



NHS dental contract reform: Food for thought for investors without the cavities

Candesic's **Tom McCabe** and **Dr Leonid Shapiro** look at how the new dental contract, scheduled for implementation in 2017, is likely to change the way investors make money in dentistry

After a tortuously slow process, five years in, light is finally visible at the end of the tunnel leading to the new NHS dental contract. The revised arrangement between the NHS in England and dentists will align payments with a longer-term view of patients' dental health rather than a 'drill and fill' activity-based model. This emerging model has the potential to offer benefits for patients, clinicians, and investors alike.

If expected changes to the NHS contract happen, we will see an expansion of the private market as established dentists exit public sector dentistry or adjust their mix of work rather than adapt to the new world.

This change presents an opportunity for market consolidation, driven by a new managerial approach alongside focus on

clinical effectiveness which corporates are better capable of implementing.

From 'drill and fill' to Preventative
Understanding the upcoming changes requires a bit of history in the evolution of NHS dentistry.

Under past NHS dentistry contracts, dentists billed per item of work delivered. Un-capped volume-based contracts rapidly improved the nation's dental health but with few checks on dentist activity, there was a suspicion of over-treatment...the 'drill and fill' characterisation of unscrupulous practices.

2006 saw the introduction of the current dental contract and the 'Unit of Dental Activity' (UDA). Dentists bid for tranches of activity; simple procedures counted as one UDA while complex procedures counted as multiple UDAs. Whatever procedures dentists did, however, had to fall within

a narrow range around the agreed UDAs commissioned. Do too much work, and you don't get paid for it. Do too little and the NHS claws back its funding. This explains the reluctance of NHS dentists to take on new patients and led to procedures sometimes being postponed until the next financial year. There have even been examples of courses of treatment left uncompleted or patients forced to take private treatment as the dentist runs out of UDAs.

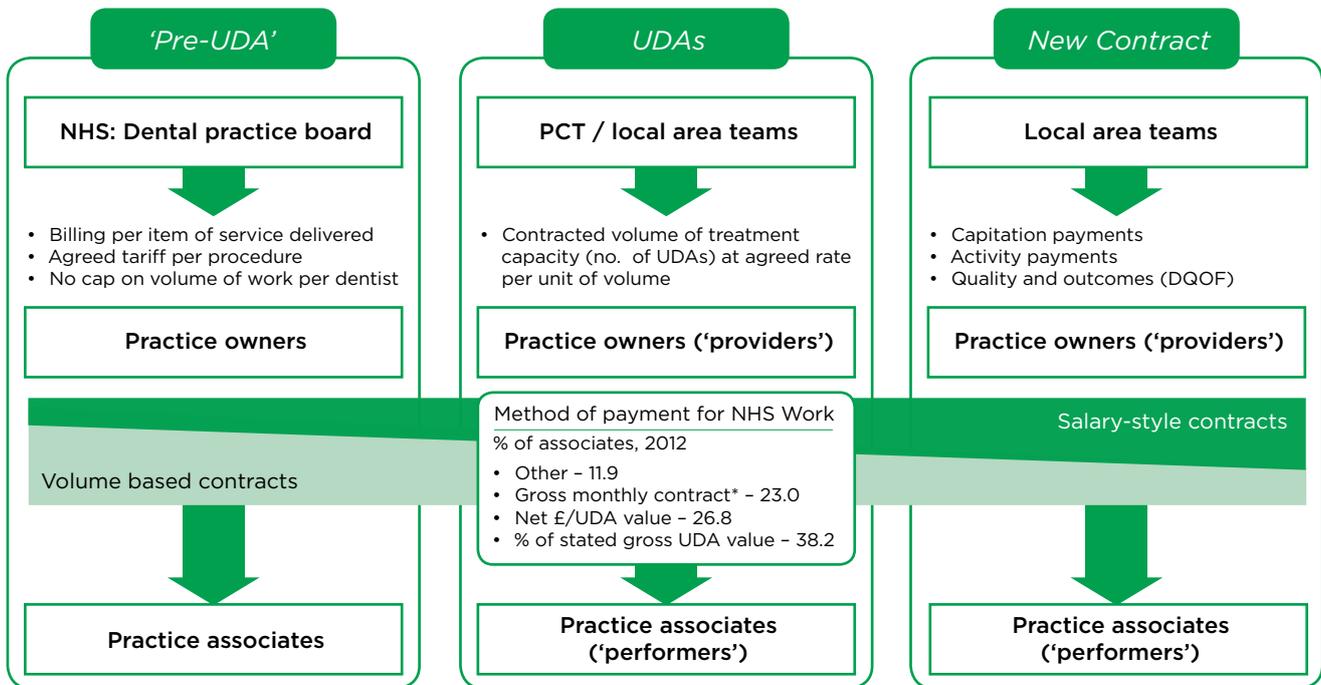
The 2006 contract was met with considerable hostility when introduced (or 'imposed', as it is commonly described by dentists). UDA values vary significantly across the country, most being £23-26 per UDA but with 4% below £20 and 11% over £30. Deprived areas with poorer dental health are less lucrative with the contract favouring high volume, low complexity appointments which attract fewer UDAs. On its introduction, 2,000 dentists voted



FIGURE 1: EVOLUTION IN NHS DENTISTRY



Evolution away from 'drill and fill' activity based funding to preventive dentistry



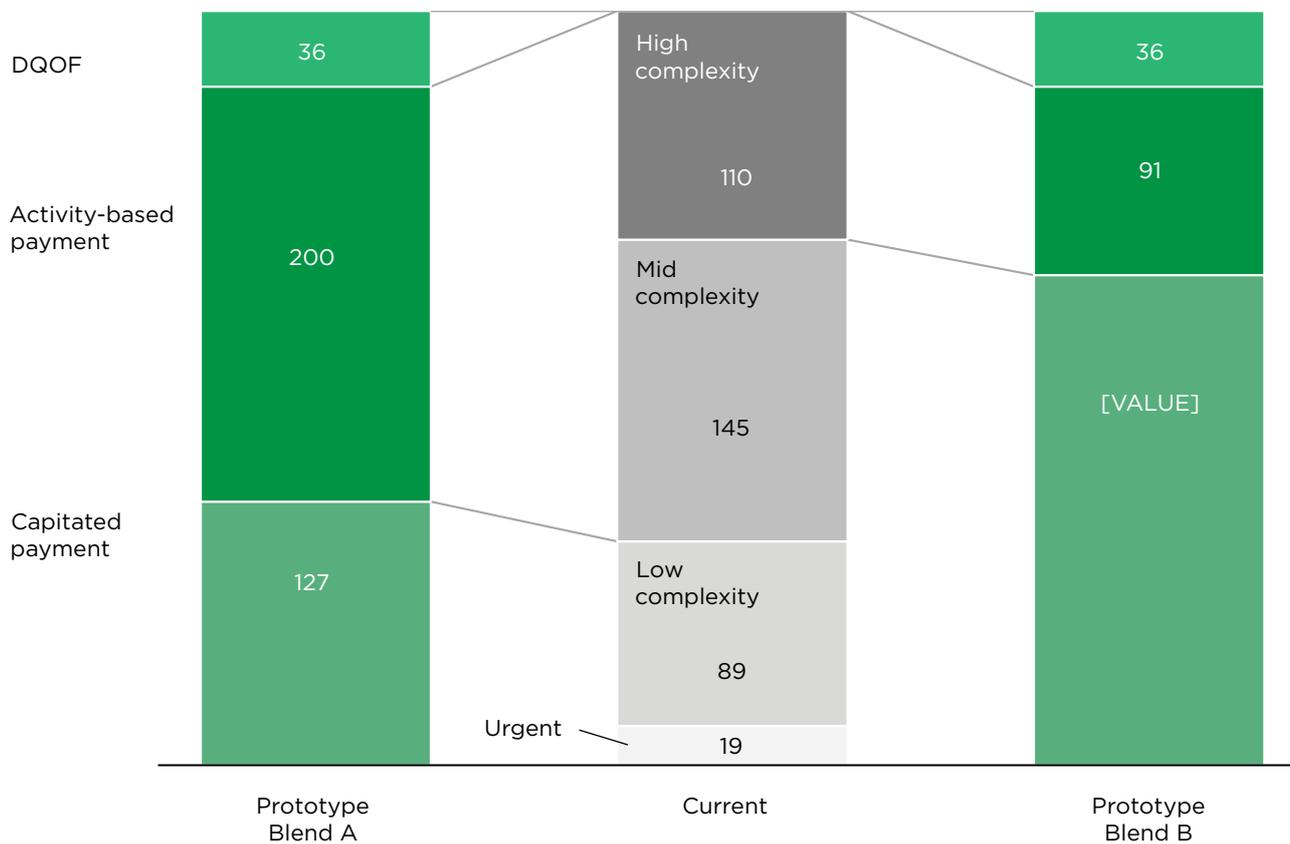
Associates continue to be self-employed and BDA research shows that they wish to remain so, even when they understand the employment rights that they would receive if employed.
British Dental Association, State of General Practice 2013

* less lab costs & % of expenses

Sources: British Dental Association 'Business Trends' 2012; Candesic analysis

FIGURE 2: POTENTIAL REVENUE IMPACT FOR A TYPICAL DENTIST OF THE TWO PROTOTYPE MODELS

£000, gross revenue = £364,000



“Prototype B seems to be favoured by dentists so far. It’s still too early to tell for sure yet though.”

- Dentist-led focus group findings

Assumptions: Revenue of a typical provider-performer conducting >75% NHS work (£364,000 revenue), activity distribution (UDAs) per band is in line with national average

Sources: HSCIC; Department of Health, Dental Contract Reform: Prototypes; Candesic analysis

► with their feet and left the NHS.

What this system has allowed, however, is the running of mixed public/private practices. Dentists can up-sell NHS patients from the chair side. Higher quality materials and cosmetic treatments are available to patients willing and able to ‘invest in their smiles’. Given the opaque and obtuse co-payment system, patients can be unaware of where state support ends and private-pay begins. For a dentist, up-selling a private restoration following an NHS examination un-bundles the course of treatment, increasing revenue per patient and maximising UDA value.

The new dentistry contract

And now, enter the new contract (figure 1), a further step away from volume-based remuneration and the introduction of a preventative mandate. The new model has three components: quality and outcomes payments; a capitated budget (dentists paid per head on their list), and a residual activity-based payment. The fixed components of the contract represent a step towards ‘salary-style’ income for dentists. To all intents and purposes, it looks like one huge dental plan for the nation which will challenge the way dentists currently deliver NHS dentistry.

‘Quality and outcomes’ payments will be made according to the Dental Quality Outcomes Framework (DQOF). This will make up 10% of a practice’s NHS revenue. Indicators such as tooth decay will be assessed alongside best practice measures of patient-reported satisfaction and safety, achieved through a basket of targets that mirror those used to assess NHS GPs.

The remaining 90% of practice income will come through a blend of capitated budget and activity-based payments. The final weighting of these is still under consultation, but either 35% or 65% of the contract value will be capitated. Here,

the dentist must play a preventative role, monitoring dental health on an on-going basis. This capitated component will certainly replace all simple treatments and may also cover some medium complexity work (figure 2).

Activity-based payments for complex treatments will remain, however, the proportion of budget available for these work will unquestionably fall.

From the launch of 70 initial pilots in 2011 to the establishment of 62 prototype sites in 2015, progress has been slow (figure 3). Full roll-out isn't expected until 2018/19, but as the parameters become increasingly certain, dentists, commissioners, and investors should all be taking stock of their

position and making the right decisions now in anticipation of the new landscape.

Implications of the new contract

Candesic believe that there are three main implications to the changing contract.

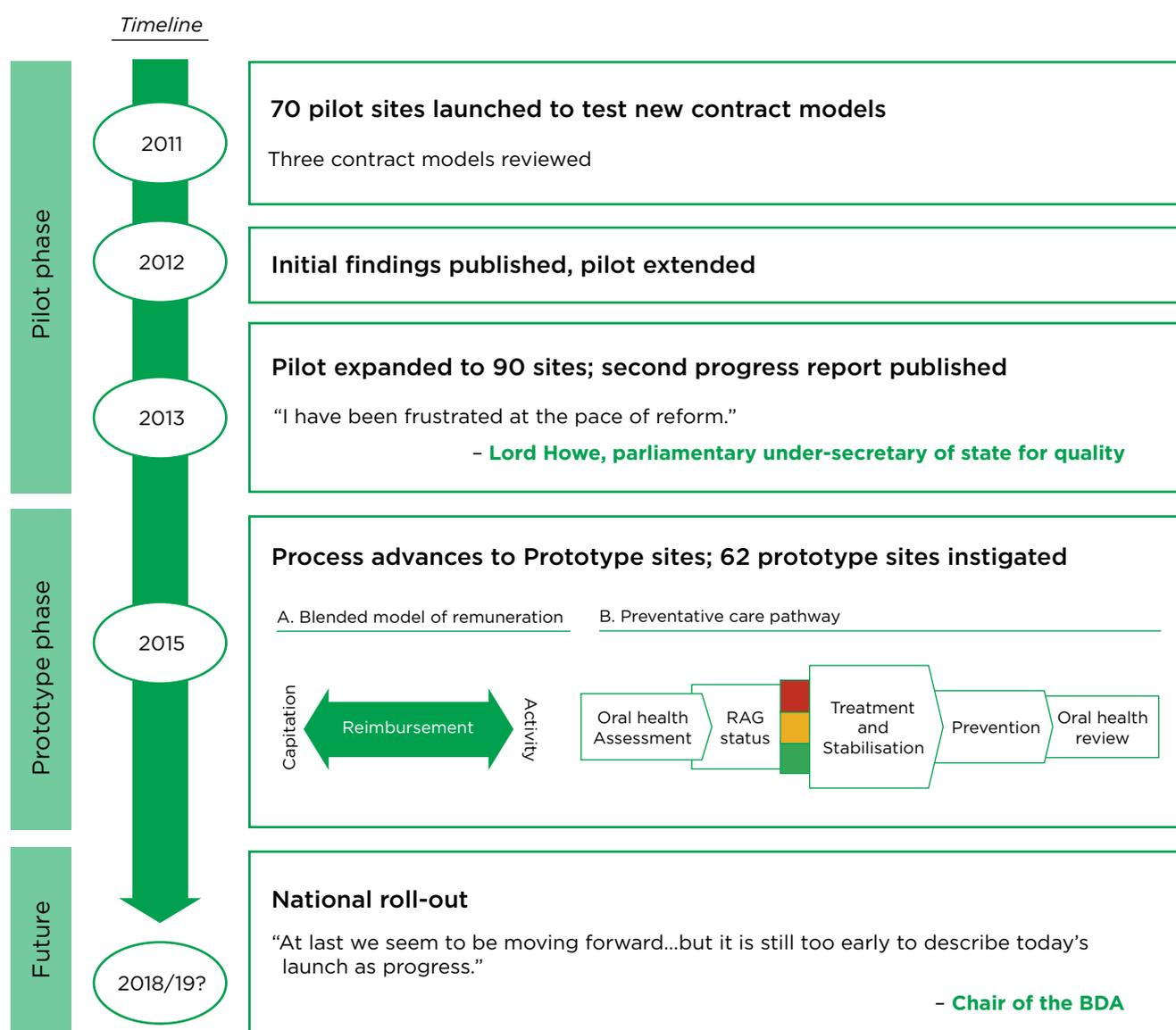
1. Budget winners and losers

The overall value of NHS dentistry is not anticipated to deviate significantly from its current trajectory (figure 4). The tight budgetary environment has seen a marginal reduction in NHS dental budgets in real terms over the past 5 years and expenditure per treatment has falling from £81/treatment in 2010 to £73 per treatment in 2013.

However, whilst the total budget is likely to remain steady, practices over-exposed to highly complex treatment will struggle to meet demand and maintain standards.

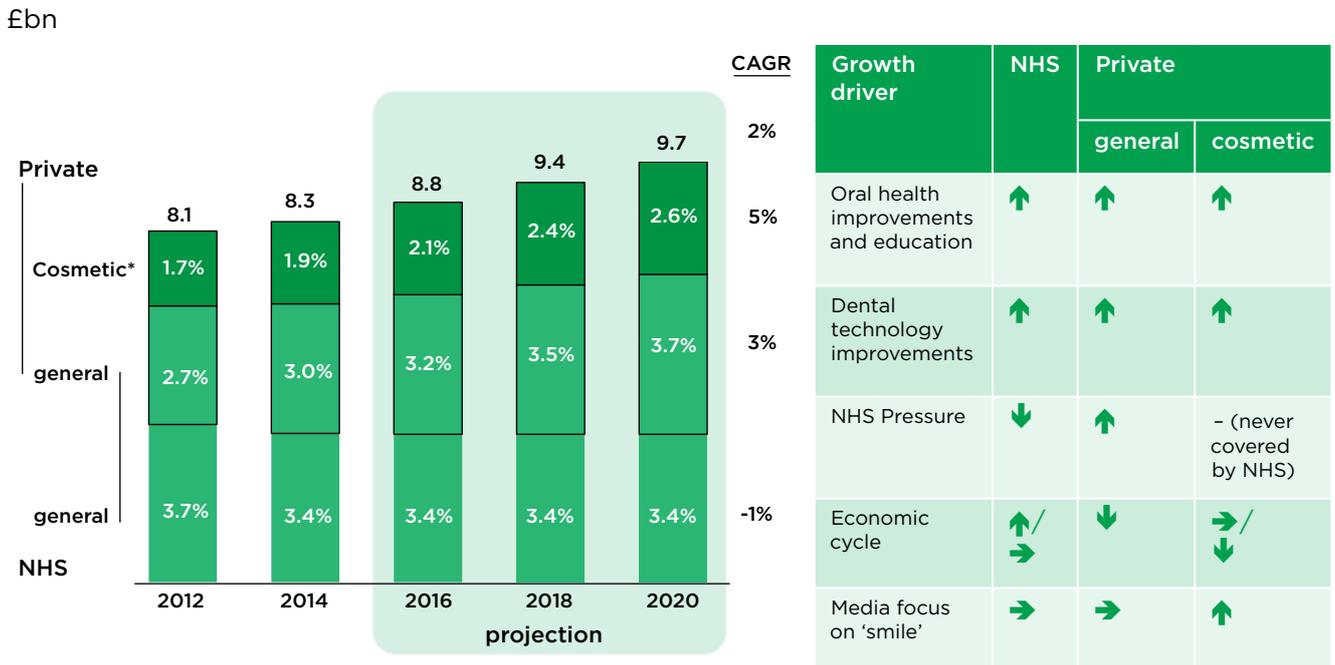
The Department of Health estimate that complex treatment will be rationalised by 20-30%. In more challenging areas of the country, this is far below the level required. Southwark Clinical Commissioning Group (CCG) spends more than 50% of its UDAs on complex activity – more than twice the proportion budgeted in the new contract. Dentists in this area will be under extreme pressure to maintain treatment standards with limited budget, and have this compounded

FIGURE 3: PROCESS OF CONTRACT REFORM



Sources: Candesic analysis

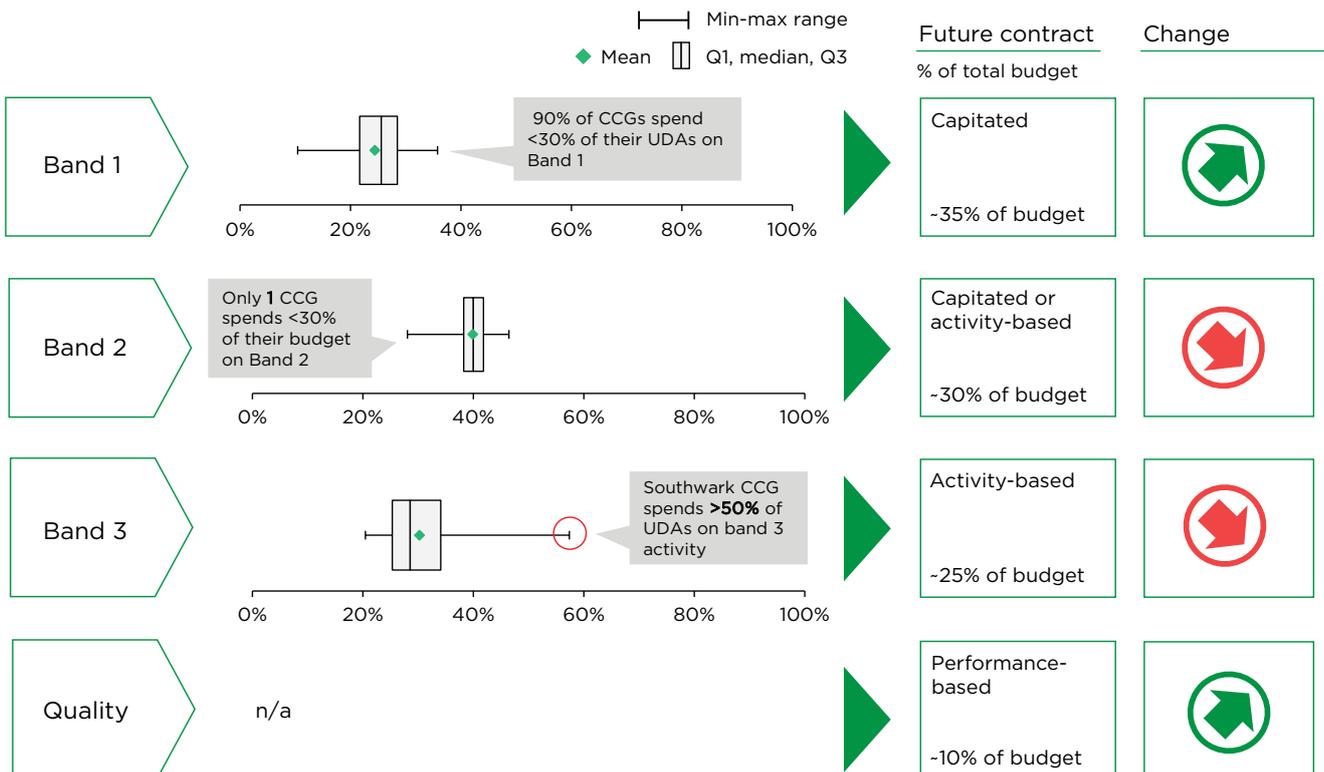
FIGURE 4: STRUCTURE OF THE UK DENTAL MARKET



* Cosmetic: cosmetic dentistry only, i.e. not Botox
 Sources: Mintel 2013 (market projection assumes NHS ringfenced and a private extrapolated CAGR); Candesic analysis

FIGURE 5: CURRENT ACTIVITY BASED EXPENDITURE ACROSS ALL CCGS

2014-15, % of total UDAs, n=211 CCGs



Sources: HSCIC 'NHS Dental Statistics'; Candesic analysis

- ▶ by new demands of preventative care and quality – beneficial in the long-run but unwelcome distractions from the day-to-day.

Dental laboratories will also be under threat, as they make the crowns and bridges to support this complex work.

In short, practices with healthy mouths will be best placed to make a success of the new contract. We estimate 35% of the budget will be available for prevention and low complexity treatment. Whilst not a true like-for-like, more than 90% of CCGs currently spend below 35% of their budget on Band 1 (simple) activity (figure 5).

2. Scale benefits

Larger practices will be better placed to make the best of the new contract in three important ways:

- Staff-skill mix – preventative care will enable dentists to use lower-skilled (and lower-waged) staff to support delivery. Larger practices with multiple chairs will be better able to absorb the recruitment and training expense and will have scope to allocate staff efficiently. A typical example from Candesic work with prototype sites was a practice of 6 associate dentists transitioning to 3 dentists and 3 therapists, saving ~£85k per year
- Additional administration – a consistent theme emerging from Candesic's work has been the growing bureaucratic burden echoed in the prototype sites. Smaller providers (especially single dentist practices) are going to find paperwork eating into consultation time, whilst larger practices with superior IT will be able to streamline processes and maximise chair time and revenue-generating activity
- Tendering – capitated budgets favour larger practices. If small practices exit, larger entities will likely have an advantage in winning bids. Smaller practices with low patient numbers may lose their contract in favour of

those with scale.

With smaller practices disadvantaged, it is probable that there will be a gradual shift in the make-up of dental provision.

3. Shift to private

Approximately 79% of dentists currently combine NHS and private practice and circa 28% of private dentistry value arising from upselling private work to NHS patients.

With charges creating a lack of transparency in the public-private patient journey, upselling may be under threat in the new contract. The new contract is expected to include a much more prescriptive care pathway, potentially inhibiting the ability to upsell treatments which are not considered clinically necessary.

Such a move would throw an unpopular curveball into the negotiations. There is clearly a tension between preventative care and private up-selling and if this is made more complex, dentists able to leave the NHS may well do so.

Morale of NHS dentists is already low, with more than 80% of practice owners reporting their satisfaction levels as 'low' or 'very low'. The reason? Money, primarily – with low NHS fees and lack of government investment the top two factors cited. Demanding NHS targets, red tape and unclear contracts also all feature highly, issues only likely to be exacerbated by the new contract.

With nearly 40% of practice owners reporting plans to sell their practice in the next 12 months, it would not take much for the new contract to accelerate divestment; any challenge to mixed provision could well be the catalyst.

Outlook for investors

So what does this all mean for potential investors?

The £3.4 billion NHS dentistry budget is channelled into a highly fragmented market, with independents making up 78% of total practices. Corporate provision is led by Integrated Dental Holdings (rebranded {my} dentist), with 650 owned centres, circa £600

million revenues and circa £186 million ebitda through a case-mix encompassing 87.5% NHS work. The chain is the clearest attempt to provide a prescriptive operating model, with centralised procurement and the use of prescribed laboratories.

The only other chain with scale is Oasis Dental Care (revenue £234 million and ebitda of £29.5 million). Oasis's clinical work is c. 50% NHS, across 300 centres nationwide.

Both chains, plus the smaller groups such as Rodericks and Southern Dental (each with less than 50 practices) are all looking to consolidate the market through acquisitions.

The change in the contract is expected to accelerate consolidation. Expanding independent practices with multiple chairs or developing regional chains will distract dentists and managers from running their business. Divestment to a corporate will allow the principal dentist, more than before, to realise the value of the practice, reduce the administrative burden, and enjoy the benefits of scale.

Key decisions for consolidators include the local dental health of the population, the dentist's motivations for divestment, and the level of clinical independence that will be granted to the dentists, who will remain self-employed.

A parallel opportunity is likely to emerge in providing business support services to NHS practices, managing additional reporting and quality requirements, too.

Optimised NHS dentistry can be very profitable and it is unclear how the new contract will impact this. Uncertainty in the market will remain, with the challenge of a new set of requirements and expectations looming. In this environment, practices are likely to weigh up their options, presenting an opportunity for new leadership to emerge and the landscape of provision to shift. Larger practices and corporates which are better able to manage risk, juggle the mix of staff, and spread the cost of the administration associated with the new contract across more practices should be well-positioned to thrive. Private dentistry will continue to grow, but, unfortunately, will still lack a major impetus for consolidation. ■

Tom McCabe is a consultant and Dr Leonid Shapiro is management partner of Candesic, a specialist health and social care consultancy serving investors, private operators, and the NHS. lshapiro@candesic.com / 0207 096 7681

