OCDO

OFFICE OF CHIEF
DENTAL OFFICER
ENGLAND

Step Change In Commissioning Dental Check By 1 (DCBy1)

Rationale , Proposal and Plan

Challenges to Improving Child Oral Health

- NHS England continues to make significant contributions to improvements in the dental health of older children and adults.
- However, no significant reductions in the dental disease of the under 5s.
  - A **quarter** of 5-year-olds have tooth decay with on average **3 or 4** teeth affected*
  - The majority of tooth decay in children under 6 is untreated*
- Multi-factorial in origin therefore solution and strategy has to be multi-factorial
- Recognise the value of many contributors but vital that we are working to one plan.
- **Main Effort** - Synchronization of activity, harmonizing of messages, across the myriad of stakeholders.

All findings from Public Health England's (PHE) 2015 national dental epidemiology survey of 5 year old children

Factors

Most of the children using NHS dental services are of school age or above (i.e >5yrs)

- Less than 12% of children attend before their 2nd birthday
- In the year prior to March 2017*:
  - Only 33% of children aged under five years attended a dentist.
  - Ranging from
    - 3% of 0-12 months
    - 20 % of 1 year olds (12-24 months)
    - 56% of 4 year olds (36 - 48 months)
- Early dental attendance has not traditionally been encouraged by all dental practices or sought by parents /carers.
- Critically not encouraged by GP/HV –health/social/educational providers
- The most common reported reason for lack of attendance is
  - “Local dentists not taking on NHS patients”**

*NHS Digital – Apr 2017

**Children’s Dental Health Survey 2013. Report 1: Attitudes, Behaviours and Children’s Dental Health: England, Wales and Northern Ireland

Consequences

- The uptake of dental care in children aged under five years has traditionally been low.
- Sadly many children do not visit a dental practice until dental disease is well established, or they are in pain & require admission to hospital.
- Most common reason for hospital admission for children aged 5 to 9 yrs*
  - 6th most common procedure in hospital for 5 year olds*
  - 9,306 admissions children under 5 yrs for tooth extractions 2016-16*
  - Cost to NHS E £7.8 million in 2015-16*
- Emotional costs for child and family
  - Life long health and social impacts

*NHS Digital and PHE – Health Matters Child Oral Health - 14 Jun 2017

accessible at https://www.gov.uk/government/publications/health-matters-child-dental-health/health-matters-child-dental-health

So What?

- Children aged under 5 years are more at risk of developing dental caries than other childhood conditions

- First attendance at 5 yrs? –
- Lost opportunities for early intervention and prevention

- Number of primary school age children is projected to increase by 13%, reaching 5.7 million over the next 25 years*.

- Over the same period, the number of children aged 12 to 16 is projected to rise by 10% to 4.1 million*.

- Cumulative evidence and modelling demonstrates we are now reaching a tipping point.

* ONS

DCby1 & Access to a Prevention Pathway

- Early dental attendance should become the norm
- Requires a paradigm shift in public thinking
- Recognition by broader health/social care providers
- Paradigm shift in dental team operating model

- Key elements;
  - National and local level public awareness of “DCby1”
  - Capacity at Practice level for DCby1 and entry into DBOH
  - A step change in commissioning to improve:
  - Uptake of “DCby1”
  - Access to the cost effective evidence-based prevention activities of “Delivering Better Oral Health”

Concept - Access and Awareness

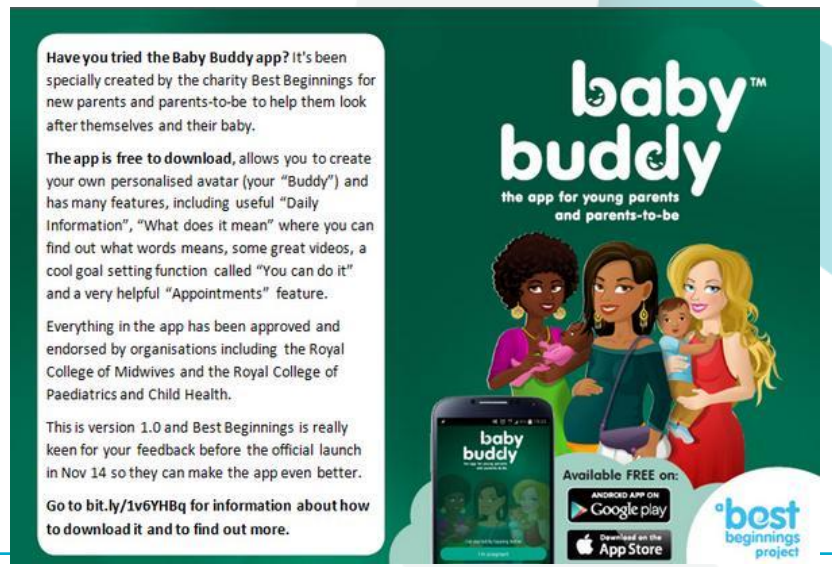
Awareness

- Public
- Social and Health Care Professionals
- Dental Professionals

Dr Milad Shadrooh
aka the Singing Dentist

Pivotal role of whole of dental profession

- Optimise all political, public and professional channels
- Harmonised National and Local Messages
- Exploiting opportunities for signposting
- Innovation and use of social media
- Patients have influence – influence your patients



Concept - Access and Awareness

Capacity

- Sufficient freedom for a NHS England contracted practice to:
  - Readily accept additional pre-school children for DCby1
  - Initiate prevention pathway via dental checks for children <2yrs
    - Typically offer 3 appointments
    - Visits 1 & 2 within one month
    - Review/reinforcement visit at 3 months,
    - Further recall based on individual risk assessment.
      - Whole Dental Team activity….GDP input is OHA

Nascent NHS E Incentive – to improve access for pre-school children

FAQ

- HOW MANY CHILDREN ARE THERE?
- HOW MANY ARE WE ACTUALLY SEEING NOW?
- HOW MANY MORE COULD WE SUPPORT?
- HOW MUCH DOES IT CURRENTLY COST?
- HOW MUCH WILL IT COST?
- WHATS THE BENEFIT?
- WHAT”S THE RISK?
- HOW IS IT FUNDED?

FAQ

- HOW MANY CHILDREN ARE THERE?
  - ➢ 675,000 per year of birth – England
- HOW MANY ARE WE ACTUALLY SEEING NOW?
  - ➢ 20% <2yrs/year - 130,000 Target Group
- HOW MANY MORE COULD WE SUPPORT?
  - ➢ Initial + 10% ⟶ Stretch Target 50%
- HOW MUCH DOES IT CURRENTLY COST?
  - ➢ £86m for population under 3 years
- HOW MUCH WILL IT COST?
  - ➢ To reach 30% Target + £2.16m in year
- WHATS THE BENEFIT?
  - ➢ 200,000 children seen - 10,000 XGAs avoided: saving **>£4.5m/annum**
- HOW IS IT FUNDED?
  - ➢ Extant In-year dental allocation of Primary Care budget – end of year reconciliation process

HOW MANY MORE COULD WE SUPPORT?

Region	2017 Attendance 12-24 mths	*Extrapolation <19% currently seen**	2017-19 increase in attendance to circa 30% of 12-24 mths	Potential additional Children commencing care with NHS E / DCby1
North East	28,400	5,400	8,500	3,100
North West	85,838	16,300	25,700	9,400
Yorks and Humber	63,858	12,500	19,000	6,500
East Midlands	53,641	10,200	16,000	5,800
West Midlands	69,806	13,250	20,000	6,750
East of England	72,505	13,750	22,000	8,250
London	129,615	25,000	38,000	13,000
South East	102,703	19,500	30,000	10,500
South West	58,033	11,000.	17,500	6,500
Total	664,399	122,750	196,700	69,800

***Extrapolation from ONS and BSA data for June 2016 – 19% of children 12- 24 months (England)**

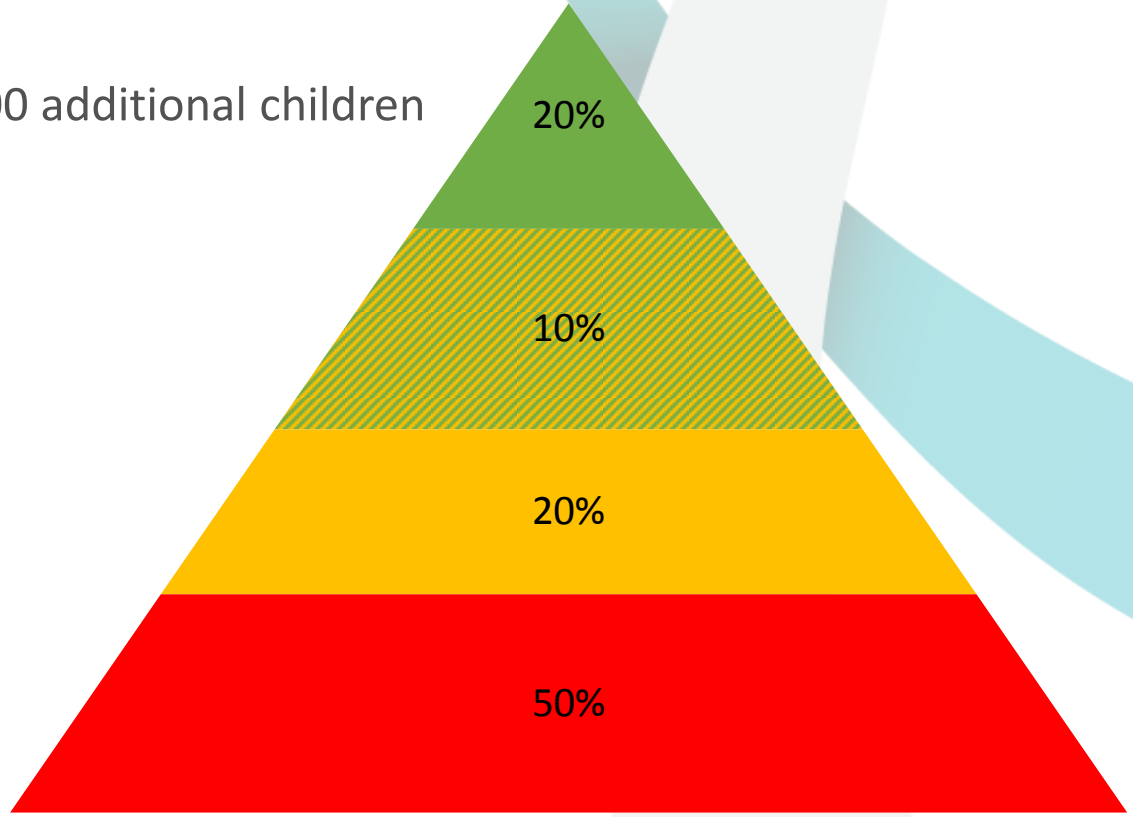
HOW MUCH MORE COULD IT COST?

Modelling based on delivering to 30% of 12-14 months olds, mean of 2 UDAs/child/annum

Region	17-19 annual target Number of 12-24 mths under NHS E dental care	Estimated number of UDAs to achieve target care delivery (mean 2.2 UDA/child)	75% of UDAs delivered within contract limit of 102%	25% delivered in excess of contract limit	Estimated annual costs out with contract – based on mean UDA rate for "Step Change Programme" £20/UDA
North East	8,500	18,700	14,025	4,675	£93.5K
North West	25,700	56,540	42,405	14,135	£282.7K
Yorks and Humber	19,000	41,800	31,350	10,450	£209K
East Midlands	16,000	35,200	26,400	8,800	£176k
West Midlands	20,000	44,000	33,000	11,000	£220k
East of England	22,000	48,400	36,300	12,100	£242k
London	38,000	83,600	62,700	20,900	£418k
South East	30,000	66,000	49,500	16,500	£330k
South West	17,500	38,500	28,875	9,625	£192.5k
Total	196,700	432,740	324,555	108,185	£2,163,700

Universal Approach

- Target – circa 200,000 children < 24months (primary group 12-24 months)
- 8,500 NHS E contracts
- 2017-19 Target to increase attendance/yr by 70,000 additional children
- 2016-17 mean:
  - 14.5 children <2 years per contract
  - 5.5. children/performer
- Target annual mean 2017 – 19
  - 23 children <2 years per contract
- Increase of:
  - + 9 children <2 years per contract



Universal Approach

- Increase of 9 children <2 years per contract
- 2 – 3 appointments per child/annum dependent on risk

- Care delivered by the dental team – estimate 2.2 UDAs/child
- Estimated 50 UDAs/contract

- 75% of target total (38 UDAs) <2 yrs seen within extant contract
- 12-13 additional UDAs per contract (over 102%)
- Estimated £255/contract/year

- NHS E Total £2,163,700*
- 2.27% of the FY 16-17 £95m NHS E "underspend" relative to allocated UDA funding 16-17

Making It Happen

NHS England Regional Directors

- Richard Barker, Paul Watson,
- Anne Rainsbury Jennifer Howells

- Confirmed that they are adopting the proposal and have nominated named leads for their areas.

Nominated Regional Reps form the Steering Group for the project

- Midland and East - Andrew Pike.
- North - Richard Armstrong, Tony Leo and Dorota Shaw
- London - Jeremy Wallman
- South – Caroline Temmink

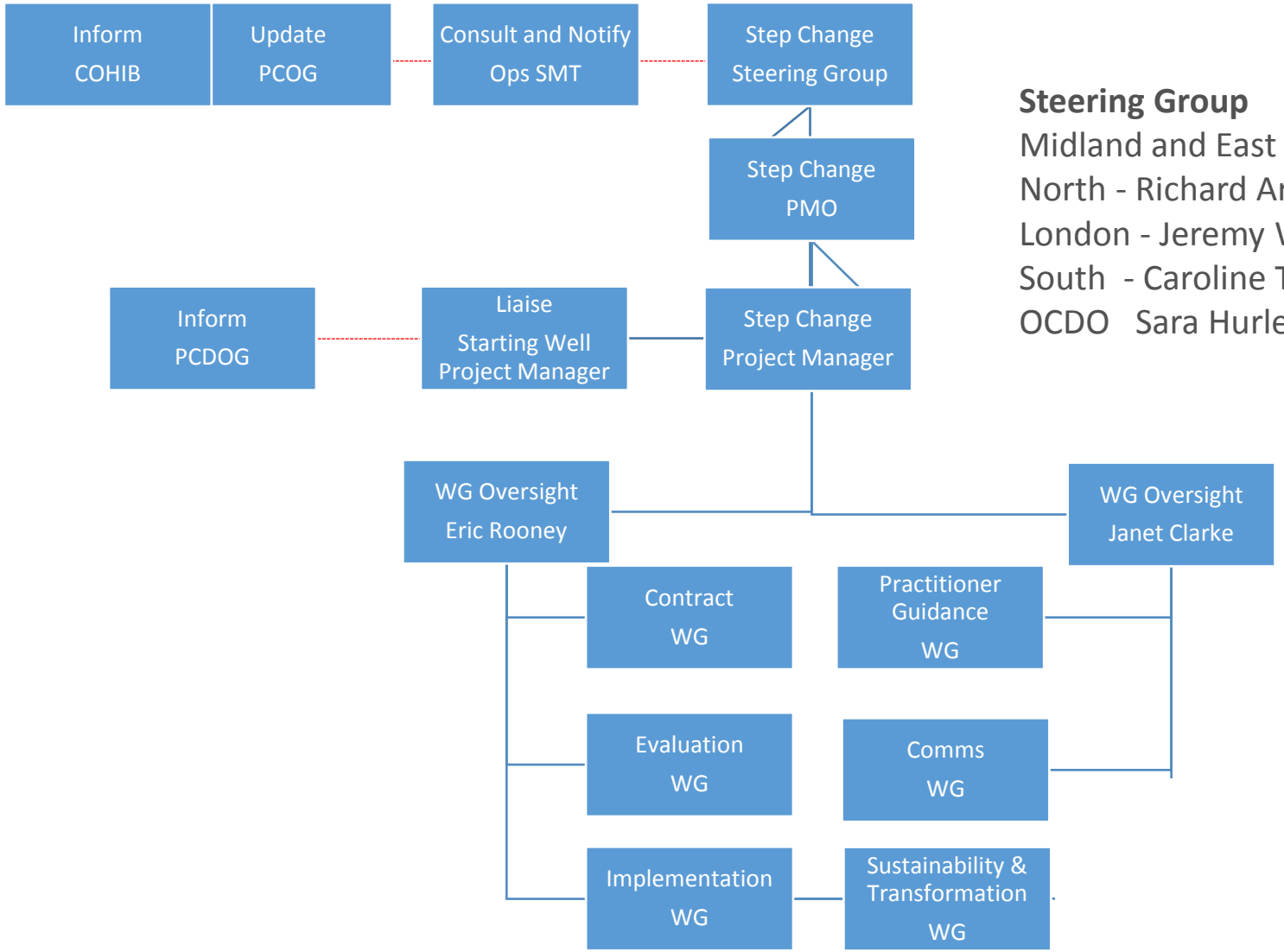
Concept into Plan into Action

- Secured requisite commitment
- Mobilize and maintain momentum - this is our **MAIN EFFORT**
- Support of the whole profession
- Central co-ord of overarching project plan
- Moving forward with the realization of the proposal with

central co-ord of:

  - Contract amendment design,
  - Practitioner guidance
  - Corporate comms
  - Implementation & Alignment with “Starting Well” – a SMILE4LIFE initiative
  - Evaluation
  - Sustainability - transformation into Business as Usual

Step Change - Project Organisation Governance and - RACI



Steering Group

Midland and East - Andrew Pike.

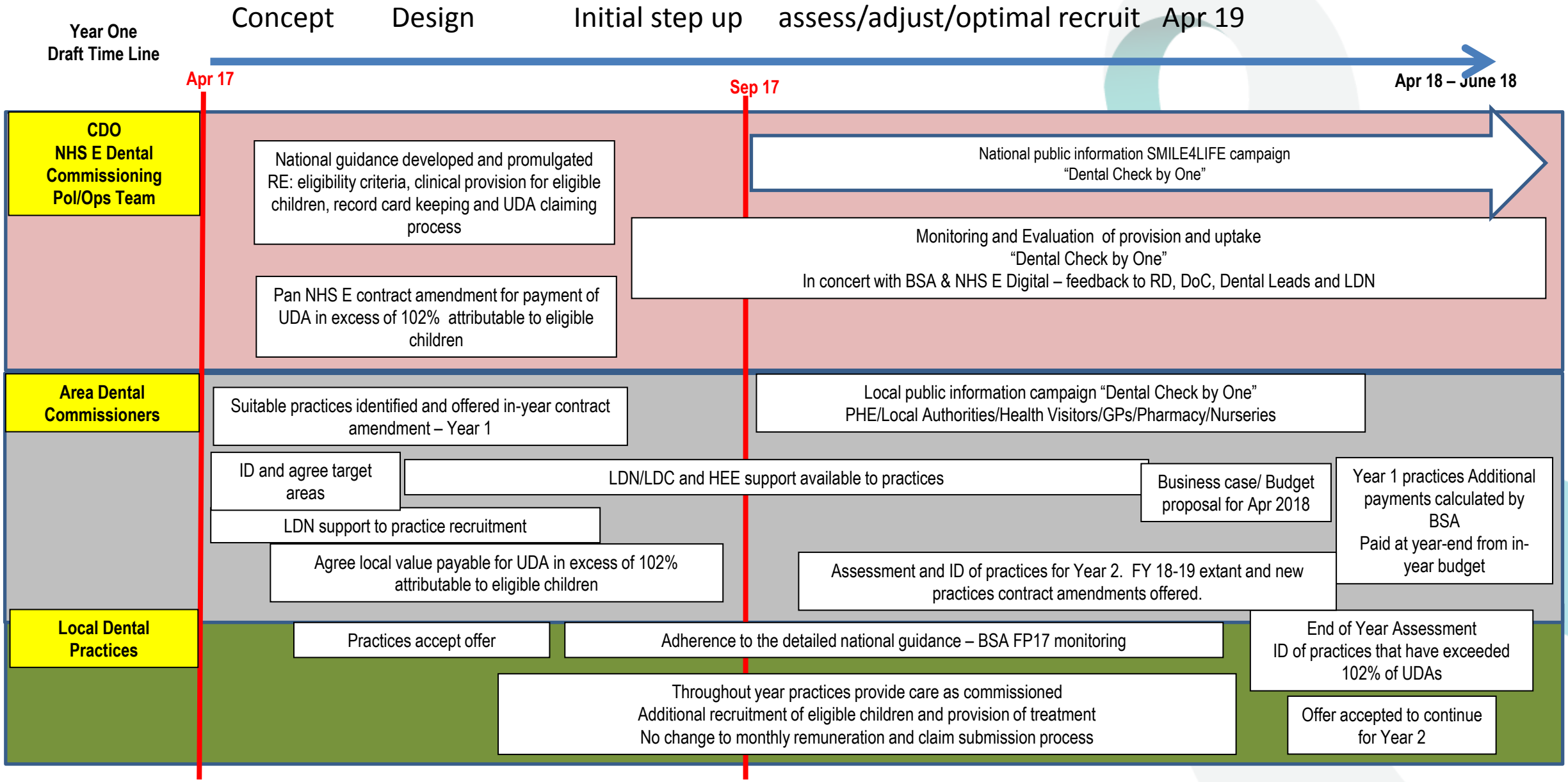
North - Richard Armstrong, Tony Leo & Dorota Shaw

London - Jeremy Wallman

South - Caroline Temmink

OCDO Sara Hurley, Eric Rooney, Janet Clarke

PHASE 1 PROJECT TIMELINE AND PROPOSED RESPONSIBILITIES

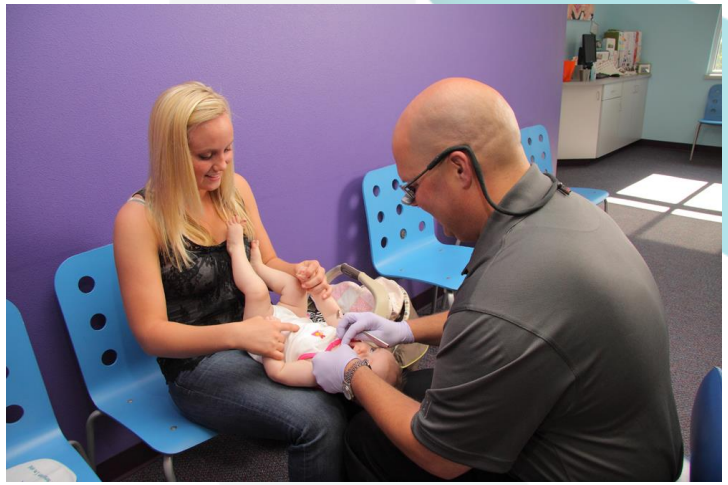


Practitioner Guidance

Clarity of Intent - Using extant guidance/Delivering Better Oral Health, Office CDO will produce

“Notes for the Avoidance of Doubt” to clarify the “ Rules of Engagement” for :

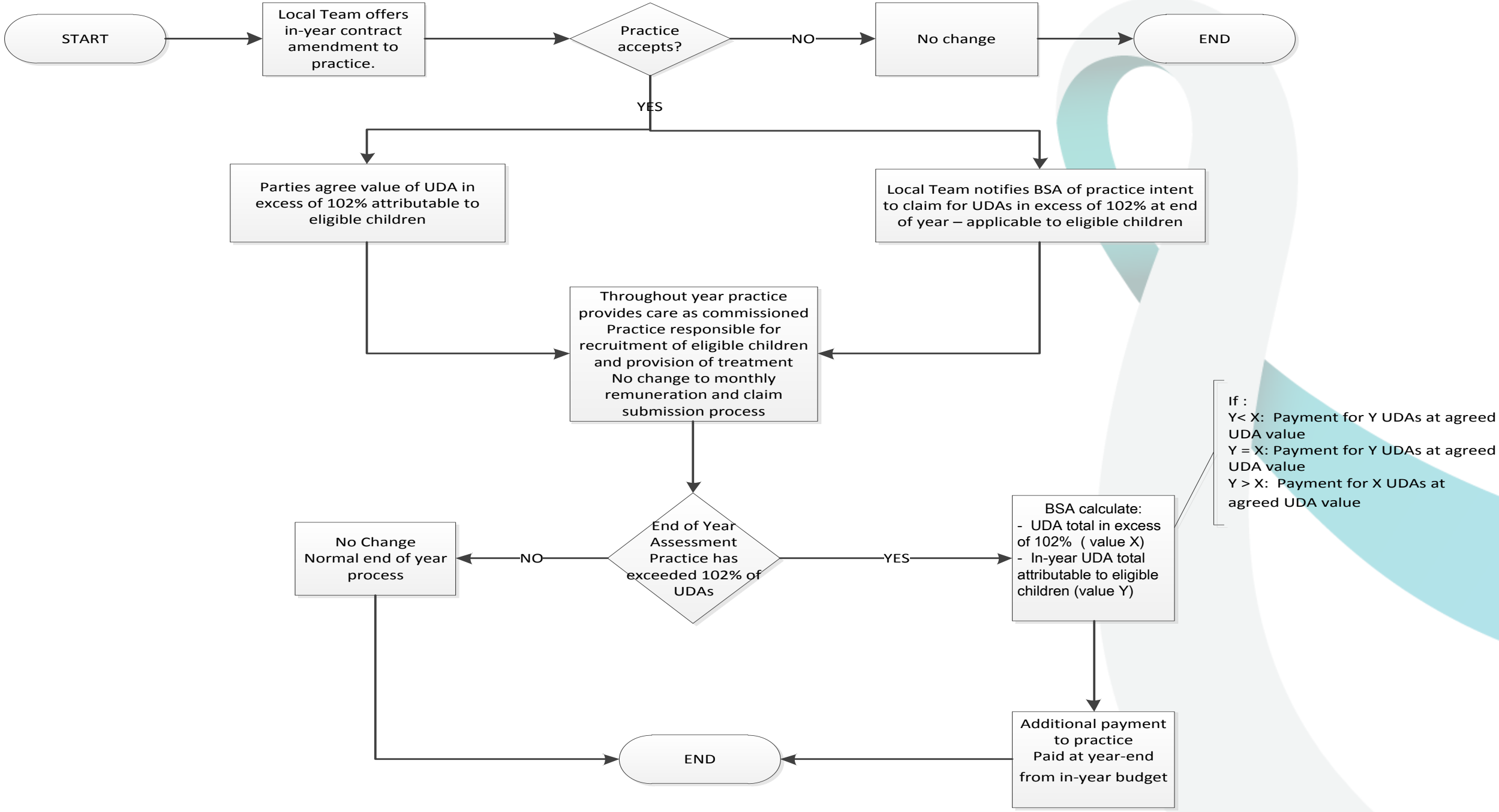
- Dental Check by One and in-practice prevention
- What constitutes Child Oral Health Assessment (COHA) (under 2 yrs) – Delivering Better Oral Health
- What elements of the COHA must be attempted/completed in order to satisfy a UDA claim/what Band to claim
- Using the whole dental team – clarifying who can deliver care/health promotion
- What must be recorded in the patient notes
- Clarifying subsequent “Delivering Better Oral Health” prevention interventions to be considered/undertaken
- If appropriate Recall versus Review i.e. new course of treatment.
- In-year monitoring-feedback
- Practitioner Guidance on End of Year activities



Contracting & Commissioning

NHS E Commissioning Ops together with BSA to take the WG lead on clarifying contract intent & coordinating:

- **Contract**
  - A common national mechanism
    - single template agreement MOU or “contract variation”
  - Common process for End of year reconciliation of performance and remuneration
  - Agreement with BSA on administration of end of year reconciliation process
  - Guidance on local adaptation and application
  - Support to future transformation & national contract amendment as necessary


START
Local Team offers in-year contract amendment to practice.
Practice accepts?
NO
No change
END
YES
Parties agree value of UDA in excess of 102% attributable to eligible children
Local Team notifies BSA of practice intent to claim for UDAs in excess of 102% at end of year – applicable to eligible children
Throughout year practice provides care as commissioned
Practice responsible for recruitment of eligible children and provision of treatment
No change to monthly remuneration and claim submission process
End of Year Assessment
Practice has exceeded 102% of UDAs
NO
No Change
Normal end of year process
YES
BSA calculate:
- UDA total in excess of 102% (value X)
- In-year UDA total attributable to eligible children (value Y)
If :
Y< X: Payment for Y UDAs at agreed UDA value
Y = X: Payment for Y UDAs at agreed UDA value
Y > X: Payment for X UDAs at agreed UDA value
Additional payment to practice
Paid at year-end
from in-year budget
END

Contracting & Commissioning

NHS E Commissioning Ops together with BSA to take the WG lead on clarifying contract intent & coordinating:

- **Commissioning***
  - Universal offer …or
  - Evidence-based targeted offer – Info on how to model for your area
  - Detailed methodology for offering /securing – common practice
  - Monitoring performer/provider/commissioner – national model for local use

*Quantity and location of practices selected to take part remains a local place based decision, as does the UDA value - but parity in outcome is desired

Costing – Area Model

- A = 2015 Area Birth Stats = 63,858
- B = Target for area 30% attendance of 63,858 = 19,157
- C = 2016 BSA CoT- attendance data for < 2yrs = 11,686

- (C/A)*100 = % pop 2yr children in area currently seen
- Example
  - (11,686/63,858) x 100 = 18.3%
    - 18.3% of <2yr cohort currently seen in area
    - 30% target attendance = 0.3* 63,858 = 19,157
    - Area Target increase required of 19,157 – 11,686 = 7,471
- Total UDA capacity for 30% of <2 yrs cohort
  - UDAs - 42,145 (2.2 x 19,157)
- 75% of UDAs (39,609) for <2yrs cohort achievable in contract
- 25% of UDAs (10,536) for <2yrs delivered in excess of 102%
- Cost for additional UDA – £211k

Implementation & Alignment with

NHS E Commissioning Ops together with CHOIB to take the WG lead

With Starting Well – implementation is single synchronised collaborative action under SMILE4LIFE umbrella

- Phase 1 LDN/LAT :
  - Clarify Intent and de-conflict
  - Scoping out potential practices, areas of greatest need and likely highest uptake
  - Developing Local Commissioning Strategy – universal or targeted with justification
  - Finding and establishing relationships with partners such as HV and Nurseries/Sure Start Centres, local media/comms, LGA, LDC and PHE opportunities .
  - Mechanism for **Recording Roll out and** monitoring LAT contract approaches, offers and uptake
    - League board on successful roll out, weekly updates quarterly reports
    - In project monitoring via BSA link with end of year feedback

Contractual implementation will lie with Dental Leads - Quantity and location of practices selected to take part remains a local place based decision, as does the UDA value - but parity in outcome is desired

Corporate Communication Plan

OCDO together with NHS E Media/Comms and PHE

A single synchronised collaborative action

- Phase 1 - Initiation
  - National Awareness programme
  - PHE Channels into Parent Information Networks
  - Public – web-based, social media, commercial partners
  - Pan- Professional – Synchronisation of messages -
  - Local Support - LDN/LAT scoping out:
    - Finding and establishing relationships with partners such as HV and Nurseries/Sure Start Centres, local media/comms, LGA, LDC and PHE opportunities.
      Linked with launch of Starting Well .
- Phase 2, 3 and 4….

Evaluation and Translation into Business As Usual

- Clarify Intent of Evaluation for each stage
- Define Measures of Success
- Define Measures of Effectiveness
- What is to be measured / analysed?
  - Baseline numbers children & OH status 2, 3 ,4 & 5 yr olds
  - Contract offers / Contract Uptake / Contract Delivery
  - New Patients seen
  - Oral health Status at start & at specified milestones
  - UDAs expended in contract
  - UDAs expended in excess of 102%
  - Costs
- Timetable for reporting, analysis & methods of presentation

- All Evidence for translating into BAU

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Thank you

Comments & Commitment