CPD

NEW Road-testing a NHS contract

Young dentist **Martin Breslin*** shares his perspective on one of the three new NHS pilot schemes being trialled in England and how it may impact the future of NHS dentistry and the role of the DCP.

Introduction

In July 2010 the Government published a White Paper with the following pledge:

'*Following consultation and piloting we will introduce a new dentistry contract, with a focus on improving quality, achieving good dental health and increasing access to NHS dentistry and an additional focus on the oral health of schoolchildren.*'[1]

The current contract which dentists in England work under has come under heavy criticism from many quarters since it was introduced in 2006. Under this contract, all treatments can be grouped into three bands of 'Units of Dental Activity' (UDAs). Practice owners (contractors) are essentially paid for 'achieving' a set number of UDAs each year (April to April). A portion of this is then paid to the associate dentist. Failure to reach this 'UDA target' can result in primary care trusts (PCTs) 'clawing' this money back. This usually results in the dentists being paid less. Conversely if too many UDAs are achieved, the dentist is not remunerated for this.

'Achieving' the 'correct' number of UDAs whilst at the same time providing the best possible care has proved very difficult. This way of working has led to many dentists leaving NHS dentistry. This has meant that fewer and fewer patients have been able to see an NHS dentist. The profession is now eagerly awaiting the details of the new NHS dentistry contract.

THE PILOTS

There are currently three different pilot models being trialled in 70 different dental practices across England.[2] The exact details of each pilot differ slightly but they are all similar in that the UDA is not the sole method of remuneration.

The 2006 contract led to a 'drill and fill' treadmill[3] with little incentive for providing preventive treatment – the main incentive being to 'reach UDA targets'.

The new pilots aim to address these issues by ensuring dentists are not simply paid for the amount of treatment provided. The Department of Health (DH) has said that the new contract will be based on 'registration, capitation and quality'.[4]

Registration

Under the 2006 contract patients are not registered with a practice. This means that they do not have an automatic right to return to a particular dentist once a course of treatment is completed.

Capitation

Instead of being paid simply for the number of courses of treatment, dentists will receive payment for the number of patients they treat. The reality will not be quite as straightforward as different people and areas have different needs so this will be a 'weighted capitation'.

Quality

The contract I am working under does still have a UDA element but there is a greater emphasis on the quality of work provided rather than the quantity. A dental quality and outcomes framework has been developed which focuses on **patient experience**, **patient safety** and **clinical effectiveness**. Key Performance Indicators (KPIs) allow a way of measuring whether or not these elements are being met satisfactorily.

** Martin qualified as a dentist in 2010 from the University of Leeds. After completing his Foundation Training year in York he took on an associate position at a newly opened practice in Bradford in August 2011, one of the few practices in England working under a new NHS pilot contract.*

Patient experience

In order to assess the patient experience, patient questionnaires are likely to form a key element. Areas being assessed include whether or not patients are free from pain and able to eat and speak properly, satisfaction with cleanliness of the practice, helpfulness of staff, waiting times and whether or not they would recommend the practice to a friend.

Patient safety

Patient safety is based on having up to date medical histories. This is something which should already be standard practice.

Clinical effectiveness

The areas being monitored are dental caries, periodontal health, soft tissue health and tooth surface loss. In order to assess these, every patient is assigned to a clinical pathway – red, amber or green.

All patients must undergo an oral health assessment (OHA) at least yearly. This consists of a thorough medical and social history as well as an extensive clinical examination (Fig. 1). This then allows each patient to be categorised into one of three (traffic light) risk categories: red, amber or green, red indicating those patients at highest risk and green those at lowest risk of experiencing dental disease.

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Patients are categorised according to the worst aspect, eg a patient who is 'green' for all medical and clinical aspects but who frequently consumes sugary foods would be in the 'red' category.

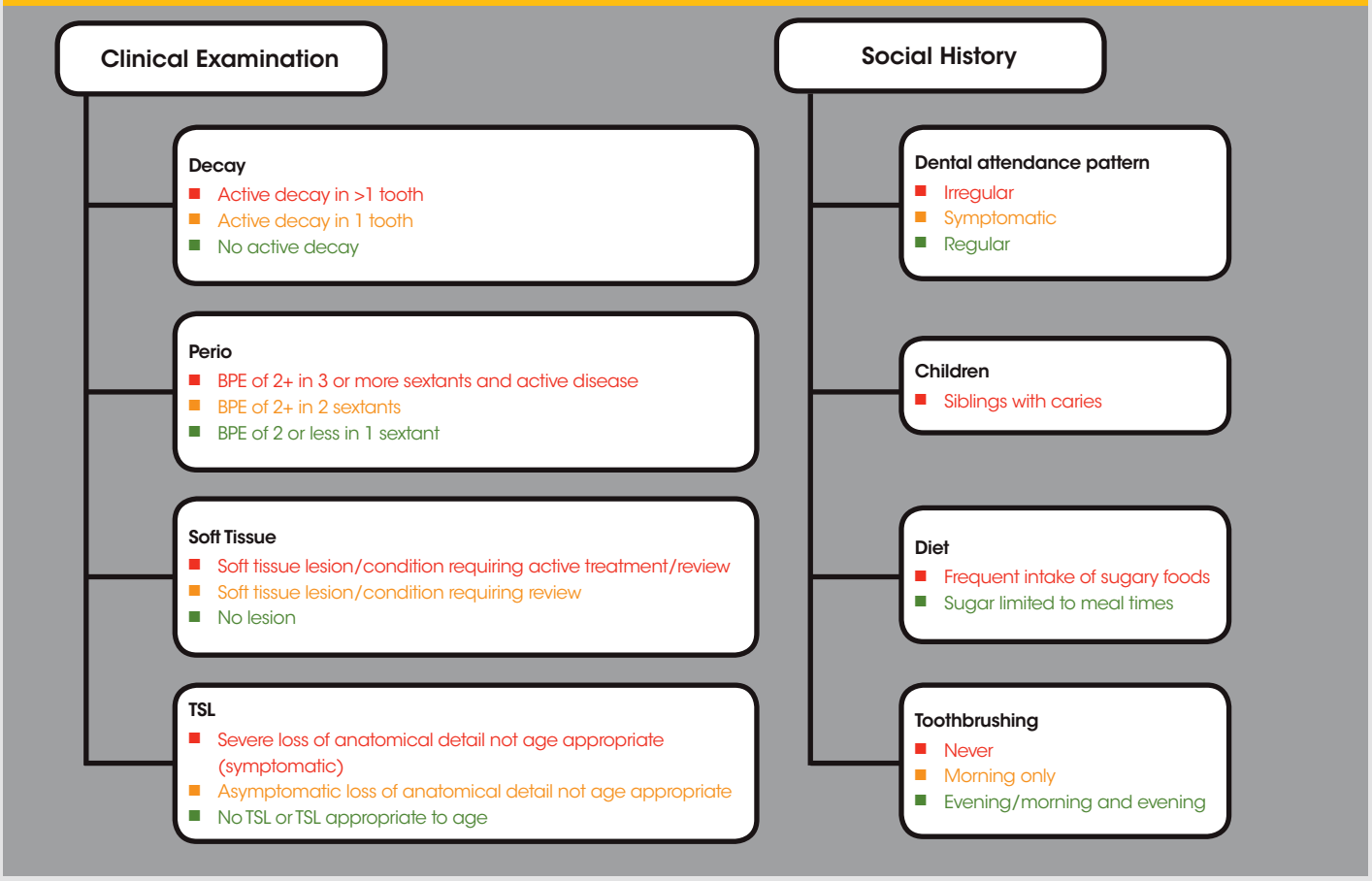
Within each pathway there are a number of evidence based interventions which need to be followed – these are largely based on the Department of Health publication *Delivering better oral health*.[5] For instance, a six-year-old in a red pathway is at high risk so should have fluoride varnish applied four times a year and fissure sealants should be applied as soon as permanent molars erupt. On the other hand, a six-year-old who is in the green care pathway should still have fluoride varnish applied twice a year.

Depending on the patient, other interventions could include smoking cessation and prescribing a high concentration fluoride toothpaste/mouthwash.

This care pathway will also help determine a suitable recall interval based on NICE guidelines.[6]

A practice will be rewarded for following the evidence based preventive advice and also for improving outcomes. Essentially, the aim is to move as many patients as possible into amber

Fig. 1 Example of clinical and selected social aspects of OHA



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and green categories and ensure they stay there. 'Points' will be gained for improving basic periodontal examination (BPE) scores and reducing the number of carious teeth.

The importance of hi-tech computer software to monitor these key performance indicators is essential if a practice is to be rewarded for providing appropriate care. The last few years have seen a large shift away from paper to fully computerised systems. In the new contract this is likely to be essential and all members of the dental team will need to have sufficient computer literacy skills to cope with this.

Another key aspect of the pilot scheme is that more complex work such as crowns and bridges should not be carried out on patients in the red risk category ie where unstable oral health and social history means this work is likely to fail long term. This is a logical approach which (with a few exceptions beyond the scope of this article) should be followed regardless of the contract in place. It is important to mention that the assigned pathway can be 'overridden' but only if there is a good reason to do so (down to clinical judgement).

The role of teamwork in the pilot contract

The practice I am working in has embraced the concept of the whole dental team working together as effectively as possible. This emphasis on prevention seen in the pilot contract allows all members of the dental team to play a key role in a patient's treatment.

This is achieved by making full use of dental care professionals' (DCPs') skills within their competencies. For example the dental therapists have a varied selection of patients referred to them by the dentists following the initial examination. The dental therapists' role includes preventive treatment, treating periodontal cases and restorative work on both adults and children. The therapists carry out a large amount of the workload leaving dentists free to carry out more complex treatments such as dentures, root canal treatments and crown and bridgework.

Additionally, extended duty dental nurses who are trained to take radiographs, provide oral hygiene instruction (OHI) and carry out fluoride application when prescribed by a dentist also have greater responsibilities in overall patient care. All team members are also trained in smoking cessation. This ensures that key messages can be reinforced, not just by the dentist but by the entire dental team.

Conclusion

The British Dental Association (BDA) has stated that they do not expect the new contract to be introduced until 2015 at the earliest.[2]

For the moment, the exact details of the new contract remain unclear. Whatever the final outcome of the new contract it appears likely that it will be very different to the current one. Rather than relying solely on the dentist to meet UDA targets, other members of the dental team will help meet KPI outcomes.

The stronger emphasis on preventive care is likely to provide more opportunities for DCPs to be involved in patient care with extended duties. In addition, the pledge to increase access and increase focus on the oral heath of schoolchildren would seem to suggest that dental therapists could become an integral part of the new contract especially as therapists would provide a cost effective means of achieving these aims, including any UDA element (if this remains in the new contract).

It is clear that a highly motivated dental team with all members working together effectively will be more important than ever.

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DENTAL CONTRACT PILOTS

There are 70 pilot sites in England: ten in London, 30 in the North, 22 in the Midlands and eight in the South of England.

The Department of Health is testing a registration and capitation model which, if implemented, would replace the UDA payment system. It is proposed that the capitation value of each patient registered multiplied by the number of patients registered with the practice would equal the future contract value (practices will not be able to increase their contract value by registering more patients). In the current pilots the notional capitation value is based on age of patient, patient gender and index of deprivation of the patient's postcode.

There has been no suggestion that the pilots will impact existing contracts. When PCTs are formally dissolved in 2013, all contracts will move to its successor body, the NHS Commissioning Board.

British Dental Association Advice Sheet