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The BDA is currently working with the Department of Health and Social Care and NHS England on dental contract reform. We want a contract that crucially puts NHS dentistry on a sustainable footing and is based on prevention. We are fighting hard to make sure that changes to general practice contracts, work for you.

1. What do you mean by new contract?

Dental contract reform is reforming the 2006 GDS contract and PDS agreement in England. It is sometimes called a new contract however we assume that those who already hold a 2006 GDS contract will retain that contract so in real terms the contract is being reformed.

New contracts are those being procured, and it is understood these will follow the new form but will be time-limited PDS agreements.

2. When is the new 'reformed' contract starting?

We do not expect a big bang start date for the new contract like in 2006. Instead as the prototypes have done, more practices will be rolled into the new contract starting in 2020 or possibly 2021 and that participation will be voluntary (but likely with NHS England Local Office agreement being required).

3. Will the new 'reformed' contract be rolled out in 2020?

If NHS England and the Department of Health and Social Care agree to reform the contract, we think there will be a voluntary roll-out from sometime in 2020 (when the current prototype regulations are due to finish). We HOPE that practices who choose to accept a contract will be able to choose the blend of contract if more than one blend is offered. Discussions are still underway on much of the detail, nothing is as yet set in stone.

How the reformed contract is currently set up

There are currently two blends of contract remuneration systems within the prototype programme,

4. What are the 2 blends?

Blend A

Payments in blend A are made up of roughly 60 per cent capitation and 40 per cent activity

Activity is paid for Band 2 and 3, and capitation payments cover all activity that would have been done under Band 1.

Blend B

Payments in Blend B are made up of roughly 85 per cent capitation and 15 per cent activity.

Activity is paid for Band 3, and capitation payments covering all activity that would have been done under Band 1 and 2.

5. Which blend is best?

The BDA believes that Blend B is the better blend for practices. It is by no means ideal and we would prefer 100 per cent capitation.

6. Can I choose which blend I want?

It has not yet been decided whether blend A or blend B or both will be available for roll-out. If there is to be a choice, we are asking for practices to have the options of choosing the blend that best suits them. Prototypes gave a preferred option, but NHS England local offices decided their blend. As independent businesses, we want you the contract holder to have a say over which blend suits you best. We will want all practices to be supplied with the relevant figures that they will need to decide whether or not to apply to take part and if so which is their preferred blend.

Capitation and treatment activity

7. What is capitation?

Capitation is a payment made for a patient still retained by the practice over the course of 3 years. If the patient is treated by another practice, then the capitation payment will cease. Capitation is rolled on every time the patient begins a new course of treatment.

8. What is 100% capitation

It is where practices have no activity targets and payment is based solely on a capitated list of patients. Payment is made to the practice on a monthly basis based on the number of patients seen within 3 years.

9. What is a capitated list?

A capitated list is a list of patients that have been seen by the practice (excluding any seen by DFTs) in the last 3 years and have not been seen at another NHS practice in England.

10. Will patients be registered with a practice?

Patients will be on a patient list if they have been seen in the practice within the last three years. We are seeking clarification from the Department of Health and Social Care about whether that means patients are officially registered with a practice or not.

11. What is a RAG rating?

R = Red

A = Amber

G = Green

The oral health assessment undertaken at the patient's first visit will risk assess the patient against a number of factors and this will help the dentist determine the patient's individual RAG status. Green patients will likely mean longer recalls and red patients will likely mean shorter recalls.

12. Why is the capitation length for patients likely to be 3 years?

NICE recall guidelines suggest some adult patients flagged green in the RAG scoring at the oral health assessment (OHA) may only need a 24-month recall. If the period of patient capitation was too short (2 years) then some patients would drop off when they may well be intending to return. If it were longer than three years, then experience has shown that many patients are unlikely to return to the practice.

13. How are capitation and activity levels set?

This is likely to be a calculation done by the NHS England local office based on your current activity. It will depend on the blend (A or B) that you receive/choose.

14. Can I make up activity if my patient numbers drop?

Not automatically, practices will not be able to make up contract performance by doing more activity if patient numbers drop without agreement by commissioners. The new system is based on a prevention model and delivering more treatment to patients does not match a prevention model. It is crucial that practices actively manage their patient lists to ensure when patients drop of the list after three years that they have recruited new patients and retained as many existing ones as possible.

15. Can I see more patients if my activity drops?

Yes. Access to healthcare is the key driver for the Department of Health and Social Care and NHS England. Commissioners will allow you to see more patients and make up for less activity. You cannot do it the other way around (See question 15).

16. What is the exchange mechanism?

This is the mechanism by which you can see more patients to make up for less activity. You can only make up for a loss in patient numbers by increasing activity with the agreement of the NHS England commissioner.

17. What is patient weighting?

Within the new remuneration system, we anticipate that patients will be given a weighting that corresponds to their age, sex and deprivation status. Deprivation is a proxy for anticipated level of treatment need. The expectation is that patients with a higher deprivation weighting will bring more money to the practice however, they may require more treatment. That should be covered by the elevated capitation payment plus the activity payments for the treatment carried out, depending on which blend you are in.

18. What is a DQOF?

The original pilots tested out a quality and outcomes framework (the DQOF) and it is anticipated that it will be used as part of the assurance framework for the contract.

Financial questions**19. Will my contract value change?**

Your contract value should not change. What you have to do to receive that contract value will differ depending on the activity or capitation targets you have.

20. Will UDA values be equalised?

We are working towards UDAs not forming part of the new 'reformed' contract. Practices will have some element of payments for activity but how that is measured is not yet agreed. The recommendation is for one national value. The GDPC is pushing for an item of service style menu for band 3 treatments but if this was agreed it would be implemented after the initial roll-out of the new arrangements. One national value will require transitional arrangements.

The GDPC existing policy is that UDAs should not be equalised in the current 2006 system.

21. What if I don't hit my target in the new system? (patient numbers and/or activity)

As with the current 2006 system, under the prototypes NHS England retain the levers within the current contract for contract holders. For example, commissioners can issue breach notices and require clawback for under-achievement of targets. After 2 consecutive breach notices for under 96 per cent of target, contracts as now can be rebased with agreement or terminated. However, under-performance is written off under 90 per cent. We do not yet know whether this 90 per cent limit will apply to rolled out contracts.

22. How are practices paid?

Practices will be paid a monthly payment by the BSA as they are now. Capitation numbers and UDA activity would be assessed at the end of the financial year.

How are associates paid?

This depends on how the practices chooses to pay their associates. The BDA recommendation would be the way to pay associates should mirror how the contract is paid. Each associate would have a discreet patient list and an appropriate activity target. They would then be paid monthly according to their personal capitation and activity targets delivered by the end of the financial year.

Contract management issues

23. Will the reformed contract be time limited?

If you hold a non-time limited GDS contract, then your contract will not be time limited. If you hold a time-limited PDS agreement there will be no change.

It is likely that in the future NHS England will not commission any non-time limited GDS contracts (contracts in perpetuity). Instead as a matter of course, all NEW contracts being procured will be PDS agreements with a time-limit.

Anyone moving from a 2006 contract to a 'new' reformed contract when roll-out happens is not taking a new contract. You are simply changing the terms and conditions of your GDS contract (in perpetuity).

24. Can I stay with the 2006 contract?

We hope that at roll-out, practices will get the choice about whether to move to the new system or stay in the 2006 contract.

25. Will I need a computer with full practice management software?

Yes, the new system has a clinical decision support system and clinical chairside IT will be needed. It will require capitation list monitoring and treatment activity management. If associates have their own practice lists, practices will need to be able to move patients between associates to cover periods of absence (parental leave or sickness) and for associates turnover.

From May 2019 all FP17/PP170 claims need to be submitted online either through practice software or via the Compass portal. It won't be practical to use the Compass portal within the new system.

Questions relating to patients

26. What about NICE dental recalls?

Following NICE dental recalls are a contractual issue. Recalls should be based upon individual patient factors and levels of risk. The dentist will decide the appropriate recall for the patient. Experience with the prototypes has shown that although recall intervals can be extended successfully it is not easy to implement quickly.

27. My patients like seeing me every 6 months why should I change?

The NICE recall guidelines should be used according to the RAG status of the patient. If practitioners are receiving a capitation payment monthly for that patient, then no matter how many times the patient visits, that sum will not increase. If a patient is worth £20 they are still only worth £20 if they come for an examination once in 24 months or 4 times in 24 months. Your appointment book however will be fully booked which cannot allow you to see more patients and increase your patient list. Remember you can increase patient numbers, not activity.

28. What will happen to patient charges?

Patient charges are the responsibility of Government. Currently they are linked to the three bands of treatment and there is no need for this to change.

29. What is the BDA doing about patient charges?

The BDA opposes patient charges. With dental contract reform we are working to ensure that the practice and the patients benefit from a new preventive system. We continue to fight the annual increases in patient charges at above inflationary levels, as these deter patients from seeking dental care.

Next steps**30. What do I need to do now/next?**

When there is a decision on the reformed contract, the BDA will notify the profession on the outcome of the discussions and the final proposals.

31. I am an associate what does it mean for me?

At the moment the BDA is working on two issues. The first is negotiating and discussing contract reform for contract holders. In addition, we are working out once we know what the contract is likely to look like, how associates will work within that new system. Making sure all dentists are removed from the UDA treadmill is our number one concern.

32. Will there be a new BDA associate contract?

Yes. We need to know exactly how the reformed contract will look so that we can ensure our model best suits practices and associates.

As with any BDA model associate contract, please get this checked by the BDA before you sign to make sure the contents are fully compatible with the BDA model contract. BDA members have full access to the contract checking service.

33. How will skill mix work?

Skill mix within a reformed contract is a business decision. Practices in the pilots and prototypes have used skill mix to varying effect. It has worked for some providers and not for others.

Glossary of terms

Bid

A bid is the offer of goods or services by a potential contract holder against the criteria set out by the tender document.

DQOF (Dental Quality and Outcomes Framework)

A framework to measure and incentivise quality improvement in specific areas.

GDS

General Dental Services contract, usually open ended without a time limit. Sometimes it is called a contract in perpetuity. A GDS contract is measured by Units of Dental Activity (UDA) and practices have an annual contract value based on activity.

Item of service

This is a list of treatments with an agreed national price.

PDS

Personal Dental Services Agreement usually is time limited. A PDS agreement does not always contain 100 per cent units of dental activity often key performance indicators (KPIs) are used to partially measure performance. Orthodontic PDS agreements contain units of orthodontic activity (UOA). PDS agreements also have an annual contract value.

Procurement

It is the process where an organisation such as the NHS puts out a tender for goods or services and potential suppliers respond with a bid describing how they will meet that tender documentation. Practice owners, partnerships or corporates bid for a contract that is offered by NHS England or Health Boards in Wales.

Rebasing

When a contract holder cannot meet their set targets over a few years, the contract is altered by the commissioner [in agreement with the practice]. The targets are lowered but the amount of the contract is also lowered. For example, if you only achieved 80 per cent over 3 years your contract target would be reduced by 20 per cent and so would the value of the contract.

Re-procurement

This is when the process has been repeated because a time limited agreement has expired or where a practice has handed back a contract to NHS England or a Welsh Health Board.

Tendering

It is the process by which NHS England is a request for someone to supply goods or services. An invitation to tender or call for competition is announced by NHS England. Bidders or suppliers are invited to put forward a bid describing how they meet the criteria set out to deliver the service on offer.