# GENERAL DENTAL SERVICES REFORM PROGRAMME

## Frequently Asked Questions (FAQs) – January 2023

Following on from the recent engagement event, and as we continue to progress with the wider GDS Reform Programme, these FAQs aim to address additional questions that have been raised over recent weeks.

### Engagement event and programme communications

**Why did the recent engagement event focus on wider reform issues and provide little information or engagement on contract reform?**

The engagement events were designed to update on issues affecting the wider profession, update on important changes within the NHS and inform of the system challenges within healthcare. Contract reform is part of the wider system reform conversations, with the profession's views having been captured in previous engagements events and reform workstreams. Discussions around the contract variation are ongoing between the BDA, LDCs, HBs and WG.

**Why isn't WG communicating and engaging with us effectively on the reform programme?**

Engagement events, workshops, FAQs, the Primary Care One website and quarterly programme updates have been used for communications and engagement on the reform programme over the last 12 months. Workstream 4, WDC, HB engagement and LDC meetings have enabled additional engagement with dental services and public-facing communication through the media has also been used to keep the public up to date on changes within dentistry in Wales.

Bangor University has also been holding interviews with stakeholders, including dental team members, which has provided an opportunity to engage and give feedback.

A form link has been included in the January 2023 programme update to ask how practices would prefer us to communicate and engage with them.

### ACORN

**Will ACORN and prevention still be retained in the new dental contract?**

Yes. The underpinning principle within the independent 2009 Steele Review was rebalancing the focus of dental care towards improving oral health via prevention, rather than just the delivery of restorative care. The clinical aspect of contract reform was a focus on an evidence-based clinical pathway, based on an oral health risk assessment. The outcome of this assessment is a guided delivery of prevention and restorative interventions, with the setting of risk-based timings for subsequent oral health reviews. The introduction of ACORN and the Principles of Care was to support that objective.

**ACORN completion – HP is referenced as seen in financial year, assume this means 'in the last 12 months' as previously confirmed?**

Yes.

**If a patient is seen in the financial year and has already had an ACORN in the preceding 12-month period, it may be envisaged that a new ACORN is not indicated for another 6 months. The patient may then, through no fault of the treating dentist, fail to return.**

**Will the dentist be credited a HP if no ACORN has been done? This would otherwise be an unnecessary repetition of paperwork, going against "Do it once, do it well".**

We can confirm that ACORN is to be carried out once a year (rolling 12 months). It is understood that not all historic patients seen in a given financial year will have ACORN done within the same financial year but providing they have had an ACORN in the last 12 months they will count as a HP if a banded course of treatment is provided.

**Is it a contract breach if practices have not filled out the ACORN?**

ACORN is a simple toolkit which supports dental teams to carry out oral health risks and needs assessment on a patient (do it well once a year). ACORN is recommended for both reform and UDA practices so that risk factors and needs of patients are well understood, discussed and prevention and dental care plans for patients reflect those risks and needs. Hence, carrying out risks and needs assessment should not be seen as a 'box ticking' or 'form filling' exercise.

## NHS Number

**How feasible is it for practices to get the NHS Number from the patient? Will comms go out to patients, to support practices in ensuring this number is available to collect?**

A significant proportion of NHS numbers can be pre-populated by the NHSBSA. When not accessible by the NHSBSA, the patient should be asked at an appointment. Patients can access their NHS number from their GP, hospital appointment letters, medical card or the patient can apply for their NHS number from https://www.nhs.uk/nhs-services/online-services/find-nhs-number/

**When will practices become aware of the 70% data capture and how will the 30% be identified and communicated to practices?**

When a FP17W is processed and scheduled, NHSBSA will look up the patient's NHS number. The NHS number will be transmitted to the contract's Dental Practice Management System (DPMS) on the 'Monthly Schedule file'.

The capture of the NHS number will be available for future submissions. The 70% data capture will not be available at go-live, however NHSBSA colleagues will communicate progress on the capture of NHS numbers in their monthly Dental Bulletins.

## Workforce

**Workforce issues are making it difficult for practices to meet the expectations set in the variation agreements. What workforce solutions are there to ensure that they will be able to meet the expectations of the new contract from April 2024?**

There are multiple factors related to the retention of staff (including pay). Skill mix, use of the whole dental team and integration of services are included in the system reform discussions.

**Skill mix seems to raise more challenges than solutions. Is there any evidence that it works?**

There is a significant body of evidence to support the use of skill-mix in dental service provision in terms of providing safe and effective care; increasing flexibility of services and patient satisfaction.[1,2,3,4] Within the NHS, diagnostic accuracy for dental caries and periodontal disease has been shown to be comparable with dental practitioners, as has oral cancer recognition.[4,5] In the most recent study undertaken in NHS dental practices, no differences were found in the oral health of patients attending clinics led by dental therapists, when compared to general dental practitioners.[6] In another recent study, when contractual conditions were conducive, skill-mix could be utilised to deliver a strong preventive model of care within the NHS using nurse-led clinics.[7]

[1] Brocklehurst P, Mertz B, Jerković-Ćosić K, Littlewood A, Tickle M. Direct access to midlevel dental providers: an evidence synthesis. J Public Health Dent 2014;74:326–35. https://doi.org/10.1111/jphd.12062

[2] Dyer TA, Brocklehurst PR, Glenny AM, Davies L, Tickle M, Issac A, Robinson PG. Dental auxiliaries for dental care traditionally provided by dentists. Cochrane Database Syst Rev 2014;8:CD010076. https://doi.org/10.1002/14651858.CD010076.pub2

[3] Barnes E, Bullock A, Chestnutt IG, Cowpe J, Moons K, Warren W. Dental therapists in general dental practice. A literature review and case-study analysis to determine what works, why, how and in what circumstances. Eur J Dent Educ 2020;24:109–20. https://doi.org/10.1111/ eje.12474

[4] Macey R, Glenny A, Walsh T, Tickle M, Worthington H, Ashley J, Brocklehurst P. The efficacy of screening for common dental diseases by hygiene-therapists: a diagnostic test accuracy study. J Dent Res 2015;94(Suppl. 3):70–8. https://doi.org/10.1177/0022034514567335

[5] Brocklehurst PR, Pemberton MN, Macey R, Cotton C, Walsh T, Lewis M. Comparative accuracy of different members of the dental team in detecting malignant and non-malignant oral lesions. Br Dent J 2015;218:525–9. https://doi.org/10.1038/sj.bdj.2015.344

[6] Brocklehurst PR, Hoare Z, Woods C, Williams L, Brand A, Shen J, et al. Dental therapists compared with general dental practitioners for undertaking check-ups in low-risk patients: pilot RCT with realist evaluation. Health Serv Deliv Res 2021;9(3).

[7] Sandom F, Hearnshaw S, Grant S, Williams L, Brocklehurst PR. The in-practice prevention programme: an example of flexible commissioning from Yorkshire and the Humber Br Dent J 2022; Apr 5:1-8.

**Will pensions and performer numbers be considered for therapists with the new contract?**

This is being included within system reform discussions, which will require further legislative changes outside of the contract reform.

**Will therapists be able to open a course of treatment in the new dental contract?**

Yes.

**Will the new dental contract tell us how to pay associates and other staff in the practice?**

No. As an independent contractor, it will be the responsibility of the NHS contract holder to attract and offer appropriate terms and conditions including payment/salary to ensure dental service delivery contractual requirements are met.

## Data

**When will HBs be able to view full year data for 2022/23, to enable financial planning?**

HBs will be able to view the full year data for 2022/23 at the end of the financial year (upon completion of June schedule month). eDEN is updated monthly. Practices have two months from the date of completion to submit their claims. As with previous years, this allows claims from a previous financial year to be submitted until the end of May and the full claims data is not available until after then for NHSBSA to collate the year end data.

**"The final, end of year, data report could change this figure but based on the current forecast, it is the best estimate to date." If changes are required will this be made against the 23/24 metrics/requirements or will HBs have to possibly repay monies to contractors?**

HBs should have the full year worth of data before making any decision on financial sanctions.

## Clusters

**What is the purpose of learning about clusters at the moment, if there is limited time and capacity to do the day job?**

Clusters are part of the Strategic Programme for Primary Care. This provides funding to HBs to invest in primary care schemes, with oversight from the Directors of Primary Care and the National Primary Care Board.

Clusters have been in existence for over a decade, with the intention of bringing together all local health and care services across a defined geographical area. Cluster working will ensure co-ordination of care that will promote wellbeing of individuals and communities. This enhanced integration will bring more services closer to home, based on population need, improving multi-professional working and giving primary and community services greater say in delivering local services. With the bidirectional interplay between oral and systemic health it is increasingly important that dental services are aligned to population need.

There are funded opportunities for individuals and practices to become involved with local cluster and collaborative initiatives.

More information can be found on the Primary Care One site:
https://primarycareone.nhs.wales/files/strategic-programme/acd-what-does-it-mean-pdf/

## UDA and contract reform

**"For every 1% increase above the HB median average for red ACORN with 4 or more interventions, the annual patient target (HP+NP) can be decreased by 2%." Does this only apply for CR practices and not UDA practices?**

While UDA practices would benefit from building their patient profile using the ACORN toolkit, mitigation applies to the reform practices only.

**For UDA practices, the expected target is 95% - do HBs apply a further 5% as part of the Regs, so target becomes 90%?**

The 5% tolerance in the regs relates to the flexibility to carryover under or over performance. So, up to 5% of the new 95% UDA target would be allowed to be carried over or if the contractor holder preferred, they could pay back.

**UDA Target - For practices with UDA contract with 5% additional tolerance, is higher UDA rate or original UDA rate used to amend contracts during this time?**

The 95% is an interim arrangement to reflect IPC changes for those staying on the 2006 UDA contract. The original UDA value including any DDRB uplifts, should be used to calculate the financial value of any underperformance.

**Option to opt in - When do practices have to confirm by? Will there be a new CVN for 23/24? HBs have still not received the revised CVN for 22/23**

This will be discussed with the Health Board teams at the regular meeting with WG. CVN for 23/24 currently being prepared by the Welsh Government legal team and will be issued to HBs by mid-March.

## Standardised forms

**Will WG issue a standardised form for HBs to capture successful case studies in their areas and share with other HBs for learning?**

A case study is a way to share what has worked in a practice and might be helpful learning for a HB's management team who can then share with other practices. Each case study is unique and is better captured as described by the practice/dental team. As such, this style of case study and information sharing does not lend itself to a template.

If HBs and practices would like to share successful case studies, please send your stories to dentalpublichealth@wales.nhs.uk and these can be shared on Primary Care One. Please do not include any confidential information.

**Will WG issue a standardised form for HBs to record practice staffing levels, to identify contracts which have obvious workforce issues? At what point do practices report their baseline - before C19 or when services resumed, compared to now? Also, do HBs consider the number the workforce has reduced by or by sessions?**

We have launched the Welsh National Workforce Reporting System (here) and all of this data will be captured through that toolkit. Communication on this has been issued to dental practices and they will be able to start adding data to the system from March.

**Will a standard collection form be shared with HBs so that we can collate and compare DNAs the same way across Wales?**

A patient's failure to attend an appointment is multi-factorial. We are communicating with the public to highlight the implications of breaking appointments. There will be no standardised form available to provide this information. However, we are exploring potential digital options to communicate with the public and patients as part of the wider system reform.

**Will WG issue a standardised form to calculate clawback? Is recovery calculation based on pre DDRB or current ACV?**

Contract management is the responsibility of the HBs. We have issued end of year guidance to support the HBs in this process.

## DNA

**How is 'Attend Anywhere' expected to help with DNA rates? Can a remote consultation attract a metric, to avoid it being additional time required alongside existing workload?**

We have early evidence from a reform practice that is using Attend Anywhere and demonstrating significant reduction in DNA rates. Using Attend Anywhere means that part of the ACORN can be pre-populated, medical history can be updated and a more accurate picture of the patient's presenting problem obtained. Access to Attend Anywhere was offered to all practices during the pandemic and remains available.

Reducing the travel time and impact of transport on the environment is all part of the wider sustainability strategy. Allocating a metric against remote consultations has been discussed within the reform programme workstreams and is being explored further within wider system reform.

**If DNA information is to be collated on an all-Wales basis, will WG provide a national template, definition of what a DNA is and guidance for every practice to collate information in the same way? NHSBSA DNA reports are not accurate. We need to ensure good record management in practice.**

We have previously issued guidance on DNA management (please see here)**.** We agree that good record management in practice is required, and the collection of the NHS number will allow patient pathways to be monitored in the future.

**DNA rates are the responsibility of the practices? They need to ensure every way possible is used to get the patient to attend the appointment and evidenced in records.**

Correct. The management of patients is the responsibility of the practice. However, all the agencies are keen to work together to reduce the number of broken appointments.

## Foundation dentists

**Does this same principle as 22/23 apply for 23/24?**

This issue is included in the guidance for 2022/23 end of year management.

**Will FDs historic patient count towards contract target? How will FD activity contribute to overall contract in practice.**

This issue is included in the guidance for 2022/23 end of year management.

## Metrics

### General

**If practices fail to meet a target, such as new patients, can this not be taken on its own merit rather than having to fail other measures to warrant HB action?**

We have issued end of year guidance to the HBs to support them with these discussions.

**Is the mitigation formula only able to be applied if a practice is reaching the HB or national average (whichever is higher) for laboratory -based work?**

We have issued end of year guidance which covers this point.

### Fluoride Varnish

**Will the child under 3 red/amber FV number be included in the global figure for children, or will it be a separate metric?**

FV target of 80% (with 5% tolerance) is for all children with ACORN risks and need as described on previous communication about metrics. (Not 80% target separately for under 3 and 3-17 yrs age groups).

**Some practices find the practicalities of achieving the metric for FV application to under 3-year-olds is very challenging in the clinical setting. Is the 0-3 FV red/amber metric being referred to for clawback this year?**

We have already factored in the tolerance for children who are uncooperative or refuse FV.

**Inconsistent wording in the document – e.g., how UDA and FV metrics are described: Target is 80% with a 5% tolerance.**

- **Is this one measure for both children and adults, or separated and achievement considered separately as per previous year?**
- **Practices should be aware that they will need robust notes/document when a child patient has not had FV applied i.e., same week in school, refusal by parent, etc.**

Separated and achievement considered separately as per previous year. ACV allocated to FV metric split 50/50.

New/Urgent patients

**Does an urgent patient have to be new to the practice or could this include historic patients?**

The patient needs to be new to the practice to count as an urgent new patient. We would expect practices to provide care to historic patients who have completed a course of treatment in the last 4 years.

**What is meant by definitive treatment? Is 'urgent' definitive treatment claimed as urgent band or a band 2 or band 3? Is it specific to the urgent issue only or a full course of treatment?**

This refers to providing appropriate treatment in order to address the specific cause of a patient's problem.

**HBs could be at risk of over commissioning. Depending on the number of practices that opt in what discretion do HBs have in terms of the urgent number?**

This is the reason why the metrics have changed for 2023/24, in response to the feedback within this first action learning year.

**There is some inconsistency in the document between 'urgent new patient' and 'new urgent patient. Where it says, 'new patient target' should it read 'new urgent patient target'?**

**What is the correct definition? 'Appointments' not 'courses of treatment'?**

An urgent patient is someone who is a non-historic patient and will be used against the urgent patient count. If they return for a full examination and course of treatment, then they will count as an additional new patient.

**Can you confirm that practices are not expected to take on a new urgent patient for ongoing care if they do not wish to do so? What happens to the new urgent patient following 'definitive' treatment?**

This is your clinical freedom, as highlighted in the answer above.

**Wording ideally should encourage practices to work with HBs as most CR practices are not able to meet urgent target on their own.**

This was within the CR guidance issued in March 2022.

**Can HBs devise their own ratio on new/urgent patients per practice, based on local knowledge?**

**Local knowledge has shown that places in some practices cannot always be filled from the waiting list, due to lack of demand for ongoing care. However, for these areas there is a significant proportion of patients just seeking emergency/urgent care. HBs should have the ability to locally "commission/amend the ask", dependent on the evidenced needs of that practice/area population.**

HBs can commission or provide dental services in different ways to meet the dental care need of local population. HBs should take account of local oral health need and understand the different types of demand for dental care and work with the practices in the area to make appropriate service provision. As such, flexible local commissioning is within the spirit of the dental reform in Wales. However, this may lead to the HB needing to manually account for activity.

**A new urgent patient will need to have an examination, but no ACORN and receive definitive treatment to count towards the new patient target (Definitive meaning up to 2 urgent apps to provide a full course of urgent treatment)? The word "exam" may lead to some confusion with practices.**

We acknowledge that the word 'examination' has caused some confusion and in this context, it refers to an assessment of the urgent presenting complaint.

Historic patients

**There seems to be a discrepancy between HP figures on eDEN compared to the figures that have been collated by dental practices. Can you please suggest possible reasons for this discrepancy?**

The only accurate figures for contract management are those produced by the NHSBSA.

If there is a difference between the data held in your Dental Practice Management System (DPMS) and eDEN, then:

- Use eDEN to download a 'patient metric data' list, this can be found on the left-side of your provider dashboard.
- Use the patient metric data list to highlight discrepancies between eDEN and your DPMS.
- While discrepancies are identified, for example due to claiming error, reconcile your claims against those in Compass. For more advice on amending your claims please consult your software guidance

Figures may appear different on eDEN for several reason, for example:

- 9179 indicators not being ticked on ACORN claims
- a claim has been submitted and amended prior to scheduling
- Errors on FP17W claim activity not appearing in totals due to rejection

After following the advice above, any remaining discrepancies should be raised to NHSBSA for support and guidance.

**What support is there for high need practices that are recalling patients every 3 months in comparison to practices with less need only having to see their patients every 12 months?**

This is the spirit of the mitigation within the end of year guidance.

End of year guidance

**What is an intervention?**

An intervention is what is recorded on the FP17W as part of the clinical dataset, e.g., 2 extractions would count as 2 interventions; 1 denture would count as 1 intervention, regardless of the number of teeth. The list of interventions is included in the 2022/23 end of year guidance document.

## Health Board responsibility/flexibility

**Do HBs have flexibility in the interim period on how they manage performance against metrics?**

Although national metrics and end of year guidance provide a once for Wales approach, HBs can use multiple local factors (including service sustainability) to ensure continued provision of dental services for their local population. Practices have been encouraged to contact their local HB contracts team throughout this interim period to discuss any specific issues.

**Will HBs have more flexibility in the new dental system compared to the UDA system?**

Yes. Innovative local commissioning or service provision taking account of dynamic local factors will be encouraged to meet the need of the local population. This will form part of the discussions around necessary legislative changes that would facilitate local innovative commissioning.

**Why can't clawback be fully ruled out in the interim period before the new contract comes into place in April 2024?**

HBs have responsibility for provision of dental care. HBs also have a financial responsibility to ensure they achieve the highest value possible from taxpayers' money that is invested into NHS dentistry. Evidence is clear that access and activities significantly drop if NHS dental contractors are paid ACV without any expectation on volume of patients or activities.

## New dental contract

**Has the new contract work started?**

Yes, this started in April 2022. The legal team is reviewing existing legislation and NHS regulations. A new contract will require a full revision of these existing documents.

**Will the new dental contract prioritise service delivery based on patient need with aim of reducing oral health inequities?**

Yes. The new dental contract will incentivise NHS dental contract holders to prioritise, see and treat patients who need dental care with the overall aim of reducing oral health inequities. This is also a legal requirement under the Wellbeing of Future Generations Act (2015) and Socioeconomic Duty (SED) Equality Act 2010.

The SED requires specified public bodies, when making strategic decisions such as 'deciding priorities and setting objectives', to consider how their decisions might help to reduce the inequalities associated with socio-economic disadvantage.

The Oral Health Response to A Healthier Wales and Senedd Health and Social Care Committee's Inquiries into Dentistry also focus on reducing oral health inequalities.

**How will quality be included in the new contract?**

- Monitoring
- Duty of candour and duty of quality
- ACORN data along with NHS numbers will help practices and HBs track outcomes of their patient population.

**Will a new contract definitely be in place for April 2024?**

Implementing a new contract is dependent on completing the negotiation phase with the professional representatives and completion of the required legislative changes. While early delivery of a new contract is desirable it is dependent on these essential stages, which introduces time constraints and may delay implementation.