EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE (PRIMARY DENTAL SERVICES) (MISCELLANEOUS AMENDMENTS AND TRANSITIONAL PROVISIONS) REGULATIONS 2013

2013 No. 364

1. This revised explanatory memorandum has been prepared by The Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 This Instrument amends the -

(a) the National Health Service (General Dental Services Contracts) Regulations 2005 (SI 2005/3361) ("GDS Regulations"), which set out the framework for General Dental Services Contracts,

(b) the National Health Service (Personal Dental Services Agreements) Regulations 2005 (SI 2005/3373) ("PDS Regulations"), which set out the framework for Personal Dental Services Agreements, and

(c) the National Health Service (Dental Charges) Regulations 2005 (SI 2005/3477) ("Charges Regulations"), which set out the charges that may be levied for NHS dental services.

2.2 The purpose of this instrument is –

(a) to implement relevant changes introduced in the Health and Social Care Act 2012 ("2012 Act"), principally the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities upon the coming into force of sections 33 (abolition of Strategic Health Authorities) and 34 (abolition of Primary Care Trusts) of the 2012 Act, and the transfer of general dental services contracts ("GDS contracts") and personal dental services agreements ("PDS agreements) to the National Health Service Commissioning Board ("the Board") from 1 April 2013,

(b) to implement the Capitation and Quality Scheme 2 which is the new pilot scheme to be introduced by the Secretary of State on 1 April 2013 to continue the piloting of a new dental contract implemented by the Capitation and Quality Scheme, following the termination of the current Capitation and Quality Scheme on 31 March 2013 and

(c) to introduce a new dental charge (the Band 1A charge) which will apply to persons receiving additional treatment from contractors participating in the Capitation and Quality Scheme 2. The policy intention was that only treatments under Band 1A that include invasive treatment that are set out in paragraphs (e) to (g) of Schedule 1A should be chargeable. This instrument however makes all treatments under the Band 1A potentially chargeable. A further amending regulation, The National Health Service (Primary Dental Services) (Miscellaneous Amendments to Charges) Regulations 2013, has been laid to also come into force on 1 April 2013 to correct this.

The instrument also makes minor and updating amendments.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None

4. Legislative Context

4.1 Part 5 of the National Health Service Act 2006 ("the 2006 Act") currently requires PCTs to provide, or secure the provision of, primary dental services in their area. This Part makes provision for regulations to be made to govern primary dental services contracts and agreements.

4.2 This Instrument amends the GDS Contracts Regulations and the PDS Agreements Regulations. These Regulations govern the way in which NHS dental services are delivered. These Regulations contain the mandatory contractual terms and conditions that must be contained in primary dental services contracts and agreements made between PCTs and primary dental contractors.

4.3 This Instrument is being made to effect consequential changes to the regulations that govern primary dental contractors, as a consequence of—
(a) the transfer of GDS contracts and PDS agreements to the Board pursuant to a property transfer scheme under section 300 (transfer schemes) of the 2012 Act,
(b) the abolition of PCTs and Strategic Health Authorities consequent on the coming into force of sections 33 and 34 of the 2012 Act, as referred to in paragraph 2.2(a) above, and
(c) the changes to Part 5 (Dental Services) of the 2006 Act made by the 2012 Act, principally changes that extend the range of persons eligible to hold a GDS contract or a PDS agreement to allow limited liability partnerships to hold contracts and agreements.

Transitional provision made by Schedules 1 and 2 to these Regulations enable transitional arrangements where, following the transfer of GDS contracts and PDS agreements to the Board on 1 April 2013, the Board takes over the functions of PCTs and Strategic Health Authorities relating to the provision of primary dental services, and becomes a party to the primary dental contracts.

Capitation and Quality Scheme 2

4.4 This Instrument also implements the Capitation and Quality Scheme 2 by making provision to provide for the temporary variation of the scheme under which NHS dental services are provided by some existing providers of NHS dental services under Part 5 of the 2006 Act, similar to the provision made in relation to the Capitation and Quality Scheme in 2011. This is to enable the Secretary of State to implement the second stage of dental pilots to be introduced from 1 April 2013 until 31 March 2015 (the Capitation and Quality Scheme 2).

4.5 For background information on the legislative context and policy background to the original Capitation and Quality Scheme, set up in 2011, please see paragraphs 4.1 to 4.6 of the Explanatory Memorandum to the National Health Service (Primary Dental Services) (Miscellaneous Amendments) Regulations 2011 http://www.legislation.gov.uk/uksi/2011/1182/memorandum/contents. Existing Regulations and directions implementing the current scheme will cease to have effect on 31 March 2013. New provision is therefore required to implement the Capitation and Quality Scheme 2, to enable current participating pilot contractors to continue into the new Scheme and new pilot contractors to participate in the new Scheme. This Instrument makes such provision.

New dental charge

4.6 Part 4 of this Instrument amends the Dental Charges Regulations to provide for a new dental charge to be introduced from 1 April 2013, where patients are receiving additional interim care as part of a treatment plan under the Capitation and Quality Scheme 2. Section 176 (dental charging) of the 2006 Act provides that regulations may be made for the making and recovery of charges for NHS dental services, subject to the exemption provision made by section 177, which sets out the persons who may not be charged for NHS dental treatment.

4.7 The new charge is implemented by providing that additional preventative treatment currently provided as part of a wider course of treatment (CoT) is to be regarded as a new CoT, for which the new charge may be levied. The components of this CoT are set out in new Schedule 1A which the Instrument inserts into the Dental Charges Regulations. This Instrument provides that any of the treatments provided under the new Schedule 1A may be chargeable. However, this is not the policy intention and a separate amending instrument will clarify that the Band 1A charge is only to be applied where the CoT includes invasive components.

5. Territorial Extent and Application

5.1 This Instrument applies to England

6. European Convention on Human Rights

As the Instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

What is being done and why?

7.1 The 2012 Act abolishes PCTs and Strategic Health Authorities and established the Board. The Act transfers responsibility for commissioning dental services from PCTs to the Board, and requires existing GDS contracts and PDS agreements to be transferred from PCTs to the Board. This Instrument makes transitional provision in respect of the abolition of, and the transfer of contracts and agreements to, these bodies.

7.2 This Instrument reflects policy changes in respect of who can hold a dental contract or agreement. It expands the range of persons who may hold a dental contract or agreement to include suitably qualified people who are in limited liability partnerships (LLPs) to hold GDS contracts and PDS agreements. It also removes references to qualifying bodies in the PDS Agreements Regulations to reflect changes in the primary legislation to refer instead to dental corporations, companies limited by shares and limited liability partnerships, as the case may be.

The Capitation and Quality Scheme 2

7.3 The Coalition Agreement committed the Government to introducing a new NHS dental contract based on registration, capitation and quality with the aim of improving oral health and increasing access to NHS dentistry. The Government also committed to piloting the key quality and capitation elements needed to design such a contract. This was particularly important to the dental profession and other stakeholders as the lack of direct piloting of the 2006 contract had attracted significant criticism. The Government set up a national steering group chaired by the Department of Health and including members from the profession (including the BDA), patient groups and academics, NHS Commissioners and a pilot dentist.

7.4 Piloting began from April 2011 under the National Health Service (Primary Dental Services) (Miscellaneous Amendments) Regulations 2011, which cease to have effect on 31 March 2013. The intention now is to move to stage 2 piloting with a slightly larger number of practices and range of services and refined remuneration and clinical models.

7.5 The original pilot scheme tested a new way of delivering care to patients, focusing on prevention of future disease through a pathway approach. Alongside this, the pilots tested a pilot Dental and Quality and Outcomes Framework (DQOF) and four variants of capitation and quality remuneration. No remuneration variant tested was intended as a prototype of a new contract. The intention set out by Ministers was to test key elements needed to design a new contract. The four payment models were intended to test different behavioural responses to the slightly different ways of remunerating for capitation and quality each type represented.

7.6 All pilots used a patient pathway that provided, through chairside IT systems, decision support on the patient's current treatment needs and level of risk of dental disease. The pathway approach was in the early stages of its development when the pilots were originally set up in 2011. This is why the Explanatory Memorandum to The National Health Service (Primary Dental Services) (Miscellaneous Amendments) Regulations 2011 refers only to oral health assessment rather than describing the full pathway approach.

7.7 The pilot pathway used in the pilots consists of an initial detailed oral health assessment. The dentist checks the patient's oral health through a clinical examination and detailed social and medical history. This risk assessment is expressed as a traffic light, with patients' oral health marked as red, amber or green. The dentist then provides any treatment the assessment shows is necessary and sets a recall interval after which the patient will have a further full oral health review. In addition, for patients marked as either amber or red on the risk assessment, interim care appointments will also be recommended at which further additional preventative treatment (including advice) can be given. The pathway approach supports, but does not replace, dentists' clinical judgement. Individual patients will vary and the dentist will consider the recommendations generated by the pathway in the light of the needs of the individual patient.

7.8 All pilots were also measured against clinical and patient indicators in a pilot DQOF. All but two pilots (see paragraph 7.12) also had 10% of their contract value dependent on performance against a DQOF. The current version of this, published in May 2011, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152039/dh_126627.pdf.pdf. The intention of a DQOF is to determine how effective payments for quality are in terms of incentivising dentists to achieve improvement in patients' oral health and in-patient experience. A few pilots were measured against the DQOF but without their contract values being dependent on it. This was to see if this would result in a different behavioural response. Pilots were remunerated in 3 models – Type 1, Type 2 and Type 3 pilots. A fourth variant could apply to pilots from any of the first 3 models. These pilots are called Type 1*, Type 2* and Type 3* pilots (see further at paragraph 7.12). Each variant was intended to provide information on different aspects needed to understand the implications of possible remuneration models.

7.9 There were 46 practices in Type 1. These received a fixed contract amount, which was the same as their contract value at entry into the pilot, and in return were expected to deliver all the NHS care they judged was clinically necessary for their patients. The intention of these pilots was to inform work to determine the appropriate size of a dentist's patient list and to calculate an appropriate daily capitation value for patients.

7.10 There were 12 practices in Type 2. These had their payments adjusted based on the number of patients that are under their care, weighted for age, sex and the Indices of Multiple Deprivation. This weighted capitation payment covered all NHS care. The intention of these pilots was to determine how treatment patterns change when a capitation system is used, rather than one based on delivering units of dental activity.

7.11 There were 12 practices in Type 3. These had their payments adjusted based on the number of patients that are under their care, weighted for age, sex and the Indices of Multiple Deprivation, but this weighted capitation payment covered only routine NHS care. There was a fixed contract amount for complex care based on the practices' previous delivery. The intention of these pilots was to determine how access to, and delivery of complex care, is affected by capitation.

7.12 In the fourth variant the DQOF financial adjustment was not applied. Pilots to which the DQOF did not apply could be drawn from any of the 3 pilot types described above. These pilots (known as starred pilots or DQOF-off pilots) were subject to the same remuneration arrangements as the rest of their type except that while they were measured against the DQOF no financial adjustment applied.

7.13 The payment mechanisms for remuneration in all types of pilot were set out in the Capitation and Quality Scheme Statement of Financial Entitlements, available at http://www.pcc-cic.org.uk/sites/default/files/articles/attachments/dental_pilot_sfe_may_11.pdf

7.14 At the end of 2011/12 the pilots were remunerated in line with these arrangements but the DQOF was not applied to any for that year. The pilots became operational in September 2011 and six months of clinical data was not sufficient to allow performance against the DQOF measures to be fairly or robustly applied.

7.15 All four variants are piloting the same patient pathway and are intended to provide information about the operation of the pathway and how the pathway approach interacts with each variant of the remuneration model.

7.16 Version 1 of the pilot patient pathway was reviewed by a clinical review group in summer 2012. The group was made up of dentists working in the pilots, consultants in public health and dental academics. This group reported to the National Steering Group. Their findings and recommendations were published in the autumn. A revised pathway, reflecting recommendations on streamlining the supporting IT arrangements and removing some clinical steps which did not add value in the view of clinicians, is planned for use in the stage 2 pilots. The pathway is itself a pilot and the intention is to review it regularly to ensure the final product is clinically and administratively fit for purpose.

7.17 Patients, dentists and dental staff views on the pilots were gathered through market research by ICM. The report found that, while improvements needed to be made, both dentists and patients welcomed the new clinical approach of providing patients with structured advice on how to improve their own oral health as well as treating any disease needs. The report can be found at https://www.gov.uk/government/publications/extension-to-dental-contract-pilot-scheme

7.18 The early learning from the first twelve months of piloting was reviewed by a sub group of the Dental Contract Reform Programme's National Steering Group. This group, made up of academics, NHS commissioners, members of the profession and chaired by Professor Steele, published a report setting out the early learning from the pilots in October 2012. Their detailed findings are set out in their report *NHS Dental Contract Pilots - Early Findings*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127035/NHS-dental-contract-pilots-early-findings.pdf.pdf. The report and experience of the pilots demonstrated that it was very early for definitive findings and that there were significant challenges to be resolved before a national contract based on robust learning could be developed. Key challenges identified included:

- understanding the reduction in numbers of patients seen in the pilots in the first year
- supporting practices to adjust to the different ways of working the preventative pathway and capitation approach requires which is culturally very different from the treatment and activity driven system in the current contract.
- understanding how the pathway and remuneration approach would fit with non high street primary care services and specifically in so called community dental services (services providing primary care to vulnerable groups and /or those having other difficulties in accessing high street care)
- managing inadvertent impacts of the new approach during piloting – as set out in paragraphs 7.28 – 7.30, patient charges in pilots delivered considerably better value for patients than for those in non-pilot practices.

7.19 The Government published, also in October 2012, its next steps on contract reform. These proposals set out in https://www.gov.uk/government/publications/extension-to-dental-contract-pilot-schemeset out

- a decision that a pathway approach would be used in any new contract
- a strong presumption that a DQOF would also form part of the quality element of any new system – subject to successful application of it as part of remuneration, something it is hoped the stage 2 piloting will allow

- a decision to establish a second stage of pilots to run from 1 April 2013 for up to two years of around 90-95 pilots. This is an increase of 20-25 on the existing 70 pilots. This second stage of pilots would expand the range of services being tested to include services providing care for vulnerable groups (so called community dental services) as well as an expanded number of high street practices. It will allow the capitation and quality elements of a new contract to be refined in the existing and new settings and allow for further testing of how the elements interact. The key questions the further piloting will address through this process are set out at para 7.18 above.

7.20 As in the first stage, the second stage pilots will not be testing a full prototype, but testing the key elements needed to design a new contract. The four existing pilot remuneration types will continue.

7.21 The Stage 2 piloting allows a rebalancing of numbers in the main Type 1 to Type 3 remuneration models. The distribution between types in the Stage 1 piloting was uneven with 46 pilots in Type 1 and 24 testing Types 2 and 3 (split evenly between these two). The reason for this was that technical limitations on the capitation simulation meant it could not, in Stage 1, fairly handle (without either disadvantaging practices or the NHS) any historic or in-year growth in NHS funding for an individual practice. Practices that had received growth were not therefore eligible for Type 2 or 3 piloting. The learning from Stage 1 piloting has allowed the capitation model to be further developed and a technical solution found that allows growth to be fairly handled in piloting and potentially in any new contract.

7.22 Ensuring sufficient and more balanced numbers in each pilot type is important for the learning so, as the Government's proposals document and invitation to practices to pilot last autumn made clear, the new pilots recruited for Stage 2 will normally be invited to become Type 2 or 3 pilots. We expect the majority of the existing pilots to want to remain in their existing pilot type so this will not completely rebalance the numbers but will mean type 2 and 3 numbers double. Type 1 will still form around half of all pilots.

7.23 The new community dental services pilots (an initial three are in the process of being recruited) will all run as Type 1 pilots. These services provide care for vulnerable groups and others having difficulty in accessing high street dental care. We therefore intend to restrict any risk to these groups by putting them all into the type where existing income is guaranteed.

7.24 Risks to the implementation of the next stage of piloting are mitigated by limiting the number of additional pilot practices and continuing, as in the first stage, the limits on the degree by which the risk to income of those taking part in pilots and expenditure by the Board when acting as commissioner can vary. The pilots will be enabled to run for a maximum period (under this instrument) of a further two years, until 31 March 2015, and there is no commitment to taking these provisions

beyond the pilot stage. The central pilot programme is funded from an existing programme budget and all other costs will be met by the practices or commissioners from existing allocations.

New Dental Charge – Band 1A

7.25 These regulations also introduce a new dental charge (Band 1A) which will apply only to patients receiving treatment from practices under the Capitation and Quality Scheme 2 and only for additional preventative care that patients may receive under the pathway. The new charge that will be set at the existing Band 1 rate from 1 April will be £18.00. This is needed to ensure patients in non-pilot practices are treated reasonably equitably with patients in pilot practices in terms of patient charges even though the way care is delivered is different under the pilot pathway.

Background to existing charges

7.26 Charges for NHS primary dental treatment are levied in bands, calculated in accordance with the Dental Charges Regulations. Under these Regulations, introduced in 2006 alongside the contract that established the UDA dental remuneration system, a banded charge is payable for a CoT. CoTs can be provided over a number of appointments on different dates.

7.27 The Charges Regulations provide that only one charge may be levied per CoT and there are 4 possible banded patient charges:

- Urgent Treatment under Band 1 (£18.00);
- Band 1 (£18.00) – Diagnosis, treatment planning and maintenance;
- Band 2 (£49.00) – Treatment;
- Band 3 (£214.00) – Provision of Appliances.

As with the existing four bands, only one charge may be levied per CoT. Band 1 includes all the treatment contained in Band 1 urgent and Band 1A. Band 2 includes all the treatment contained in Band 1 and Band 3 includes all the treatment contained in Bands 1 and 2. If need is identified during a CoT that falls into a higher band the CoT is converted into the higher band and the patient charged (if applicable) at the rate appropriate for the band of treatment provided. So if a patient has a check up and no treatment is needed they are charged at Band 1. If at that check up a need for fillings is identified then they are charged at Band 2 not Band 1 + Band 2. Similarly, if at an interim care appointment a need for diagnosis is established, the patient is charged once at the appropriate band to the treatment actually provided, e.g. Band 1 if diagnosis and preventative care only, Band 2 if fillings are required, and Band 3 if appliances are required.

Why an additional banded charge is needed

7.28 The learning from the existing pilots has been that the existing NHS charges system interacts with the different patterns of care in the pilots in a way that results in patients in pilot practices receiving considerably more care per patient charge than patients in non-pilot practices. This is because under the existing regulations, CoTs must include an initial examination at which there would be diagnosis and all care planned at that diagnosis must be delivered before the CoTs are closed.

7.29 Interim care consists of appointments scheduled for 3, 6 or 9 months after an oral health assessment (or review) and any associated definitive treatment. At these appointments patients receive additional preventative care or advice based on their risk of future dental disease. They are not diagnosed or necessarily clinically examined. The treatment to be delivered at such appointments is planned by a dentist at the preceding oral health assessment or review. The lack of an assessment and the pre-planning of the treatment together means that under the current Charges Regulations interim care forms part of a single CoT that includes the original oral health assessment or oral health review. Interim care is delivered months after the oral health assessment or review, which results in care in pilots being delivered in fewer but longer CoTs than in non-pilots. Since currently only one charge may be levied per CoT, patients are paying proportionately less for care than in non-pilots.

7.30 The lower average charges for care collected during the Stage 1 piloting raised two key issues:

- They are inequitable for patients – with patients in non pilots being disadvantaged
- They do not provide a realistic test of patient response to the new pattern of care under normal charging conditions
- They also reduce the total funding raised from pilots for the NHS through patient charge revenue.

What is being proposed

7.31 Ministers therefore set out their intention in “Proposals for stage 2 piloting” to amend the Charges Regulations to create an additional banded CoT and therefore charge for interim care in the Capitation and Quality Scheme 2 pilots. This is being implemented as the new Band 1A CoT and charge. The instrument provides that the charge will only be payable by those patients receiving treatment from a pilot contractor under the Capitation and Quality Scheme 2 arrangements. It will only be payable for the defined additional preventative CoTs being provided as part of the care pathway provided to patients under the pilot scheme. The proposals are available on the Government website, at https://www.gov.uk/government/publications/extension-to-dental-contract-pilot-scheme.

7.32 The new Band 1A charge level will be the same as the existing Band 1 urgent and Band 1 charge – which will be £18.00 from 1 April 2013. Setting the charge for Band 1A at the existing Band 1 level avoids creating confusion in this pilot stage for patients and dental staff moving between pilot and non-pilot practices. The Band 1A CoT will include one or more of the following items:

a) The giving of specific advice in relation to diet, hygiene, personal habits and oral health in respect of a person to enable that person to be aware and to be able to take steps to prevent dental and oral disease;
b) The giving of instructions on techniques and practice required by a person in relation to their dental hygiene to enable that person to improve their dental health and prevent oral disease;
c) Checking a person's compliance in relation to the self care plan proposed at the oral health assessment or oral health review;
d) The provision of a prescription for high fluoride toothpaste or mouth rinse if considered required (when delivered together with one or more of (a) (b) (c) (e) (f) or (g))
e) The surface application of primary preventive measures such as topical fluoride varnish applications, and fissure sealants if required and necessary;
f) Scaling and polishing if required;
g) Follow up root surface debridement if required

7.33 In comparison, the Band 1, Diagnosis, treatment planning and maintenance CoT includes the following:

a) Clinical examination, case assessment and report
b) Orthodontic case assessment and report
c) Advice, dental charting, diagnosis and treatment planning
d) Radiographic examination, including panoral and lateral headplates, and radiological report
e) Study casts including in association with occlusal analysis
f) Colour photographs
g) Instruction in the prevention of dental and oral disease, including dietary advice and dental hygiene instruction
h) Surface application as primary preventive measures of sealants and topical fluoride preparations
i) Scaling, polishing and marginal correction of fillings
j) Taking material for pathological examination
k) Adjustments to and easing of dentures or orthodontic figures
l) Treatment of sensitive cementum

The key difference between Band 1A and Band 1 CoTs is that the Band 1 CoT includes assessment and diagnosis and the Band 1A CoT does not. This is because its purpose uniquely within the four existing bands is to deliver pre-planned advice and preventative care only, not to diagnose or act as an additional check up.

Charging for Band 1A treatments

7.34 This instrument provides that the charge will apply where any item of treatment in Band 1A is provided so that all Band 1A CoTs would be chargeable, where the other requirements (patient eligibility for example) were met. However the policy intention was that in the Capitation and Quality Scheme 2 pilots only Band 1A CoTs that included invasive treatment included as components (e) to (g) of Schedule 1A would be chargeable. This discrepancy is being corrected by laying a further set of amending Regulations, The National Health Service (Primary Dental Services) (Miscellaneous Amendments to Charges) Regulations 2013, which will also come into force on 1 April 2013. This means that only Band 1A CoTs that include one or more of items (e) to (g) listed in paragraph 7.32 will be chargeable.

7.35 The restriction of charging to this sub-set of treatments within Band 1A is because we do not know what the response of patients would be to paying for advice only CoTs. The response of patients to the new preventative approach and interim care appointments has been very positive. The evidence and learning report published in 2012 drew on market research carried out by ICM (available at https://www.gov.uk/government/publications/extension-to-dental-contract-pilot-scheme) into patient response to the pilot approach. Patients strongly welcomed the new more proactive approach to preventing disease and the part they could play in that. However, so far there had been no separate charge for prevention. How much patients will pay for purely preventative advice is untested. If patients responded by rejecting this element of care this could invalidate the learning about the clinical approach the pathway takes.

7.36 Whether patients in the longer term would be willing to pay for advice only is something that will be tested through surveys and other work with patients and practices before any new contract is developed. At this stage it is the clinical value of such appointments that is being tested. While the behavioural response of patients is important, it was also important not to create unnecessary barriers to attendance at purely preventative advice appointments at this early stage.

Safeguards for patients

7.37 Patients are encouraged to take up the offer of interim care under the pathway but this, as with any part of NHS dental care, is a free choice for the patient to accept or decline. Additional protections are being put in place in the pathway for stage 2 piloting to allow patients who do not want interim care to remain on a managed pathway. Interim care offers patients episodes of preventative care and advice that are additional to the preventative care and advice offered as part of their regular cycle of oral health assessment, treatment and review. However, we recognise that not all patients will want to take up the full range of preventative care on offer.

7.38 The current pathway software being used in the existing pilots (known as version 1) includes an urgent assessment route where the patient is given urgent treatment and then has a choice whether to enter the full pathway approach. Last summer, the clinical review recommended that a third arm to the pathway should be developed for version 2 that offered an option between urgent care and the full preventative approach. This third arm will allow patients in the stage 2 pilots to receive full oral health assessments and regular oral reviews but if they wish, to opt out (having had the benefits explained to them) of the additional interim care appointments offered between reviews.

7.39 Dentists collect all NHS charges on behalf of the NHS. Such charges are passed on to the NHS in their entirety and form no direct part of the individual dentist's remuneration. All NHS charges collected by dentists are fully deductible from payments made to dentists holding GDS contracts and PDS agreements under payments directions made by the Secretary of State (see paragraph 3.8 (deductions in respect of NHS charges) in the General Dental Services Statement of Financial Entitlements published on the Department of Health website www.dh.gov.uk). Each charge is attached to a CoT. As with all NHS dental charges and particularly any new charge there is a risk of patients being accidentally or even deliberately misinformed about their rights and possibly mischarged for care. There are a number of safeguards in place to pick up accidental mischarging and reduce fraud. The financial incentive for dentists to collect and keep an NHS charge is low. If a dentist charged for a CoT intended to be free to the patient and passed on that charge to the NHS (as they are required to) the charge would be returned to the patient and the dental practice advised that they should not have made the charge. If the dental practice raised a charge and retained it in the practice this would be a breach of their NHS contract and potentially, depending on their intention, fraud.

7.40 A less detectable event is a private charge being levied for part or all of a patient's dental treatment that the patient understands to be an NHS charge for NHS treatment but which is actually a private charge for private treatment. Posters displaying the three currently possible NHS charges are required to be displayed in all dental practices, including pilots and, if deliberate, such mis-selling is a potential breach of a dentist's NHS contract.

7.41 All parts of NHS dentistry including the pilot practices are subject to a rigorous anti-fraud procedure. In the case of patient charges, this takes the form of a random selection of patients from every practice, who are sent a questionnaire from the NHS Business Services Authority. This asks patients what treatment they have received, what they have paid under the NHS, and whether they are satisfied with that treatment. Where there is a discrepancy between the treatment they have received and the amount they have been charged this is investigated further. Where there is evidence of systematic abuse NHS Protect (the organisation tasked with ensuring NHS probity) can take action.

7.42 In the case of pilots, the number of patients who receive questionnaires is significantly higher than the normal sample (because they are intensively evaluated as part of the pilot process), so the risk of inappropriate charging going undetected is lower in pilots than in non-pilot practices. The pilots will have patient leaflets and posters made available explaining interim care and the new charge. All pilots are aware that in addition to the regular questionnaire, their patients may be selected for focus groups and other programme evaluation (as a number were in the evaluation of the existing pilots). The level of scrutiny the practices are under as a result of piloting acts as an additional deterrent to deliberate fraud and means that any genuine misunderstandings can be picked up and corrected as speedily as possible.

7.43 The National Health Service (Primary Dental Services) (Miscellaneous Amendments to Charges) Regulations 2013 will provide for two other changes to the arrangements for Band 1A charges which increase protections for patients in regard to the new charging arrangements. It will amend regulation 6 of the Charges Regulations to provide that patients receiving a Band 1A CoT have the full protection of the existing regulation on so-called “continuations”.

7.44 The current Charges Regulations provide that if a patient receives further NHS dental care within two months of a previous CoT banded at the same or lower band as the treatment previously received, no additional patient charge is levied. Provision had been made at Regulation 13A(4) of the Miscellaneous Amendments Regulations, to provide that where a Band 1A CoT was followed within two months by a further Band 1A or Band 1 CoT, no new charge could be made. However, it did not provide that the same would apply where a Band 1, 2 or 3 CoT was followed within two months by a Band 1A CoT. The new amendment provides that should this occur, patients in the pilots will have the same protections from being recharged for care within two months as patients in non-pilot practices.

7.45 The transitional provision made by regulation 13B inserted into the Charges Regulations by the Miscellaneous Amendments Regulations could, in the unusual event of a course of interim care provided over a number of appointments which spanned the 1 April 2013 introduction of the new charge, result in persons having to pay for treatment that they had received at a time when it would not have been chargeable. This is not the policy, so to correct this inadvertent retrospective effect, the Department has made an amended regulation 13B. This provision ensures that nobody will be charged under the new Band 1A charge for treatment provided before 1 April 2013.

Other changes being made

7.46 The Instrument also reflects—

(a) the abolition of local involvement networks and the establishment of Local Health Watch organisations by the 2012 Act; and

(b) the establishment of the newly established Special Health Authority known as Health Education England, which will have a role in the education and training of dentists.

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Consolidation

7.47 In introducing this Instrument, the Department of Health considered the possibility of consolidation of the resources required and other sources of information for those who might use the Regulations. Each time the GDS Contract and PDS Agreements Regulations have been amended previously, the Department has issued electronically -

- a consolidated GDS contract and PDS agreement template incorporating the latest legislative changes and
- a standard variation notice for use by PCTs (in future, the Board) when amending GDS contracts and PDS agreements.

7.48 The Department intends to publish consolidated GDS contract and PDS agreement templates, which will reflect amendments made by this Instrument.

7.49 Through necessity, the Department has had to concentrate on the implementation of the 2012 Act and on the implementation of the Capitation and Quality Scheme 2, but will keep the need to consolidate the GDS Contracts Regulations and the PDS Agreements Regulations under review.

7.50 Payments to GDS and PDS contractors are set out in the Statements of Financial Entitlements (SFEs) which are directions made by the Secretary of State. New directions are being made and will effectively be a consolidation to take account of the 2012 Act. These directions are consolidated with effect from 1 April 2013.

7.51 The Department has no plans to consolidate the Dental Charges Regulations but will keep the need to consolidate these Regulations under review.

8. Consultation outcome

8.1 The British Dental Association (BDA) has been consulted on this Instrument and the Capitation and Quality Scheme 2 Directions and has indicated that it is content. The BDA supports the transfer of dental commissioning from PCTs to the Board and the expansion of the range of persons able to hold a GDS contract or PDS agreement.

8.2 The Department also consulted the BDA, and patient representative groups, Citizens Advice Bureau (CAB), Which, and the Patients Association, specifically on the Regulations implementing the Capitation and Quality Scheme 2 and the introduction of the new dental charge which will apply to patients receiving treatment under the Scheme 2. All were content with the Regulations as laid. The BDA and the Patients' Association have been consulted on the further amendments being made through The National Health Service (Primary Dental Services) (Miscellaneous Amendments to Charges) Regulations 2013 to ensure policy on the new Band 1A charge is accurately reflected in the Regulations. Both bodies supported the policy intention of restricting charges to a sub-set of treatments under Band 1A and therefore support the further amending Regulation required to deliver this.

9. Guidance

9.1 In relation to the amendments made to the GDS Contracts Regulations and the PDS Agreements Regulations consequential on the 2012 Act, the Department of Health does not propose to issue guidance on the impact of these Regulations.

9.2 Those contract holders participating in the Capitation & Quality Scheme 2 are receiving the following support and guidance -

(a) training events are being held for all those taking part in the scheme to familiarise them with the pilot approach to clinical care (the care pathway, the payment mechanisms, new IT software and the evaluation and monitoring requirements of the scheme);
(b) guidance documents will be produced to explain the scheme, the payment mechanism, the Capitation and Quality Scheme 2 Statement of Financial Entitlements and the new patient charging arrangements; and
(c) the Department has a well established team in place to support the existing pilots and those joining in Stage 2 of the Scheme.

9.3 A Patient Information Leaflet titled "Pilots - Patient Information", relating to the Capitation and Quality Scheme 2 will be produced to explain the pilot arrangements to patients. This leaflet will be published on the Department of Health's website www.dh.gov.uk. Contractors participating in the Capitation and Quality Scheme 2 are required to display this leaflet in their practices.

10. Impact

10.1 The impact on business, charities or voluntary bodies is negligible.

10.2 The impact on the public sector is negligible.

10.3 This change to regulation will not impose any additional costs upon, nor alter the benefits to, contractors. The overall charges paid by the public for NHS dental treatment will not change either. The changes being made in relation to the introduction of the new dental charge only apply to patients receiving treatment under the Capitation and Quality Scheme 2. They will only apply to provide that patients receiving treatment under this scheme pay charges for such treatment that are in line with NHS dental charges payable by patients not being treated under the Scheme 2. As the intention is to bring these payments into line and thus ensure greater equality as between groups of patients receiving NHS dental treatment, it was considered by the Department that an Impact Assessment was not required.

11. Regulating small business

11.1 NHS dental practices are exempt from the Small Firm Impact Test as they are considered part of the public sector due to their provision of primary dental services for the NHS. Public sector organisations are exempt under this test.

12. Monitoring & review

12.1 Monitoring of GDS contracts and PDS agreements will become the role of the Board after 1 April 2013. However, the Secretary of State will retain responsibility for the terms and conditions of contractors contained in Regulations and for the consolidation of those Regulations.

12.2 The Secretary of State will keep the Board's performance under review in line with the Secretary of State's duty under the 2006 Act, as amended by the 2012 Act.

12.3 The existing Capitation and Quality Scheme was reviewed and the learning published in the reports described in paragraphs 7.16 to 7.19 above. The Capitation & Quality Scheme 2 will also be evaluated at regular intervals to determine the effect on the key areas being tested. The changes monitored will include changes in the oral health of patients, the number of patients accessing NHS dentistry, changes in the payments made to participants in the Scheme, patient experience and satisfaction, and the impact on the use of the dental workforce. The changes to patient charges will be kept under close review, in particular, in relation to their acceptability to patients, patient behaviour and the impact on patient charge revenue raised during the Scheme 2.

13. Contact

Helen Miscampbell, Department of Health, 020 7972 5950,
Helen.miscampbell@dh.gsi.gov.uk
Christopher Perfect, Department of Health, 020 7972 5510,
christopher.perfect@dh.gsi.gov.uk