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Dental Contract Management Handbook

**Author**  
DH

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**Target Audience**  
PCT CEs, SHA CEs, Foundation Trust CEs, PCT Chairs, Directors of Finance

**Circulation list**  
Directors of HR

**Description**  
This dental contract management handbook has been produced for use by PCT teams involved in management of primary care dental contracts to support them to manage effectively and confidently their dental contracts. The approach taken assumes that contract management activity will be carried out by a multi-disciplinary team that contains the range of skills and understanding that are essential to the effective management of dental contracts.

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**Superseded Docs**  
n/a

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**For recipient’s use**
Good oral health is important to everyone.

For many people, the achievement of good oral health involves the ability to access high quality NHS dental services at a reasonable cost.

Access is improving and a recent Which? survey showed that 88% of people who tried to access an NHS dentist were successful.

However, in some parts of the country, more work needs to be done before the public feel they have good access.

Since March 2009, the Dental Access Programme has been working with the NHS and dentists to improve access.

Its work covers four areas:

• developing an improved national measure so we can effectively measure the patient’s experience of access
• working with the NHS to increase the amount of high-quality NHS dental services for patients
• supporting the NHS to effectively manage local contracts to ensure quality, performance and value for money
• ensuring information is available to patients so they are aware of the availability of NHS dental services and their entitlement to them.

This handbook supports the third of these goals. It brings together the latest evidence and best practice with emphasis on providing practical support.

We hope you will find this handbook helpful in your work to continue to improve access to NHS dental services for patients.

Dr Mike Warburton
National Director for Dental and GP Access
Department of Health

David Lye
Head of Dentistry and Eye Care Services
Department of Health
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The NHS Operating Framework identifies increasing access to NHS dentistry as a key priority for PCTs and this is reflected in the handbook to the NHS Constitution. While access continues to improve, there is still too much variation in the availability of services, the value for money they provide and the oral health outcomes they deliver.

Better contract management is a key lever for change. Well managed contracts deliver value for money and the potential to treat the greatest number of people. Poorly managed contracts will mean that money that could be spent providing more effective treatment or treating more patients may be wasted.

Today, over 90% of funding of NHS dentistry is committed in existing contracts. In 2008/09, 41% failed to deliver their contracted activity. Improved performance in this area alone could mean access to an NHS dentist for a further one million people.

Contract management will need to be focused on quality as well as productivity. The NHS spends around £2billion a year on dentistry. In some regions, extractions under general anaesthetic remain the single biggest reason for hospital admissions of children. Dental decay and periodontal disease are largely preventable, but remain a significant public health issue. There is a clear correlation between poor oral health and other factors, including material deprivation and learning disability.

A ‘getting the UDAs’ approach to performance management will not on its own deliver better access, value for money or quality. PCTs need to be clear what these payments are funding. Without robust needs assessment and clear understanding of gaps in performance, they will be unable to determine whether dentists are addressing access and health inequalities issues or simply increasing treatments for existing patients.

Well performing PCTs manage dental contracts against the standards set by world class commissioning – particularly in the areas of market management, procurement, clinical leadership and engagement with patients.

Cooperation between the PCT dental and finance teams is essential to monitor spending against dental budgets; to manage under-delivery, appropriate treatment patterns, recall and treatment intervals; and to ensure compliance with the PCT’s standing financial instructions, financial policies and procedures.

Successful contract management must be done with providers. This handbook recognises that the management of the contract sets the tone for the wider relationship and encourages PCTs to work with providers to set expectations and manage issues.

The handbook supports PCTs in identifying the range and mix of skills they need and in developing appropriate management frameworks. It provides a complete set of references and knowledge map to the relevant legislation and guidance. It also provides practical tools to improve contract management processes.

The need to deliver universal access to dentistry remains as pressing as ever. The economic climate and the public health agenda require that access is also synonymous with productivity and quality. Contract management is key to these aims. The handbook helps PCTs to assess their capabilities as contract managers, to identify weaknesses in their current positions and take clear, practical steps to address them.
World-class commissioning sets an important context for increasing access to quality NHS dental services that are good value for money. PCTs, as local leaders of the NHS are required to deliver ‘world-class outcomes’ for their local populations. PCTs are expected to demonstrate a number of key competencies including strong vision and strategy, sound partnerships, robust health intelligence, and effective systems of performance management and governance.

“The operating framework for 2010/11 makes it clear that the NHS is committed to the aim of ensuring that by March 2011 everyone seeking NHS dental services has access to them.”

The world-class commissioning guide to NHS dentistry makes it clear that the key challenges facing PCTs are to improve access, quality and oral health for local people. This supports PCTs’ duty to ensure that the services they commission for local people are of high quality and that they receive care appropriate to their needs.

The Operating Framework for the NHS in England sets out the terms of engagement and direction for the NHS. Applied to dentistry, these goals demand increased access to high quality NHS dental services that represent good value for money for taxpayers. PCTs are now also facing the quality and productivity challenge, which exhorts PCTs to raise the performance bar higher still across the range of services they deliver.

Well-performing PCTs are characterised by demonstrable clinical and executive leadership. Specialist clinical leadership is offered by consultants in dental public health who are responsible for ensuring that PCTs have plans in place to meet their populations’ needs. Dental practice advisers who can give recommendations to PCT commissioning and contracting managers about clinical issues also have important roles to play.

Recent surveys by Which? (2009) and Citizens Advice (2008) confirm that the public remains concerned about the availability of NHS dental services and provide a reminder that while access itself may be improving, public perception must also change.

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1 The Handbook to the NHS Constitution for England, Department of Health, January 2009
2 World-Class Commissioning, adding life to years and years to life, Department of Health 2007
4 Further details of these surveys are available at: http://www.pcc.nhs.uk/dentalaccess-news/3076
The Which? report maintained that three million people in England tried but were unable to get an NHS appointment in the last two years. It also claimed that a further 4.5 million people have stopped trying to find an NHS dentist, having had problems in the past.

The Citizens Advice survey focused on the effectiveness of PCT dental helplines and found a correlation between poor helpline services and difficulty of getting appointments.

Locally conducted surveys also point to the importance of improving current dentistry access levels from the perspective of patients and public. A survey conducted in 2008 by Ipsos MORI called Understanding Public Perceptions of Information and Access to NHS Dentistry in the West Midlands revealed a wide range of misunderstandings and misperceptions around the ease, or otherwise, of finding out where NHS dentists were located and being able to make an appointment. Confusion around treatment pricing structures was also apparent, pointing to a need for more and clearer communication around patient charges.

**Importance of dental health**

Oral health is central to healthy living and a key marker of the health of a community. Whilst oral health in England is steadily improving, people living in areas of material deprivation or people who are vulnerable or at risk for a variety of reasons, such as having special needs, have poorer oral health and reduced access to appropriate dental services. Dental decay remains a significant public health issue; it is the commonest disease of childhood. Periodontal disease is a common condition in adulthood and the most frequent reason for tooth loss. The NHS spends over £2 billion annually treating both diseases which are, on the whole, preventable.

Understanding the oral health needs of a given population and developing an oral health strategy are central to becoming a world-class commissioner of dental services. It is important that PCT primary care commissioners and performance/contract management teams are aware of the wider picture – this is the role of the consultant in dental public health. The PCT needs to understand demand, identified needs and gaps in service provision in order to confidently challenge underperformance and set their contribution to better access and quality of services in context. A performance management approach based solely on Units of Dental Activity (UDAs), will not necessarily deliver increased access, value or quality but may simply encourage dentists to increase levels of treatment on existing patients. The reality is new patients are not all high needs and a PCT performance management team can make a sensible assessment of likely need given where the practice is, the number and proportion of new patients being taken on and the total number of patients for a given contract value. Performance management is not possible without information management – the effective triangulation of data and analysis of the clinical data set.

Good quality NHS dental services offer:

- evidence-led preventive care and interventions, as defined by Delivering Better Oral Health;
- appropriate recall intervals for patients;
- value for money.

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5 World Class Commissioning: Improving dental access, quality and oral health, DH Jan 2009
Good providers understand that effective use of resources is more than a matter of getting those with high standards of oral health to see a dentist every six months. It is also about creating opportunities for access to care for those with an identified or urgent need. If this can be achieved by some PCTs it can be achieved in all.

A more effective use of resources will ensure alignment with the oral health needs of the population resulting in:

• greater access
• improved service delivery
• improved oral health outcomes.

The access programme and contract management

In recognition of the need to improve access to dental services across the country the Department of Health has developed the Dental Access Programme. The programme has four work streams:

• developing a new indicator for dental access. Following feasibility testing the Department announced in the NHS Operating Framework 2010/11 that it will introduce a new indicator of public experience of accessing dental services. This will be used as a formal measurement of delivery of access for all who want it from 1 April 2011. To aid with delivery planning, PCTs will have initial results of performance against the new measure available in summer 2010. PCTs will continue to be measured on progress against plan on the 24-month ‘patients seen’ data

• supporting additional procurement of dental services which will enable the NHS to increase the capacity of good quality NHS dental services to meet local demand via open and transparent procurements by developing an access template agreement supported by regular regional workshops

• supporting effective and focused contract management by PCTs to ensure that dental contracts deliver high quality services and accessible services by providing clear guidance on contractual issues and effective use of data through E Reporting

• communications and stakeholder engagement to support local and regional initiatives to raise patient awareness of the availability of good quality, local NHS dental services and their entitlement to access them.

This handbook focuses on contract management.
Who is the handbook for?

This handbook is to support PCT teams effectively and confidently to manage their dental contracts. The approach taken assumes that contract management activity will be carried out by a multidisciplinary team that contains the range of skills and understanding that are essential to the effective management of dental contracts, including:

- clinical and executive leadership
- commissioning
- contracting
- financial management skills
- an understanding of E Reporting and payments on line
- clinical input
- an understanding of the legislative and regulatory framework within which contracts should be managed.

PCTs are urged to read the handbook in conjunction with the guide, Primary and Community Care Services: Improving Dental Access, Quality and Oral Health, which sets the management of dental contracts within the context of the wider commissioning cycle. The handbook also assumes that staff new to NHS dentistry will have taken advantage of other resources for acquiring basic knowledge, such as the Building Foundations series of events delivered by NHS PCC.

NHS PCC has also published recently a salaried primary dental care services toolkit which PCTs may want to use in conjunction with this handbook to support them to look at the full range of primary dental services they commission.

How to use the handbook

The main aim of this handbook is to provide a resource for PCTs on key aspects of contract management. It covers the issues regularly raised by PCTs and reflects their feedback on areas where additional support would be useful. All of the recommendations are in line with the objectives of the Dental Access Programme and the need to ensure that the services PCTs commission provide value for money for taxpayers. Additionally, they reflect world-class competencies and the recommendations of the Steele review.

PCTs may wish to use the handbook as the basis for reviews of local contract management policies and to involve stakeholders including patient groups, local dental committees and clinicians in the review process.
What’s in the handbook

The following topic areas are covered:

Building relationships with providers
Improving clinical leadership needs to be seen as intrinsic to contract management. This section focuses on helping PCTs to develop clinical engagement and leadership. It recognises that constructive relationships between commissioners and providers are vital in meeting people’s oral health wants and needs.

As important as it is for PCTs to tackle underperformance by providers, it is vital that they recognise, acknowledge and share good practice.

Key contract management priorities
This section focuses on:

• reducing contract underdelivery
• managing for appropriate treatment patterns.

Many PCTs will already have made good progress in tackling contract underdelivery, so part of this section of the handbook may cover familiar ground. Managing for appropriate recall and treatment intervals, however, is likely to be a new area for most. It is important that work on this goes hand-in-hand with work on minimising under-delivery – otherwise PCTs may find that as inappropriate attendances reduce, the level of under-delivery rises.

Finance
It is important that dental teams have a clear understanding of the main functions that are undertaken routinely by the finance team.

This section covers:

• systems to monitor the dental budget against committed resources
• internal working relationships to ensure that finance and dental teams have a joint approach for monitoring and assessing dental spend
• ensuring compliance with the PCT’s Standing Financial Instructions, financial policies and procedures.
• management and monitoring of patient charge revenue.

Dental functions of PCTs
This section describes the functions that should be out carried by PCTs to manage their contracts effectively, with examples from high-performing PCTs.
Building relationships with providers
The starting point of effective contract management is the building of productive relationships with providers. A positive dialogue between the PCT and its providers is vital in helping PCTs understand their practices’ performance in context and a crucial step in becoming a world-class commissioner.

PCTs should consider mechanisms to create a supportive and developmental environment for clinicians, whereby clinical issues can be discussed openly and solutions developed. (‘Clinicians’ in this context means contractors and associates, PCT dental advisers, dental nurses, hygienists and dental public health consultants.) Clinical support mechanisms might be developed within a single PCT or across several PCTs, and might include:

- peer support for the PCT’s dental adviser
- links with dental clinical tutors regarding training issues
- protected learning time to discuss issues and resolve problems
- clinical audit and peer review
- aid for single-handed practitioners where appropriate.
Building relationships with providers

03.01

OBJECTIVES

• Constructive, positive relationships with dental providers
• Ensure providers understand PCT dental policies/objectives/performance expectations
• Ensure PCT understands the issues, constraints faced by and aspirations of providers

OUTCOMES

Maximise access to and quality of services through clinical engagement.

KEY TASKS TO COMPLETE | WHEN
--- | ---
Recognition for high-performing practices | On a regular basis
Support local clinical networks (eg dental nurse forum) and clinical/practice development (eg DwSIs, business skills) | On a regular basis
Development programme to support local clinicians develop as clinical leaders/champions | Ongoing
Coordinated annual visit programme covering all providers: • to review previous year’s performance and current in-year performance (possibly linked to practice self-assessment toolkit) • dental practice adviser (clinical issues) • dental reference service | July – October
Active participation in local oral health advisory group (or equivalent) meetings | Quarterly
Specialist advice from a consultant in dental public health | As appropriate
Liaison meetings with local dental committee | Quarterly
Ensure clinical input into PEC and PCT commissioning/clinical governance forums | Ongoing
Local providers have named PCT contact for any issues/problems and respond in a timely manner | Ongoing
Regular PCT newsletter to all providers | Quarterly
Information for potential providers (as part of PCT market management strategy) | As appropriate
RESOURCES
Regulatory and legislative documents
GDS contract regulations
PDS contract regulations

Briefing material
- Practice visit checklist
- Practice self-assessment toolkit
  - Template letter to practices
  - Self-assessment proforma (GDS practices)
  - Self-assessment proforma (PDS practices)

Other supporting material
- WCC competencies for dentistry – see competency 4
- Factsheet 16 – Local Dental Committees and model framework constitution for LDCs
- Guidelines for the appointment of Dentists with Special Interests (DwSIs)
- Appointment and induction of dental adviser (good practice example from Hampshire and IOW PCT – see Appendix A)
- Model job description and person specification for a dental practice adviser (Appendix B)
- Model job description and person specification for a consultant in dental public health (Appendix C)

This theme links particularly to world class commissioning competencies: 4 (collaborating with clinicians) – and 7 (effectively stimulating the market to meet demand and secure required clinical, and health and well-being outcomes).

A constructive relationship between commissioner and providers is vital. To quote a PCT dental practice adviser: “If the only time you meet a practice is at contract performance reviews when you tell them off, your relationship is likely to be a negative one.” A suggested approach is to use a collaborative, cyclical process (see diagram next page), aimed at ensuring that:

- providers understand what the PCT wants, and what this means for them and their practices
- the PCT understands the issues, constraints faced by and aspirations of its current providers
This approach is multi-faceted and ongoing. It will take time to build up trust and credibility. Engagement is likely to be needed on multiple issues with different groups and/or at different levels, at different times. Dental providers are likely to want to know:

• **What does the PCT expect of me/my practice?**
• **How will I be monitored/measured?**
• **What happens if things go wrong?**
• **What support can the PCT offer me and my practice so that we can improve?** (For example, premises and equipment, infrastructure and access to staff training.)
• **What business opportunities are there likely to be?**

Practices need to understand what the PCT’s commissioning plans and market management strategy actually mean for them. Management does not just relate to current providers – PCTs will also need to consider how they wish to see their local dentistry market develop over time to meet the aims and objectives of their oral health strategy. This might, for example, encompass holding ‘market days’ to inform potential providers about the PCT’s commissioning plans, or using different procurement techniques such as competitive dialogue to develop innovative solutions to particular issues.
This diagram illustrates a framework for engaging dental health care professionals in a PCT’s service development and quality agendas. Such engagement is needed on multiple issues and at different levels, and may also link to neighbouring PCTs – for example, uni-disciplinary groups, consultant in dental public health networks and dental practice adviser forum.
Building relationships with providers

Adopt an engaging style
- involve dentists from the outset
- work with the leaders/early adopters
- communicate often, candidly
- avoid channelling everything through principals – don’t forget associates
- clinical advocates are important!
- value clinicians’ time with your time.

Find common ground
- improve patient outcomes
- reduce hassle and wasted time
- understand opportunities and barriers.

Prioritise for results
- use the 20/80 rule.

Show commitment – at the top
- get PEC/board sign-off.

Approach
- use data sensibly – to generate light, not heat
- make the right thing easy to try
- make the right thing easy to do
- resource the carrot as much as the stick
- choose messages and messengers carefully
- get good, impartial clinical advice.

Promote system and individual responsibility for quantity

PCTs may wish to use the framework illustrated in the diagram above in conjunction with the list of key tasks on page 03.01 – the framework describes the ‘how’ while the list of key tasks describes the ‘what’.
Understanding the vocational training timetable

The vocational training cycle spans 21 months, from November through to end July – see timeline diagram below. Understanding the key dates in this timetable can give PCTs the opportunity to influence training issues, as well as local recruitment/retention.

Vocational Training Timeline

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov</td>
<td>Dec</td>
</tr>
<tr>
<td>Recruitment of training practices</td>
<td>Practice visit</td>
</tr>
<tr>
<td>Marketing to potential VTs</td>
<td>Roadshows – VTs decide which practice to apply to</td>
</tr>
<tr>
<td>Dental graduates qualify</td>
<td>Application to relevant PCT performer list</td>
</tr>
<tr>
<td>VT starts work at practice</td>
<td></td>
</tr>
<tr>
<td>VT seeks permanent job</td>
<td></td>
</tr>
</tbody>
</table>

PCTs may wish to invest in practice infrastructure to help them achieve training status.

It is important that pre-employment checks are completed in time to enable VTs to start work in August.

At this point, if they wish to employ a VT, practices need to know whether the PCT is able to offer additional funding.
Key contract management priorities
There are many issues that dental commissioners will regularly focus on. Nationally there are two areas that stand out as potential priorities to ensure optimal access for all patients:

- reducing contract underdelivery
- managing for appropriate recall and treatment patterns:
  - Band 1 to Band 1 within 0-2 months, 3-5 and 6-8 months
  - Band 2 to Band 2 within 0-2 months
  - Band 3 to Band 3 within 0-2 months

Many PCTs will already have made good progress in tackling contract underdelivery, so much of this part of the handbook covers familiar ground. Tackling recall and treatment patterns, however, is likely to be a new area for most. It is important that this goes hand-in-hand with work on minimising underdelivery – otherwise PCTs may find that as the number of inappropriate recall/treatments reduce, the level of underdelivery rises. It is therefore suggested that PCTs develop and agree a local policy managing these two key areas with a view to maximising access. The starting point will be to understand what is happening in each practice.
Underdelivery

OBJECTIVES
- Reduce underdelivery of contracted UDAs to within 4%
- Ensure UDAs are delivered evenly throughout the year
- Ensure underdelivery is managed appropriately

OUTCOMES
Maximised access to services through local delivery of contracts in line with contracted activity

KEY TASKS TO COMPLETE | WHEN
--- | ---
PCT performance management framework signed off by PCT board | Review annually
Visit programme to review previous year’s performance and current in-year performance | July – October
Use quarterly NHS Dental Services reports to identify UDA activity, exceptions, access, quality indicators | Quarterly
Identify exceptions and manage within your performance framework | Monthly
Ensure POL is up to date (new and existing contracts) | Monthly
Use NHS Dental Services monthly data to identify trends as an early warning system | Monthly
Manage mid-year reviews | Mid-October
Negotiate contract changes, eg rebasing of contracts | As appropriate
Send letter to practices reminding them to make their end-of-year submission (alerting them to potential over/underdelivery where necessary) | January
Manage end-of-year reviews | July onwards
Recovery of money within appropriate timescale via NHS Dental Services | As appropriate
Balanced scorecard information relating to each provider collected and shared with contractors | Ongoing
RESOURCES

Regulatory and legislative documents
GDS and PDS contract regulations

Guidance
- Recovering payments – now refreshed

Contract data
- E Reporting
- POL user guides

Briefing material

Other supporting material
- Balanced scorecard
- World-class commissioning competencies for dentistry

Templates
- Template letter to practices re: end-of-year submissions (Appendix D)
- Template letter to practices re: end-of-year submissions and warning of potential over/underdelivery (Appendix D)
- Dental practice contract management checklist (Appendix E)
- Template contract variation notices – increased capacity and decreased capacity

Underdelivery
This theme links to commissioning competency 10 (effectively managing systems and working in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes), as well as to competency 4 (collaborating with clinicians).

Why it is important to tackle underdelivery
In 2008/09, over 40% of providers delivered less than 96% of their contracted activity, and many PCTs either wrote off underperformance or did not recover monies they were entitled to under the Dental Regulations. Put another way, if all of these underperforming contracts had been re-based, and the funding transferred to other providers, this could have provided dental services for up to an extra 1.2 million people.

The last two years (2007/08 and 2008/09) have seen considerable growth in PCT dental budgets; however, given the current economic downturn, it is ever more important that PCTs tackle underperformance robustly if they are to meet the dental access commitment as set out in the 08/09 Operating Framework by March 2011.

Providers need to understand what the PCT expects of them in performance terms, and what the consequences of underdelivery might be. Equally, the PCT must have regard to the problems or constraints faced by providers that impact adversely on performance.
What the regulations say

The GDS and PDS regulations require that the level of activity to be delivered must be specified in a contract/agreement. Underdelivery of activity greater than 4% is defined as a breach of contract. The regulations also distinguish between breaches that can be remedied and those which cannot. Underperformance is an example of a contract breach that can be remedied. PCTs should note that the Regulations require that, where there has been a contract breach and the situation may be remedied, that the PCT must issue a Remedial Notice before taking any action it is entitled to under the contract to remedy the breach. See PCC Briefing Note on Handling Contract Breaches at http://www.pcc.nhs.uk/uploads/Dentistry/july_07/handling_contract_breaches.pdf

Approach

To tackle underdelivery successfully, PCTs should consider the following approach:

• utilise fully the E Reporting system so that they have all the necessary information relating to their contracts to enable them to prioritise their efforts appropriately

• have a clear performance management framework, signed off by the PCT board as suggested in Section 7 of the world-class commissioning guide to NHS dentistry. This should describe the regulatory context as well as PCT expectations and set out the processes for dealing with contract failures (including underperformance in successive years), any disputes arising and the types of mitigating circumstances that the PCT will consider. The framework should also make clear how the PCT will deal with overperformance. This framework will be underpinned by a robust, cyclical process of contract management.

Using the E Reporting system to identify and manage underdelivery

Below is a screen shot from the quarterly exception reports that are sent to PCTs. The exceptions to look for are ‘Low activity’ and ‘No activity’.

<table>
<thead>
<tr>
<th>Contract Number</th>
<th>Name or Company Name</th>
<th>Reason for Exception</th>
<th>Total FP17s</th>
<th>Late FP17s</th>
<th>Contracted UDA</th>
<th>Processed UDA</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>Late reporting</td>
<td>546.00</td>
<td>47.00</td>
<td>546.00</td>
<td>8.61</td>
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<tr>
<td>2</td>
<td>A</td>
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<td>16,497.00</td>
<td>3,553.75</td>
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<td>3</td>
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<td>5</td>
<td>D</td>
<td>Low activity</td>
<td>2,640.00</td>
<td>270.80</td>
<td>2,640.00</td>
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</tr>
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<td>6</td>
<td>E</td>
<td>Adult patient mix</td>
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<td>0.00</td>
<td>8.00</td>
<td>0.00</td>
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<td>7</td>
<td>F</td>
<td>Over delivery</td>
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<td>G</td>
<td>Low activity</td>
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</tbody>
</table>
PCTs may also find it useful to look at the Vital Signs report (PDF version) – see below. This gives a warning message (at the bottom of the activity table) if the percentage of processed general activity is lower than expected based on historic information about contracts that have delivered the 96-104% of their contracted general activity over a full financial year. (Please note that the orthodontic versions do not currently use this warning message.)

The dashboard available on E Reporting (see opposite) also highlights risk of underdelivery.
PCTs may wish to take a different approach to consistently and occasionally underperforming contracts. To differentiate between the two, the report ‘Contracts under performing in 2007-08 and 2008-09’ (see below) may be useful. It provides a list of contracts within a PCT that underperformed according to the end-of-year figures for these two consecutive years.

<table>
<thead>
<tr>
<th>Contract Number</th>
<th>Provider name or company name</th>
<th>2008 contracted UDA</th>
<th>2008 achieved UDA</th>
<th>2008% achieved</th>
<th>2008 contract value (£)</th>
<th>2009 contracted UDA</th>
<th>2009 achieved UDA</th>
<th>2009% achieved</th>
<th>2009 contract value (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A</td>
<td>9,641</td>
<td>6,588</td>
<td>68.3</td>
<td>162,069</td>
<td>9,641</td>
<td>5,676.00</td>
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<tr>
<td>2 B</td>
<td>2,051</td>
<td>1,952</td>
<td>95.2</td>
<td>39,142</td>
<td>2,051</td>
<td>1,959.00</td>
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<tr>
<td>3 C</td>
<td>36,119</td>
<td>33,925</td>
<td>93.9</td>
<td>761,231</td>
<td>36,119</td>
<td>30,622.00</td>
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<td>4 D</td>
<td>4,321</td>
<td>3,996</td>
<td>92.5</td>
<td>98,432</td>
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<td>4,101.80</td>
<td>94.9</td>
<td>101,915</td>
<td></td>
</tr>
<tr>
<td>5 E</td>
<td>4,064</td>
<td>3,546</td>
<td>87.3</td>
<td>75,972</td>
<td>4,064</td>
<td>3,454.70</td>
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<td>6 F</td>
<td>6,982</td>
<td>5,816</td>
<td>80.4</td>
<td>123,341</td>
<td>6,982</td>
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<td>87.1</td>
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<td>7 G</td>
<td>635</td>
<td>397</td>
<td>62.5</td>
<td>12,236</td>
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<td>8 H</td>
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<td>8,637</td>
<td>75.7</td>
<td>268,761</td>
<td>11,407</td>
<td>10,053.30</td>
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<td></td>
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<tr>
<td>9 I</td>
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<td>56.9</td>
<td>10,753</td>
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<td>296.00</td>
<td>57.1</td>
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<td></td>
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<tr>
<td>10 J</td>
<td>1,586</td>
<td>1,185</td>
<td>74.7</td>
<td>30,003</td>
<td>1,586</td>
<td>1,153.60</td>
<td>72.7</td>
<td>31,096</td>
<td></td>
</tr>
<tr>
<td>11 K</td>
<td>9,315</td>
<td>7,026</td>
<td>75.4</td>
<td>187,167</td>
<td>9,315</td>
<td>96,894</td>
<td>0.0</td>
<td>96,894</td>
<td></td>
</tr>
</tbody>
</table>

The three flowcharts that follow illustrate the processes PCTs might consider adopting in dealing with different performance scenarios (in practice, it is likely that these would reflect the PCT’s agreed performance management framework):

1) where there is a single instance of underdelivery >4% and no other performance issues

2) where there is underdelivery > 4% and a previous history of underdelivery (which may or may not be associated with other performance issues)

3) where there is a single instance of underdelivery ≤4% and no other performance issues.

The grey boxes in each flowchart indicate that there is a regulatory requirement relating to that particular part of the process. Alongside each flowchart (also in grey) is a summary of the relevant regulations.

The performance history of a contract may span several years, during which time there may well have been some turnover of PCT staff and consequent loss of organisational memory. It is important therefore to keep a clear record of each step along the way – what happened, when, why, who – so that the PCT is in a position to show that it has acted reasonably throughout and in accordance with the relevant regulations. It is also recommended that any important communications (eg remedial or breach notices) are either hand-delivered to the practice and a written receipt obtained or sent by registered post (not recorded delivery as this does not prove the document has been received).
Variations, remedial and breach notices and contract terminations are dealt with in the GDS and PDS Regulations, Schedule 3, Part 9.

Where a contractor has breached the contract and the breach is capable of remedy, the PCT shall, before taking any action it is otherwise entitled to take by virtue of the contract, serve a remedial notice on the contractor requiring it to remedy the breach.

A remedial notice shall specify:
• details of the breach
• the steps the contractor must take to the satisfaction of the PCT in order to remedy the breach
• the notice period (usually a minimum of 28 days from the date of the notice).

Where a PCT is satisfied that the contractor has not taken the required steps to remedy the breach by the end of the notice period, the PCT may terminate the contract with effect from such date as the PCT may specify in a further notice to the contractor.

Dealing with contract underdelivery > 4%, where there is no previous history of underdelivery

1. Problem identified
2. PCT investigates. This is likely to include informal discussion with the practice concerned to confirm the position and identify any mitigating circumstances
3. Remedial breach confirmed. PCT identifies which Regulations (GDS or PDS) and any local contract clauses that have been breached
4. PCT discusses action required to remedy the breach and timescale with practice
5. Remedial notice issued to practice
6. Has practice complied with remedial notice within the required timescale?
   - NO
   - YES
7. Breach notice issued to practice
8. Contract terminated
9. Matter resolved – no further action
If, following a breach notice or a remedial notice, the contractor:
(a) repeats the same breach; or
(b) otherwise breaches the contract resulting in either a remedial notice or a breach notice, the PCT may serve notice on the contractor terminating the contract with effect from such date as may be specified in that notice.

The PCT can only exercise its right to terminate the contract if it is satisfied that the cumulative effect of the breaches is such that to allow the contract to continue would be prejudicial to the efficiency of the services to be provided under the contract.

If the contractor is in breach of any obligation and a breach notice or a remedial notice in respect of that breach has been given to the contractor, the PCT may withhold or deduct monies which would otherwise be payable under the contract in respect of that obligation which is the subject of the breach.

Dealing with contract underdelivery > 4%, where there is previous history of underdelivery (which may or may not have involved issuing of remedial breach notices)

Problem identified

PCT investigates. This is likely to include informal discussion with the practice to confirm the current position, previous history of underdelivery and identify any mitigating circumstances

Further remedial breach confirmed. PCT identifies which regulations (GDS or PDS) and any local contract clauses that have been breached

Are there any serious performance issues giving rise to contract failure?

NO

PCT negotiates re-basing of the contract with practice

Contract variation issued to practice

Matter resolved – no further action

YES

Consider using local resolution process

Remedial notice issued to practice (if appropriate)

Has practice complied with remedial notice within required timescale?

YES

NO

Remedial notice issued to practice in accordance with regulations

Contract terminated
Under the regulations (GDS Regulation 19), underdelivery of 4% or less is not a breach of contract, provided that the contractor agrees to provide the UDAs/UOAs it has failed to deliver within a given period determined by the PCT.

The period allowed for making up any underdelivery must be at least 60 days.

There is nothing to prevent the PCT from agreeing that the contractor may make good the underdelivery in different ways, for example:

- payment of the cash equivalent
- a mix of cash and activity.

To ensure consistency, it is recommended that PCTs set out how under-performance will be handled in their performance management frameworks.

**Dealing with single instance of contract underdelivery ≤ 4% and no other performance issues (delivery ≥ 30% at mid-year point)**

1. **PCT writes to contractor highlighting risk of underdelivery (March/April)**
2. **PCT produces annual report (by 30 June) and arranges annual performance review with contractor**
3. **Annual performance review confirms underdelivery ≤ 4%**
4. **Contractor agrees to make good the underdelivery within timescale specified by PCT (not less than 60 days)**
5. **Contractor provides agreed activity within specified timescale**
## Managing for appropriate recall and treatment intervals

### OBJECTIVES

- Ensure dentists recall patients in line with NICE guidelines
- Ensure patients aware that recall is based on their clinical need ie not always six monthly)
- Identify and focus on areas most likely to have maximum impact locally

### OUTCOMES

- Improved quality of care provided to patients
- Appropriate clinical care provided to patients
- Access to NHS dentistry improved

### KEY TASKS TO COMPLETE

<table>
<thead>
<tr>
<th>Task</th>
<th>WHEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCT’s policy shared with key stakeholders, including patient groups and LDC and signed off by PCT board</td>
<td>One off</td>
</tr>
<tr>
<td>Publicise policy to local contractors. Ensure new performers are informed</td>
<td>As required</td>
</tr>
<tr>
<td>Ensure practitioners understand their contractual commitment to following NICE guidelines and that the PCT will monitor this in line with its performance framework</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Carry out local benchmarking to identify norms and outliers</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Review treatment profiles at contract level</td>
<td>Quarterly or monthly as necessary</td>
</tr>
<tr>
<td>Visit programme to discuss concerns highlighted by data review: consider previous year’s performance and current in-year performance</td>
<td>July – October</td>
</tr>
<tr>
<td>Report to board on outcomes of visit programme and any individual contracts where further action is required</td>
<td>As necessary</td>
</tr>
<tr>
<td>Ensure patients and the public are aware of what NICE guidelines mean for them</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Ensure messages to patients/public about recall intervals and access/availability of NHS dental services are included within your communications strategy.</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
RESOURCES

**Regulatory and legislative documents**
- The National Health Service (General Dental Services Contracts) Regulations 2005
  www.opsi.gov.uk/si/si2005/20053361.htm
- The National Health Service (Personal Dental Services Agreements) Regulations 2005
  www.opsi.gov.uk/si/si2005/20053373.htm
- NHS (Dental Charges) Regulations 2005
  www.opsi.gov.uk/si/si2005/20053477.htm
- NHS (Dental Charges) Amendment Regulations 2006
  www.opsi.gov.uk/si/si2006/20061837.htm

**Guidance**
- NICE CG10, Dental recall – recall interval between routine dental examinations,
  NICE http://guidance.nice.org.uk/CG19

**Contract data**
- E Reporting
- POL User Guides

**Briefing material**
- PCC guidance (below)
- National re-attendance data (NHS Dental Services)
- Handling performance issues in NHS dentistry contracts

**Other supporting material**
- Balanced scorecard
- World-class commissioning competencies for dentistry
Managing for appropriate recall and treatment intervals

Historically, dental patients have been encouraged to attend their dentist every six months. Those with the highest level of motivation and in general better oral health have come to expect this from contact with dental services – they attend for reassurance and often receive a scale and polish, rather than attending after an interval that is based on their oral health needs.

The recently published Independent Review into NHS Dentistry in England includes concerns about patients being recalled ‘more frequently than would seem justified’.

National data show that over-frequent recalls are occurring for patients being treated under all Bands. However, for Band 2 and Band 3 courses of treatment in particular, treatments following in quick succession may also be an indicator of poor quality or inappropriate clinical care.

This is against a background of NICE guidance which recommends for adult patients that they should be recalled between three months and two years dependent on their clinical needs.

Early information from PCTs who have started to tackle inappropriate care indicates that action on clinically inappropriate patterns of treatment has delivered as a side benefit significant access gains. More detailed work will be undertaken with PCTs as part of the dental access programme to understand how PCTs can manage for appropriate recall and treatment intervals to improve the quality of care being delivered to patients. The results of this work will be published in summer 2010.

The purpose of this section of the handbook briefing note is to assist PCTs to begin local work with their dental contractors to review rates of recall where it appears that adult patients are being recalled too frequently.

It is essential that PCTs have clinical input to this work, both dental and public health.

Data

National data\(^{10}\) indicates that considerable levels of activity are attached to attendances by the same patients within a relatively short period of time, eg:

- Band 1 followed by Band 1 courses of treatment:
  - within a 0-2 month time period – 0.4m UDAs
  - within a 3-5 month time period – 1.5m UDAs
  - within a 6-8 month time period – 3.8m UDAs
- Band 2 followed by Band 2 courses of treatment within a 0-2 month time period – 2.8m UDAs
- Band 3 followed by Band 3 courses of treatment within a 0-2 month time period – 1.0m UDAs

What the regulations say

NHS (GDS contracts) Regulations 2005\(^{11}\) require a contractor to provide mandatory services to a patient by providing to that patient a course of treatment (see 04.24 below for further details). PDS contractors who are not limited to additional services should also provide mandatory services. GDS and PDS contractors must in accordance with the Regulations work within current NICE guidelines. This is a required clause\(^{12}\) under the Regulations and must, therefore, be included in all GDS and relevant PDS contracts.

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10. Figures as at March 2009. For incomplete courses of treatment that have no date of completion the acceptance date has been used.
11. The National Health Services (General Dental Services Contracts) Regulations 2005, The National Health Services (Personal Dental Services) Regulations 2005
12. The National Health Service (General Dental Services Contracts) Regulations 2005: Schedule 3, Reg 24, part 2, para 14
The GDS and PDS regulations both state:

National Institute for Clinical Excellence guidance. The contractor shall provide services under the contract in accordance with any relevant guidance that is issued by the National Institute for Clinical Excellence (13), in particular the guidance entitled ‘Dental recall – Recall interval between routine dental examinations’ (14).

For adult patients NICE recommends that patients should be recalled between three months and two years dependent on their clinical needs. The recommendation for children is an interval of between three and 12 months.

The actual interval should be assessed by the dentist based on the patient’s needs. The dentist should discuss the recommended recall interval with the patient and record this interval, and the patient’s agreement/disagreement with it, in the clinical record.

If NICE recall guidance is not being implemented appropriately then there may be implications for the effectiveness and quality of care being delivered to patients. In addition the impact both in terms of loss of access and efficiency may potentially be significant.

Additionally, where patients are recalled within two months for a further course of treatment within the same or lower charge band no patient charge is incurred but UDAs are accrued by the contractor.

Historically, dentists used a recall interval of six months for the majority of patients, irrespective of their oral health. The data would seem to support the view that many dentists have continued with this practice. The figures above suggest that if PCTs were to follow NICE guidelines more closely, then the number of repeat attendances could be reduced.

It is likely that following NICE guidelines more closely would free up time for more new patients to be seen.

Approach

Analysis of the data at national levels suggests that PCTs will want to tackle the following areas initially:

• patients who have had a Band 1 course of treatment and who return for a further course of treatment within 0-2 months, 3-5 and 6-8 months
• patients who have had a Band 2 course of treatment and who return for a further course of treatment within 0-2 months
• patients who have had a Band 3 course of treatment and who return for a further course of treatment within 0-2 months

PCTs are recommended to focus on Band 3 followed by Band 3 and Band 2 followed by Band 2 recalls in the first instance but to do this within the context of a wider clinical education programme around the NICE guidelines to ensure that all contractors are aware of the six month recall issue.

14. This guidance is available from NICE’s website, www.nice.org.uk
PCTs may wish to begin with courses of treatment that occur within 0-2 months in all three bands as there are likely to be few clinical reasons why these should occur and this is outside of the NICE recommendation of three months for the minimum treatment interval. It is recommended that Band 3 treatment intervals of 0-2 months are reviewed first, as while there may be individual cases where the particular circumstances are such that this is appropriate, as a pattern of activity this would be hard to justify on clinical grounds and so the PCT’s approach is likely to be supported by the profession locally.

This does not mean, however, that other areas should be ignored in any discussions with practices. Once practices have been prioritised, PCTs may also want to look at other combinations such as Band 3 followed by Band 2, for which it is equally difficult to explain high volumes with intervals of under three months. PCTs will need to decide what, in their particular circumstances, the next most cost-effective combination would be to pursue.

**What should PCTs expect to see?**

The table below looks at what should normally be delivered under each treatment band together with possible reasons for repeat attendances within relatively short time intervals. It should be emphasised that it is a requirement under regulations that when any banded course of treatment is provided (with the exception of Band 1 Urgent) the patient should receive an examination and assessment and be offered all proper and necessary dental care and treatment required at that time.

<table>
<thead>
<tr>
<th>What should be delivered</th>
<th>Reasons for short recall intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Band 1</strong></td>
<td><strong>Band 1</strong></td>
</tr>
<tr>
<td>Band 1 courses of treatment (excluding band 1 urgent treatment) include those treatments defined in Schedule 1 of the NHS (Dental Charges) Regulations 2005. These treatments relate to diagnosis, preventive advice and interventions, treatment planning and maintenance and include such items as: clinical examination, radiographs, surface application of primary preventive interventions, dietary and oral hygiene advice, scaling and polishing.</td>
<td>Where a patient attends for repeated band 1 courses of treatment at intervals of between three and six months this may be justified based on an assessment of their individual risk of or from dental disease. This should only apply to treatment intervals of three months or more. Those under two months are outside of NICE guidelines. For example, some patients may have physical difficulty in maintaining a satisfactory standard of oral hygiene, or may suffer from medical conditions that increase their risk of developing dental disease. For most contracts this is only likely to apply to a minority of patients.</td>
</tr>
<tr>
<td><strong>Band 2</strong></td>
<td><strong>Band 2</strong></td>
</tr>
<tr>
<td>Band 2 courses of treatment include those treatments defined in Schedule 2 of the NHS (Dental Charges) Regulations 2005. These treatments include for example, non-surgical treatment of periodontal disease, permanent fillings, root treatments, extractions and additions to existing dentures. An FP17DC or equivalent should be provided to the patient for any Band 2 course of treatment and a copy should be available as part of the clinical record.</td>
<td>There will be occasions where a patient returns within a short period of time for a further Band 2 course of treatment for perfectly valid reasons, eg a problem with a tooth /teeth that could not have been identified during the previous course of treatment. Possible examples might be where a filling has fractured or been lost or where an acute apical abscess arises. It is also possible that a Band 1 urgent course of treatment may be followed by a Band 2 course.</td>
</tr>
<tr>
<td><strong>Band 3</strong></td>
<td><strong>Band 3</strong></td>
</tr>
<tr>
<td>Band 3 courses of treatment include the provision of appliances defined in Schedule 3 of the NHS (Dental Charges) Regulations 2005. Appliances provided under Schedule 3 include the provision of porcelain veneers, gold inlays, crowns, bridges and dentures. Where a Band 3 course of treatment is provided an FP17DC or equivalent should be provided to the patient and a copy should be available as part of the clinical record.</td>
<td>There may be a small number occasions where a patient returns for a further Band 3 course of treatment within a relatively short period of time eg as for Band 2, a problem with teeth that could not have been identified during the previous course of treatment. A possible example might be the fracture of a crown following an episode of trauma, requiring replacement.</td>
</tr>
<tr>
<td>Performance Number (1)</td>
<td>Principal Practice &amp; Service Location (2)</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>001</td>
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<tr>
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<td>4</td>
<td>001</td>
</tr>
<tr>
<td>5</td>
<td>001</td>
</tr>
</tbody>
</table>
Specifically, the following reports provide relevant information:

1) PCT exception data report – look particularly at contracts with the following exceptions:
   - multiple FP17s
   - free repairs/replacements
   - urgent
   - continuations
   - incomplete treatment

2) Quarterly PCT re-attendance

3) Health Body Vital Signs At a Glance report

4) Vital Signs At a Glance contract report (extract below)

5) Vital Signs contract report

6) Vital Signs report for health body

Year-end versions of the Vital Signs reports are also available.

In addition to these reports, a new template has been developed to allow PCTs to enquire specifically into the intervals between courses of treatment, classified by treatment band at either end of the interval, and by length of interval and type of patient, for each contract. The five screenshots of the prototype version illustrate what can be done with this template. The PCT chosen for illustration is unexceptional – it does not have particularly extreme cases.

Figure 2 gives an overview of the Band 3 followed by Band 3 courses of treatment in a particular PCT scheduled during a particular quarter. A total of 659 courses of treatment fell into this category, of which there were 103 where the interval was under three months; 93 where the patient had exemption or remission from charges; nine where the patient was liable to pay full patient charge (though may not have done so because of the continuation and free repair and replacement rules); and one child. A further 108 had intervals of between three and six months, of which 96 had patients with exemption from or remission of patient charges.

Figure 3 shows all the contracts providing the Band 3 followed by Band 3 intervals in Figure 2, listed in order of the number of Band 3 followed by Band 3 cases with an interval of less than three months.
The top four of these contracts have nine or more Band 3 followed by Band 3 intervals below three months, and Figure 4 shows how the detail of the first of these contracts - with 14 Band 3 followed by Band 3 cases - can be explored further, showing the full distribution of intervals between Band 3 and Band 3, and the types of patient involved. For this contract, all 14 cases were for patients with exemption from or remission of patient charges.

To set the work on Band 3 followed by Band 3 in context, and to provide pointers to the next area to tackle, figure 5 shows, at PCT level, the distribution of intervals between other combinations, and particularly the number of intervals below three months. Band 3 after Band 2 and Band 2 after Band 2 are likely next areas for investigation in this PCT. Figure 5 gives the full distribution across different intervals. Both figures 5 and 6 are partial pictures – the full template gives every combination, for reference. The analysis of Band 3 comes first, followed by Band 2 and so on.

**Figure 2: PCT Band 3 to Band 3 (filtered) showing re-attendance intervals and patient charge status**

**Re-attendance report: Band 3 to Band 3 PCT analysis**
Range of schedule months registered from January 2009 to March 2009
Range of schedule months returned by the system from January 2009 to March 2009

**Re-attendance intervals: current charge Band 3 and previous charge Band 3**

<table>
<thead>
<tr>
<th>Patient Charge Status</th>
<th>Number of FP17s</th>
<th>Under 3 Months</th>
<th>3 to 6 Months</th>
<th>6 to 9 Months</th>
<th>9 to 12 Months</th>
<th>12 to 15 Months</th>
<th>15 to 18 Months</th>
<th>18 to 21 Months</th>
<th>21 to 24 Months</th>
<th>24 to 27 Months</th>
<th>27 months or more</th>
<th>No previous FP17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exempt</td>
<td>560</td>
<td>93</td>
<td>96</td>
<td>101</td>
<td>77</td>
<td>39</td>
<td>23</td>
<td>18</td>
<td>17</td>
<td>14</td>
<td>82</td>
<td>0</td>
</tr>
<tr>
<td>Non-Exempt</td>
<td>87</td>
<td>9</td>
<td>10</td>
<td>13</td>
<td>11</td>
<td>4</td>
<td>11</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Child</td>
<td>12</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>659</td>
<td>103</td>
<td>108</td>
<td>117</td>
<td>90</td>
<td>43</td>
<td>36</td>
<td>20</td>
<td>18</td>
<td>16</td>
<td>108</td>
<td>0</td>
</tr>
</tbody>
</table>

- a) Under 3 months
- b) 3-6 months
- c) 6-9 months
- d) 9-12 months
- e) 12-15 months
- f) 15-18 months
- g) 18-21 months
- h) 21-24 months
- i) 24-27 months
- j) Under 3 years
- No previous claim
Figure 3: Contract Band 3 to Band 3 (only first page shown)

Re-attendance report: Band 3 to Band 3 PCT analysis
Range of schedule months registered from January 2009 to March 2009
Range of schedule months returned by the system from January 2009 to March 2009

Re-attendance intervals: current charge Band 3 and previous charge Band 3

<table>
<thead>
<tr>
<th>Contract Number</th>
<th>Number of FP17s</th>
<th>Total FP17s</th>
<th>% of FP17s for the same patient ID re-attending within 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Band 3 to Band 3</td>
<td>Under 3 Months</td>
<td>All FP17s</td>
</tr>
<tr>
<td>110</td>
<td>14</td>
<td>1,255</td>
<td>293</td>
</tr>
<tr>
<td>50</td>
<td>12</td>
<td>606</td>
<td>120</td>
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<tr>
<td>23</td>
<td>9</td>
<td>313</td>
<td>59</td>
</tr>
<tr>
<td>45</td>
<td>9</td>
<td>313</td>
<td>59</td>
</tr>
<tr>
<td>39</td>
<td>7</td>
<td>1,185</td>
<td>232</td>
</tr>
<tr>
<td>14</td>
<td>6</td>
<td>721</td>
<td>128</td>
</tr>
<tr>
<td>32</td>
<td>5</td>
<td>1,390</td>
<td>328</td>
</tr>
<tr>
<td>19</td>
<td>4</td>
<td>639</td>
<td>36</td>
</tr>
<tr>
<td>15</td>
<td>4</td>
<td>158</td>
<td>19</td>
</tr>
<tr>
<td>30</td>
<td>4</td>
<td>465</td>
<td>77</td>
</tr>
<tr>
<td>16</td>
<td>4</td>
<td>2,134</td>
<td>457</td>
</tr>
<tr>
<td>7</td>
<td>4</td>
<td>415</td>
<td>104</td>
</tr>
<tr>
<td>59</td>
<td>3</td>
<td>1,500</td>
<td>322</td>
</tr>
</tbody>
</table>

Figure 4: Contracts with Band 3 to Band 3 (filtered) showing re-attendance intervals and patient charge status

Re-attendance intervals: current charge Band 3 and previous charge Band 3

<table>
<thead>
<tr>
<th>Patient Charge Status</th>
<th>Number of FP17s</th>
<th>Under 3 Months</th>
<th>3 to 6 Months</th>
<th>6 to 9 Months</th>
<th>9 to 12 Months</th>
<th>12 to 15 Months</th>
<th>15 to 18 Months</th>
<th>18 to 21 Months</th>
<th>21 to 24 Months</th>
<th>24 to 27 Months</th>
<th>27 months or more</th>
<th>No previous FP17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exempt</td>
<td>100</td>
<td>14</td>
<td>15</td>
<td>18</td>
<td>15</td>
<td>7</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Non-Exempt</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Child</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>14</td>
<td>18</td>
<td>18</td>
<td>19</td>
<td>7</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>19</td>
<td>0</td>
</tr>
</tbody>
</table>
Figure 5: PCT treatment bands (current and previous) under 3 months re-attendance (only first page shown)

<table>
<thead>
<tr>
<th>Current Patient Charge Band</th>
<th>Previous Patient Charge Band</th>
<th>Total Number of FP17s</th>
<th>Under 3 Months</th>
<th>% of FP17s for Current Band V Previous Band</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 3</td>
<td>Band 1</td>
<td>532</td>
<td>98</td>
<td>18.0%</td>
</tr>
<tr>
<td>Band 3</td>
<td>Band 1 Urgent</td>
<td>431</td>
<td>307</td>
<td>71.2%</td>
</tr>
<tr>
<td>Band 3</td>
<td>Band 2</td>
<td>879</td>
<td>207</td>
<td>23.5%</td>
</tr>
<tr>
<td>Band 3</td>
<td>Band 3</td>
<td>659</td>
<td>103</td>
<td>15.6%</td>
</tr>
<tr>
<td>Band 3</td>
<td>Charge Exempt</td>
<td>78</td>
<td>53</td>
<td>67.9%</td>
</tr>
<tr>
<td>Band 3</td>
<td>No Previous FP17/Unbanded</td>
<td>303</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Band 3</td>
<td>Other</td>
<td>30</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Band 1</td>
<td>2,167</td>
<td>273</td>
<td>12.6%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Band 1 Urgent</td>
<td>1,057</td>
<td>757</td>
<td>71.6%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Band 2</td>
<td>3,056</td>
<td>458</td>
<td>15.0%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Band 3</td>
<td>647</td>
<td>122</td>
<td>18.9%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Charge Exempt</td>
<td>172</td>
<td>108</td>
<td>62.8%</td>
</tr>
<tr>
<td>Band 2</td>
<td>No Previous FP17/Unbanded</td>
<td>1,158</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Band 2</td>
<td>Other</td>
<td>195</td>
<td>43</td>
<td>22.1%</td>
</tr>
</tbody>
</table>
Possible actions

PCT policy

PCTs may find it helpful to set out clearly their approach to managing for appropriate treatment and recall intervals and how they will approach practices where there is a perceived issue. It is recommended that views are sought from the dental practice adviser and that any policy is discussed at an early stage with patient groups, local clinicians and the local dental committee.

Data analysis: questions and issues

The data should be analysed in different ways. The raw numbers should be looked at together with proportions. This along with the contract manager’s local knowledge and the PCT’s oral health profile should help PCTs to decide the order in which they tackle individual contracts. Whilst PCTs are likely to want to focus on those contracts which are likely to yield the largest access gains, it is important that the smaller contracts where possible concerns are identified are not ignored as a high incidence of inappropriate recall intervals may be an indicator of clinical quality issues in any practice and may have potentially important consequences for patient care.

Where the data show possible concerns regarding the quality or appropriateness of patient care, these should not be looked at in isolation but considered together with other contract data and information. For example, the use of exception reports in this regard has already been discussed. It is important that the particular circumstances of a contract and the activity it has been set up to provide are also considered, as these may explain an otherwise unusual pattern of activity as seen from the data alone.
Additionally, clinical data-set information should be looked at and recommendations made by the dental practice adviser. Where a contract shows unusually high reattendance rates for Band 2 or Band 3 courses of treatment it may be helpful to see if there are also unusually high levels of provision of a particular treatment type within that band. This may help to inform discussions with the provider as it could be clinically appropriate (due to the level of treatment an individual patient is willing to undergo) or may illustrate a provider generating UDAs in a way that cannot be explained by clinical need.

Examples of the types of questions PCTs may want to consider when analysing practice data may include:

**Band 1**
- Is the patient base relatively stable or are large numbers of new patients being seen? This data is available from Vital Signs reports as the change in patients seen over a 24-month period
- Review the percentage of same patient IDs seen within three months and 3-9 months (available from Vital Signs reports) and consider against figures for contracts for the PCT as a whole
- Review the quarterly PCT General Contract Clinical Data Set report. Is a high proportion of activity being delivered by Band 1 courses of treatment and is this level high across all patient categories (exempt adults, non-exempt adults, children)? This information is also available in the new report template described in section 6, figure 4
- What is the overall size of the contract and the potential number of UDAs affected?
- Do clinical records show evidence that NICE guidance on recall intervals is being applied?

**Band 2**
- Has the contract appeared in any exception reports?
- Review the percentage of same patient IDs seen within three months and 3-9 months (available from Vital Signs reports) and consider against figures for the PCT as a whole
- Is there a high percentage of continuations?
- Review the Year-End Contract Report Summary. Are relatively high proportions of activity being delivered by Band 2 courses of treatment? Is this across all patient categories (exempt adults, non-exempt adults, children). Review Band 2 clinical data set information against national averages
- Is any other evidence of clinical concerns available from DRS reports?
- What is the size of the contract and the potential number of UDAs affected?
Band 3

- Has the contract appeared in any exception reports?
- Is there a high proportion of continuations? This information is available from Vital Signs data
- Review the Year-End Contract Report Summary. Are there any particularly high levels of provision of particular Band 3 treatments when compared with the PCT as a whole (for example: veneers, inlays, crowns)?
- Review the quarterly PCT General Contract Clinical Data Set report. Is a high proportion of activity being delivered by Band 3 courses of treatment and is this high across all or particular patient groups (exempt adults, non-exempt adults, children)?
- Are the same patients being seen within a short time period for further Band 3 course of treatment and are many Band 3 courses of treatment completed within a very short time period?
- What is the size of the contract and the total number of UDAs affected?
- Is there any other evidence of clinical concerns available from DRS reports?

Information sharing and discussion with contractors

The PCT should discuss any concerns raised as a result of the data review with the provider at a practice visit (section 4.25 looks in more detail at a number of individual cases). It strongly is recommended that a PCT clinical adviser, for example the dental practice adviser, is involved in the discussions as clinical input to the review process is essential. Where a provider is being asked to explain a particular pattern of clinical activity it may be helpful to both the provider and the PCT to make reference to clinical records as part of this discussion and clearly the PCT needs clinical input to inform such a discussion. Examples of the types of clinical issues that may be discussed might include:

- pattern of recalls within a short time period, with high levels of provision of a particular treatment type within that band, with only a single tooth being treated as part of any individual course of treatment (CoT). Such a pattern of treatment would be difficult to justify clinically across a contract as a whole and may be an indication of either inappropriate or poor quality patient care. For example where patients attend for repeated Band 2 CoT within a short time period with only a single filling being provided at each CoT, this would not normally be justified as a pattern of treatment across a contract
- similarly such a pattern of recalls for Band 3 CoT to provide single crowns, veneers or inlays would not normally be considered appropriate
- patterns of recalls within a short time period for the provision of treatments where an alternative treatment may have been as clinically effective. For example, the provision of small single surface gold inlays where a direct restoration appropriate to Band 2 could have been provided
- the provision of fissure sealants as a primary preventive measure with activity recorded as sealant restorations under Band 2, rather than as fissure sealants appropriate to Band 1, without appropriate supporting evidence from clinical records would not be appropriate
- the provision of a full upper or lower denture as a Band 3 CoT followed by a further Band 3 CoT a few months later to provide the opposing denture would not be considered appropriate as a pattern of activity across a contract. Where new full upper and lower dentures are required these should normally be provided together as a single CoT.

As part of this discussion, comparative data should be shared with practices to show where they sit within the range for the PCT.
It is likely that with most contractors a clinical discussion based on their data will be sufficient to agree a resolution to any concerns that have been identified. PCTs may want to agree an action plan with the contractor that describes actions to be undertaken by the contractor and any PCT support and/or actions that have been agreed. It should include review dates.

However, if no agreement is reached with the contractor, PCTs may want to ask the Dental Reference Service (DRS) to undertake a clinical review (see section on clinical records below) or advise on other monitoring that may be appropriate.

Finally, if the DRS findings support the PCTs’ concerns and no agreement is reached after these checks have been carried out, PCTs may want to formalise their management of the process for that contractor through the issue of a breach notice.

For further advice on managing contract breaches see:
Handling Breaches of NHS Dentistry Contracts, NHS PCC

Finally, it is important to point out that at all stages of their processes for addressing recall issues, PCTs ask whether there are any serious patient safety issues or material financial risks to PCT? If the answer to this is ‘yes’ then the PCT’s existing processes for managing such cases should be followed.

**Clinical records**

Clinical record checks should be used to evidence whether NICE recall guidance is being applied effectively as these should record:

- previous disease experience
- risk factors
- recommended recall interval.

There will be variations between practices and PCTs and a range of factors will need to be taken into account when reviewing compliance with NICE guidelines:

- numbers of new patients being seen within the last 24 months: low numbers coupled with high levels of short recall intervals may support the view that NICE guidelines may not be being adhered to
- age profile of the population, eg an ageing population may require more frequent recalls for periodontal treatment or repeat restorative work
- local oral health profile.

However, none of these is likely to justify high levels of short recall intervals across whole contracts.

Routine clinical record checks are carried out by the Dental Reference Service for all contracts. Providers who have frequent re-attendance across their contract would need to demonstrate identified clinical need and treatment plans to support this.

It is important to note that it is a contractual requirement to provide (and retain a copy of) a treatment plan in the form of an FP17DC (or equivalent) for patients undergoing Band 2 and Band 3 courses of treatment, and where the patient requests one. In addition, the DRS can be requested by PCTs to carry out specific clinical checks where the PCT has particular concerns. It should be noted that the DRS will not be able to carry out additional checks on all practices so PCTs may want to target their resources where they have significant concerns.

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16. The National Health Services (General Dental Services Contracts) Regulations 2005: reg 24, schedule 3, part 2, para 7.1
Process for managing for appropriate recall and treatment intervals

Draft PCT policy shared with LDC

Board signs off policy

Policy published to local contractors

Contracts prioritised for further review as a result of data analysis and application of local knowledge

Are there serious patient safety issues or material financial risks to PCT?

NO

PCT visits contractor to discuss the issue (needs commissioning and clinical input)

Provider agrees with PCT diagnosis

Provider disputes diagnosis

PCT and provider agree action plan

Consider review by Dental Reference Service

DRS finds evidence to support PCT’s concerns about poor practice which provider accepts

Provider does not accept findings; Both parties need to consider whether to formalise process

YES

Refer to:
Handling Breaches of NHS Dentistry Contracts

Handling Suspension of NHS Dentists
Course of treatment

NHS (GDS contracts) Regulations 2005, Part 1, para 2 defines a course of treatment as follows:

(a) a course of treatment, means that:

(i) where no treatment plan has to be provided in respect of a course of treatment pursuant to paragraph 7(5) of Schedule 3 (treatment plans), all the treatment recommended to, and agreed with, the patient by the contractor at the initial examination and assessment of that patient has been provided to the patient; or

(ii) where a treatment plan has to be provided to the patient pursuant to paragraph 7 of Schedule 3, all the treatment specified on that plan by the contractor (or that plan as revised in accordance with paragraph 7(3) of that Schedule) has been provided to the patient;

Mandatory services

NHS (GDS contracts) Regulations 2005 require a contractor to provide mandatory services to a patient by providing to that patient a course of treatment. This is defined in regulations as meaning:

(a) an examination of a patient, an assessment of his oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment; and

(b) the provision of any planned treatment (including any treatment planned at a time other than the initial examination) to that patient, provided by, except where expressly provided otherwise, one or more providers of primary dental services, but it does not include the provision of any orthodontic services or dental public health services.

Urgent treatment is separately defined as a course of treatment in Regulations.

‘Complete’ in relation to a course of treatment, is defined as meaning that:

(i) where no treatment plan has to be provided in respect of a course of treatment pursuant to paragraph 7(5) of Schedule 3 (treatment plans), all the treatment recommended to, and agreed with, the patient by the contractor at the initial examination and assessment of that patient has been provided to the patient; or

(ii) where a treatment plan has been provided to the patient pursuant to paragraph 7(5) of Schedule 3, all the treatment specified on that plan by the contractor (or that plan as revised in accordance with paragraph 7(3) of that Schedule) has been provided to the patient;

and ‘completed’ shall be construed accordingly.

Following completion of a course of treatment, a contractor would normally advise the patient when they should next attend for an oral health review. In advising the patient of a suitable interval for recall the contractor is required in regulations to provide services under the contract in accordance with any relevant guidance issued by the National Institute for Clinical Excellence, in particular the guidance entitled ‘Dental Recall – Recall interval between routine dental examinations’[17]. This guidance advises that the intervals between oral health reviews should be determined specifically to meet the needs of individual patients based on an assessment of disease levels and the risk of or from dental disease. For patients less than 18 years of age it is recommended this interval should be between three and 12 months and for adult patients over the age of 18 years between three and 24 months. The recall interval should be reassessed at each oral health review.

17. http://www.nice.org.uk
Contract review cases

While the scenarios described below are fictitious, they bear similarities to a number of real cases and describe contracts where high levels of recall of the same patients, within a relatively short period of time, have been identified within each treatment band. They give details of possible approaches PCTs may wish to consider when reviewing contractors’ activity.

A. Band 1
Contract: a GDS contract to provide mandatory services with a contract value of £900,000 and activity of approximately 28,000 UDAs.

Issues:
• Vital Signs data shows a relatively stable patient base with only a small number of new patients being seen within a 24 month period.
• The percentage of same patient IDs seen within three months and between 3-9 months are 20% and 59% respectively, and these are some of the highest figures for this PCT.
• Around 28% of UDAs for this contract are delivered by Band 1 CoTs. The quarterly PCT General Contract Clinical Data Set report shows a rate of recording scale and polish in relation to Band 1 treatments of 52/100 FP17s, which is high compared to the national average of 38.8/100, and low rates of recording of primary preventive measures.
• The average number of days between Band 1 courses of treatment for this contract is 210 days.
• The clinical data set information does not show a high rate of preventive treatments being associated with Band 1 treatments.

B. Band 1
Contract: a GDS contract to provide mandatory services with a contract value of £1.1 million and activity of approximately 50,000 UDAs.

Issues:
• Vital Signs data shows little change in patients seen over a 24 month period.
• The percentage of patients with the same ID seen within three months and 3-9 months are 22% and 67% respectively.
• The Year-End Contract Summary report shows that 41% of the activity for this contract arises from Band 1 CoTs, with comparative local and national data showing this contract has a high number of Band 1 treatments across all patient categories (children, exempt adults and non-exempt adults).
• Analysis of quarterly data for adult patients re-attending for a further Band 1 CoT shows approximately 80% of adult patients re-attending for further Band 1 course of treatment do so within eight months.
• A DRS report had noted that while for the particular patients examined on their visit the identified recall interval appeared satisfactory, there was no evidence in the clinical records that NICE recall guidance was being applied and that written treatment plans and FP17DCs needed to be available as part of the clinical records (where required by regulations).

C. Band 2
Contract: a GDS contract to provide mandatory services, with a contract value of £1 million and activity of 43,500 UDAs.

Issues:
• The contract has appeared in exception reports for late reporting.
• Vital Signs data shows the percentages of patients with the same ID seen again within three months and 3-9 months are 22% and 61% respectively.
Key contract management priorities

- Year-End Contract Report Summary shows that 45% of the reported activity for the contract is delivered by Band 2 courses of treatment and that around 8% of UDAs arise from continuations. The number of fillings, root fillings and extractions are low compared to national data per 100 FP17s.

- Information from DRS reports shows concerns regarding provision of very small single surface inlays for which no justification could be identified and also concerns regarding the NHS/private interface, these concerns being supported by unsolicited information from a patient questionnaire suggesting that patients were encouraged to see the hygienist under private arrangements.

- Analysis of quarterly data for adult patients returning for a further Band 2 course of treatment shows that 84% of patients were returning for further Band 2 treatment within eight months and that 34% returned within two months for a further Band 2 CoT. This data was based on more than 340 Band 2 CoT in the quarter.

D. Band 3

Contract: a GDS contract to provide mandatory services with a contract value of £1.3 million and activity of just over 51,000 UDAs.

Issues:

- Vital Signs data showed continuation of treatment to be high (7.1% compared with PCT as a whole at 3.1%) and urgent treatment to be above PCT average at 13.5% compared with 7.6%.

- Crowns, veneers and inlays were above PCT averages on the Year-End Contract Report Summary, with the provision of inlays being four times greater than the PCT average.

- The provision of Band 3 treatments to children was above the PCT average at 11/100 FP17s.

- Detailed analysis of Band 3 claim data showed a number of instances of provision of Band 3 treatments to the same patient within a short period of time, with a number of instances where charge paying patients had been treated as continuations.

- Analysis of quarterly data for adult patients attending for a further Band 3 CoT showed that 76% of the patients were seen again within eight months.

- In the first instance discussion of these findings with the provider was advised, in particular the necessity for the provision of large numbers of inlays.

E. Band 3

Contract: a GDS contract to provide mandatory services, with a contract value of £225,000 and associated activity of 9200 UDAs.

Issues:

- The contract had appeared previously on exception reports in relation to treatment on continuation, incomplete treatments and low activity.

- Vital Signs data showed the percentage of free repair items for this provider to be 4.2% compared to a PCT average of 1.7%.

- Examination of data in relation to Band 3 CoT showed a number of instances where Band 3 treatments had been completed in a single day and a number of cases of multiple Band 3 treatments within a short period of time.

- Analysis of quarterly data for adult patients attending for a further Band 3 CoT showed that for a single quarter 88% of patients attended for a further Band 3 CoT within eight months (based on 42 Band 3 CoT).

- A routine DRS clinical record review noted eight Band 3 CoT for a single patient within an 18 month period.

- Clinical notes were generally very brief, in some cases no radiographs were present to support the provision of cast restorations and in others radiographs were of poor quality.
It is important that PCTs manage their dental budget in line with their local Standing Financial Instructions (SFI), governance framework and scheme of delegation which details the financial responsibilities, policies and procedures adopted by the PCT. These ensure that all financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

There are a number of key tasks and responsibilities that need to be undertaken to ensure appropriate and robust management and reporting of dental expenditure. It is important that the finance teams and dental teams work closely and have appropriate input into a number of aspects of the financial and quality management of NHS dentistry.

To ensure the appropriate financial management of dental resources, PCTs will need to:

- have an understanding of how the dental allocation is made up – further details are in Appendix F
- have appropriate systems in place to monitor the current and future financial commitments against dental funding streams
- develop internal working relationships to ensure that finance and dental teams have a joint approach for monitoring and assessing dental expenditure
- manage and optimise patient charges revenue.
**OBJECTIVES**

- To have a clear understanding of the make up of the dental budget (Appendix F)
- To have systems in place to reconcile the dental budget against committed resources
- Comply with PCT Standing Financial Instructions (SFIs)
- Appropriate management of patient charge revenue (PCR)

**OUTCOMES**

- Appropriate use of the dental budget to maximise access to and quality of NHS dental services

**KEY TASKS TO COMPLETE**

<table>
<thead>
<tr>
<th>CONTRACT PAYMENTS AND REVIEWS</th>
<th>WHEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments to contractors</td>
<td></td>
</tr>
<tr>
<td>• Ensure that the Payments Online (POL) system is kept up to date and accurately reflects each contract value</td>
<td>Monthly</td>
</tr>
<tr>
<td>• Entries for estimated net pensionable pay on POL are periodically checked and updated when new performers start</td>
<td>On-going</td>
</tr>
<tr>
<td>• Entry of each performer’s actual net pensionable is made on POL so that any year-end adjustments to superannuation contributions can be made</td>
<td>Annually (by September)</td>
</tr>
</tbody>
</table>

**End of year**

- In accordance with local performance framework to assess the end-of-year performance of each contract, and calculate the value of underdelivery which may be reclaimed from the contractor | Annually (after 30 June) |

**Contract reviews**

- Ensure that there is appropriate finance input to inform the contract review process for dental contractors | As required |
### Internal Financial Planning and Reporting

**Internal Working Arrangements**
- Need for dental team to work closely with finance colleagues
- Appropriate use of the E Reporting system to monitor contracts  
  
<table>
<thead>
<tr>
<th>WHEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>On going</td>
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</table>

**Internal Reporting**
- Produce monthly statements on dental expenditure and income (part of the monthly financial timetable)
- Ensure that dental finance forms part of the primary care budget reports within the appropriate management reporting structure  
  
<table>
<thead>
<tr>
<th>WHEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
</tr>
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<td>On going</td>
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</tbody>
</table>

**Monitoring of Dental Spend and Management of Patient Charge Revenue (PCR)**
- Ensure that monthly payments to providers are accurate
- Monitor the collections of PCR, taking into account previous years’ trends and known changes to contracts
- Develop forecasting of dental expenditure and PCR
- Ensure appropriate use of any in year non-recurring monies (use of the conditional grants agreements)
- Ensure finance input into contract negotiations for new activity or contracts  
  
**Cost Recharge to PCT**
- Ensure that the monthly total net cost to the PCT is reconciled back to the detail contained in the Monthly Record of Daily Cash Advances report produced by the Department of Health. The Payment and Recharge Summary report produced by NHS DS can also be used in this process  
  
<table>
<thead>
<tr>
<th>WHEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
</tr>
</tbody>
</table>

**Accruals**
- Calculation of monthly PCR accruals as part of the monthly reporting process
- Ensure that PCR is appropriately accounted for at year-end, within the annual accounting process. The NHS DS time lag report produced monthly in quarter 4 may also be used to support this calculation  
  
<table>
<thead>
<tr>
<th>WHEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
</tr>
<tr>
<td>Year-end</td>
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</tbody>
</table>

### External Financial Planning and Reporting

**DH Returns**
- Accurate and timely completion of the quarterly FIMS returns  
  
<table>
<thead>
<tr>
<th>WHEN</th>
</tr>
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<tbody>
<tr>
<td>Quarterly</td>
</tr>
</tbody>
</table>
RESOURCES

Internal expertise
- Finance department
- Internal audit

External support
- NHS PCC dental helpdesk: www.pcc.nhs.uk/helpdesks
- NHS PCC advisers: www.pcc.nhs.uk/contact
- External audit

Regulatory and statutory documents
- PCR regulations: http://www.opsi.gov.uk/si/si2006/20061837.htm

Supporting documents
- Understanding the dental allocation (Appendix F)
- Recovering contract payments http://www.pcc.nhs.uk/163
- Useful NHS DS reports, templates and dashboard available to support the contract management process (Appendix G)

Financial Management of NHS dentistry

This element of the handbook links to two of the World Class Commissioning Competencies, namely No. 6 (Prioritise Investment) and No. 11 (make sound financial investments to ensure sustainable development and value for money).

a. Contract Payments and reviews

- Payments to contractors

Payments to contractors are undertaken by NHS Dental Services (NHS DS) who act as the paymaster on behalf of all PCTs in England and LHBs in Wales. The information entered onto the Payments Online (POL) system is used by NHS DS to make the monthly payments to dentists alongside the information submitted by the dentists on the FP17 form.

It is therefore essential that the information is accurate and up-to-date. Each PCT will have named individuals from within finance, contracts or dental commissioning teams who are responsible for keeping the system up-to-date. The system also requires that all transactions undertaken are appropriately authorised, and a clear audit trail is essential, detailing amendments and alterations to the system. Each PCT will have its own process for deciding who uses the system and the administrative organisation of its use. An example form used by a PCT to record contract amendments to the system is included within Appendix H.
NHS DS provide regular updates to users, and there is support available via the helpdesk and a user guide manual, which provides detailed guidance on the use of POL.\(^{18}\)

When entering contract values and associated activity there are a number of key points to note: (Further information and guidance is provided with the Payments Online guidance)

- **UDA/UOA activity:** The totals entered should reflect the actual amount of UDAs/UOAs that the contract should achieve in the current financial year. If the contract is not open for a full year then the activity should be pro-rated accordingly.

- **Total Contract Value:** This figure should be entered as the full annual amount as the system will divide this figure by 12 to make the monthly payment. The system will also calculate part monthly payments where the contract starts or ends part way through the month. The actual start date or end date must be entered for this calculation.

b. **Debt management**

There are a number of situations where a debt can occur and PCTs need to recover monies from contractors, different processes need to be followed depending on whether the contract is open or closed.

Where a contract is still open, the PCT can arrange to recover the funds via the POL system. Once the provider has agreed a repayment plan this can be recorded and monitored using dedicated adjustment codes. This ensures that the full value of the adjustment can be reflected in the PCTs’ financial figures. Section 15 of the POL guidance provides details of this process.

It is essential that the recovery of the money is collected via the NHS DS and the money is not receipted directly into the PCT’s bank account. This is so that the debt can be appropriately accounted for and any adjustments required around superannuation contributions actioned.

If a payment has been made directly to the PCT, it is essential that NHS DS are informed immediately and arrangements made to pay over the funds to NHS DS.

Where a contract has already closed, PCTs will not have the facility to recover the debt through a repayment process and therefore the PCT will need to follow up the debt and arrange for this to be collected.

There are a number of measures that PCTs can also take to minimise the level of debt in the first place:

- **Ensure that POL is kept up to date.** Once it is known that a contract is closing, undertake the appropriate steps within the POL system to record this information. Section 20 of the guidance provides details of this process. PCTs have a legal duty to provide an end of contract reconciliation within four months from the end of the contract.

- **The PCT has the facility to retain payment prior to contract closure,** which is one way to help reduce the risk of ‘negatives’ or debts on closed contracts. Negatives can occur due to receipt after contract closure of the FP17s submitted for work that was performed under the contract before it closed, and the associated patient charges have still to be recovered. It could also relate to arrangements for financial recovery of underperformance once the performance information for the contract has been finalised. Once the final PCR and any underperformance repayments have been processed, any retained final payment can be released with either a final net sum due to the contractor or a residual debt, which will then need to be recovered.

• Regular submissions of FP17s ensure that PCR is collected on a timely basis. Where contractors retain forms and submit in batches, there is a risk that there is an insufficient level of baseline payment to offset the PCR income against. This will therefore leave the contract with a ‘negative’ position. PCTs can monitor the level of negative payments through the ‘PCT Held and Negative Payment Summary’ report which is produced as a standard report on a monthly basis, an example of which is shown below:

Negative and held payments as at September 2009
All the values shown below are in £

<table>
<thead>
<tr>
<th>Negative Payment Summary</th>
<th>Total</th>
<th>Sep-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline payment</td>
<td>2,793.03</td>
<td>2,793.03</td>
</tr>
<tr>
<td>Maternity/paternity/adoptive leave</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Sickness</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Business rates</td>
<td>115.44</td>
<td>115.44</td>
</tr>
<tr>
<td>VDP service cost</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Trainer’s grant</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Trainee’s salary &amp; ENIC</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Seniority</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>PCT specific items</td>
<td>(6,340.14)</td>
<td>(6,340.14)</td>
</tr>
<tr>
<td>Patient charge revenue</td>
<td>45.60</td>
<td>45.60</td>
</tr>
<tr>
<td><strong>Net cost</strong></td>
<td>(3,386.07)</td>
<td>(3,386.07)</td>
</tr>
<tr>
<td>Employer pension contribution</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Net charge to PCT</strong></td>
<td>(3,386.07)</td>
<td>(3,386.07)</td>
</tr>
</tbody>
</table>

| Deductions & additions                       |         |         |
| Collection of money on behalf of PCT        | 0.00    | 0.00    |
| Debt recovery                                | 0.00    | 0.00    |
| Legal and compliance deductions             | (28.00) | (28.00) |
| DSD charges including global crossing       | 0.00    | 0.00    |
| Employees’ pension contribution             | 0.00    | 0.00    |
| **Net payment to dental contract**          | (3,414.07) | (3,414.07) |
c. Employers’ superannuation contribution costs

Under the NHS pension scheme regulations, PCTs will continue to be liable for paying the employers’ superannuation contributions in respect of pensionable earnings of all dental practitioners, ie providers, performers and vocational trainees, where they are members of the NHS pension scheme. The NHS DS undertakes the collection process on behalf of PCTs as defined in the administrative provisions in the Statement of Financial Entitlements (SFE)\(^ {19}\). Further details of the superannuation process is set out in more detail in section 4 of both GDS and PDS SFEs.

Every month NHS DS calculate the employers’ and employees’ superannuation contribution from the estimated net pensionable earnings (NPE) entered on POL by PCTs. Net pensionable earnings are calculated as 43.9% of the gross NHS earnings of the dentist. The estimate is supplied to PCTs by providers and should be updated each time a performer leaves or joins the practice. It is the PCT’s responsibility under the relevant SFE to take all reasonable steps to agree the NPE with the contractor before entering the information on POL. Once collected it is a legal obligation that all contributions are paid to the Pension Agency before the 19th of each calendar month following the month they are collected.

The employees’ superannuation contributions are deducted from the monthly pay of the provider and are shown on the pay statement alongside the amount deducted for employers’ contributions. The individual performer receives a monthly superannuable statement which clearly shows the amounts deducted for employees’ and employers’ contributions.

At the end of each year NHS DS, as part of the Annual Reconciliation Report\(^ {20}\), send a Net Pensionable Earnings Declaration form to every contract holder so they can declare the actual net pensionable earnings paid to each performer.

The contract holder is required to review the information provided within the Annual Reconciliation Report and sign to declare the actual net pensionable earnings earned within the contract by each performer for the financial year. The report will include details of the estimated figures for each performer under the contract. The contract holder is required to review these figures, and update where the actual earnings differ from the estimate. Where the estimates are correct the contractors must still sign and return the form supplied by NHS DS by the due date, usually by the end of July each year. It is a contractual requirement for each contract holder to complete this declaration. Completed declarations will be recorded by NHS DS, copied and forwarded to PCTs so they can review the updated figures and record any changes to the details on POL. PCTs need to have completed this process by the end of September, so that NHS DS can process all of the necessary adjustments to individual superannuation contributions in time to be included in the October schedule for payment in November.

In order to ensure that PCTs can budget for the likely expenditure associated with employers’ superannuation costs there are a number of key tasks that can be undertaken:

- ensure no contracts are paid before the estimated net pensionable pay for each performer is entered on POL, this should ensure co-operation from providers
- ensure that providers inform the PCT every time someone leaves or joins the contract so that NPE is included within POL. Appendix I is an example of a form that a PCT may wish to use to collect this information
- do annual checks at the start of the financial year with contract holders to ensure that the estimated NPE is as accurate as possible for each performer under the contact
- when budgeting for superannuation costs, as a rule of thumb the maximum employers’ superannuation liability should not exceed 14% of 43.9% of contract values


• be aware that providers must give net pensionable earnings for each performer on the contract to ensure any residue of the 43.9% for performers who are not superannuable is not being ‘given’ to other performers on the contract to artificially uplift their pensions thereby adding additional costs for PCTs

• when checking the end-of-year declaration ensure all performers have an entry to ensure the above doesn’t happen

• make sure every provider has completed the declaration; it is a requirement of the NHS pension scheme and the provider’s contract that this is completed and signed accordingly

• remember every performer who is not paying contributions is in danger of losing their in-service entitlements such as death in service, which could have an impact on PCTs who for superannuation purposes are classed as the employer, eg if someone who considers they are in the scheme dies but is not in the scheme.

d. End of year

Contractors have 60 days after a course of treatment is completed to ensure that the necessary paperwork is submitted to NHS DS. Therefore, at the year-end position, PCTs will need to wait until NHS DS has completed and issued the final year-end reports, which are produced by 30 June at the latest each year. It is recommended that no definitive action should be taken about under/over delivery until this information is received.

The underdelivery section of this handbook deals with the procedures and processes that PCTs need to follow when dealing with underdelivery at year-end. There is a briefing paper called ‘Recovering Contract Payments’ which provides advice on to PCTs on the year-end process when recovering contract payments.

Where the PCT has made a decision to recover money for underdelivery of activity at the end of year, it is suggested that PCTs work on the straightforward basis of dividing the contract value (less any elements specifically relating to other services not measured by UDAs) by the total number of UDAs. This will give a £ per UDA and this ‘unit amount’ should be recovered for each UDA underdelivered. Appendix J is an example of a form used by a PCT to assess the end-of-year position of its contracts.

PCTs are entitled, if they consider it appropriate, to recover the full amount on un-delivered activity (ie 100% not 96%), and may wish to agree a repayment plan over a set period of time with the contractor for the recovery. Where a contract has delivered in excess of 100% of its contracted activity PCTs are not obliged to pay for this activity.

Where contractors have delivered between 96% and 100% of their contracted activity, PCTs will need to ensure that the undelivered activity is carried forward to the next financial year for delivery. This detail should be entered onto the POL system so that this activity is recorded and monitored.

e. Contract reviews

As part of the performance management process the PCT will undertake a schedule of contract reviews with its contractors. It is important that there is the opportunity for finance teams to input into the process, and attend review visits, if this is required. Some areas in which the finance team can provide input may include information on annual contract uplifts, financial calculations at the year-end and superannuation queries.


22 http://www.pcc.nhs.uk/163
2. Internal financial planning and reporting

a. Internal working relations

Effective financial management of the dental budget requires close working relationship between the budget holder and the dental finance manager.

Each PCT has its own processes and procedures and this handbook is not trying to influence or change these. Regular liaison between the finance team and the contracts or commissioning managers for dentistry is essential, and may include discussions on:

• Performance issues – for example, problems with late reporting in a contract not only affects the UDA delivery, but may also have an associated financial risk relating to the deduction of PCR collected by the contractor from payments, which the finance team will need to take into account.

• Internal budget reports, expenditure year to date, and forecast end-of-year positions – the finance team regularly produce budget statements for all areas of expenditure and income. The dental team will need to input into this process to ensure that all planned expenditure is accurately accounted for and to ensure that the dental team are fully aware of their financial position when making decisions around planning and developing services. The finance team should be involved in supporting dental teams to assess the affordability and value for money of contracts, in particular when commissioning new activity or contracts.

• The accuracy of the POL system is also key to ensure that accurate and timely payments are made to dentists. If the system is not kept up to date then the PCT is at risk of making inaccurate and untimely payments which will create further work and expense, as well as making monthly reports inaccurate. An example of this would be where a contract is due to close, and the ‘closed date’ has not been entered into the appropriate field within POL in time to allow any adjustments to be made to monthly payments.

b. Internal reporting

As part of the monthly finance reporting process, the PCT finance team will produce budget statements for each service area. The ways in which these budget statements are organised and produced are determined on a local level, but it is important that this information is shared with the dental team and the designated budget manager. The reports should be reviewed regularly to ensure that they accurately reflect the current position, and forecast expenditure includes all known service developments. Reporting timetables will be agreed at beginning of year, to include scheduled time for discussion between the budget manager and finance.

It is also important to ensure that financial matters concerning dental services are reported regularly to the appropriate management board, which should include details of known and planned expenditure for dental services. It is good practice to include a regular report on dental services to the PCT board, either as a specific report or part of the primary care reports.

c. Monitoring of dental spend

In order to effectively monitor dental spend, PCTs will need to ensure that there is an appropriate plan/budget in place to be able to routinely monitor the level of spend against budget. PCTs should also consider the profile of expenditure to ensure accurate forecasting of dental expenditure.
The key components of the dental budget include:

1. Gross cost of contract values agreed with the dentists
2. Anticipated levels of PCR

PCTs will also need to plan for the following costs when calculating budgets for ongoing and new services:

- **Superannuation** – Section 1c provides details of how the employers’ superannuation costs are calculated and paid. PCTs need to ensure that they have up-to-date information on the estimated net pensionable earnings for each dental practitioner who is a member of the NHS pension scheme. For budgeting purposes the maximum liability for superannuation costs will be 14% of 43.9% of their gross contract values.

- **Cost of out of hours services** – All PCTs are responsible for the provision of these services for their population. Local arrangements may vary, and some services will be provided across a number of PCTs. The appropriate cost/recharge should be included within the overall dental budget.

- **Seniority payments** – These are payments made in respect of individual dental performers who meet the eligibility criteria listed within the Statement of Financial Entitlements (SFE) which is broadly based on the individual reaching the age of 55. When a dentist meets these criteria then they are entitled to receive a monthly payment, and their contract holder will make an application to the PCT in writing for this payment to commence. Section 6 of the SFE sets out how the payment is calculated and the maximum amount that is payable. To forecast future seniority commitments PCTs may wish to use any workforce information that may be available to assess the potential costs.

- **Payments for maternity, paternity and adoption leave** – Dental performers are entitled to payments from the PCT in respect of maternity, paternity or adoption leave taken, provided the eligibility criteria are satisfied. Section 8 of the SFE provides details of the eligibility criteria for each category of leave. Where a dentist meets these criteria then they are entitled to receive a weekly payment, calculated on the basis of the dentist performer’s estimated monthly pensionable earning. Where this payment is required, the contract holder is required to make an application to the PCT in writing for this payment. The conditions attached to these payments are also listed within this section of the SFE.

- **Long-term sickness leave** – A contract holder is entitled to receive sickness leave payments in respect of a dentist performer that it employs or engages in respect of a complete week of sickness absence, subject to the eligibility criteria set out in Section 9 of the SFE. Sickness leave payments are only payable in respect of a maximum of 22 weeks in any period of 52 weeks. The conditions and calculation of leave payment is set out in detail within Section 8 of the SFE.

- **Non-domestic rates** – A contract holder may be able to claim reimbursement of the non-domestic rates payable in relation to any premises where services are provided under its contract. The eligibility criteria is set out in Section 10 of the SFE and where these conditions are met then the contract holder must make an application to the PCT which must include the demand notice from the local authority for the financial year for which the claim relates to. The proportion of the non-domestic rates to be reimbursed will depend on the proportion of total gross income that relates to the NHS contract. The detail of this calculation is included within the SFE. If the contractor does not meet the eligibility criteria the PCT still have discretion to pay by virtue of section 112 of the NHS Act 2006.
• **Vocational trainees** – Since April 2006, the Department of Health formally allocates funding for vocational trainees to SHAs to enable them to direct resources in-year to those PCTs that require funding for VT placements. This funding is then passed to those PCTs as a supplementary allocation specifically to fund approved placements of VTs within dental practices. This funding covers the salary costs of employing the vocational trainee, provides payment to the performer who is providing the training to the vocational trainee and a payment to the contract holder to cover service costs. Section 7 of the SFE provides details of the payments and conditions in relation to vocational trainee payments. If the contractor does not meet the eligibility criteria the PCT still have discretion to pay by virtue of section 112 of the NHS Act 2006.

Appropriate planning and monitoring of these costs will ensure that PCTs can accurately monitor and manage spend within resources available. PCTs also need to ensure that the additional costs identified above are taken into consideration when budgeting for the costs of extended and new services. When planning new or extended services it is important that there is appropriate financial input at all stages of the process.

**d. Management of patient charge revenue (PCR)**

Because of the way in which PCT budgets are derived PCTs are at risk of variation between the indicative patient charge revenue and the actual PCR recovered. The patient charge incurred by fee-paying patients is based on the treatment banding system, and charges are reviewed each year.

The charge for each band of treatment is listed below (from April 2009):

<table>
<thead>
<tr>
<th>Band 1 (Urgent)</th>
<th>Band 1</th>
<th>Band 2</th>
<th>Band 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 UDA £16.50</td>
<td>1 UDA</td>
<td>3 UDAs</td>
<td>12 UDAs £198.00</td>
</tr>
</tbody>
</table>

Feedback from some PCTs is that the actual receipt of patient charge revenue has been lower than the assumed levels included within the AWP. However, as the new contract has been in place for over three years, PCTs are more likely to be able to make an assessment of the expected levels of PCR.

There are a number of variables that will affect the level of PCR collected by each PCT:

- the number of UDAs commissioned
- the number of UDAs actually delivered
- the proportion of charge-paying and exempt patients treated
- the number of charge-exempt treatments given to patients who would normally pay charges.

With respect to an individual contractor, where PCR is less than expected, there are six main recommended points of discussion between the PCT and the contract holder, namely:

- zero or low activity
- late reporting of activity
- patient mix
- high incidence of multiple courses of treatment (particularly for exempt patients)
- high incidence of urgent treatment (particularly for exempt patients)
- high incidence of charge-exempt treatments.
Each of these areas is covered in more detail below, and further details can be found in the PCR guidance issued by the Department of Health23.

i. No activity

Contractors are required to submit FP17 forms (or electronic equivalent) within two months of the date of completion of a course of treatment24. Without this data, the NHS DS cannot make PCR deductions from the contractor’s monthly payments or credit the contractor with UDAs. This also affects the ability of PCTs to be able to make accurate forecasts of full-year PCR, and understand levels of performance delivery.

ii. Low activity/delays in reporting

Where activity is significantly below the level that would be expected at the given point in the financial year, PCTs need to establish urgently the reasons for this. This may include a longer than expected time lag between completing and reporting courses of treatment. PCTs can monitor low activity via a number of reports available via the NHS DS. Appendix G lists the reports available.

iii. Patient mix

In some cases, PCTs and contract holders may have agreed (when contracts were first agreed in 2006), that the practice may restrict services to children or more generally to exempt patients. However, if there is no agreement of this kind in the contract, there is a contractual requirement to accept patients for treatment without discrimination between charge-payers and those patients exempt from paying for treatment.

If there has been a significant reduction in the proportion of courses of treatment given to charge-paying patients, this could reflect fewer charge-paying patients coming forward and/or being accepted for treatment; and/or little change in the underlying mix of patients, but a change in the relative frequency with which charge-paying and exempt patients receive courses of treatment. There may be an expected reason for changes in the underlying patient mix, eg an expansion in the service provided by the practice and a deliberate attempt to target increased capacity at areas of greater deprivation. If, however, there is a significant and unexpected reduction in the underlying patient mix, the PCT should establish the reasons for this with the contract holder.

iv. Multiple courses of treatment

Dentists should not be providing a second course of treatment if it is to address dental problems that have been identified – or should reasonably have been identified – during the first course of treatment. For instance, if a patient receives an examination and is asked to return later for a scale and polish (eg by a hygienist), this constitutes a single course of treatment. Similarly, if a patient receives a filling and is asked to return later to have a second filling (or other treatment) done, this constitutes a single course of treatment.

Where multiple visits are incorrectly reported as multiple courses of treatment, this will reduce the level of service provided by the contractor over the course of the year and provides poor value for money. If, in addition, multiple courses of treatment are given disproportionately to exempt patients, this will cause a PCR pressure. The ‘Managing inappropriate treatment patterns’ section of this handbook covers this area in detail.

v. Urgent courses of treatment

Urgent treatments are allowed for within the regulations in what should be limited circumstances where a dentist judges that immediate treatment is needed to relieve severe pain or to prevent significant deterioration in the patient’s oral health. There are some reports of dentists routinely only agreeing to see new patients on the basis of an initial ‘urgent treatment’. This would be a clear misapplication of the regulations.

24 GDS / PDS Regulations
vi. Charge-free items

Other areas that may lead to a reduction in the level of PCR collected:

- continuations of treatment (where a course of treatment is completed but a charge-paying patient then needs further treatment within two months, the further treatment is provided at no charge to the patient, but the dentist receives the appropriate UDAs)
- charge-free repair or replacement of certain restorations, and
- prescription-only treatments.

e. Accruals for PCR

Due to the nature of dental reporting, there will always be a time lag in the figures reported for patient charge revenue. Therefore, PCTs can choose to make monthly accruals to reflect this within the monthly finance reports. NHS DS have produced a report, which calculates the impact of this time lag and the indicative PCR accrual, which can be applied in the monthly budget statements. This information is provided in the ‘Time Lag Report’, which is produced on a monthly basis during quarter 4, an example of which is shown below:

<table>
<thead>
<tr>
<th>Months of treatment claimed on FP17s for XXX for the schedule period January 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total UDA</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>22,500</td>
</tr>
</tbody>
</table>

PCT finance will also need to ensure that appropriate accruals are made for patient charge revenue in the year-end accounts. This is for PCR that is collected for the activity reported between 1 April and 31 May.

Where contractors have delivered between 96% and 100% of their contracted activity, and the undelivered activity is carried forward to the next financial year for delivery, the finance team will need to ensure that the appropriate adjustments are made in financial reporting to account for the fact that the activity will be paid for in one financial year and delivered in the next financial year.

As part of this process the finance team need to ensure that any PCR accruals made are reversed once actual PCR receipts are made, to ensure an accurate position is reported for PCR.

f. Cost recharge to PCT

NHS DS acts as the paymaster on behalf of all PCTs in England, and makes all monthly contract payments. The details of what is paid to each contract is based on the entries made to the POL system, which is adjusted to reflect the value of PCR that has been reported as collected by each contract. The total net cost to the PCT is then recharged to the PCT via a cash top slice and the value will reconcile back to the detail contained in the ‘Monthly Record of Daily Cash Advances’ report which is produced monthly by the Department of Health. In addition NHS DS produce an equivalent top-level report entitled ‘Payment and Recharge’, supported by a detailed report, ‘Contract Payment Report’, setting out the contracts against which payments have been made.)
g. Conditional grant agreements

Due to the length of time associated with procuring new services, PCTs may find that they have a non-recurring element of funding available. A template agreement and accompanying guidance have been developed for use between a PCT and contractor to cover the issue of grants in these circumstances.

The template agreement provides a legal framework under the terms of which PCTs can provide supplementary funding (from either revenue or capital budgets) to NHS contractors outside existing contractual arrangements for specified capital expenditure which may be required to enhance the quality of NHS service provision.

The intention of the template is to offer a mechanism whereby funding is provided in grant form as an incentive to support the continued provision of NHS dental services under existing GDS or PDS contracts for an agreed term.

It is down to the PCTs to decide upon the appropriate use of this funding, but some examples of schemes that PCTs have already used include: funding for decontamination equipment, IT services and infrastructure and NHS signage.

3. External financial planning and reporting

a. Department of Health FIMS return

The Financial Information and Management System (FIMS) is the term given for a series of financial reports that PCT finance department are required to complete detailing their local budget plans and expenditure to support the DH and SHA monitoring of the dental financial performance. FIMS reporting requirements are set annually by the DH and SHA.

The key elements of dental expenditure data that have to be separately identified in FIMS returns, at plan stage and in quarterly monitoring returns:

a. Gross expenditure associated with primary care dental services broken down by:
   i. contractor-led services
   ii. trust-led services

b. Patient charge income derived from dental expenditure broken down by:
   i. contractor-led services
   ii. trust-led services

Each quarter monitoring return sets out the year-to-date position and the forecast outturn. The fourth quarter return, submitted in April sets out the draft outturn position, which should also mirror the position reported in the PCT’s statutory annual accounts in June.

In order to comprehensively and accurately complete dental FIMS returns it is essential that:

• dental commissioning leads and the financial teams liaise closely over the analysis and reporting of primary care dental expenditure

• PCTs correctly distinguish between contractor-led and trust-led services.

The reported position in FIMS should be routinely reconciled to the PCT internal finance reports.

PCTs may find it helpful to refer to the monthly PCT payment and recharge report provided to them by NHS DS which provides details of gross expenditure and patient charge income for contractor-led services.
Dental functions of PCTs

This section of the handbook includes some of the key messages from the January 2009 document ‘Primary Care and Community Services: Improving dental access, quality and oral health’

This section also highlights some of the characteristics of high performing PCTs and identifies some of the functions that they have adopted to ensure a multi-disciplinary approach and form an effective and appropriate management.
Dental functions of PCTs

Since 1 April 2006, primary care trusts have had responsibility for commissioning primary dental services to reflect local needs and priorities. This includes agreeing and monitoring local contracts with dentists or corporate bodies for the delivery of primary dental services.

This means that primary care trusts now have an integrated responsibility for commissioning both general dental care and more specialist dental care, regardless of whether it is provided in general practice, in community-based salaried services, or in hospitals.

The 2006 reforms introduced:

• a new statutory responsibility for PCTs to secure dental services that meet local needs
• local commissioning, with PCTs managing devolved budgets for dentistry and local contracts with dental providers.

There are several responsibilities placed on PCTs, including:

• assessing need
• assessing demand for dental services
• mapping existing services
• identifying what needs to change
• developing the vision
• describing the patient offer
• producing a strategic service model
• making it happen via a range of powerful commissioning tools and levers.

PCTs’ powers to manage contracts derive from a framework of secondary legislation. A world-class commissioner of primary dental care will have a good understanding of this legislative framework and how to apply it in an appropriate and timely manner. The relevant regulations are:

• The National Health Service (General Dental Services Contracts) Regulations 2005 www.opsi.gov.uk/si/si2005/20053361.htm
• The National Health Service (Personal Dental Services Agreements) Regulations 2005 www.opsi.gov.uk/si/si2005/20053373.htm
• PCT Dental Services Directions 2006 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4132909
• The National Health Service (Performers Lists) Regulations 2004 www.opsi.gov.uk/si/si2004/20040585.htm
• The National Health Service (Performers Lists) Amendment Regulations 2005 www.opsi.gov.uk/si/si2005/20053491.htm
• NHS (Dental Charges) Regulations 2005 www.opsi.gov.uk/si/si2005/20053477.htm
• NHS (Dental Charges) Amendment Regulations 2006 www.opsi.gov.uk/si/si2006/20061837.htm
• The Functions of PCTs (Dental Public Health) (England) Regulations 2006 www.opsi.gov.uk/si/si2006/20060185.htm
Transparent use of performance information

Without good comparative information on the quality of the services provided, PCTs cannot effectively manage performance, support quality improvements or provide information for patients and the public.

In line with the principles of ‘Measuring for Quality Improvement’ (see letter from David Nicholson and Sir Bruce Keogh to NHS chief executives of November 2008), you should make sure that you have a robust and balanced set of quality measures in place for primary dental care. These should be developed in collaboration with local clinicians and patient groups.

A quality framework or ‘scorecard’ can draw together and triangulate data from a variety of sources, including national data (e.g. reports published by the NHS Information Centre or NHS Business Services Authority) and local data (e.g. information from practice visits and patient feedback).

Together, this balanced set of data:
- enables PCTs and practices to reach an objective and rounded view of performance
- suggests the key metrics to be used in structured performance reviews
- encourages self-assessment and peer review
- helps keep the public informed about quality and performance.

The process of developing a quality scorecard is itself extremely valuable. It stimulates focused discussion with providers about current performance, strengths and weaknesses, and priorities for the future.

There are a number of examples of comprehensive scorecards that PCTs have already developed, and NHS Primary Care Commissioning has developed a step-by-step guide together with specific guidance and suggested definitions for dental scorecards.

Nationally available performance data

Regular information is available via NHS Dental Services. This enables PCTs to review performance at PCT and individual contractor level in four key domains and identify outliers and risk areas:
- access, measured by the number of unique patients seen in the previous 24 months
- activity, measured using data on commissioned activity reported by PCTs on the Payments on Line System and reported back to PCTs electronically
- expenditure, including planned PCT expenditure against budget available
- quality, including seven indicators using information from FP17s and the responses http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093831

26 www.pcc.nhs.uk/346
27 www.pcc.nhs.uk/360
**Characteristics of high performing PCTs**

Whether a PCT has 10 or 100 dental contracts in place successful PCTs have similar characteristics in terms of dental commissioning and contract management.

They invariably adopt a multi-disciplinary approach to all aspects of the work and utilise the relevant skills from each discipline to form appropriate clinical leadership and management.

- **Dental public health advice** – preferably via a consultant in dental public health. Entrance to the specialty is through a SAC accredited training and competency assessment. The GDC holds and regulates the specialist list. The public health specialist should ensure that health needs assessments are robust and appropriately focused at the needs of the population and that PCTs can understand the impact of demographic factors on contract management. The consultant will offer specialist advice on the appropriateness of service delivery, service redesign and the development of care pathways. A consultant in DPH can also act as an objective advocate for patients leading to improved health outcomes and improvements in quality of service delivery. All such consultants are part of a wider regional and national network sharing good practice and are able to bring a wider perspective to the shaping of future services.

- **Annual review processes** – These should have board level sign-off and should ideally be separate from contract review and mid-year contract reviews. Any contract review process should relate to the PCT’s commissioning approach and oral health strategy and should be informed by a robust and timely oral health needs assessment and an understanding of dentistry. It should contain no surprises and be fair, transparent and ensure consistency for the PCT, contractors and patients. Any review policy should:
  - assure the PCT that the appropriate clinical needs of patients are being met and that demand is being managed
  - assure the PCT that current best practice and guidelines are being adhered to
  - ensure equity and fairness for all providers
  - ensure continuity of patient services
  - ensure the development and provision of high quality of services
  - give providers confidence in the review process
  - provide stability for providers where appropriate
  - review services against identified needs
  - ensure value for public money
  - be consulted on with stakeholders
  - communicated with all dental contract providers
  - have board approval.

- **Annual contract reviews** – These should take place with each contract provider on an annual basis following the release of the end-of-year reports. Ideally these review meetings will involve a team approach from the PCT and may typically include a commissioner, contract management, finance and a clinical adviser to the commissioning team. There should be a clearly identified agenda and process provided to the practice prior to any meeting taking place.

- **Mid-year reviews** – These are undertaken as per the annual contract reviews above to those contract holders whose performance is deemed to be below acceptable levels at the mid-year point.
• **Provision of information to practices** – It is good practice to ensure that practices receive up-to-date and timely information from the PCT. Whilst practices may already receive information from NHS Dental Services on their contracted positions, it is useful if PCTs also inform practices on a regular basis of their performance. This should ideally include additional information such as information from patient surveys. PCTs should consider producing user friendly versions of their oral health needs assessments and associated commissioning plans so that practices are aware of the commissioning priorities of the PCT.

• **Oral health commissioning group** – Successful PCTs adopt a multidisciplinary approach to the strategic planning and commissioning of dental services. This approach involves key PCT personnel including finance, consultants in dental public health, dental commissioners and dental practice advisers as well as representatives of the dental community including members of the LDC, the PPI lead and PALS. This group would help to structure thinking, development, agreement and reviews of PCT commissioning strategies.

• **Operational/monitoring/management group** – This group implements initiatives identified by the oral health commissioning group and monitors, informs, and reports on development issues.

• **Dental practice adviser** – Good dental practice advice is essential to the successful commissioning and contract monitoring functions within the PCT. A good adviser will organise, manage and develop a programme of quality assurance for dental practices, general dental practitioners and their teams. The adviser is the conduit between the PCT dental commissioning function and clinical colleagues in primary care. They work with PCT officers and the consultant in dental public health to develop clinical leaders and work with the PCT’s clinical governance lead to implement and assure standards for better health in dentistry. This can be instrumental in establishing effective peer review and clinical audit processes and can also be relied on to establish practitioner advice and support schemes. Advisers perform an important function in contributing to the identification and management of poor clinical performance within the contracting process. They contribute to the work of reference committees and performance panels.

• **Use of dental reference officer reports** – These provide a useful external validation of clinical performance. The reports should be received by the general dental practice adviser. These reports can form part of the annual review process where PCTs should be taking a holistic approach to contract management. The reports should be shared with the consultant in dental public health for oversight and to assist with strategic planning. This approach can help identify common dental training needs and assist with the identification of a training and workforce development and education programme.

• **Clinical leadership and engagement** – World-class commissioning demands that local clinical leaders are identified and developed. A clinician who understands the dental agenda and is focused on improvement of clinical outcome and quality of services can be a powerful advocate and catalyst for change. Clinicians are more likely to respond positively to another clinician than to a commissioner.

• **Local dental committee engagement** – The LDC is a statutory body that has been elected to represent the local profession. It has a key advocacy role to play for the profession. A well functioning LDC can give equal challenge or support to a PCT as well as a fellow professional. They can provide a voice in ensuring that equity and fairness for dentists is being achieved. Excellent LDCs can perform this function whilst supporting improvements in services and outcomes for patients.
• **Performer list application/management** – Ensure that robust processes exist for the management of the dental performer list and have a clear understanding of the performer list regulations. It is essential that the entire dental team is familiar with the performer list regulations and understand the requirements for inclusions, reasons for suspensions and ultimately removal from a PCT list. PCTs will ideally have poor-performance panels that review evidence and make decisions on when it is appropriate to demand extra training, impose a suspension or ultimately remove a provider from the performer’s list.

• **Patient Advice and Liaison Service (PALS)** – This help line can be a useful source of information for addressing quality issues within some dental practices and a useful resource for assessing demand for NHS dental services as well. The simplest way of gauging unmet demand is to have in place a well-publicised dental access helpline, both for people seeking urgent care and those seeking help in finding a regular NHS dentist, and to monitor systematically the nature of these needs and your ability to offer people services that meet those needs.

• **PCR reconciliation** – Regular and consistent monitoring of PCR can provide for better management of the overall dental budget within a PCT, but more significantly can assist hugely in the overall contract monitoring framework that the PCT has adopted. Identifying factors at individual practice level that may be contributing to projected shortfalls in dental patient charge revenue will allow PCTs to work with dental practices to take corrective action.

The six main areas recommended for discussion between PCTs and dentists to establish potential reasons for shortfalls in PCR are:

1. No reported activity
2. Low reported activity and/or late reporting of activity
3. Patient mix
4. High incidence of multiple courses of treatment (especially for exempt patients)
5. High incidence of urgent treatment (especially for exempt patients)
6. High incidence of charge-free items

• **Managing the vocational training process** – PCTs need to be fully aware of the timetable for the recruitment of vocational training practices and the recruitment of vocational trainers (VTs). It is vital that regular contact is maintained with both the local deanery and practices to ensure that all necessary procedures for inclusion on the performer list and CRB checks are performed prior to a VT starting their placement. PCTs will need to ensure that appropriate contracts are in place between the practice, VT and PCT and that full understanding exists between both parties.

• **Team training** – Ensuring that any team is provided with the appropriate training to provide them with the skills necessary to undertake the roles associated with the commissioning and contract management of dental services is vital if the best services are to be secured for patients and the best value achieved for the PCT. Encouraging team training helps to ensure that not only are skills shared and developed across the whole team but it reinforces that commissioning and contract management of dental services are most successful when undertaken using a multidisciplinary approach.

• **Public and patient engagement** – World-class commissioning competencies require PCTs to demonstrate that they undertake PPE activities as part of their commissioning processes. Dentistry should not be excluded from this. PCTs may wish to consider a range of options for undertaking this activity which could be through engagement with local involvement networks, community groups, practice participation groups or other patient forums. These activities are useful in ensuring that patients and public are aware of the PCT’s vision, key local priorities and delivery objectives for services. Gathering patients’ views will help not only support overall commissioning intentions but will help in the development of appropriate self-care materials for patients and the public.
Questions for the board

Are the access needs of the local population being met for dentistry – is there ‘noise’ in the system?

Where does improving access to NHS dental services fit in the PCT’s priorities list?

Is there an oral health commissioning strategy in place and is it informed by an up-to-date oral health needs assessment?

How does dentistry measure up to the quality and productivity challenge?

Are the dental services we commission going to meet CQC requirements?

How does the PCT ensure adequate clinical and patient engagement in dentistry?

Can the PCT demonstrate that dental services are good value for money?

Does the PCT have robust systems for the performance management of dental contracts?

Does the PCT have effective governance and leadership in place to manage and develop dental services appropriately?
Questions for the executive team

Are we leading on access to NHS dentistry?

Are decisions being taken at the appropriate level in the PCT?

What is our level of engagement with patients and the public – do they know what to expect when accessing NHS dental services?

Have we continuous and meaningful engagement with NHS dentists and are we confident that we are leading professional change?

Does the PCT commissioning team have access to specialist and/or impartial dental clinical advice?

Do we understand local oral health needs and are we prioritising investment to improve access?

Is there adequate capacity and competency within the dental contract monitoring team?

Are we effectively managing contracts to achieve best value and quality?
Are we making full use of available data and are we meeting our Vital Signs trajectory?

Are we investing capacity in sound contract management – do we know what we are paying for and do we claw back resources from inefficient or ineffective contract delivery?

How are we stimulating the market to open up access to NHS dentistry?

Are we aligned with the principles and rules of co-operation and competition, including management of provider expectations, governance, procurements, mergers and acquisitions?
Questions for the overview and scrutiny committee

Can everyone in the area, who wants to do so, find a NHS dentist?

Are inequalities in access to dental services being addressed?

Are oral health needs understood and reported?

Does the PCT have a fair, open and transparent approach to procuring and managing dental contracts?

Does the PCT protect patients by ensuring the quality of dental services?

Does the PCT have audited processes for monitoring efficiency and effectiveness of dental contracts?
## Appendices

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A Appointment and induction of a dental practice adviser

Background

This is usually a part-time post and is most successful when it is undertaken by a practising NHS dentist from a neighbouring PCT area. It is usually helpful if the dentist does not hold a contract with the PCT to mitigate a potential conflict or personal interest issues. Consultants in DPH and dental practice advisers can be hosted by one PCT on behalf of a number of PCTs working in consortia to provide a team of advisers and support staff with a wide range of experience and interests.

Appointment advice

Our experience indicates that PCTs should seek to appoint dentists who have considerable experience of NHS general dental practice. Dentists from salaried services rarely have the same experience.

When appointing a dental practice adviser, PCTs should clearly define the role and key relationships, ie:

- it is desirable that the applicant has a postgraduate qualification because this will demonstrate a commitment to continuing professional development
- preferably the applicant should also be able to demonstrate experience of working in other branches of dentistry because the role will often bring the adviser into contact with or PCT advice sought about other branches, eg secondary care or salaried services
- a wide clinical experience is useful so that advice can be given to patients and PCT complaints teams
- the applicant should have the respect of his or her local colleagues
- good communication and IT skills are essential
- the applicant should be well informed about NHS contract and regulations, performers list regulations, complaints systems, GDC standards, clinical governance and good clinical practice.

After appointment

A clear infrastructure in the PCT supported by demonstrable clinical and executive leadership is necessary.

Clinical leadership can come from a consultant in dental public health working closely with or managing dental practice advisers. Dental practice advisers have an important role to play in clinical governance and in clinical input to the contracting review process when it is required. A regular cycle of practice visits can be agreed with PCTs with administration support from both PCT and team administrators.

Key steps to take:

- ensure exposure to PCT induction and policies
- set up mentoring by another more experienced adviser
- provide IT and administration support
- agree a training programme and a training budget
- provide funding support for role development
- allow dedicated time for post and avoid ad hoc arrangements
- involve DPA in PCT processes and dental policy decisions
- remember that line management is important and needs to be supportive.
Once in post
• ensure that DPA has enough office time to keep up to speed with current guidance, deal with correspondence, reports etc.
• has access to desk and IT and administration when in office
• encourage to link with other DPAs and deanery tutors
• annual appraisal and update personal development plan.

Ongoing training opportunities
• Certificate in Practice Appraisals (Faculty of General Dental Practice)
• Certificate in Dental Health Services Leadership and Management (Faculty of General Dental Practice)
• Diploma in Dental Practice Advice (in planning)
• Deanery courses in leadership and education
• National Association of Dental Advisers, Conference
• Dental Tutors’ Conference
• BDA Conference
• Faculty of General Dental Practice
• NCAS events
• NHS PCC events
• PCT leadership and management training.

B Job description and person specification for a dental practice adviser

<table>
<thead>
<tr>
<th>TITLE</th>
<th>PCT dental practice adviser (DPA)</th>
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<tbody>
<tr>
<td>APPOINTMENT</td>
<td>The DPA will be appointed by XX sessions/XX days per week.</td>
</tr>
<tr>
<td>ACCOUNTABILITY</td>
<td>The DPA will be accountable to the medical director of NHS Anytown and key elements of the role will be directed and managed by relevant leads with the organisation.</td>
</tr>
<tr>
<td>KEY WORKING RELATIONSHIPS</td>
<td>Lead for professional affairs, consultant in dental public health, lead for clinical governance and primary dental care commissioning lead.</td>
</tr>
<tr>
<td>BASE</td>
<td>The dental practice adviser will normally be based within the [relevant] directorate. The post requires a close working relationship with the primary care commissioning and dental public health teams based [wherever].</td>
</tr>
<tr>
<td>INDUCTION &amp; TRAINING</td>
<td>1. The induction and training of the DPA will be determined by the needs and experience of the appointee in the first instance.</td>
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<tr>
<td></td>
<td>2. The DPA must keep up-to-date with the knowledge and skills required to fulfil the role, including local and national rules and regulations governing and pertaining to general and personal dental services within the NHS, and the responsibilities of primary care trusts in the delivery of dental services.</td>
</tr>
</tbody>
</table>
The DPA role will cover the following elements with specific objectives to be agreed on an annual basis:

1. Contribute to the development and implementation of a framework to manage concerns regarding professional performance in dentistry. This will include investigating concerns and advising on disciplinary procedures for dental practitioners employed or contracted by NHS XXXXX.

2. Contribute to professional advice to improve the quality of dental service delivery in liaison with the consultant in dental public health. Assist in the development of dentists with special interests (DwSI).

3. Organise, manage and develop a programme of quality assurance for dental practices and their teams to meet ‘Standards for Better Health’ requirements. This duty includes developing an approach of self-assessment and continual improvement within dental practices and will include supporting a programme of practice visits (at least once every three years) to all contractor premises. You will produce reports and provide support to practices by agreeing action plans to ensure continual improvement. This responsibility will be important in the development of the XXXXXXX standard within primary care dental teams and in the longer term support practitioners to revalidate by developing the production of quality accounts for dental practices.

4. Provide advice, guidance and support as requested by primary care dental commissioning team on contracting matters to facilitate and support the effective, procurement, provision and assurance of high quality, preventive NHS dental care in primary dental care services.

5. Provide advice on clinical and operational issues related to the NHS dental contract and independent dental contractor status.

6. Advise professional affairs on the management of the dental performers’ list, including conditional inclusion requirements, when appropriate. Work with the postgraduate dental dean on the delivery of assessed vocational training where necessary.

7. Work with the consultant in dental public health to deliver the oral health strategy as approved by XXXX PCT board in [date].

8. Work with PCT officers to implement a system that assures ‘Standards for Better Health’ are being met and can be evidenced within primary dental care. This will include supporting the development of peer review, clinical audit and appraisal in practice.

9. Work with the PCTs complaints manager and PALS officer to facilitate the resolution of dental complaints, including liaison with patients and practices where necessary.
Working objectives:

10. Establish and manage a dental practitioners advice and support scheme to ensure that practitioners are working safely and receive early advice and support.

11. Attend appropriate committees, in particular the clinical dental leads group, the local dental committee (by invitation) and the clinical engagement group.

12. Establish and maintain collaborative links with the vocational training scheme (where appropriate) and liaise with the local postgraduate dental tutor in order to ensure and contribute to appropriate postgraduate activity for the dental team.

13. Liaise with other dental organisations, including the postgraduate deanery, British Dental Association, Faculty of General Dental Practice and the dental defence organisations as required.

14. Maintain links with other dental practice advisers to share and utilise good practice.

15. Foster the development of multi-professional matrix working and learning.

16. Acquire and maintain the skills and knowledge necessary to fulfil the role of a DPA. This includes skill in mentoring and counselling, knowledge of the rules and regulations governing NHS dentistry and commissioning and contracting within the NHS. The DPA should be aware of the priority areas defined by NHS XXXXXX and the Department of Health.

17. Promote the roles and development of dental care professionals where appropriate.

18. Provide timely reports, when requested on programmes and key areas of work.

19. Carry out such other duties as may be designated by the medical director.

PERFORMANCE REVIEW

The DPA will undergo an annual performance review and agree objectives for the year. The DPA will be expected to have a personal development plan.

REMUNERATION

Three days per week at the GP00 £XXXXX or GP01 £XXXXX depending on experience. Locum payments can also be negotiated if required to allow backfill of NHS dental primary care service to an annual maximum of £5,000 per session per annum.
Performance management
The postholder will participate in performance management systems locally (and this may include providing information for performance monitoring or updating the Performance Accelerator) that reflect the values of the organisation, particularly in terms of being ambitious, challenging and accountable.

Health and safety at work
Management ensures the adoption of safe work practices consistent with health and safety.
The postholder must not wilfully endanger themselves or others whilst at work. All accidents must be reported and potential hazards identified.
The postholder must be responsible for all trust property and the reporting of all potential or actual breaches of security.
The PCT operates a no-smoking policy.

Mandatory training programme
As an employee of the primary care trust the postholder must participate in the mandatory training programme.

Equality and diversity
Support the equality and diversity agenda within the directorate.
Ensure that the impact on equality and diversity of proposals and policies within own area of responsibility is assessed and action taken to reduce any negative impact.

Disability Discrimination Act
The primary care trust may make ‘reasonable adjustments’ to the post/place of work in order to facilitate the employment of individuals with a disability. These adjustments will be in line with the requirements of the Disability Discrimination Act 2006.

Any other duties within the framework of the post
The postholder may be required to undertake other duties and responsibilities within the framework of the post.
As this post is developmental within a new and changing PCT structure, the role will be reviewed with the postholder within a year of appointment.
## PRIMARY CARE TRUST PCT DENTAL ADVISER – PERSON SPECIFICATION

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
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<tbody>
<tr>
<td>BDS or equivalent. Current registration with the GDC.</td>
<td>Relevant postgraduate qualification (e.g. MFGDP(UK)).</td>
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| Experience | Substantial experience in primary dental care clinical practice which must include current or recent experience in NHS nGDS or nPDS practice. Broad understanding of the structure and working of the dental services. Evidence of personal CPD. Commitment to adult learning and CPD. | Experience as a dental practice owner/Provider Previous experience in mentoring. Understand the importance of the dental team in the provision of oral care. Ability to motivate and develop others. Member of professional societies. |

| Postgraduate Education | | |
|------------------------| | |
| Good communication and interpersonal skills. Credible member of the dental community. Commitment to equality, diversity and human rights. Ability to establish and maintain good working relations with PCT officers and members of the dental profession. Motivation and initiative. Ability to work as a member of a team. Demonstrable evidence of good organisational ability. Willingness to participate in personal training and development. IT skills – word processing, e-mail, basic web skills. Demonstrate public service values and ethics. | Ability to prioritise and organise own time. IT skills (or be prepared to learn) – basic word processing, spreadsheets and databases. Ability to prioritise and organise own time. Has received skills training in mentoring and/or counselling. Evidence of course organisation and management. Report writing and investigation skills |

| Personal skills and attitudes | | |
|-----------------------------| | |

| Knowledge | Sound knowledge of clinical governance and related national policy. | Understanding of standards for better health and operating framework. |

| Networks | Ability to build local and regional networks, relevant to the role. | Existing involvement in local and regional networks. |
D  Template letter to GDS practices regarding end-of-year submissions including optional paragraph warning of potential underdelivery

It is suggested that this letter is sent to practices at the beginning of January each year.

[insert PCT name]
[date]

Dear [insert contractor name]

Contract number:

**End of year submission** [insert financial year]

As you will know, the PCT is required to produce an annual reconciliation report for each of its dental contracts by 30 June each year for the previous financial year.

I am therefore writing to remind you that, in accordance with the Paragraph 38 of the NHS (General Dental Services) Regulations 2005, the latest date for submission of FP17 forms for courses of treatment completed or terminated in the financial year [ ] is 31 May.

Please ensure that all FP17 forms are sent to NHS Dental Services on or before this date. Late submissions may not be taken into account when calculating the annual activity delivered under your contract.

[extra para to be adapted as appropriate and used in the case of potential underdelivery]

At your mid-year review on [date] we discussed the activity delivered up to 30 September [insert year] and agreed a plan to ensure that you would be able to deliver your contracted level of UDAs by the year-end. Our current projections as at [insert date] indicate that you are still at risk of underdelivery by [insert no of UDAs and % of contracted activity].

If you have any queries relating to this letter, please do not hesitate to contact me on [insert tel no] or [insert email address].

Yours sincerely

[insert PCT manager name]
## Dental practice contract management checklist

<table>
<thead>
<tr>
<th>Name and address of Practice</th>
<th>Date of Visit</th>
<th>Attendees</th>
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<table>
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<tr>
<th>Contract number</th>
<th>Self-assessment proforma completed?</th>
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### Activity and Finance

- Contract value and activity
- Performance history: under-or over-delivery
- £ owed to PCT?
- Policy for minimising DNAs
- % DNAs
- Contract variations?

### Access

- No of new patients expected
- Re-attendance
- Daytime urgent access slots available?
- Evening/weekend availability?
- Opening hours?
- Taking new NHS patients?
- DDA compliance
- Practice ansafone message

### Quality and Governance

- Patient leaflet available?
- NHS Patient charges notice on display?
- Complaints
- Decontaminaton

### Practice development

<table>
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<tr>
<th>Follow up actions agreed</th>
<th>By</th>
<th>When</th>
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Appointment of a consultant in dental public health

In establishing a post the job description and person specification must be approved by the local SAC adviser. This appointment can be a shared arrangement across a number of organisations.

Job description for a consultant in dental public health

Title & grade of post: consultant in dental public health

Appointment: PAs negotiable WTE 10
The job plan will specify sessional commitments
The postholder may also hold an honorary appointment in one of the dental academic teaching institutions

Salary: Consultant scale in accordance with new Consultant Contract (2003)

Accountability: The appointee will be managerially accountable to the director of public health
Professionally accountable to PCT board

Introduction

The role of the consultant in dental public health is to provide leadership and specialist advice to the PCT on oral health and dental services. To work towards the improvement of oral health and reduction of oral health inequalities and access/uptake of services in the area covered by PCT. Local commissioning of dental services is a relatively new responsibility for PCTs and the consultant will have a key role in this process ensuring that commissioned services meet the needs of local communities and supporting the development of local providers in line with World-class commissioning and the Operating Framework.

The PCT has recently developed an oral health strategy which includes a commissioning plan. The new consultant will be responsible for leading on the implementation of this strategy and for providing advice and support to both commissioners and providers of NHS services.

Job summary

The consultant in dental public health will provide specialist dental public health advice and leadership in relation to oral health and dental services for PCT.

The key aims of this post are to improve oral health in the context of overall health and to reduce inequalities in both oral health and in access/uptake of dental services through the effective delivery of the PCT’s oral health strategy.

The postholder’s main responsibilities will be:

1. Oral health needs and demands assessment
   - assessing oral health needs, inequalities, services and standards of oral health care throughout the community
   - commissioning, and/or if appropriate, conducting surveys and studies in order to assess oral health needs and inequalities
   - managing, analysing and interpreting oral health and dental service data to support the PCT’s planning and commissioning roles
   - ensuring that the PCT’s responsibilities for oral health needs assessment and epidemiological surveillance are met to national standards as required by the Department of Health
   - collaborating with other consultants in dental public health in relation to oral health needs and demands assessment, comparative needs assessments and benchmarking.
2. Commissioning and evaluation of dental health services

- developing, implementing and performance managing local oral health strategies and commissioning plans
- contributing, as appropriate, to PCT and local authority strategies for health improvement and the reduction of inequalities, and ensuring appropriate input into local delivery plans and community plans
- improving access to dental services for residents and ensuring appropriate access is available for vulnerable groups
- monitoring the provision, quality and effectiveness of oral health care services and oral health promotion programmes
- advising the PCT in relation to:
  - population oral health needs
  - the commissioning (or where appropriate, provision) of services for oral health promotion and for dental care which meet the needs of the population and which comply with the appropriate quality standards
  - the procurement and contracting processes through which health services are commissioned and monitored
  - service specifications to meet identified needs, negotiation and monitoring of service agreements
  - the delivery of national targets for dental services including specialist dental care and the development of clinical care pathways and clinical networks
  - the measurement and performance management of quality in dental services
- working with the general dental practice adviser to implement Standards for Better Health within dental services
- providing support and encouragement for dental service provider development.

3. Promoting oral health

- promoting oral health and evidenced informed preventive oral health care
- promoting the oral health of vulnerable groups in the population and reducing inequalities related to oral health and inequitable access to oral health care
- providing advice from the critical appraisal of the evidence base for the effectiveness of interventions to improve oral health and from the evaluation of oral health services
- advising the PCT on water fluoridation and working closely with the strategic health authority to assess the feasibility of water fluoridation
- promoting the delivery of evidence-based prevention and oral health improvement in general dental practice
- working collaboratively for oral health through local strategic partnerships
4. Research and development
• initiating and participating in research projects to investigate problems relating to local oral health needs, service provision and other related public health issues
• participating in applied research which will lead to improvements in oral health and dental services
• commissioning applied research to provide information to support the dental commissioning agenda
• managing knowledge and getting research into clinical practice
• collaborating with academic and clinical partners to improve the evidence-base for oral health improvement and dental practice.

5. Teaching and training
• participating in the deanery dental public health specialist training programme
• providing an input to undergraduate and postgraduate teaching of dental public health
• supporting the continuing professional development of dental professionals
• providing an input into workforce planning through regional dental workforce planning groups.

6. Effective communication
• acting as the PCT’s lead for oral health and dentistry
• leading on the development of an effective dental team within the PCT in order to ensure a joined up approach to oral health and dentistry within PCT
• promoting the effective dissemination of information between the SHA, PCT and providers
• leading on the development of an effective mechanism for engagement with local dental professionals and other stakeholders
• providing advice and information to the general public and the media on clinical and public health dental issues
• contributing, as required, to the director of public health’s annual report and other PCT communications.

7. Management and specialist duties
• providing leadership on oral health matters and for the dental profession across PCT
• to be an active member of the oral health advisory group or similar/successor group(s)
• working with dental commissioners of neighbouring PCTs and other consultants in dental public health in appropriate regional groups
• supporting the director of public health and colleagues within the PCT to contribute to the smooth running of the department
• advising the local authority overview and scrutiny committees on oral health and dental service issues as required
• manage/work closely with the PCT’s general dental practice adviser to ensure high standards of care
• developing quality and risk management in dentistry within an evaluative culture.

8. Professional development
There is a requirement for the consultant:
• to undertake continuing professional development to meet General Dental Council standards
• to participate in dental public health audit including regional audit
• to agree an annual job plan and participate in annual appraisal.
Public health directorate

**Staffing**
The directorate includes a director of public health, consultants in public health, public health managers, and public health trainees.

**IT, secretarial support and other internal resources**
There is administrative support and access to IT and information analyst support. Library facilities are available in Manchester PCT.

**Local training and CPD arrangements**
The directorate has trainees in public health as part of the deanery rotation and regular journal club sessions.

**GENERAL CONDITIONS**

**Terms and conditions of service**
The appointment is subject to the terms and conditions for consultants in dental public health in England and Wales, as agreed nationally and in accordance with the new consultant contract (2003).

**Communications and working relations**
The department aims to maintain the goodwill and confidence of its staff, service users and the general public. To assist in achieving this objective it is essential at all times for employees to carry out their duties in a courteous and sympathetic manner. Each member of a team is expected to establish and maintain positive interpersonal relationships with other members. Positive relationships are characterised by open communication, trust and respect.

**Human resources policies and procedures**
All duties and responsibilities must be undertaken, at all times, in compliance with the trust’s HR policies and procedures.

**Health and safety**
All employees must be aware of the responsibilities placed upon them under the Health & Safety at Work Act (1974) to ensure that the agreed safety procedures are carried out to maintain a safe environment for employees and visitors.

**General**
The duties of this post are subject to review at regular intervals in the light of developments within the department and changes may be made to this job accordingly. This job description is not exhaustive and may be amended from time to time as the needs of the service change. The job description will be reviewed annually as part of the performance appraisal and development scheme.

**No smoking**
The PCT has a no smoking policy. There is a strict no smoking policy within the PCT premises.
Confidentiality
You must not disclose, either during or after the termination of your employment, any information of a confidential nature relating to the PCT, its staff, its patients or any third party, which may have been obtained in the course of your employment. Such information must be handled securely at all times, including home and remote working if applicable.

Data protection
The postholder will be expected to hold data only for the specified registered purpose and to use or disclose data only to authorised persons or organisations as instructed. Any information held on a computer or word processor should only be obtained, processed and/or used in a fair and lawful way.

Equal opportunities policy
It is the aim of the employing organisation to ensure that no job applicant or employee receives less favourable treatment on grounds of gender, religion, race, colour, sexual orientation, nationality, ethnic or national origins or is placed at a disadvantage by conditions or requirements which cannot be shown to be justifiable. To this end, there is an equal opportunities policy in place and it is for each employee to contribute to its success.

Flexibility
The postholder may, with their agreement – which should not reasonably be withheld – be required to undertake other duties which fall within the grading of the post to meet the needs of this new and developing service. Staff will develop flexible working practices both within public health and at other organisational levels as appropriate, to be able to meet the challenges and opportunities of working in public health.
## PERSON SPECIFICATION

**Post:** Consultant in Dental Public Health

**Hospital:**

<table>
<thead>
<tr>
<th>Attainments</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
<th>HOW ASSESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Registration</strong></td>
<td>• Full registration with the United Kingdom General Dental Council (GDC)</td>
<td>• Possession of a Certificate of Accreditation or eligibility for a CCST in Dental Public Health</td>
<td>CV and Documentation</td>
</tr>
<tr>
<td><strong>Specialist listing</strong></td>
<td>• On the GDC Specialist Register in Dental Public Health or within six months of eligibility for inclusion</td>
<td>• Membership/Fellowship in Dental Public Health or equivalent</td>
<td>CV and Interview, Documentation</td>
</tr>
<tr>
<td><strong>Professional Qualifications (see Footnote)</strong></td>
<td>• Fellowship in Dental Surgery or Membership of the Faculty of Dental Surgery, or equivalent</td>
<td>• Membership/Fellowship in Dental Public Health</td>
<td>CV and Documentation</td>
</tr>
<tr>
<td></td>
<td>• Masters degree in Dental Public Health or equivalent</td>
<td>• Membership/Fellowship of the faculty of Public Health Medicine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Intercollegiate Fellowship Examination in Dental Public Health or equivalent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Higher Degree by Thesis (Honorary Consultants for Academic Appointments only)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Training (see Footnote) | Successful completion of an SAC-approved four year minimum training programme in Dental Public Health (three years if in possession of an SAC approved Masters qualification), or within six months of completion, or equivalent | CV/Interview |
| | • Current holders of an NHS or honorary NHS consultant contract in Dental Public Health are eligible to be short listed | |
| | • Applicants who are Nationals from another EEA country or overseas would have to show equivalence to the four years minimum training period in the National Health Service required for Dental Public Health | |

| Teaching | • Experience of postgraduate and undergraduate teaching | CV/Interview |
| | • Training in teaching | |

| Audit | • Effective participation in audit | CV/Interview |

| Research | • Research relevant to Dental Public Health | Publication in refereed journals |
| | • Ability to appraise scientific literature critically | CV/Interview |

| Management | • Able to prioritise and deliver high quality work against a background of change and uncertainty | CV/Interview |
| | • Experience of achieving innovation and change | |

| Personal | • Strongly held commitment to improving health including dental health, public health ethics and fostering learning environment | CV, Interview and possible presentation |
| | • Articulate and able to advocate for health | |
| | • Commitment to team working | |
| | • Excellent written, oral and presentation skills | |
| | • Strategic thinker | |
| | • Self-motivated, proactive and innovative | |

| General | • Satisfactory pre-employment health screening | Human Resources check |

---

1. The above criteria should be considered minimal and trusts would be entitled to add other criteria (both essential and desirable) to take account of local circumstances.
2. The professional qualifications and training requirements listed apply to individuals who are currently undertaking training to consultant level, or have completed specialist training within the last few years. Existing consultants and other individuals, who have gained entry to the specialist list during the mediated entry period, will not be expected to hold all or any of these professional qualifications and might not have followed the established training pathway, which is why the term ‘or equivalent’ is used.
3. Current holders of an NHS or Honorary Consultant Contract in Dental Public Health are eligible for short-listing.
4. Applicants who are nationals from another EEA country or overseas would have to demonstrate equivalent training/qualifications.
5. For Honorary Consultant posts linked with Senior Lecturer/Professorial appointments a higher degree by thesis, research relevant to dental public health and publications in peer reviewed journals would be additional essential criteria.
F Understanding the dental allocation

1. Introduction

Local commissioning of dental services commenced on 1 April 2006, and in order for PCTs to effectively undertake this role, budgets were devolved to the PCTs to manage. Prior to this date, the majority of primary care dental costs were funded through a ‘non-cash limited’ budget which was held centrally by the Department of Health.

PCTs receive their dental allocation each year via a non-recurrent resource allocation, which is notified usually via an AWP (Allocation Working Paper) issued in January/February for the following financial year.

PCTs commission NHS dental services on a gross cost basis, against which deductions are made for the level of patient charge revenue collected by the contractor, to determine net monthly payments. Department of Health make an indicative assessment of the level of patient charge revenue to be collected when calculating each PCT’s allocation, ensuring that PCT allocations are funded on an equivalent net cost basis.

As a result, PCTs are at risk of variation between the indicative patient charge revenue and the actual PCR recovered.

2. Historical calculation of the dentistry budgets – 2006/07

2006/07 was the first year that PCTs received a devolved budget for primary care dental services.

The dental budget was calculated for each PCT, and allocated on a net cost basis, which reflected two main factors:

• the most recent levels of gross expenditure, which was derived from the PCTs service commitment at that point in time, covering expenditure on GDS services in the area, and also the PDS pilots that were in operation, together with a growth element to reflect continuing expansion of the dental workforce and NHS dental services

• the forecast levels of patient charge income associated with this level of gross expenditure, based on the new system of patient charges.
In setting the net budget, the Department of Health had to make a number of assumptions about the levels of activity agreed as part of the new contracts with dentists and the associated patient charge income that PCTs were expected to receive.


Funding for 2009/10 continues to be by means of a non-recurrent resource allocation for primary care dentistry. In addition, PCTs can choose to direct further resources to dentistry from their main NHS allocation, if they consider it appropriate in the light of local needs and priorities.

Following the 11% increase in 2008/09, a further 8.5% was announced for 2009/10 onwards. This is a total increase of £385 million nationally over two years, which provide PCTs with the resources to help resolve the problems of access to NHS dentistry.

The funding methodology for 2009/10 for initial PCT allocations included a baseline uplift of 3% on the 2008/09 net allocation, which was to ensure that all PCTs received growth over and above the DDRB uplift, which was confirmed as 0.21% for 2009/10. In addition, further growth monies (£25 million) make progress towards equalising funding per head of population (FPHP) across SHA areas, which gave SHAs a differential share of the additional growth monies depending on whether the area was above or below the national average of FPHP. SHAs were then asked to decide how the additional growth element be distributed amongst its PCTs, to take into account local circumstances and priorities. Allocations were made to PCTs on this basis by the Department of Health.

4. Funding for vocational trainees

In line with arrangements followed since April 2006, the Department of Health formally allocates funding for Vocational Trainees to SHAs to enable them to direct resources in year to those PCTs that require funding for VT placements. This funding is then passed to those PCTs as a supplementary allocation specifically to fund approved placements of VTs within dental practices.

5. Ring-fencing of dental funding

The net allocation received by PCTs is ring-fenced until March 2011 requiring dental allocations to be fully deployed on primary care dental services. This is an extension on the original date, which was March 2009, and was announced by the Minister Ann Keen on 5 March 2008.

If PCTs have any queries regarding their dental allocation they are advised to contact their local SHA in the first instance.
G  NHS DS – Useful reports, templates and dashboard available to support the contract management process

Underdelivery:

Reports:
- Exception reports – quarterly
- Vital Signs reports – quarterly
- Mid-Year Statement of Activity
- Preliminary Annual Statement of Activity
- Annual Statement of Activity
- Contract Summary report – monthly
- Monthly PCT Contract General Report

Templates:
- Contracted UDA Delivery 09-10 by Contract Number – run on a monthly basis to keep track of contracts not delivering

Managing for appropriate recall and treatment intervals:

Reports:
- Vital Signs reports – quarterly
- Quarterly PCT Re-attendance
- Exception reports – multiple FP17s – quarterly

Templates:
- Number of claims per patient
- Breakdown of activity data for patients with multiple FP17s reported
- Re-attendance template
- New Patient Template

Financial Management:

Reports:
- Monthly PCT Contract Payment
- Monthly PCT Payment and Recharge Summary
- PCT Held and Negative Payment Summary
- Monthly PCT Contract General Report

Templates:
- Finance Skeleton Report
- PCT_LHB Specific Items breakdown
**H Example form to record contract amendments**

<table>
<thead>
<tr>
<th>Input Sheet Contract Baseline Amendment</th>
<th>Ref Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Number:</td>
<td></td>
</tr>
<tr>
<td>Contract Name:</td>
<td></td>
</tr>
<tr>
<td>Narrative:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Contract details:</th>
<th>£</th>
<th>Activity</th>
<th>Activity</th>
<th>Rate £ /</th>
<th>Rate £ /</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>UDA</td>
<td>UOA</td>
<td>UDA</td>
<td>UOA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Input – Payments Online</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Released</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forecast updated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix – Example of a form used by PCTs to collate the estimated net pensionable earnings of dental performers

Part A

<table>
<thead>
<tr>
<th>Practice Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Number:</td>
<td></td>
</tr>
<tr>
<td>Practice Address:</td>
<td></td>
</tr>
<tr>
<td>Total Contract Value:</td>
<td></td>
</tr>
<tr>
<td>43% of contract value</td>
<td></td>
</tr>
</tbody>
</table>

Part B

It is the responsibility of the Contractor to indicate the breakdown of the total contract value within the practice. This is required for superannuation (pension) purposes. If performers are not part of the NHS Pension Scheme please indicate.

<table>
<thead>
<tr>
<th>Contractor Names(s):</th>
<th>Performer Names(s):</th>
<th>NHS Pension Yes/No</th>
<th>Estimated Net Superannuable Pay p.a. £</th>
<th>Date of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please ensure all performers on the contract are listed

Total estimated Net Pensionable Pay (cannot exceed 43.9% of the total contract value)

Please attach a separate sheet if there is not enough space in the boxes above.

Signed (Contractor): ________________________________

Date: ____________________________________________

Please return to ____________________________________________________________________________________
### Example year end contract performance evaluation

<table>
<thead>
<tr>
<th>Contract Number</th>
<th>xxxxxxxxxx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Name</td>
<td>xxxxxxxx</td>
</tr>
<tr>
<td>Contract Start Date</td>
<td>1 April 2006</td>
</tr>
<tr>
<td>Contract End Date (if appropriate)</td>
<td>n/a</td>
</tr>
<tr>
<td>Contract Purpose</td>
<td>General</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Baseline Contract Value £s</th>
<th>£472,205.79</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value of non-UDA items within contract</td>
<td>£15,000.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contracted UDA</th>
<th>18,002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracted UOA</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjusted UDAs delivered (as per NHS DS EOY report)</th>
<th>15,001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of UDAs delivered</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year-End Action</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of UDAs delivered</td>
<td>83.3%</td>
</tr>
<tr>
<td>% of UDAs under-delivered or (over-delivered)</td>
<td>16.7%</td>
</tr>
</tbody>
</table>

| % of UDAs to be carried forward | 0.0%   |
| Number of UDAs to be carried forward | 0.0 |

| Number of UDAs to be reimbursed | 3,001.00² |
| Value of underdelivery           | £76,217.90² |

1 If under-delivered UDAs are 4% or less – carry forward.
   If delivery is over 100% no carry forward.
2 If under-delivered UDAs over 4% reimbursement.
3 Baseline contract value divided by contracted UDA (adjusted for non-UDA items).
1.6. Introduction

PCTs need to understand and manage their local dental budget and patient charge income to ensure continuing access to NHS dental services, and to inform future planning and development of local services.

Local commissioning of dental services commenced on 1 April 2006, and in order for PCTs to effectively undertake this role, budgets were devolved to the PCTs to manage. Prior to this date, the majority of primary care dental costs were funded through a “non-cash limited” budget which was held centrally by the Department of Health.

PCTs receive their dental allocation each year via a non-recurrent resource allocation, which is notified via an AWP (Allocation Working Paper).

PCTs commission and pay for NHS dental services on a gross cost basis, against which deductions are made for the level of patient charge revenue collected by the contractor. Therefore, the Department of Health make an indicative assessment of the level of patient charge revenue to be collected when calculating each PCT’s allocation, so that when the allocation is received it is on a net cost basis.

2.7. Historical calculation of the dentistry budgets – 2006/07

2006/07 was the first year that PCTs received a devolved budget for primary care dental services.

The dental budget was calculated for each PCT, and allocated on a net cost basis, which reflected two main factors:

- The most recent levels of gross expenditure, which was derived from the PCTs service commitment at that point in time, covering expenditure on GDS services in the area, and also the PDS pilots that were in operation, together with a growth element to reflect continuing expansion of the dental workforce and NHS dental services
- The forecast levels of patient charge income associated with this level of gross expenditure, based on the new system of patient charges.

In setting the net budget, the Department of Health had to make a number of assumptions about the levels of activity agreed as part of the new contracts with dentists and the associated patient charge income that PCTs were expected to receive.

Further details on this background information can be found in the Department of Health Factsheet 4 – PCT Dentistry budgets 2006/07 and Patient Charge Income (Gateway reference 5917)29


Funding for 2009/10 continues to be by means of a non-recurrent resource allocation for primary care dentistry. In addition, PCTs can choose to direct further resources to dentistry from their main NHS allocation, if they consider it appropriate in the light of local needs and priorities.

Following the 11% increase in 2008/09, a further 8.5% was announced for 2009/10 onwards. This is a total increase of £385 million nationally over two years, which provide PCTs with the resources to help resolve the problems of access to NHS dentistry.

The funding methodology for 2009/10 for initial PCT allocations included a baseline uplift of 3% on the 2008/09 net allocation, which was to ensure that all PCTs received growth over and above the DDRB uplift, which was confirmed as 0.21% for 2009/10. In addition, part of the growth monies (£25 million) was used to equalise funding per head of population (FPHP) across SHA areas, which gave SHAs a variable share of the growth monies depending on whether the area was above or below the national average of FPHP. SHAs were then asked to decide how the growth element be distributed amongst its PCTs, and allocations were made to PCTs on this basis by the Department of Health.

4.9. Funding for vocational trainees

In line with arrangements followed since April 2006, the Department of Health formally allocates funding for Vocational Trainees to SHAs to enable them to direct resources in year to those PCTs that require funding for VT placements. This funding is then passed to those PCTs as a supplementary allocation specifically to fund approved placements of VTs within dental practices.

5.10. Ring-fencing of dental funding

The net allocation received by PCTs is ring-fenced until March 2011. This is an extension on the original date, which was March 2009, and was announced by the Minister Ann Keen on 5 March 2008. This ring-fenced budget is the ‘minimum floor’ spend that a PCT must use for NHS primary care dentistry and which cannot be used for any other purposes. PCTs can, if they so wish supplement their dental budget with additional funding from their main NHS allocation.

If PCTs have any queries regarding their dental allocation they are advised to contact their local SHA in the first instance.
<table>
<thead>
<tr>
<th><strong>Glossary of terms</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Additional Services</strong></td>
</tr>
<tr>
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<tr>
<td><strong>Alveolus</strong></td>
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<tr>
<td><strong>Amalgam</strong></td>
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<tr>
<td><strong>Advanced mandatory services</strong></td>
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<tr>
<td><strong>Associate</strong></td>
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<tr>
<td><strong>Bridge</strong></td>
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<tr>
<td><strong>Care index</strong></td>
</tr>
<tr>
<td><strong>Caries</strong></td>
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<tr>
<td><strong>Crown</strong></td>
</tr>
<tr>
<td><strong>Cosmetic dentistry</strong></td>
</tr>
<tr>
<td><strong>CACV</strong></td>
</tr>
<tr>
<td><strong>Common risk factor approach (CRFA)</strong></td>
</tr>
<tr>
<td><strong>Contract holder</strong></td>
</tr>
<tr>
<td><strong>CoT</strong></td>
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<tr>
<td>Glossary</td>
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<tr>
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</tr>
<tr>
<td>DC01</td>
</tr>
<tr>
<td>DMFT/dmft</td>
</tr>
<tr>
<td>Deciduous teeth</td>
</tr>
<tr>
<td>Dental performers list</td>
</tr>
<tr>
<td>Dentate</td>
</tr>
<tr>
<td>Dentist with a special interest (DwSI)</td>
</tr>
<tr>
<td>Dental care professionals (DCPs)</td>
</tr>
<tr>
<td>Dental caries</td>
</tr>
<tr>
<td>Dental sealants</td>
</tr>
<tr>
<td>Dental appliance</td>
</tr>
<tr>
<td>Dental trauma</td>
</tr>
<tr>
<td>Dentition</td>
</tr>
<tr>
<td>Dental body corporate (DBC)</td>
</tr>
<tr>
<td>Domiciliary services</td>
</tr>
<tr>
<td>Enamel</td>
</tr>
<tr>
<td>Endodontics</td>
</tr>
<tr>
<td>Edentulous</td>
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<tr>
<td>E Reporting</td>
</tr>
<tr>
<td>Term</td>
</tr>
<tr>
<td>-------------------------------------------</td>
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<tr>
<td>Erosion</td>
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<tr>
<td>FHSAA</td>
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<tr>
<td>Fluoride</td>
</tr>
<tr>
<td>Fluoride varnish</td>
</tr>
<tr>
<td>Water fluoridation</td>
</tr>
<tr>
<td>FIMS</td>
</tr>
<tr>
<td>Fissure sealants</td>
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<tr>
<td>Gingiva</td>
</tr>
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<td>Hygienist</td>
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<tr>
<td>Implant</td>
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<td>IOTN</td>
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<td>Mandatory services</td>
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<tr>
<td>Maxillo-facial surgery</td>
</tr>
<tr>
<td>MOS</td>
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<tr>
<td>NHS Dental Services</td>
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<td>Normal surgery hours</td>
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<tr>
<td>NACV</td>
</tr>
<tr>
<td>Occlusion</td>
</tr>
<tr>
<td>Oral cancer</td>
</tr>
<tr>
<td>Oral mucosa</td>
</tr>
<tr>
<td>Orthodontics (orthodontic services)</td>
</tr>
<tr>
<td><strong>PCR</strong></td>
</tr>
<tr>
<td><strong>Periodontics (perio)</strong></td>
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<tr>
<td><strong>Performer</strong></td>
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<td><strong>Periodontal disease</strong></td>
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<tr>
<td><strong>Professional registration number</strong></td>
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<tr>
<td><strong>Restorative dentistry</strong></td>
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<tr>
<td><strong>Sedation services</strong></td>
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<td><strong>SFE</strong></td>
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<tr>
<td><strong>Specialist services</strong></td>
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<tr>
<td><strong>Therapist (oral health practitioners)</strong></td>
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<tr>
<td>Abbreviation</td>
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<td>UDA</td>
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<td>UOA</td>
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<td>Urgent treatment</td>
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<td>VT</td>
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