

- To: • All dental practices in England
- cc. • ICS primary care leads
• ICS chief executive designates
• Regional directors of commissioning
• Regional directors of primary care and public health

NHS England
Wellington House
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19 July 2022

Dear colleagues,

Outcome of 2022/23 Dental Contract Negotiations

This letter sets out a package of initial reforms to the NHS dental contract which seek to address the challenges associated with delivering care to higher needs patients and making it easier for patients to access NHS care.

These reforms represent the first significant change to the contract since its introduction in 2006. They follow 12 months of engagement with stakeholders and the profession, and in recent months a set of more focused conversations with the British Dental Association, after NHS England was asked by the government to lead on the next stage of dental system reform in March 2021.

Six aims were agreed with the profession as part of this process, specifically that any changes should:

1. Be designed with the support of the profession
2. Improve oral health outcomes
3. Increase incentives to undertake preventative dentistry, prioritise evidence-based care for patients with the most needs and reduce incentives to deliver care that is of low clinical value
4. Improve patient access to NHS care, with a specific focus on addressing inequalities, particularly deprivation and ethnicity
5. Demonstrate that patients are not having to pay privately for dental care that was previously commissioned NHS dental care
6. Be affordable within NHS resources made available by Government, including taking account of dental charge income.

This initial reform package comes at a time when the sector is returning to usual activity levels following the Covid-19 pandemic, which saw a significant fall in dental capacity due to both public health and infection prevention and control measures.

The important changes outlined in this letter start the process to address these challenges, but they do not end it. We will move quickly to a next phase of engagement with patient and sector representatives, starting in the summer of 2022, to build on these changes and tackle longer-standing concerns.

Proposals to take effect this year

Changes will be made across six areas over 2022/23. These are set out in more detail in the annex. We will:

- Introduce enhanced UDAs to support higher needs patients, recognising the range of different treatment options currently remunerated under Band 2
- Improve monitoring of and adherence to personalised recall intervals
- Establish a new minimum indicative UDA value
- Address misunderstandings around use of skill mix in NHS dental care, whilst removing some of the administrative barriers preventing dental care professionals from operating within their full scope of practice
- Take steps to maximise access from existing NHS resources, including through funding practices to deliver more activity in year, where affordable
- Improve information for patients by requiring more regular updating of the Directory of Services

Next steps

There are a number of important implementation steps which will follow this announcement, including variations to certain contracts, and a set of changes to guidance and the FP17 form. Both the changes to Band 2 UDA allocation and the requirement to update the Directory of Services will need to be implemented by regulation, and the intention is to work with the Department of Health and Social Care to make the necessary changes in Autumn 2022. We will in the meantime work quickly to reconvene sector representatives to agree the next phase of reform.

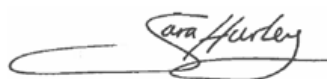
We recognise these past few years have been challenging for many practices and want to also take this opportunity to thank you and your teams for your hard work and commitment in continuing to maintain and deliver high quality care for patients.

Yours sincerely,



Ali Sparke

Director for Dentistry, Community
Pharmacy and Optometry
NHS England



Sara Hurley

Chief Dental Officer, England

Annex: dental reforms to be implemented in 2022

1. Improving care to high needs patients

Having listened to the concerns of clinicians that some aspects of care required by higher needs patients were not sufficiently remunerated, and in with our aim of prioritising care for patients with the highest needs, we will be amending the UDAs awarded to some Band 2 care:

- Where a patient requires filling or extraction of three or more teeth in a course of treatment and/or non-molar endodontic care to permanent teeth this will attract 5 UDAs.
- Similarly, a course of treatment requiring the provision of molar endodontic care to permanent teeth will attract 7 UDAs, recognising that this care can be more time consuming.

All other Band 2 care will continue to attract 3 UDAs.

This change will not affect any individual contractor's agreed UDA target. We will amend the current FP17 to support collection of the clinical information necessary to make these calculations.

2. Introduction of a minimum indicative UDA value

We recognise some of the concerns shared during our engagement that recruitment and effective delivery of care in some parts of the country is constrained by very low indicative UDA values, impacting on patient access. To address this, we will introduce a minimum indicative UDA value of £23 from 1st October 2022. This will be delivered through a reduction to the agreed UDA targets of impacted practices and an associated contract variation. We will monitor the effect of this change over time at affected practices, to gather data to inform any further future action in this area.

3. Personalisation of recall intervals

To support the important focus on care for those with higher needs, we need to maximise the impact of all NHS dental care currently delivered, by focusing on interactions which have the highest clinical value. Adherence to 'NICE Guidance CG19 on Dental Checks: intervals between oral health reviews' is already a contractual requirement, however there is evidence to suggest that a default recall interval of 6 months is recommended to many patients with low oral health risk, despite the limited evidence base for this in terms of improvements in oral health outcomes. Patients accessing NHS dental care should be advised of their personalised recall interval based upon an assessment of their oral health risk. For some people, this might mean that a recall interval of less than 6 months may be advised. However, for those with good oral health we expect to see recall intervals more usually to be 12 months, or even 24 months.

We recognise that, to be effective, this will require a culture change for some clinicians and also patients, since we recognise that some patients with good oral health may press clinicians for 6-monthly check-ups. To support this change, we will produce patient facing materials for practices to have these conversations and are working with the Personalised Care Institute to develop some material on shared decision making in dentistry to be launched later this financial year.

Our approach was informed by the engagement we undertook. Rather than focusing on collecting detailed risk factor information, we will be leaving this to clinical practices, and instead will be collecting minimum data, focused on oral health need as collected at the check-up. We will amend the FP17 to collect data on the number of untreated decayed teeth, the highest sextant BPE score and the length of the recommended recall period. These data will be shared back with practices to support benchmarking, personal reflection and peer review. It will also be used to review and monitor changes in recall practices.

4. Promoting the more effective use of skill mix

Our engagement revealed that there are some common misunderstandings regarding skill mix in dental practices. We will be taking steps to address some of these misconceptions. Specifically, we will issue guidance which clarifies how skill mix and Direct Access in NHS practice can be used whilst working within the framework of existing regulations.

We will also remove the administrative barriers through amending the FP17 and other IT systems from 1 October 2022 which have prevented dental therapists, and others, operating within their scope of practice and competence from opening courses of treatment.

We will work with the GDC and other stakeholders to promote good practice in the use of skill mix and to address any concerns and questions contract holders may have.

5. Making better use of resources

Where not all contracted activity is delivered this represents a loss of patient access to the NHS. Current rules prevent commissioners in most circumstances being able to release funding quickly from contracts where not all activity will be delivered, and so have limited ability to reinvest this money in year in practices which are able to deliver more. As set out in the six aims of reform, it is critical over time to ensure we are maximising patient access from the funding we have available, and in particular from the small proportion of contracts where there is persistent under-delivery.

Our initial step to address this will be to encourage commissioners and contractors to work collaboratively, particularly for contracts where 30% of activity has not been delivered in the first half of the year, to consider reducing the annual activity requirement

by 10%, on a voluntary basis only, allowing the opportunity for other practices to use these resources to treat more patients.

We have agreed that where a dental contractor has delivered less than 96% of their contracted activity for three consecutive years, and no voluntary plan or reduction can be agreed, commissioners will be able to unilaterally reduce the size of a contract to the highest level of delivery in the preceding 3 years. The initial three-year period will include 2019/20, the last year prior to the pandemic, 2022/23, and 2023/24. It will then roll forward on an annual basis always excluding the pandemic period of 2020/21 and 2021/22, recognising that this period was exceptional.

6. Supporting practices to deliver more NHS care

Following the steps outlined above will enable commissioners to increase access for patients using all available resources, maximising the care that can be delivered and allowing greater opportunities for those practices who can deliver more to do so. To support and increase the level of reinvestment, we will amend the contract to allow contractors to deliver up to 110% of their actual contract value on a non-recurrent basis, subject to the agreement of their commissioner and where resources are available locally. This additional activity will be funded at the existing indicative UDA value. We will seek to start making these opportunities available to providers this year, backed up by changes to the SFE.

7. Improving information for patients

The current NHS Directory of Services is frequently out of date which makes it difficult for patients to find an NHS dentist. To address this, we will require practices to update their details on a quarterly basis as a matter of routine and to make an ad hoc and unexpected changes to opening times as and when these occur. This will have the effect of making it easier for patients to find a practice and for the system to support patients to access care.