Department of Health

NHS England

Dental Contract Reform
LDC Conference

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Going to cover today

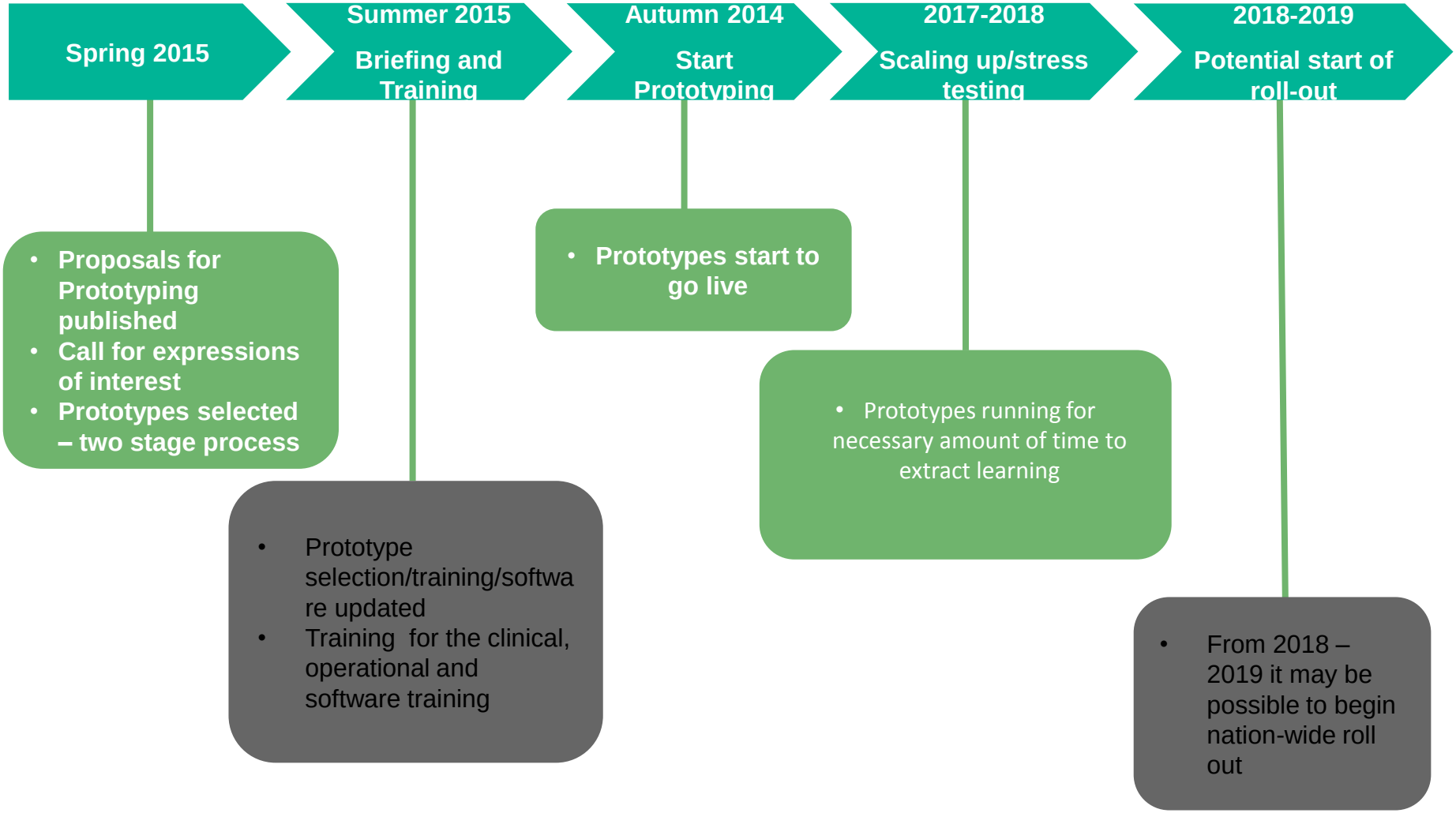
Policy overview

- Timeline for reform
- Selection of prototypes
- What success looks like/learning from the pilots
- Training for prototypes – a new approach

Prototype remuneration

- Overview of core remuneration mechanism
- How the core remuneration mechanism will work
- Applying DQOF adjustments

High level timeline for reform



Selection of prototypes

- All practices which met the eligibility criteria were considered for selection.
- Selection not a merit exercise.
- Selection criteria focussed on the need to create a balanced group: factors included: geography, practice size, patient mix.
- Aiming for around a 100 initial sites.
- Selection complete from pilots – 62 selected.
- Selection from UDA sites (over 200 applicants) almost complete.

What the prototypes will test

Preventative pathway

• The prototypes will use the same pathway and clinical approach as the pilots. No changes are being made to the pathway for prototyping

DQOF

- Seeking to measure and remunerate for quality of care and outcomes. Up to 10% of remuneration against delivery on quality and out come measures (DQOF)

Remuneration

- Remuneration for prototypes is new system. Prototypes will use blends of capitation and activity. Aim is to balance incentives. Not a target system.

Registration

- The pilots have been testing (and prototypes will continue to test) a shadow form of registration.

Success measures

We will be looking to capture 3 high level measures of success:

- Access: prototypes will need to be able to provide care for at least the same number of patients as UDA system
- Appropriate care: we will measure outcomes (caries and perio) and treatment volumes to check appropriate care has been delivered
- Value for money: Care to patients can be delivered within the existing budget envelope

Learning from the pilots

- The fall in access was a key issue with the pilot scheme. But there were exceptions where access either never fell or was recovered.

- Programme of visits to 9 pilots to understand:
  - What actions pilot had taken to maintain/increase access
  - The approach to clinical care

- Each visit led by a DS Clinical Advisor and experienced manager with a background in provider dentistry

- Information gathered before the visit on performance, practice characteristics, and sample clinical records reviewed by the CA

- All staff groups interviewed to get their take on clinical care delivery and the approach to maintaining/increasing access

Learning from the pilots

Common success factors:

- Strong leadership and communication. A clear clinical ethos, a focus on contractual delivery.
- All staff understood the purpose of the pilots and their roles and responsibilities
- Pro-active contract management by the provider.
- Performers had stake in delivery.
- Strong use of skill mix where available
- Using the pathway as a decision support not decision replacement. Confidence in adapting it without compromising its principles.

Training and support/assurance

- The whole dental team needs to be trained not just the provider/business manager
- The pathway approach requires a different ethos – whole dental team needs to understand this, not just owners/dentists
- More focus on “How to manage the contract” is needed (e.g. using the data effectively; motivating/monitoring associates)
- Clinical and software training need to be linked but not too closely: dental teams need to understand the pathway first, and then how the software supports it.

Training and support/assurance

- National support will continue for prototypes but be delivered in a different way.

- More realistic approach in terms of any eventual roll out.

- What will be different?
  - More focussed training, use of webinars, on-line presentations, briefing packs, small scale meetings
  - Prototype support streamlined with access to central team via mail box
  - Software process streamlined with queries direct to suppliers not via programme

- Commissioners will continue to lead on contractual and assurance matters, with national support.

Prototype remuneration

Going to cover in this section on remuneration:

- Overview of core remuneration mechanism
- How the core remuneration mechanism will work
- Applying DQOF adjustments

Overview of core remuneration mechanism

In the prototypes a practice's contract value will be split between:

- A capitation element for which the practice will be expected to have a minimum number of capitated patients on their list – a practice's capitated patient numbers will be measured at year end

- An activity element for which the practice would be expected to deliver a minimum level of activity.

Contractors will be free to switch funds from activity to capitation. They will not be free to do the reverse - this will need commissioner agreement and be exceptional.

The remuneration mechanism is designed to mirror as far as possible the current system with respect to tolerances on delivery and carry-forward.

It also seeks to provide the greatest flexibility for practices in terms of managing delivery of patient numbers and activity by combining performance against these before applying the tolerances for delivery and carry-forward.

How the prototype remuneration mechanism is expected to work

- A practice's notional remuneration levels (prior to the additional adjustments subsequently outlined) will be adjusted on a pro-rata basis if capitation patient numbers or activity are above or below the expected levels

- Unless a commissioner has indicated otherwise, practices may over-deliver on capitated patient numbers to off-set any under-delivery in expected levels of activity

- Unless a commissioner has indicated otherwise, a practice may not over-deliver on activity to off-set under-delivery in expected capitated patient numbers – the maximum remuneration level relating to activity would be set at a % level above the remuneration level achieved in relation to capitated patient numbers.

- For example if this was set at 2% and the practice's capitated patient numbers were only 97% of the expected level, their activity remuneration level would be limited to 99% of the full contract value associated with activity.

How the prototype remuneration mechanism is expected to work

- A tolerance will be applied with respect to the remuneration adjustment relating to capitation and activity – a practice will be allowed to carry-forward under-delivery of up to 4% and will be allowed to over-deliver by up to 2% (which may be paid by the commissioner or carried forward)

- The tolerances described above will be applied to the overall remuneration level combined for capitation and activity – this effectively means practices have some tolerance on delivery of both patient numbers and activity from year to year

- Where the overall remuneration level for capitation and activity falls below 96%, financial recovery may be applied up to 10% of contract value. This adjustment is separate to any subsequent DQOF financial adjustments.

- DQOF financial adjustments will be calculated based on the contract value of the practice.

Applying DQOF adjustments

- DQOF financial adjustments will be calculated based on the contract value of the practice.

- A practice will have 10% of this remuneration level at risk based on DQOF performance i.e. a practice would lose 10% of that remuneration level if they score 0 points on the DQOF.

- Where a practice achieves less than 1000 points, any contract value deducted is entered into a notional national pool to be redistributed amongst other prototype practices based on their relative performance. Practices can be remunerated up to 102% of their contract value based on this additional payment.

- The mechanism means that practices can be remunerated based on their relative DQOF performance whilst the total expenditure for commissioners and total income for providers as a whole remains unchanged.