REGULATORY APPRAISAL

NATIONAL HEALTH SERVICE, WALES

THE NATIONAL HEALTH SERVICE (GENERAL DENTAL SERVICES CONTRACTS) (WALES) REGULATIONS 2006

Background

1. In the main, NHS dental care and treatment is currently provided by 'high street' dentists under general dental services (GDS) arrangements, under section 35 of the National Health Service Act 1977.

2. Since 1998, an alternative system of dental service provision has been piloted under the National Health Service (Primary Care) Act 1997. Under these Personal Dental Services (PDS) pilots, an annual contract sum is agreed between the provider of the service and the Local Health Board (LHB) commissioning the service for an agreed level of NHS commitment. Payments under the PDS agreement are made in 12 instalments.

3. Remuneration payments to dentists under both GDS and PDS pilots are undertaken by the Dental Practice Board (DPB) for England and Wales. The DPB is also responsible for establishing the probity of NHS payment claims and the verification of dental charges in relation to each course of treatment. An England and Wales Special Health Authority, the NHS Business Services Authority (BSA) is to be established and will take over the functions of the Dental Practice Board from 1 April 2006. Payments to dentists under both systems are made net of the dental charges due under the 1989 Regulations.

4. PDS piloting has proved popular with dentists and their patients in England and Wales and currently a little under 20% of dentists are working in PDS pilot schemes in Wales. Under these pilot arrangements, dentists are better able to use their professional skills to relate dental services more closely to patients' oral health needs. Patients with lower treatment needs are seen less frequently and courses of treatment become simpler. Evidence from over five years of piloting PDS shows that a reduction of at least 10% in dentists' overall activity (courses of treatment and individual items of treatment) can be expected with an improvement in clinical effectiveness, cost effectiveness and appropriateness of treatment provided.

5. In GDS, 51% of adult courses of treatment involve examination, scale and polish or diagnostic work with no other dental intervention. At least some of these courses of treatment are of questionable health gain. By adopting the new ways of working demonstrated in the PDS pilots, dentists are able to undertake fewer courses of treatment and, subject to agreement with LHBs, see greater numbers of patients. This has the potential to improve the working lives of dentists and their teams and also improve access to NHS dental services.

6. Building on the experience of PDS piloting, provisions in the Health and Social Care (Community Health and Standards) Act 2003 will underpin modernised, locally sensitive primary dental services properly integrated with the rest of the NHS. Under the new arrangements, LHBs will be able to enter into contracts for the provision of primary dental services to meet all reasonable requirements or provide the services themselves. Remuneration of providers under the contract will be by annual contract value, as under the PDS piloting arrangements.

7. The 2003 Act provides for two types of contract: GDS contracts and PDS agreements. Under a GDS contract, the contractor will be required to provide a range of dental services set out in the GDS Contracts Regulations. New PDS agreements will be the 'permanent' version of PDS piloting and will provide for greater flexibility in the services to be provided. Additionally, a wider range of potential providers will be permitted to hold contracts, including healthcare professionals other than dentists. PDS agreements will, for example, be used for commissioning specialised services such as orthodontics.

<u>Reason for change</u>

8. There is a high level of discontent with the current arrangements for the provision of GDS. Dentists tell us that the remuneration system, based on payment for individual items of service, feels like a treadmill and is their main cause of dissatisfaction. It is thought to act as a barrier to dentists agreeing to undertake NHS dental work.

9. The report of the Health Committee inquiry '*Access to NHS Dentistry*' (19 March 2001) considered the general dental service remuneration system at the heart of the problem. The fee structure encourages the move of dentists out of the NHS. It also discourages preventive dental care and the continuing maintenance of good oral health. The Committee concluded the time was ripe for reform.

10. The 2003 Act provides a legislative framework for implementing the reform of primary dental care services identified in '*Routes to Reform, A Strategy for Primary Dental Care in Wales',* which was published in September 2002. New forms of contracting should remove existing perverse incentives for the payment system to influence the type of treatment. This will establish a better approach to patient oral healthcare based on the clinical needs and wishes of the patient. Treatment will then only be offered if it is both clinically desirable and clinically effective. Incentives in the new contracting regime will be aligned towards these ends, which implies a different approach to the issue of patient registration and payment. Clinical pathways, as are now adopted across much of medical practice, are being developed and will be applied in dentistry. They build on available evidence and best practice. Dentists will then record their clinical interventions and note the outcomes, rather than receiving a fee for each intervention.

Purpose and intended effect of the measure

11. These Regulations revoke The National Health Service (General Dental Services) Regulations 1992. They will implement provisions in the Health and Social Care (Community Health and Standards) Act 2003 to create a new locally led dental service, which allows dentists to spend more time with each patient,

provides more appropriate clinical care and is far more sensitive to the variety of ways in which patients now wish to access NHS dentistry. The new system is to be in place by 1 April 2006.

12. Their intended effect is that for the first time every LHB will:

    - have a duty to secure or provide primary dental services to the extent that it considers necessary to meet all reasonable requirements, rather than the current passive role of enabling GDS to be delivered where a dentist has agreed to provide them for a patient who has requested them;

    - have financial resources for primary dental services directly allocated to them to commission primary dental services to meet local health needs from dental practices, dental corporate bodies or to provide the service itself;

    - have the power to commission suitable high street specialised dental services more cost effectively, close to where patients live and to help reduce outpatient waiting times for consultant led services by reducing inappropriate referrals;

    - have resources, which follow patients rather than dentists so that if a provider ceases to provide primary dental services, or reduces commitment to the NHS, the LHB will still hold the finances to commission services from an alternative provider; and

    - be enabled to provide assistance and support, including financial support to providers of primary dental services, strengthening the partnership between LHB and its providers.

13. Under a GDS Contract, the contractor will be required to provide a range of dental services set out in the Regulations to be known as ‘mandatory services’. Remuneration under the new contract will not be on an item of service basis (as it is under the current arrangements for GDS).

Risk Assessment

14. The new dental contract is based closely on the contract being introduced in England, although officials have been working with British Dental Association Wales and the dental profession to amend the contract where possible to reflect needs and address difficulties here. However, our timetable is inextricably linked to the one in England and the reforms in England are due to come into effect at the same time. Any delay in implementation in Wales would put Wales seriously out of step and have an immediate and negative effect on retention and recruitment of dentists providing NHS care. There would also be substantial additional cost in maintaining different payment and charging arrangements for dentists in Wales with the Dental Practice Board.

Options

Option 1: Do Nothing

15. If the Regulations are not made the existing system would remain and the benefits of the reforms for patients and dentists would not be put in place.

Option 2: Make the Legislation

16. Improved access to an NHS dental service better aligned to patients needs. There is also the potential to enhance clinical effectiveness, cost effectiveness and appropriateness of oral healthcare for the patients. In addition the reforms will lead to improved working lives for dentists and their dental teams. Dentists and practice staff will benefit from reduced bureaucracy and detailed form filling.

Benefits

17. The move to local commissioning of NHS primary care dental services offers a fresh start for dentists and patients. The reforms allow dentists to provide more appropriate clinical care, spend more time with each patient and, subject to agreement with LHBs, expand overall capacity. These reforms place dentistry more firmly in the mainstream of the NHS, an easy to access service, providing appropriate clinical care and giving out key public health messages to encourage self care wherever possible.

18. For dentists, the reforms will provide a guaranteed income, scope to plan services and an end to the item of service treadmill, which provides incentives to maximise the items of treatment provided to maintain income, rather than provide the care necessary to maintain oral health. This may act as a deterrent to dentists working for the NHS. In contrast, the new system removes outmoded treatment incentives and allows time to advise patients of their role in maintaining oral health.

19. Dentists and patients will benefit from new Regulations allowing a wider range of professionals to be involved in providing NHS dental care. This will enable the dental team to increase the focus on preventive measures to combat dental disease and to tackle serious oral health inequalities, particularly in children.

20. For patients, the range of treatments provided by the NHS will be clearer. Each dental surgery will be required to display details of the new banded system of dental charges in their surgery. Dentists will still be able to offer NHS and private dental care and continue to see their existing patients, and this applies whether the existing patients are children and/or exempt adults. But dentists who provide private care will be required to give information and advice on private treatment choices and methods of payment. The choices for patients will become much more transparent.

21. Patients should receive a more appropriate level of service as the local NHS more closely aligns resources for dentistry with local need and commissions services accordingly. The new local commissioning system means that if a dentist leaves a practice the resources for his contract revert to the LHB. Therefore the level of resource for NHS dentistry in a local area remains constant and is not affected by the decision of an individual dentist. The current

remuneration system arbitrarily distributes resources according to the location and commitment of General Dental Practitioners not local oral health needs, and ensures an inequitable distribution of resources.

22. LHBs' new responsibility for local dental services will enable them to commission services to meet particular local oral health needs. The new contracts with local dentists will be longer term agreements, replacing the open ended nature of the current arrangements whereby dentists can decide what work they undertake, with an agreed level of service. Access for patients will be determined by the contract agreed with the LHB, not the preference of an individual dentist.

23. LHBs can judge the relative benefits of dental service provision and oral health measures as they seek to address oral health inequalities and ensure equitable access to NHS primary care dental services.

Costs

24. Growth of NHS dental services, and increasing access, is a key aim of the reforms and an additional £15m has been made available for this from 2006-07 onward. Current expenditure on GDS is non-cash limited and the intention is to secure the existing level of NHS dental services within the existing budget resources (with appropriate uplifts for pay and prices). Net expenditure in 2004-05 was some £80.041 million. It is proposed that the current expenditure on dentistry will be protected and that the spend on GDS move from a national budget into local allocations. There will be a floor on this expenditure, so that LHBs will be required to spend at least at the current level on dentistry. They can spend more than this if they wish, but cannot spend less.

25. Practices are guaranteed the same level of gross income as that in the test period (October 2004-September 2005), increased by the agreed Doctors and Dentists Review Body (DDRB) uplift (3.4% for 2005-06), for comparable levels of commitment work.

26. To support LHBs, local dental committees and dentists to help prepare for the changes and to implement reform, funding of £990,000 was incurred in 2004-05. This was made up as follows:

    - £440,000 - £20,000 to each LHB in terms of supporting the dental change agenda allowing them to support leadership in LHBs; improve organisational development to successfully implement the contract; support Local Dental Committees; developing dental leadership skills; improve communication and review and update dental competencies in line with the development of the dental reforms; and

    - £550,000 - The equivalent of £1,000 per dental practice (pro rata on NHS commitment). This was in response to the DDRB recommendation that financial assistance to practices was required to assist them to prepare for the new contractual arrangements.

27. The above allocation to LHBs to help them get to grips with the changes is recurrent in 2005-06 and 2006-07. This funding has come from the Health and Social Services Main Expenditure Group (Payments to Contractors Budget Expenditure Line).

28. There are currently 533 dental practice addresses in Wales, most providing GDS and some 80 others PDS pilots. The 2006 Regulations will apply to all dental practices from 1 April 2006. Both paper and electronic changes to practices' administrative systems will be required for the new charging regime. Currently, dentists' NHS fees and the related charges change each year, requiring amendments to practices' administrative systems, so upgrades for April 2006 should not incur significant additional costs.

29. Dentists and practice staff will benefit from reduced bureaucracy and detailed form filling as a result of the move from over 400 different charges related to individual items of treatment to recording only course of treatment categories related to the banded patient charges.

30. About 30 million 'item of service' claims are submitted to the DPB each year, 70% of which are electronic (England & Wales figure). If the simpler data to be submitted saves 1 minute per electronic claim and 1.5 minutes per paper claim, then the saving at dental practices is the equivalent of around 300 fulltime posts (some 20 in Wales) per year (assuming 40 hours a week, 45 weeks a year). There are likely to be similar savings at the DPB and its successor body the BSA.

31. It is planned to use National Assembly directions to delegate the LHB administrative functions, including payments, in relation to GDS contracts and PDS agreements to the BSA. The BSA will verify patient charges in relation to the appropriate treatment band in order to make payments to the contractor net of patient charges. This enables the BSA to provide the LHB with regular activity monitoring information. LHBs' administrative costs should not increase. Because it will be easier to track patient charge levels, the BSA will also gain from the reduced bureaucracy of the new contracting arrangements and patient-charging regime.

32. The National Institute for Health and Clinical Excellence (NICE) guidance on dental recalls (*Dental recall: Recall interval between routine dental examinations*) advising a recall interval related to the patient's oral health risk factors, means that patients will typically only need to visit the dentist every eighteen months as opposed to the current 6 monthly norm. This is likely to free up additional capacity at dental practices with the potential to improve access to NHS services.

33. Under the new contracting arrangements, dentists will agree an annual contract value to be paid to the contractor in monthly instalments. Because the total annual contract value is agreed in advance with the LHB, in future, there will be no financial incentive for dentists to unnecessarily complicate a course of treatment to maximise earnings. As now, the patients' charges payable will be

collected by the contract holder and the monthly contract payment will be reduced by the amount of the patient charges due

Social impacts

34. Following an oral examination, a dentist will set out for the patient the type and extent of dental work required and which band that falls into. The patient will then make the payment for that band and be entitled to, within that course of treatment, all the treatment agreed to. Since the payment is set in advance, the patient will know exactly what the course of treatment will cost and can plan accordingly. Payment can be made upfront, during the course of treatment, or at the end.

35. The new contracting regime may help encourage dentists to do more NHS dental work because it is simpler to calculate charges and to explain them to patients.

Impact on Small Firms

36. The British Dental Association, British Orthodontic Society and other stakeholders, including the Dental Laboratories Association, contributed to the development of the policy for local commissioning of primary dental services. From this, limited initial soundings have not identified any significant impact on small businesses.

37. Small practices and businesses were particularly encouraged to contribute their views.

Competition assessment

38. Because of the nature of the NHS dentistry market, the new contracting regime is likely to have little or no impact on competition. The new Regulations will impose no additional burden on small businesses providing NHS dentistry and will have no adverse affect on competition.

39. The new contracting regime and associated charging system may help encourage dentists to do more NHS dental work because it is simpler to operate, calculate charges and to explain to patients.

40. Of the 533 dental practice addresses in Wales, most will be providing GDS and some 80 others PDS. Some of these practices may be owned by dental corporations. A dental corporation means a body corporate which, in accordance with the provisions of the Dentists Act 1984, is entitled to carry on the business of dentistry. No dental corporation has more than 10% market share in Wales.

41. It is, therefore, unlikely that any costs involved in administering the new contracting regime, calculating and collecting dental charges under the 2006 GDS Regulations or 2006 PDS Regulations, will have a substantially different effect on dental businesses than the 1989 Regulations and 1992 Regulations, nor are they likely to change market structure as a result. New dental practices entering the market would incur no extra penalty in operating under these Regulations.

42. There are a limited number of relatively small companies providing and maintaining dental practice software management systems. The new dataset necessary for the administration and verification of the new charging regime is a subset of the item of service codes currently submitted to the DPB for payment purposes. The DPB, Department of Health and Welsh Assembly Government have been working closely with all of the practice software system suppliers to ensure that the necessary upgrades to the IT software can be written with minimum disruption.

43. Administration of the new contracting arrangements and associated patient charging will be the responsibility of LHBs. The National Health Service Business Services Authority will undertake activity monitoring and patient charge verification as part of its payments function on behalf of all LHBs under National Assembly direction.

Consultation

With Stakeholders

44. The draft Regulations together with guidance were published for information and comment on 9 September 2005. This was part of a wider discussion with the dental profession on an England and Wales and Wales only basis. The Regulations and guidance were particularly aimed at dentists, including representative bodies such as the British Dental Association Wales (BDA Wales) and LHB Directors of Primary Care, who have an interest and responsibility for negotiating the new contract values and for managing the new system of local dental commissioning. In addition, they were published on the Welsh Assembly Government website at: www.cmo.wales.gov.uk/content/work/chief-dental-officer/index-e.htm and details included in updates sent to all dentists in Wales. There have been a number of discussions between the BDA Wales, others in the dental profession and Assembly government officials. During these discussions a number of concerns were raised about the detail of the Regulations. These included:

- the system of monitoring under the new ways of working;
- selective acceptance of patients i.e. seeing children or exempt patients only;
- opening times of practices;
- provision of services to violent patients;
- ending contracts if a practitioner dies;
- charging for missed appointments;
- mixing of NHS and private treatment; and
- governance arrangements.

45. As a result of comments received from the consultation and discussions with the BDA Wales, others in the profession and LHBs, changes have been made to the draft Regulations:

- the amount of work (weighted courses of treatment) to be provided in 2006-07 will be 10% less than that provided in the test period, without any

loss of income and will then form the baseline for future monitoring of the GDS contract. Additionally, a further 5% tolerance over the year will be accepted before this triggers a discussion between the contractor and the LHB. (The percentages being applied in England are 5% and 4% respectively);

- it had never been intended to prevent dentists continuing to see their existing patients and this applies whether the existing patients are children and/or exempt adults. Given the concern and misunderstanding about the proposals we put the matter beyond doubt and revised the Regulations and guidance;
- clarification has been made to reflect normal opening hours;
- clauses extended to include irrevocable breakdown in relationship as reason to cease treatment to a patient;
- extension to the period during which the practice can continue to run by the contractor's personal representatives;
- charging for missed appointments not allowed under new system but it is recognised that this is a sensitive issue and it is part of the continuing discussions with the profession; and
- no change to the Regulations but clarification provided. Rules around mixing are largely unchanged (the restrictions on mixing on the same tooth are removed). Dentists will have to provide all treatment that is necessary to maintain a patient's oral health as is now the case. This does not mean providing treatments which are not clinically necessary.

With Subject Committee

46. The draft Regulations were notified to the Health and Social Services Committee via the list of forthcoming legislation on 13 July 2005 (HSS(2)-09-05(p.2a)) and were identified for detailed scrutiny.

47. The Committee scrutinised these Regulations at its meeting on 23 November 2005 (HSS(2)-12-05(p.4)). One amendment was proposed to the Regulations in relation to age bias and Members voted in favour of the amendment. However, because the issue was a legal one, it was agreed that the Welsh Assembly Government lawyers and also Counsel to the Assembly would be asked to consider the amendment further. The Directorate of Legal Services (DLS) advised that the Regulations already covered the proposed amendment, so the amendment has not been included in the Regulations. A transcript detailing the discussion is attached at Annex A.

48. The Minister for Health and Social Services wrote to the Chair of the Health & Social Services (H&SS) Committee on 19 January 2006 advising him of the legal advice received from DLS on the above amendment. The Clerk to the H&SS Committee has since confirmed that no responses were received.

Review

49. These Regulations require those holding contracts for the provision of primary dental services and dentists employed directly by LHBs to collect NHS dental charges only in accordance with the new Regulations. Failure to comply with the Regulations may amount to a breach of contract or of the employee's terms and conditions of service. LHBs have sanctions, including the issue of remedial

notices and breach notices, in relation to their contractors or their members of staff. A breach of contract could mean that the contractor could no longer provide primary dental services under NHS contract.

50. Contract holders will be required to submit to the BSA data for activity monitoring and patient charge verification. Data from this process will be provided regularly to both the LHB and the provider of the service.

51. The Assembly Government is carrying out a public communications campaign in the run-up to April 2006. This explains to patients what the changes will mean for them, how their future care will be provided and how the new charging system will work. This includes an information leaflet for practices to give to patients.

Summary

52. It is widely acknowledged that there is a need for the reform of primary dental care services, in particular the need for a new GDS contract in Wales. The proposed new contract puts an emphasis on preventive care, local sensitivity and improving quality and access, which recurrent themes are underpinning the wider reform programme currently underway across the NHS. For dentistry, these aims will be achieved primarily through the introduction of local commissioning of primary dental services by LHBs. They will enter into local contracts with dentists for the provision of these services. The overall intention is to secure the existing level of NHS dental services within existing resources and through the provision of additional resources expand access to the public and improve oral health.