End of Year review and performance management of practices participating in the GDS Reform Programme: All-Wales approach

Background:

The Units of Dental Activity (UDA) system, while simple in terms of administration, solely measured a practices performance according to the clinical activity undertaken. It is widely acknowledged that delivery against the UDA target is not an indicator of overall performance of a practice, as it does not consider the needs and risks of a defined local population or encourage a preventive approach to patient care. In addition, the current UDA system encourages NHS practices to re-circulate a high volume of low risk/need patients. This approach to healthcare delivery is unique in the NHS, where patients with the lowest need are prioritised. Contract reform aims to redress this inequality in access by re-directing care to those with the greatest clinical risk and need.

Practices that opted into a primary care contract variation in 2022/23 have been working under a non-UDA measured system, focussing on delivery of preventive dental care for an annual number of new and existing patients.

During 2022/23 several qualitative methods have been employed to gain feedback from practices, health boards and principal stakeholders. Data held by NHSBSA has been and will continue to be analysed to further develop our understanding of practice performance against the metrics. The insight from this data analyses have been invaluable in informing this guidance. We appreciate that the complete picture of delivery against 2022/23 metrics will not be available until full year data is available (summer 2023).

One of the key themes within the feedback, from both practices and health boards, has been the variation between practices regarding the need and risk profile of their specific patient population and the impact this has on the practice's capacity to deliver against the volume metrics. In simple terms practices want to be rewarded for doing the right thing and accepting patients with high treatment need. This aligns with Dental Reform principles, requiring re-orientation of primary dental care to encourage delivery of prevention based on need. This approach is more likely to achieve improved oral health for those patient populations using NHS dental services. Currently the Reform Programme, through the various workstreams, is analysing patient-level ACORN data to inform the design of the new dental contract, primarily one that will incentivise a risk- and needs-based approach. Robust clinical monitoring will be needed to ensure high quality care is provided, as the UDA activity targets will have been removed.

2022/23 and 2023/24 will be interim years leading to the introduction of a new GDS dental contract in 2024. This is the initial stage of an overarching dental system reform for Wales. This guidance outlines the first step in taking account the variation in patient need between dental practices. There will be further learning and insights available from stakeholder groups when the 2022/23 full year data is available. This will inform next year's end of year contract management guidance and the future dental contract.

For the two years before 2022-23 financial sanctions were either suspended or limited to the fluoride varnish metric. Understandably the value of sanctions was very low in

those years. This approach cannot continue indefinitely as there must be mechanisms in place to demonstrate value for money when using public funds.

Ultimately any decision on financial sanction rests with the commissioning Health Board and this guidance does not seek to remove their autonomy or their local flexibility. Before any consideration is given to financial sanctions it is imperative that the practice and health board have an open conversation to understand the reasons why the volume metrics have not been achieved; this should be the starting point before any formula for mitigation is applied. Under performance is multifactorial and cannot be understood just by looking at “the numbers”.

This guidance seeks to ensure that a practice is not disadvantaged for seeing a disproportionate or above the health board average of red ACORN patients. While the following guidance is designed to ensure that such practices are supported and not disadvantaged, there will be scenarios where a financial sanction is appropriate, when Health Boards will have to decide when to apply that course of action. This guidance cannot cover all possible scenarios.

The guidance is intended for contract variation practices only. The guidance will assume that the fluoride and recall metrics have been achieved. Failure to meet this element of the contract variation has been clearly defined when setting out the contract variation offer in March 2022.

1. Practices that have met 2022/23 metrics

It is expected that all practices have delivered personalised prevention using the ACORN and DBOH (Delivering Better Oral Health Prevention: an evidence-based toolkit) principles. As such, it is also expected that all practices will meet the delivery of fluoride varnish applications as outlined in the Welsh Government communication on 3 March 2022 setting out the arrangements for the 2022/23 contract variation offer. It is understood that there will be variation even between the practices that have met the expected metrics. These variations provide learning opportunities for Health Boards in setting up monitoring mechanisms for 2023/24 and beyond.

The ACORN profile for practices will be available in eDen and should be reviewed to determine how the volume metrics have been met. Health Boards should capture successful case studies in their areas and share with other Health Boards for learning and to inform the reform programme.

Health Board Primary Care teams should ask themselves several questions such as:

- Is a practice’s ACORN profile and treatment delivery (eg; proportion of Band 1, Band 2 and Band 3) profile similar or different to Health Board’s average?
- Are the number of FP17Ws ie; Courses of Treatment delivered on patients with one or more Red on ACORN, within the 12 month timeframe, similar to the Health Board average?

Nationally there will be important learning that will inform the new dental contract, especially further refinement, or development of key performance indicators (quality indicators and monitoring mechanisms required once a new contact is introduced).

2. Historic Patient (HP) and New Patients (NP)

The target of 1280 HP and 260 NP for 177.65K ACV are interchangeable providing the NP metric has been met. For example, if a practice has seen 270 NP and 1270 HP then the practice can be assumed to have achieved the metrics.

3. Mitigation Formula

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%.

For example: If the HB median average for Red ACORN with 4 or more interventions is 50% and a contract's mean average for Red ACORN with 4 or more interventions is 51%, the annual number of patients to be seen by the practice can be reduced by 31 patients for every 177.65k ACV (2% of 1540 total for every 177.65k ACV).

The mitigation formula should be applied first and then the 5% tolerance can be applied to this new target calculation if needed.

The mitigation formula will remove the need to factor in staffing levels directly. However, HBs should record the staffing levels to identify contracts which have obvious workforce issues. Lack of workforce will confirm why a practice has failed to meet the volume metrics confirming the need for a financial sanction for under delivery. A reduced or inappropriate workforce is not a reason for mitigation.

Additional Notes

The definition of a high needs red ACORN patient is currently assumed to be 4 interventions and above. This is calculated by adding 1 to the average of 2.8 (the average number of interventions per patient that require an intervention) and then rounding up. The final, end of year, data report could change this figure but based on the current forecast, it is the best estimate to date. Interventions for the purpose of this guidance are defined as the following items:

- endodontic_treatment_-_number_of_teeth
- permanent_fillings_&_sealant_restorations_-_number_of_teeth
- extractions_(general)_-_number_of_teeth
- crowns/onlays_provided_-_number_of_teeth
- upper_denture_(acrylic)_-_number_of_teeth
- lower_denture_(acrylic)_-_number_of_teeth
- upper_denture_(metal)_-_number_of_teeth
- lower_denture_(metal)_-_number_of_teeth
- veneers_applied_-_number_of_teeth
- bridges_fitted_-_number_of_teeth
- advanced_perio_rsd_-_number_of_sextants
- onlay_with_cusp_-_number_of_teeth
- pre_formed_crowns_-_number_of_crowns

- upper_and_or_lower_metal_denture_-_number_of_dentures
- prevention_and_stabilisation_-_number_of_teeth
- non-surgical_extraction_-_number_of_teeth
- surgical_removal_-_number_of_teeth

The NHSBSA eDen dashboard will, at year end, display the average Red ACORN high needs patient data (4 plus interventions) and the contract holder's Red ACORN high needs patient data (4 plus interventions) making it easier for contracting teams to apply mitigation if required.

In addition, mitigation will only be applied if a practice is reaching the Health Board or National average (whichever is higher) for laboratory-based work such as crowns and dentures. This figure will be made available at year end. This will prevent mitigation being applied to practices who have not provided a full range of NHS care.

Foundation Dentists Activity and Contract Year-End Management

The notional historic 1820 training UDA's is NOT to be converted into contract variation metrics and added to the main contract.

New patients seen by the FD working in a contract variation practice over the total of 69, will count towards the main contract new patient metrics. This is a threshold not a target and no sanctions are relevant if not reached.

Practices remaining on UDA's will have the notional target reduced by 5% in line with main contracts on UDA's, thus any in excess of 1729 will count towards practice main contract.