id guide</td>
<td>New finance payment and recharge summary</td>
</tr>
<tr>
<td>Electronic data transmission by treatment location id</td>
<td>NPE guidance</td>
</tr>
<tr>
<td>Electronic data transmission by treatment location id</td>
<td>NPE performer’s guidance</td>
</tr>
<tr>
<td></td>
<td>NPE provider’s guidance</td>
</tr>
<tr>
<td></td>
<td>NPE return declarations</td>
</tr>
<tr>
<td></td>
<td>NPE summary</td>
</tr>
<tr>
<td></td>
<td>NPE update guidance</td>
</tr>
</tbody>
</table>

Managing dental services (v1.0) 04.2017  63
Number of contracts by CCG area team level
Patient flow in report
Patient flow out report
Patient questionnaire exception report
Patient questionnaire exception report guidance
Patient questionnaire response reports
user notes
Patient questionnaires by contract
Patient questionnaires by area
Payment additions and deductions rolling quarter
Payment and recharge
Payment and recharge summary
PCO CRS report by provider
PCT progress against contracted activity
PCT year-end vital signs at a glance contract
PDS plus monitoring report guidance
Performer EOY rollover
Performer report
Progress against contracted activity notes
Provider EOY rollover
Provider EOY rollover - not processed
Quarterly contract exception report
Quarterly general vital signs
Quarterly PCO exception summary report
Quarterly vital signs report guidance PCT Questionnaire summary reports user notes
Re-attendance report
Report notes
Schedule processing dates
SD86C
Specific items pay detail
Summary of patient benefit eligibility checks

Superannuation guidance for the NPE declaration
Time lag
Under performance
Under performance report
VDP report
VDP report guidance
Vital signs - at a glance
Vital signs at a glance contract report
Vital signs at a glance PCT report
Vital signs contract report
Vital signs rankings report guidance
Vital signs report for health body
Vital signs reports technical explanations
Year-end activity
Year-end benchmark figures
Year-end contract data
Year-end contract report
Year-end contract summary
Year-end ethnicity report
Year-end GDS-PDS contract report
Year-end performer breakdown
Year-end reconciliation sample
Year-end reconciliation superannuation
Year-end statement guidance - final version
Year-end statement guidance - interim version
Year-end statement guidance - preliminary version
Year-end VDP report
Year-end vital signs
Year-end vital signs at a glance report
Year-end vital signs contract ranking report
Year-end vital signs contract report
Year-end vital signs report for health body
Clinical guidance

This section is primarily for dentists, but is also useful for primary care organisations. Dentists should understand their NHS contract and the associated regulations which underpin it. This section supports the dentist in delivering their contract.

The relevant legislation (as amended) is:
- The National Health Service (General Dental Services Contracts) Regulations 2005
- The National Health Service (Personal Dental Services Agreements) Regulations 2005
- The National Health Service (Dental Charges) Regulations 2005

Throughout the regulations reference is made to PCTs. The relevant changes relating to the abolition of PCTs is covered in the Health and Social Care Act (2012). For the section relating to the provision of Dental Services (Schedule 4, Part 5), see appendix 7. In summary, where Primary Care Trust is detailed in the regulations, substitute “the Board”

Completion of the FP17 claim form

Under the NHS regulations, a contractor must send an FP17 (or electronic equivalent) for every course of NHS dental treatment within two months of the date of completion of treatment. The form must be signed by the dentist and the patient. Guidance on how to complete the form is available on the NHSBSA website.

Completion of the FP17DC form

The NHS Regulations state that a contractor is required to issue a written form FP17DC (Appendix 1) to patients who are accepted for treatment under Band 2, Band 3 or if providing any part of the treatment under private contract, or where the patient requests one. An electronic equivalent version of the form FP17DC is an acceptable alternative.

The Department of Health wrote to all contractors in April 2016, reminding them of their obligations with regard to the issuing of form FP17DC (Appendix 2).

Treatment on referral and completion of the FP17RN form

The FP17RN (Appendix 3) is a referral notice form, primarily intended to give the patient details of why they're being referred. The form FP17RN must be completed when patients are referred to another provider who holds either an additional or advanced mandatory
services referral contract and for referral into secondary care in a hospital setting. The form is not required for referral for orthodontic services.

All sections of the FP17RN should be completed by the referring practice:

- Section A of the form asks for details of the patient
- Section B asks for details of the dentist that the patient is being referred to
- Section C asks for details of the treatment to be provided and the patient charge to be collected.

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

The patient’s main dentist carries out the treatment that they have proposed (excluding that to be provided on referral) and charges the patient for this. The dentist will receive the appropriate number of UDAs / UOAs for the treatment completed. The paper FP17 or the EDI claim is completed in the usual way and no additional boxes need to be crossed. The second dentist, who is providing treatment on referral under Additional Services, completes the treatment required and charges the patient separately for this course. The second dentist will receive the appropriate number of UDAs / UOAs for the treatment provided. For domiciliary and sedation services, the FP17 / EDI claim will require entries in Part 6 indicating ‘treatment on referral’ and which service has been provided where applicable. There are no equivalent boxes to complete for orthodontic claims which are made on form FP17O.

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

The patient’s main dentist refers a patient to another dentist, each dentist will be credited with UDAs associated with the treatment they actually provided only the collection of patient charges will remain unchanged and it will still be the responsibility of the referring dentist to collect any patient charge. This will be based on the charge band for the entire course of treatment. The treatment band should be entered into box G ‘Referral for Advanced Mandatory Services’ on the form FP17.

The dentist providing the treatment on referral under Advanced Mandatory Services claims the UDAs appropriate to the treatment provided however no charge is levied as the patient would have already paid for the full course of treatment. The dentist providing treatment on referral under Advanced Mandatory Services submits an FP17 or EDI claim and will need to cross ‘Treatment on referral’ in Part 6 to ensure that no patient charge is deducted.
Summary

Advanced Mandatory referrals:

The patient’s own dentist carries out the examination and refers the patient for an element or elements of treatment that are beyond their skill level to another contractor who holds a contract with the PCO to carry out that treatment.

The patient only pays one patient charge and the dentists each receive UDAs for the treatment they have completed.

Additional Services referrals:

This covers treatment on referral for sedation, domiciliary and orthodontics (where UOAs apply). All of the patient's treatment is carried out as two separate courses of treatment and therefore two patient charges are appropriate where a patient charge is applicable.

Referral to secondary care:

The patient’s own dentist carries out treatment and submits a claim as appropriate. The patient is referred to secondary care for the additional treatment.

NICE recall guidance

Under NHS Regulations, dentists are expected to deliver care to patients in accordance with NICE guidance.

NICE has published guidance (https://www.nice.org.uk/guidance/cg19) on dental recall intervals and for adult patients, recommends that patients should be recalled between three months and two years and the recommended interval for children is between three and 12 months. The actual interval should be assessed by the dentist based on the patient’s needs. Dentists should discuss the recommended recall interval with the patient and record this interval, and the patient’s agreement/disagreement with it, in the clinical record. The recommended interval should also be recorded on the form FP17.

Delivering better oral health


If the guidance has been followed, then the ‘Best practice prevention according to Delivering Better Oral Health offered’ box on the FP17 should be ticked.
Orthodontic treatment

Entitlement to NHS-funded orthodontic treatment

Most contractors only have contracts to provide treatment to under-18s as most Area Teams only commission adult orthodontics from secondary care providers (who normally restrict treatment to patients with an IOTN DHC grade 5).

Index of Orthodontic Treatment Need (IOTN)

A useful guide to the IOTN can be found on the website of the British Orthodontic Society.

Retention and replacement retainers

This is covered in the guidance produced by the British Orthodontic Society and the Department of Health in 2008 (Appendix 4) and on page 50 of the NHS England Commissioning Guide for Orthodontics.

Repair and replacement of appliances

The repair and replacement of orthodontic appliances necessitated through ‘fair wear and tear’ is included in the units of orthodontic activity credited at the commencement of treatment. Replacement appliances necessitated by an act or omission by the patient are covered by Regulation 11 of the NHS (Dental Charges) Regulations 2005. The patient should be given a receipt and a copy of the form FP17R/11 (Appendix 5) and advised to send the completed form plus a copy of the receipt to the NHS Business Services Authority in Eastbourne. The performer/contract holder should also submit an FP17O (Appendix 6) with Box A of Part 6 completed. If the patient’s appeal against the charge is successful (e.g. mitigating circumstances or financial hardship) the fee is reimbursed to the patient directly by the NHS Business Services Authority. The contractor keeps the patient’s charge.

General advice for dentists

What can be provided through the NHS

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

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

The National Health Service (General Dental Services Contracts) Regulations 2005 specify the mandatory services that must be supplied under a General Dental Services contract. Under a Personal Dental Services Agreement there may be some variation in the mandatory services supplied, which will be agreed with the Area Team.

**Incomplete courses of treatment**

For any Band 1, 2 or 3 incomplete treatment claim, the dentist must have started the treatment to claim the UDAs and not just planned the treatment, e.g. the dentist prepares a tooth for a crown or records impressions for a denture, but the crown or denture are not fitted, they can claim Band 3 incomplete and claim 12 UDAs.

**Free repairs and replacements**

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

- fillings
- root fillings
- inlays
- porcelain veneers
- crowns.

Repeated free repairs and replacements of the same restoration in a tooth may indicate poor treatment planning or inadequate quality of treatment. Although the patient does not pay for free repairs and replacements there is a cost to the NHS. Dentists should discuss treatment options with patients to minimise the risk of poor quality care involving “patching up” teeth with repeated free repairs.

**Urgent treatments**

National Health Service (GDS Contracts) and (PDS Agreements) Regulations 2005 define “urgent treatment” as meaning:

“a course of treatment that consists of one or more treatments listed in Schedule 4 of the NHS Charges Regulations (urgent treatment under Band 1 charge) that are provided to a person in circumstances where:

(a) a prompt course of treatment is provided because, in the opinion of the contractor, that person’s oral health is likely to deteriorate significantly, or the person is in severe pain by reason of his oral health condition; and
(b) treatment is provided only to the extent that is necessary to prevent that significant deterioration or address that severe pain”.

The National Health Service (Dental Charges) Regulations 2005 go on to state:

“and “urgent course of treatment” shall be construed accordingly.”

While Department of Health Factsheet 7B (Gateway reference 6990) provides guidance on two specific scenarios, it notes that the regulations do not provide rigid rules to cover all eventualities. Practitioners are therefore required to apply their clinical judgement as to whether an urgent course of treatment is appropriate and this will vary depending on the particular circumstances of each individual case.

Where an urgent course of treatment is considered appropriate then treatment should be provided to the extent necessary to prevent that severe significant deterioration in oral health or address severe pain, which may take place over more than one visit. Factsheet 7B quotes such an example.

Factsheet 7B makes clear that there may be circumstances where an urgent course of treatment is followed by other (non-urgent) treatment, which would be a separate banded course of treatment attracting a further patient charge where appropriate. In other circumstances it may be more appropriate to regard any initial care and treatment provided to address a patient’s immediate presenting complaint or symptoms as the first visit of a banded course of treatment to provide all proper and necessary treatment. It is essential that any patient attending for any course of treatment understands the basis of that course of treatment and gives appropriate consent, which should be recorded accordingly in the clinical records.

Due to the plethora of presenting symptoms and conditions, it is not possible to stipulate categorically which clinical scenarios should be classified as ‘urgent’, and which should not. However, the classification of treatment provided and the resulting claiming approach should be based on patient needs and expectations, and a clinical decision made by the practitioner informed by these.

If a clinical adviser review of patient treatment claiming is carried out and the patient record entries do not support the claim as submitted the clinical adviser will identify the appropriate band from the information available and suggesting that the provider reconsiders the claim.

It is also worth considering that whilst the decision as to whether a course of treatment constitutes an urgent course of treatment is a matter of clinical judgement as clinicians we would also include patients’ understanding of available treatment options, costs and clinical benefits should also be taken into account in accordance with GDC Standards.

**Requirements for a course of treatment / splitting courses of treatment**
The term “splitting” is not defined within the regulations but the term is generally used to describe the deliberate intention not to deliver all necessary treatment in a single course of treatment, i.e. the treatment required by a patient is unreasonably or un-necessarily split across a number of courses of treatment.

If a dentist is repeatedly splitting treatment across several courses of treatment, this will be highlighted in the activity monitoring reports from NHS Dental Services.

**Emerging themes from the NHS Dental Services 28 day activity review**

The 2015/16 Dental Activity Review focused on claims for re-attendance within 28 days of a previous course of treatment. While there will be some instances where this is justified the data suggest that, for a small number of contracts, this may be occurring at rates well above what would be expected. The key objective was to identify and change behaviours that may be detrimental to the profession, patients or the taxpayer.

**The requirement to carry out and record a full/comprehensive examination**

The contracts require that:

1. every course of treatment, except an urgent course of treatment, includes “an examination of the patient, an assessment of his oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment”.

2. “[you,] the contractor shall ensure that a full, accurate and contemporaneous record is kept in the patient record in respect of the care and treatment given to each patient under the agreement, including treatment given to a patient who is referred to the contractor”.

The GDC’s Standards for the Dental Team (September 2013) includes at 4.1.1: “You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients”.

The Faculty of General Dental Practitioners’ ‘Good practice guidelines on clinical examination and record keeping’ sets out recommendations on what should be included and recorded for a sufficient examination of a patient for each course of treatment. Details are given for both an initial examination and subsequent recall examinations.

For the reasons set out above, a full/comprehensive examination for each course of treatment must be carried out and a full and accurate contemporaneous record of all aspects of the examination, assessment and treatment planning must be made. Whilst this
would be appropriate for a ‘non-urgent’ Banded course of treatment, you would not expect to see a ‘full’ examination where ‘urgent’ care is provided.

**Receiving a patient on referral**

With regard to a clinician receiving a patient on referral, the clinician accepting the patient should carry out an appropriate examination. This should be relevant to the treatment for which the patient has been referred. A full medical history should be recorded.

On completion or treatment the receiving dentist should send a written report to the referring dentist confirming treatment has been completed and what follow-up consultations, if any are required.

**Mixing of services provided under the contract with private services**

1. If a patient needs:

   a) A filling on a molar tooth where an amalgam is clinically suitable and the patient wishes a white filling, can I place a white filling as an NHS item, gain the UDAs while adding some charge to the normal patient charge under Band 2?

   b) Transparent brackets for NHS orthodontic cases, provide them and charge an additional private fee

   c) Provide better quality private teeth on a NHS baseplate and charge the patient a private fee?

   Answer: No. The contractor shall not ‘demand or accept a fee or other remuneration for its own or another’s benefit from (a) any patient of its for the provision of any treatment under the contract, except as otherwise provided in the NHS Charges Regulations’. Item 22.

The National Health Service (General Dental Services Contracts) Regulations 2005 SI 2005 No.3361 state in relation to private treatment and treatment planning:

Schedule 3 Other Contractual Terms:

Paragraph 7; Treatment Plans and in particular sub paragraph (2)

If the patient, having considered the treatment plan provided pursuant to sub-paragraph (1), decides to accept the provision of private services in place of all or part of services under the contract, the contractor shall ensure that the patient signs the treatment plan in the appropriate place to indicate that he has understood the nature of private services to be provided and his acceptance of those services.

Paragraph 10 sub paragraph 3 states:

A contractor shall not, with a view to obtaining the agreement of a patient to undergo services privately—

(a) advise a patient that the services which are necessary in his case are not available from the contractor under the contract; or
(b) seek to mislead the patient about the quality of the services available under the contract.

To summarise; the contractor must offer all necessary treatment available under mandatory services to the patient, however if an informed discussion between the contractor and the patient (in line with the NHS GDS Regulations) and the patient decides to have elements of or all treatment privately then this must be recorded and signed by the patient on treatment planning form FP17DC or electronic equivalent.

**Regulation 11**

Regulation 11 is the treatment band that applies to replacement NHS dental appliances, when the original was lost or broken, due to an act or omission by a patient. This also applies to stolen appliances. Both the original and the replacement appliances must be provided under the NHS for Regulation 11 to apply.

A Regulation 11 doesn’t apply to the two month continuation rule regardless of the time lapsed since the course of treatment has been completed, it would still be considered as a Regulation 11 course of treatment.

**Patient charges and activity**

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

- 12 UDAs are awarded for replacement general appliances.

- UOAs are not awarded for replacement orthodontic appliances. The orthodontist keeps the patient charge instead.

For further information on Regulation 11, please refer to [NHS Dental Services Ask Us](https://www.nhsdentalservicesaskus.nhs.uk) page.
Key practice information

Commissioners and dentists in primary care need to work together to ensure that NHS resources for primary dental care are used in the most effective way. Together, commissioners and providers aim is to provide the best possible quality and quantity of care for NHS patients where the focus is on meeting patients’ needs over serving a demand.

This section of the guide supports dental providers to operate within NHS guidelines, regulations and good practice. The dental contract management section is a tool for new and existing contract/commissioning managers as well as the wider dental community and is applicable only to UDA based contracts excluding those within the dental contract reform programme and advanced mandatory and additional services.

Compass

Compass is a web based system that helps you manage your contract.

Compass gives providers and performers:

- visibility of contract information
- visibility of financial information
- visibility of the progress of claims as they are being processed
- online correction of paper FP17s
- increased visibility of pension information
- improved access to performance and financial reports

The system provides you with the functionality and information to help you monitor the delivery of your contracts and enables you to take a more active role in ensuring that you are able to deliver expected activity over the course of the year.

Accessing compass

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

If they’re unsure how to do this then they should contact the NHSBSA’s Dental Services helpdesk by sending an email to nhsbsa.dentalservices@nhsbsa.nhs.uk or by ringing 0300 330 1348

Where to get help on Compass

How to … guides are available on our website and take you step by step through some of the main tasks you need to do in Compass www.nhsbsa.nhs.uk/Compass
Our online knowledge base ‘Ask Us’ also contains a lot of information on how to use the system. AskUs

Claims processing

You should submit your FP17s promptly and on a regular basis. It’s recommended that FP17s are submitted on a daily basis, but failing that at least once a week. Additionally, you should regularly check your responses if you transmit you FP17s using EDI. For practices that submit paper FP17s you should login to Compass to check for any FP17s that have failed validation. A guide is available on the NHSBSA website to help you with this.

Common errors

Below is a list of the top ten reasons claims reject from processing.

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

Paper FP17 rejections

To reduce the chance of paper claims rejecting please make sure they have been fully completed, in black ink wherever possible. It’s also easier for our systems to process your claims if the patient’s forename and surname are completed in block capitals and you enter a cross in the appropriate boxes instead of a ‘tick’ or circling the box.

Forms are processed much more quickly if they’re sent electronically.

Online amendment of paper claims

Compass has functionality in it to enable you to amend your rejected paper claims online; this is the only way you can correct your rejected claims.

This means you can:
• amend claims much quicker instead of waiting for us to return the claims to you to correct
• reduce the risk of missing the two month deadline for the submission of claims
• amend claims that have already been processed without the need to complete a schedule query form (CSS8)
• correct claims before they’re processed

A guide is available on the NHSBSA website which you takes you through how to amend rejected claims in Compass.

Late submission rule

In line with paragraph 38 of the NHS General Dental Services Regulations and paragraph 39 of NHS Personal Dental Services Regulations, valid FP17s should be received by NHS Dental Services within two months of the date of completion of a course of treatment. Any FP17s received outside of that period will be processed and the patient charge deducted. However, no units of dental activity will be awarded for the course of treatment. The only exceptions to this rule are incomplete treatment and orthodontic courses of treatment.

When we validate claims against the late submission rule we use the date the claim is received, whether this is receipt to the WebEDI service for electronic claims or receipt of paper claims to our Newcastle offices.

If you are unhappy with UDA not being credited due to the late submission rule, you will need to speak with your Commissioner to discuss if the UDAs for late submitted FP17s can be included towards your contracted UDA.

For the 2016/17 financial year only, as contractors will be unable to monitor the impact of any late claim on their performance against contract, NHS England has decided to turn off the two month rule across all contracts.

Activity

You can regularly monitor your contracted activity levels by checking Compass.

Allocation of UDA to financial years

We will apply the following criteria to assess whether the activity data submitted on a FP17 will qualify for inclusion in the 2016/17 reporting year.

• all activity data collected from FP17s scheduled in any of the 12 schedule months from April 2016 to March 2017.
• all activity data collected from FP17s scheduled in April 2017 and May 2017 that have a treatment completion date prior to April 2017.
Managing dental services (v1.0) 04.2017

- all activity data collected from FP17s, which were received by 31 May 2017 with a treatment completion date prior to 1 April 2017 and scheduled.
- amendments to previously scheduled FP17s that were received and processed up to the scheduling date of the contract in June 2017.

These criteria apply to each financial year.

**How to view your current activity**

To view your latest activity information log in to your Compass account and select Activity from the left hand menu, then click on Activity Search. A guide to how to view your current activity information is available on the [NHSBSA website](https://www.nhsbsa.nhs.uk/compass).

You can self-monitor your contracted activity levels through regular checking of Compass so you can ensure that you maintain your contracted activity levels throughout the year.

**Pay statements and schedules**

Every month we make available to each provider a pay statement and to each performer a copy of their monthly superannuation allocation and a summary of forms processed. The pay statements and schedules are available in Compass. To view them log in to your Compass account and select Payments from the left hand menu. Then go to Monthly Statements and enter the necessary information.

To find out when each month’s pay statements are available to view and download in Compass check the Schedule Programme available on the [NHSBSA website](https://www.nhsbsa.nhs.uk/compass). Guidance is available to help you view and download pay statements and schedules.  

**Payments**

**Payments made under the Statement of Financial Entitlement**

Claims for parental leave, sickness and non-domestic rates will be processed by the NHSBSA on behalf of NHS England in line with the eligibility criteria in the Statement of Financial Entitlement (SFE).

Providers can claim for additional payment items in respect of their performers’ long term sickness leave and parental leave (maternity, paternity and adoptive leave). Providers can also claim for reimbursement for non-domestic rates that meet the criteria specified in the [Statement of Financial Entitlement](https://www.nhsbsa.nhs.uk/compass).

In order to claim for these additional payment items practitioners must complete the relevant [application form for personal payment under the Statement of Financial Entitlement](https://www.nhsbsa.nhs.uk/compass) and submit it to the address on the top of the form.
Non Domestic Rates

Providers are entitled to reclaim non domestic rates paid for premises where services are provided under an NHS contract where they are responsible for paying those rates. In order to claim payment for non-domestic rates practitioners must complete the Application for Personal Payment under the Statement of Financial Entitlement form available on the NHSBSA website.

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

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

More information about claims for parental leave, sickness leave and non-domestic business rates is available in the Statement of Financial Entitlement and in Ask Us.

Viewing payments in Compass

You can view the payments set up for your contract in Compass. Information on how to view them is available on our website and in Ask Us.

Cheque payments

Following a recent NHS England internal audit, the NHSBSA will no longer accept cheque payments from contractors. This is to ensure one national process to manage claw backs and minimise the financial risk of negative contractor schedules.

The option for cheque payment has now been removed from Compass and contractors are now only able to pay monies to the NHSBSA via BACS.

Pensions and superannuation

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

Annual Reconciliation Reports

All providers and performers are required by law to confirm their net earnings for each financial year by 30 June of the next financial year i.e. net earnings for 16/17 has to be confirmed by 30 June 2017. We refer to this as the annual reconciliation process. It’s important that this is completed because your net earnings are used to calculate your
entitlement to statutory payments, such as sickness, as well as to keep accurate pension records.

You have both a statutory obligation and a contractual requirement to declare your net pensionable earnings (NPE) or net pensionable earning equivalent (NPEE).

NPEE is your net GDS/PDS income that you would have notified to us if you were in the NHS Pension Scheme, excluding any payment for maternity, paternity, seniority, long term sickness and trainer’s grant.

To confirm your NPE/NPEE you should log in to your Compass account and click on the Pensions menu item, then select the Annual Reconciliation Report (ARR) Contract Selection option.

Performers will receive an email to notify them that their NPE/NPEE figures are available for confirmation once they’ve been reviewed by their provider.

Information on how to complete your ARR is available on the NHSBSA website and in Ask Us.

**Timetable**

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

**Patient eligibility checks for free or reduced cost NHS dental treatment**

The NHSBSA has a duty to check patient claims for free or reduced cost treatment. If your patients claim free NHS dental treatment that they’re not entitled to, they could be facing a penalty charge of up to £100 – as well as the original treatment charge. It’s estimated that £60m worth of NHS dental patient charges a year are at risk from patient error or fraud. This is money that could be used on frontline NHS services.

If a patient is certain that they qualify for free treatment, they should show proof of their entitlement to the practice staff before signing the patient declaration on the FP17 / FP17PR.

If they are not sure whether they qualify, they should pay for their treatment – they may subsequently be able to claim a refund.
If the patient currently has to pay but has a low income, they may be entitled to help with the cost of their dental treatment and other NHS charges through the NHS Low Income Scheme. Information on how to apply is available at: https://www.nhsbsa.nhs.uk/nhs-help-health-costs. If their application is successful, they may be entitled to a refund of recent charges.

Information for patients and practice staff is available to download from the NHSBSA website.
Appendix 1: Form FP17DC
What NHS dental care means to you

Emergency arrangements
Whenever possible please contact us about urgent treatment during normal surgery hours. If you need to be seen the same day, please get in touch as early in the day as possible. If an emergency arises out of hours, please telephone the Primary Care Trust for advice.

Replacements free of charge
If you are 16 or over and a filling, root filling, veneer, inlay or crown provided by me under the NHS within the last 12 months has to be replaced, you will not be charged if you return to me, unless:

a) the treatment was temporary; or
b) it was provided against my advice; or
c) the replacement is necessary because of accident; or
d) a different treatment is necessary because a satisfactory replacement is not possible.

This NHS cover does not apply to any private treatment you may have.

Dental treatment charges
I want you to understand the treatment being offered and any charge which may apply. Overleaf is a treatment plan and an estimate of the cost. Within 2 months of completion of the course of treatment detailed overleaf, should you require further NHS treatment in either the same or lower charge band, you will not normally need pay again.

Please ask if you do not understand this or need any further information.

Treatment on referral
With your agreement, it may be necessary to refer you to another dentist under NHS arrangements, for part of your course of NHS dental treatment. Where this happens you will not be asked to pay a further charge for your NHS dental treatment: only one charge will be made by your referring dentist, as outlined in the treatment plan overleaf.

What the NHS will provide
The NHS provides all the treatment necessary to secure and maintain your oral health. There are some treatments (mainly cosmetic) which are not available under the NHS, and you may choose to have these privately. You may also choose to have some treatment privately as an alternative to NHS treatment. If you wish to have some private treatment then I shall give you a written estimate beforehand, on this treatment plan.

Paying for NHS treatment
Patients aged 18 and over normally pay charges for NHS treatment.

There is no charge if you are:

- pregnant
- if you have had a child in the last 12 months
- if you are aged 18 in full-time education
- if you or your partner are named on a current HC2 NHS charges certificate
- if you or your partner are named on a valid NHS tax credit exemption certificate
- if you or your partner receive Income Support, Income-based Jobseeker's Allowance or Pension Credit Guarantee Credit.

If you are not in any of these groups, but have a low income, you may still be able to get help with NHS charges. You can get a claim form HC1 from any Social Security office.

Please note; The following benefits, on their own, do not entitle you to help with health costs: Incapacity Benefit, Disability Living Allowance, Pension Credit Savings Credit and Contribution-based Job Seeker's Allowance.

Cancelling appointments
If you have to cancel an appointment, please give as much notice as possible in order that it may be offered to someone else. If you miss appointments I may be unable to provide further treatment.

Regular care
Taking good care of your teeth is important. Come and see me regularly for checkups and advice. Some people need to see their dentist more than others and I shall advise you when to return next.

Please keep this document safe: it explains how to use the NHS dental services and what to do in an emergency.
Appendix 2: Department of Health letter

Gateway reference No 04957
April 2016

To: All NHS Dental Services Contract Holders

Communicating with patients – NHS Dental Charges Poster, Leaflet and Treatment Plans

Dear Colleague

You should have already received your annual updated copy of the NHS dental charges poster and ‘NHS dental services in England’ patient information leaflet.

Ensuring that there is clear communication with patients about the treatment they will receive, and the NHS charges that will apply for such treatment, is a priority for both NHS England and the Department of Health. Though the poster that is required to be displayed, and the accompanying leaflets, are provided free of charge to all NHS dental contractors, a sizable minority of patients report not noticing the poster when they visit their dental practices, and not being aware of NHS charges and how they apply.

It is a key requirement of all NHS dental contractors that patients receiving NHS treatment are provided with accurate and clear information, from contractors and their staff, in relation to their NHS treatment (and any private treatment they receive alongside a NHS course of treatment).

You are contractually required to:

- display the NHS charges poster, which is supplied free of charge to all practices holding an NHS contract, in a prominent position in your practice; and
- provide a written treatment plan to all patients when you have agreed to provide a Band 2 or Band 3 course of treatment at the time of the initial examination. In relation to a Band 1 or a charge exempt course of treatment, you are required to provide a written treatment plan if you have agreed to provide part of that course of treatment privately, or if a patient has requested written details of the course of treatment to be provided.

You have also been provided, free of charge, with a leaflet setting out the NHS dental charges and details of those entitled to free NHS dental treatment.

To ensure that you comply with your contractual obligations, please consider where you put the poster. As referred to above, it needs to be in a prominent position, which means it needs to be clearly visible to patients visiting your practice. If it is the case that you have more than one waiting room in your practice, we are happy to provide extra copies of the poster to help ensure that it is prominently displayed anywhere patients are likely to see it.

Failure to prominently display the poster or to provide patients with written treatment plans for proposed Band 2 or Band 3 courses of treatment (or Band 1 courses of treatment in the applicable circumstances), amount to breaches of the contractual terms of your contract or agreement, which could result in further action on the part of NHS England. Please be aware
that as well as NHS England, patient representative groups and the regulators may all be looking out for the poster if they visit your practice. This underlines the importance that is placed by all of these bodies on good and effective communication with patients.

Yours faithfully

Peter Howitt
Deputy Director
Department of Health

Dr David Geddes
Head of Primary Care Commissioning
NHS England
Appendix 3: Form FP17RN
Patient information

1 Where you are referred to another practitioner or service provider for part of a course of NHS dental treatment, you will only be required to pay one NHS charge. The NHS charge will be paid to the practitioner who refers you.

2 Where you are referred to another practitioner or service provider for a new course of NHS treatment, such as a course of treatment involving sedation or domiciliary (home) visits, you will pay the appropriate NHS patient charge for that course of treatment to the practitioner providing treatment. The dentist who referred you may also need to charge you for any treatment provided before you were referred.

3 The primary dental service contractor you are referred to will provide you with a treatment plan listing the treatment they are to provide (unless you have been referred for an examination and advice only). You may choose to have some treatment privately as an alternative to NHS treatment. If you wish to have some private treatment then you will be provided with a written estimate beforehand, on the treatment plan.

4 If you do not wish to be referred to the particular practitioner or service provider detailed on this form, please let your dentist know, either verbally or in writing and they will endeavour to make other suitable alternative referral arrangements.
Appendix 4: Liability of Practitioners for continuing care after completion of active orthodontic treatment

Liability of Practitioners for continuing care after completion of active treatment

BOS have already reported to all members that at a meeting with the Department of Health (DH) on 31st October it was agreed to have further discussions.

The DH have now agreed the following:

DH’s Position on Completion of Active Orthodontic Treatment.

Setting an artificial time limit for supervised retention within the regulations risks causing unintended consequences. Under old GDS an orthodontist could claim for minimum 5 months supervised retention with an option to extend - at reduced fee- normally for not more than 4 months.

In most cases under the new regime a 12 month retention period would be about right for all but a very few exceptions.

Orthodontists should accept the differing requirements of individual patients, and an artificial time limit for supervised retention would interfere with this. Should a patient request extended retention on completion of retention this would appear to be more for cosmetic reasons than dental health. In these circumstances it is no longer "proper and necessary treatment" and therefore not within the terms of the NHS contract.

We have agreed with BOS a line to this effect and they will advise their members.

BOS Comment.

This ruling means that orthodontists have a continuing responsibility for patients for at least twelve months after completion of active treatment, including repairs to retainers.

If a patient wishes to continue retention indefinitely the orthodontist has the discretion to make a judgement about the clinical necessity for this. Where the need to extend retention is judged to no longer be “proper and necessary” it is not a part of the NHS contract.

Chris Kettler
Executive Secretary, BOS

14th January 2008
Appendix 5: Form FP17R/11

Replacement Appliance Refund Claim Form

Part A
Patient’s Details
Surname
Forename
Address
Date of Birth
Day
Month
Year
Sex
Male
Female
Parent/Guardian’s
Surname
Initial
Title
Postcode

Part B
I wish any refund to be paid into the following bank account:
Name(s) of account holder(s)
Full name of bank, building society or other account provider
Sort code of the bank, building society or other account provider
Account number
If a building society account, the building society roll or reference number

Part C (Part C must be completed by the dentist)
Provider Name, Address and Location Number:

Part D
Date appliance provided
Date charge paid
Charge paid £ 
(A receipt must be enclosed)

Part E
Please describe the steps you took to take care of this appliance prior to it being lost or damaged beyond repair and how it was lost or damaged:
Part F

☐ The original appliance was not lost or damaged due to lack of reasonable care by the patient or the patient’s parent/guardian.

Part G

☐ This charge will cause me undue financial hardship.

Please send proof that you received one of the following benefits or a copy of the exemption certificate you are named on, otherwise it will take longer to process your claim.

On the date the charge was paid I was named on one of the following certificates:

☐ NHS Tax Credit Exemption Certificate
☐ NHS Low Income Scheme HC2 Certificate
☐ NHS Low Income Scheme HC3 Certificate which limits the amount paid to: £

Please provide details of the certificate you hold:

Certificate number:

Dates the certificate is valid for:

From [ ] to [ ]

Day Month Year

On the date the charge was paid, I, or my partner, was in receipt of one of the following benefits:

☐ Income Support
☐ Income-Based Jobseeker’s Allowance
☐ Income-Related Employment and Support Allowance
☐ Pension Credit Guarantee Credit

Please explain why paying this charge will cause you undue financial hardship

When completed please send this form to the:

NHS Business Services Authority, 1 St Annes Road, Eastbourne, East Sussex, BN21 3UN

Patient’s Declaration:

I hereby claim a refund of the charge paid for a replacement NHS dental appliance.

I declare that the information I have given is correct and complete. I understand that if it is not, appropriate action may be taken. To enable the NHS to check I am entitled to help with NHS charges and to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information from this form by and to the NHS Business Services Authority, Primary Care Trusts, Local Health Board, Department for Work & Pensions, HM Revenue & Customs and this dental contractor or practitioner.

I am the patient ☐ or parent/guardian ☐ named overleaf

Signature: ____________________________

Print Name ____________________________ Date: ____________________________
Appendix 6: Form FP17O
PATIENT DECLARATION (This side of the form must be completed by, or on behalf of, the patient)

I would like the dental provider named below, or their representative, to examine me under the NHS and to give me any necessary care and treatment that I am willing to undergo within NHS arrangements.

I agree to pay the statutory charges for the NHS dental services I receive, unless I have submitted a valid claim for free or reduced cost NHS dental services. I will be informed in writing of any NHS dental services overpaid, and that I may have to pay the FULL amount prior to treatment.

I agree, if necessary, to have my dental records examined by the NHS Business Services Authority or other authorized body. I declare that the information I give on this form is correct and complete. I understand that if it is not, inappropriate action may be taken against me.

To enable the NHS to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information to and by the NHS Business Services Authority, NHS England, Department for Work & Pensions, HM Revenue & Customs and local authorities.

I agree that some data processing will take place in either India or Sri Lanka before processing in the UK.

Your personal data will be deleted within 10 years of receipt into our systems.

If you are signing for the patient, give details below:

Name (in CAPITALS) ________________________ Signature ________________________ Date ____________

Relationship to patient ________________________

What is your ethnic group? Please choose ONE selection from this list to indicate your ethnic group:

- White British
- White Irish
- Other White background
- White & Black Caribbean
- Other Black background
- White & Black African
- Other mixed background
- Asian or Asian British Indian
- Other Asian background
- Black or Black British Caribbean
- Chinese
- Any other ethnic group

CLAIM FOR FREE OR REDUCED COST NHS DENTAL SERVICES

YOU MUST READ THIS FORM BEFORE YOU SIGN IT. ONLY SIGN IT IF IT IS CORRECT.

The patient is responsible for the accuracy of this claim, NOT the dental practice.

If you are not certain if you are entitled to receive free or reduced cost NHS dental services you MUST pay at the dental practice. If you subsequently confirm that you were entitled to free or reduced cost dental services, you can claim a refund. If you have applied for a qualifying benefit or exemption certificate but have not received it yet, you must pay and claim a refund where you do receive it.

Routine checks are carried out on claims where evidence of entitlement is shown to the dental practice. If you are found to be wrongly claimed free or reduced cost NHS dental services, you will have to pay a penalty charge of up to £100. You will not have an opportunity to pay for the services first to avoid the penalty.

a) I am entitled to free NHS dental services because on the first day of treatment:

- I am under 18 years of age.
- I am 18 years of age and in full time education
- I am pregnant
- I had a baby in the last 12 months
- I am currently in prison or a young offender's institution

b) I am entitled to free NHS dental services because during the course of treatment I, or my partner, receive:

- Income Support (Incacity benefit and Disability Living Allowance does not count)
- Income-based Jobseeker's Allowance (Contribution-based does NOT count)
- Income-related Employment & Support Allowance (Contribution-related does NOT count)
- Pension Credit Guarantee Credit (Savings Credit on its own does NOT count)

These are the ONLY benefits that entitle you to free NHS dental services. Other benefits such as Council Tax Benefit, Housing Benefit, receipt of State/Private Pension, NHS Prescription Charge Medical Exemption Certificate, or any other benefit does not count.

c) I am entitled to free NHS dental services because I am named on one of the following certificates that is valid during the course of treatment:

- H12 Certificate
- NHS Tax Credit Exemption Certificate (Card)

(You are not automatically entitled because you receive Tax Credits; there are qualifying conditions. If you qualify you will be sent an exemption certificate/card)

d) I am entitled to reduced cost NHS dental services because:

- I am named on an H3 Certificate that is valid during the course of treatment which limits the amount I have to pay to £________

If you are signing for the patient, give details below:

Name (in CAPITALS) ________________________ Signature ________________________ Date ____________

Relationship to patient ________________________
Appendix 7: Health and Social care Act 2012, Schedule 4, Part 5 Dental Services

PART 5
DENTAL SERVICES

42 (1) Section 99 (duty relating to primary dental services) is amended as follows.
(2) For subsection (1) substitute—
“(1) The Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its powers so as to secure the provision of primary dental services throughout England.
(1A) Arrangements made for the purposes of subsection (1) may include arrangements for the performance of a service outside England.”
(3) Omit subsection (2).
(4) In subsection (3)—
(a) for “Each Primary Care Trust” substitute “The Board”, and
(b) for “for which it makes provision” substitute “for which provision is made”.
(5) Omit subsection (4).
(6) For the cross-heading preceding that section substitute “Duty of the Board in relation to primary dental services”.

43 (1) Section 100 (general dental services contracts: introductory) is amended as follows.
(2) In subsection (1), for “A Primary Care Trust” substitute “The Board”.
(3) In subsections (3) and (4), for “the Primary Care Trust” substitute “the Board”.
(4) In subsection (3), in paragraph (a), after “dental services” insert “or services which are to be performed outside England”.

44 In section 102 (persons eligible to enter into general dental services contracts), in subsection (1), for “A Primary Care Trust” substitute “The Board”.

45 In section 103 (general dental services contracts: payments), in subsection
(3)(d), for “a Primary Care Trust” substitute “the Board”.

46 In section 104 (general dental services contracts: required terms), in subsection (3) for “a Primary Care Trust” substitute “the Board”.

47 (1) Section 106 (persons performing primary dental services) is amended as follows.

(2) In the following provisions, for “a Primary Care Trust” substitute “the Board” —

(a) subsection (1), in each place it occurs,
(b) subsection (3)(j),

Health and Social Care Act 2012 (c. 7)
Schedule 4 — Amendments of the National Health Service Act 2006
Part 5 — Dental services

314

(c) subsection (4)(a), (b) and (d), and
(d) subsection (6)(a) and (b).

(3) In subsection (2), for paragraph (b) substitute —

“(b) the Board is responsible for a dental service if it secures its provision by or under any enactment.”

(4) In subsection (3), in paragraph (c), omit the words from “as to” to “and”.

48 (1) Section 107 (arrangements by Strategic Health Authorities for the provision of primary dental services) is amended as follows.

(2) For subsection (1) substitute —

“(1) The Board may make agreements, other than general dental services contracts, under which primary dental services are provided.”

(3) Omit subsection (7).

(4) For the title to that section substitute “Arrangements by the Board for the provision of primary dental services”.

(5) The provision which may be made by virtue of section 304(10)(a) of this Act in an order under section 306 of this Act providing for the commencement of this paragraph includes, in particular, provision enabling the National Health Service Commissioning Board to direct Primary Care Trusts to exercise its functions under section 107 pending the commencement of section 34 of this Act.
49 (1) Section 108 (participants in section 107 arrangements) is amended as follows.

(2) In subsection (1)—

(a) for “A Strategic Health Authority” substitute “The Board”, and

(b) omit paragraph (g).

(3) In subsection (3), in the definition of “NHS employee”, in paragraph (b), omit “Primary Care Trust or”.

50 (1) Section 109 (regulations about section 107 arrangements) is amended as follows.

(2) In subsection (2), for “Strategic Health Authorities” substitute “the Board”.

(3) In subsection (3), after paragraph (c) insert—

“(ca) make provision with respect to the performance outside England of services to be provided in accordance with section 107 arrangements,”.

(4) In subsection (6), for “a Primary Care Trust” substitute “the Board”.

51 Omit section 110 (transfer of liabilities relating to section 107 arrangements).

52 (1) Section 112 (assistance and support) is amended as follows.

(2) In subsection (1), for “A Primary Care Trust” substitute “The Board”.

(3) In subsection (2)—

(a) for “a Primary Care Trust” substitute “the Board”, and

(b) for “the Primary Care Trust” substitute “the Board”.

Health and Social Care Act 2012 (c. 7)
Schedule 4 — Amendments of the National Health Service Act 2006
Part 5 — Dental services

53 (1) Section 113 (Local Dental Committees) is amended as follows.

(2) In subsection (1), for the words from the beginning to “other Primary Care Trusts” substitute “The Board may recognise a committee formed for an area”.

(3) In subsection (3)(b), for “the Primary Care Trust” substitute “the Board”.

(4) In subsection (6), for “a Primary Care Trust” substitute “the Board”.

(5) Omit subsection (7).

(6) In subsection (10)—
(a) for “Primary Care Trust” substitute “The Board”, and
(b) in paragraphs (a) and (b), for “the Primary Care Trust” substitute “the Board”