Moving towards local commissioning – innovative dental contracting

1. Introduction

The new dental commissioning arrangements took effect on 1 April 2006. However, both dentists and Primary Care Trusts / Local Health Boards see 2009 as the key date from when local commissioning 'proper' takes effect.

This guidance for Local Dental Committees sets out the current reforms 'contracting', importance of the changes that we expect will take effect from 2009 and some innovative models of dental contracting. It discusses

- What 'commissioning' involves and the importance of April 2009
- The flexibility within the current contract regulations
- Some initial ideas for innovation, especially with regard to alternatives to UDAs; and
- Next steps for LDCs, with details of the support available from the BDA

2. 'Contracting' and 'commissioning'

The Chief Dental Officer for England has described the reforms to primary care dentistry as a two stage process – contracting and then commissioning.

The first stage was moving from an inflexible national system based around fee per item of service, to a system based on locally-agreed contracts between dentists and their Primary Care Trusts or Local Health Boards (herein referred to as PCOs – primary care organisations). The transitional protections in place for general dental practitioners working under the previous arrangements required PCOs to contract with them for broadly the same amount of money and level of service as was provided historically.

The second stage is *commissioning*, which refers to more than just contracting; it is the planning and design of how to deliver healthcare, following a process of identifying patient needs and available resources. Rather than being competitive, it can be done by PCOs (the commissioner) and dental contractors (the providers) working together throughout the process. Commissioning implies a greater degree of flexibility and creativity than contracting.

It is not the case that commissioning begins in April 2009; it started in 2006. But because of the income protection for existing NHS dentist, PCOs have to date had little leeway in commissioning new or different services.

3. April 2009 – why this is an important date

There is a degree of uncertainty around what will and will not change from April 2009. Two provisions that are due to end at this date are the ring-fencing of the dental budget held by PCOs and the transitional earnings protection given to dental contractors. The issue of ring-fenced funding is discussed later in this document.

The ending of the income protection for general dental practitioners (GDPs) is significant. General dental service (GDS) contracts are open-ended contracts which, subject to agreement of both parties, cannot be terminated by the PCO unless the terms of the contract are breached, the contractor ceases to meet the legislative requirements for providing dental services or the practice is sold and the contractor ceases to provide services from that address. This is in contrast to personal dental services (PDS) agreements, which are time-limited and will end on an agreed date.

However, the PCO may vary the terms of the contract without the dentist's consent where it is necessary to comply with "any direction given by the Secretary of State", such as the Statement of Financial Entitlements (SFE). The SFE is the document containing details of the pay and benefits to be paid to dental contractors and performers and contains the three year guarantee of contract values that ends in April 2009. The BDA understands from the Department of Health that there will be a revised SFE for application after 2009 (with contract values agreed before then), which will detail the process by which contractors and PCOs must follow if either party wishes to make variations to contract values. We expect many PCOs not to make changes to contract values but the opportunity may be there for them to do this if they wish.

The power of PCOs to vary contract values would, we have been told, be subject to grounds of reasonableness and to an appeal process; as yet the detail of the new SFE and of any independent appeal stage is not known and is a cause of some uncertainty. However, we expect this to permit the PCO to reduce high UDA values, based on the justification of obtaining best value for money. Money 'saved' is therefore freed-up for the PCO to allocate elsewhere. In addition, dental contractors who will not be able to operate their business at this lower UDA value may be forced out of the NHS entirely, thus allowing PCOs additional freedom to commission new services.

This factor, combined with contracts naturally ending due to a change of contractor (perhaps caused by retirement or a move to private practice), means that PCOs are increasingly obtaining the flexibility to commission dental services, rather than to merely replace an existing service like-for-like, as was the aim at April 2006.

The BDA is keen for there to be early discussion between LDCs and PCOs on the lead-up to 2009 in order to reduce uncertainty, and for the DH to publish as early as possible – and on the basis of a full public consultation – the provisions of the revised SFE.

4. Innovative contracting

The new dental commissioning arrangements were promoted by the Government as being able to give PCOs the tools to improve the oral health of their populations. In

the first year there have been few examples of PCOs adapting the new contracting arrangements to solve particular problems; they have instead largely relied on the model contract supplied by the DH.

Whilst it is certainly the case that the model contract is based on mandatory contractual terms, this section considers how much room for manoeuvre a PCO might have in the content of their contracts and suggest some ways that innovation is possible without an amendment to the GDS or PDS contract regulations.

5. What might a PCO want to do?

It is important first of all to appreciate what PCOs' pressures and priorities are when commissioning dental services:

- provision of services in a location where treatment needs are very high and attendance is not regular
- access to NHS care for patients with urgent treatment needs
- dental services for older people, who frequently have high treatment needs
- practices who are able to see a high number of new patients

LDCs will also need to consider the wider context in which PCOs operate:

- maintaining financial balance and predictable income – in the context of patient charge revenue collection, which comprises approximately 25 per cent of a PCO's dental budget
- achieving best value for money and efficiency savings from all sectors of healthcare
- other spending priorities: from 2009 the ring-fenced dental budget is due to end

This guide will go on to explain ways in which PCOs may commission dental services without using Units of Dental Activity (UDAs) either as the sole or main output measure. However, it has to be noted that, even if the Department of Health were to amend the contract regulations in this respect, PCT finance managers may still regard UDAs as the best monitoring tool for ensuring the delivery of the most cost-effective dental service.

Whilst it is important for LDCs to be minded of this, it is vital that they explain to PCO commissioners the shortfalls of UDAs in terms of meeting their oral health and prevention-oriented priorities as identified in *Choosing Better Oral Health*.

6. Legal background

Firstly, to clarify what flexibility is permitted within the current regulations:

[PLEASE NOTE: this is not a comprehensive assessment of the flexibility within the contract regulations, rather some key issues identified by the BDA. If LDCs have additional queries, please email them to ldctaskforce@bda.org so that answers can be included in revisions to this document]

Units of dental activity
The GDS/PDS regulations require that contracts must detail the number of UDAs to be provided annually, which must be calculated according to the banded course of treatment the patient has. Of course, in order for it to be a valid contract, it must have a monetary value. So whilst this often leads to the calculation of a *notional* UDA value – by dividing the contract value by the number of UDAs – the calculation of the contract value does not need to link with UDAs, or indeed to any other measure of activity.

Services to be provided
If a contractor provides mandatory (general) services under GDS or PDS contracts, the entire range of mandatory services has to be provided. Within the current regulations it is not possible to provide a 'core service' for patients.

However it is possible for PCOs to issue evidence-based clinical protocols and guidelines on the availability of NHS treatments or for clinical governance purposes. This happened in some PDS pilots prior to April 2006. For example, a PCO would be permitted to decide that bonded crowns would only be available on the NHS following approval from a Dental Reference Officer.

In contrast to GDS contracts**,** PDS agreements must state the services to be provided by the contractor. Mandatory services do not have to be provided as they do in GDS contracts, but if only a limited range of clinical care is going to be provided to patients they have to be provided as 'advanced mandatory services' i.e. provided on a referral basis only. So this type of contract does not provide a mechanism for delivery of only a core service either.

Contractors
GDS/PDS contractors can be a wide range of organisations. A group of practices could organise themselves into a corporate body or a partnership for the purposes of contracting with the PCO and operate from designated sites within one contracts. Operating as a corporate body for contractual purposes requires trust and joint working but allows contract management expenses to be shared and for negotiation as a larger group.

7. Contract monitoring – flexibility around UDAs

The method used to monitor the new NHS contract, UDAs, is perhaps the reason most commonly identified by the profession for its pessimism about the new arrangements. Research conducted by the British Dental Association in March 2007 showed that 97 per cent of dentists felt as though they worked on a 'treadmill' and that only 11 per cent though the new arrangements had improved access to NHS services. The unit of dental activity *as a rigid target* is frequently cited as the cause for these – and other – problems.

The BDA understand that many PCOs appreciate the limits of UDAs as method of monitoring performance and that they are keen to move away from reliance on UDAs.

As clarified above, whilst the contract regulations require details of the number of UDAs to be provided, *this need not necessarily link to the contract value*. For example, it may be that the PCO and dental contractor agree a system of payments which are, in effect, in addition to the notional UDA value. This may monitored by looking at some of the other priorities PCOs are required to consider, including access, especially for particular groups of patients, continuity of care and quality issues.

It may be that PCOs and dentists wish to move away from UDAs in their entirety as a measure of contractual performance. In which case a *very* low notional UDA value could be agreed – a 10 pence UDA perhaps – where instead the majority of the contract is both funded and monitored via alternative means designed to best suit local needs, such as patient numbers or time. This might include capitation payments for each patient, payments for expenses or sessional payments.

PCOs might wish to be assured that patient charge revenue will be collected or that the contractor will provide services for both charge payers and non-charge payers. However if a contractor complies with the regulations in terms of patient acceptance there should be no reason why a PCO should have to include targets relating to these aspects of performance.

At the time of writing – just over one year into the new arrangements – PCOs have yet to implement this sort of creativity. However, the BDA is aware that many PCOs are now discussing with their dentists these and other alternative ways to contract for NHS services. The BDA intends to update this advice with real case studies detailing creativity in local commissioning.

The ideal way for us all to learn which contractual models provide both the best level of care to patients and a fair deal for NHS dentists is to test different ways of working and to share that good practice over the next two years. So please contact the BDA with examples of this sort of pragmatic approach to local commissioning ldctaskforce@bda.org

8. Next steps

Next steps for LDCs

Whilst local commissioning is already underway, April 2009 is the date from when some of the transitional provisions expire. The ring fencing of the dental budget is also due to end at this time, so although PCOs must still "meet all reasonable requirement… to provide primary dental services within its area, or secure their provision within its area", there is an added degree of uncertainty for NHS dentists and their patients.

Through the BDA's revived LDC Newsletter we are stressing to LDCs the importance of engaging with their PCOs (and patient representatives) as soon as possible to together plan local services. The timescale is tighter than it may at first appear: in order to become involved in PCO's internal planning process for 2009, LDCs need to be feeding into Local Delivery Plans for 2008-9 to establish dentistry early on. LDCs need to be feeding into the draft plan, which will be discussed *from autumn 2007*.

Local Delivery Plans for 2009 must then be influenced. By being proactive now, LDCs can influence both the design and size of NHS dental services from 2009.

These are the key messages in the local commissioning process for LDCs and commissioners:

- All structures and processes need to be put in place as soon as possible to allow effective local commissioning of dental services from 2009.

- Local Oral Health Strategies must be included in PCOs' Local Delivery Plan (LDP) for 2008-2009 in order to be effective in 2009. The first draft of the LDP will be submitted in **October 2007**, and dentistry must be included at this stage.

- LDCs must apply pressure to PCOs to ensure that dentistry is adequately represented and that they are kept fully informed about the new structures and personnel that have been put in place for commissioning dental services.

- LDCs need to understand if and how Practice Based Commissioning will affect dental commissioning; the BDA will shortly be providing more information about this.

- Once the personnel and structures are in place, LDCs must ensure adequate representation and involvement in developing a local oral health strategy / dental action plan. It may be the case that a strategy is based on the best evidence already available, rather than necessarily conducting a full epidemiological study, which is both time consuming and expensive, though undoubtedly useful

- It will be crucial in monitoring service delivery outcome that PCOs undertake assessment of patients' needs and communicate with patient groups. Issues such as NHS access and travel time are important for patients.

- Effective communication between commissioners and providers will be one of the keys to providing a good service

- For dentists, it will be critical to understand how the contract will work and what services the PCT needs – and what they can supply.

Next steps for the BDA

Whilst there is a degree of flexibility within the contract regulations as they exist currently, the BDA will continue to lobby the DH for amendments to the contract regulations to remove UDAs as a required monitoring tool. Whilst UDAs may in some cases be useful as part of a basket of measures, in others they are not. This should be left to the discretion of PCOs and dental contractors.

The BDA is also increasing our support for LDCs in this commissioning process. Part of our role is to act as a conduit of information between LDCs; sharing good practice. To this end, we would like to encourage LDCs to keep us informed of their

experiences of this process – good and bad – and what further assistance you might need from us ldctaskforce@bda.org

We would also encourage LDCs to become active members of their regional liaison group of LDCs, as the BDA will increasingly use these forums as a way of advising and assisting groups of LDCs.

Advice and assistance from the BDA
The BDA publishes a great deal of advice for members and LDCs, including:

Advice sheet
E11 Introduction to GDS/PDS in England and Wales

Advice notes
46 First year reviews in GDS and PDS
75 NHS disputes procedure model paragraphs
77 NHS Contract Termination
78 NHS Model Patient Information Leaflet
50 Working with PCTs
81 Additional services (orthodontics, sedation and domiciliary services)
82 NHS Performers List – England and Wales
83 NHS mid-year reviews
84 NHS contract tendering
86 Practice visits by Dental Reference Officers
87 The first year-end in GDS/PDS (England and Wales)

These documents are available from the BDA website www.bda.org or by emailing practicesupport@bda.org

Inn addition, the BDA is developing advice for LDCs on topics including: negotiation training, working with PCTs, commissioning, oral health assessments and other related topics. We intend to deliver this via meetings of the regional groupings of LDCs: more information will be sent to you shortly.

Finally, we have recently commenced a newsletter for PCOs, in order to demonstrate constructive working relations between dentist and their commissioners (for example, in order to minimise disputes and administrative problems that arise). This will be copied to LDCs.

British Dental Association
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