From the Director of Access

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For Action: **SHA Chief Executives**
PCT Chief Executives

For Information: **SHA Directors of Finance**
SHA Directors of Performance
SHA Directors of Primary Care
SHA Dental Leads

Dear Colleagues

NHS PRIMARY DENTAL CARE SERVICES: IMPLEMENTATON OF LOCAL COMMISSIONING

1. I am writing to highlight some important issues in relation to:

   - 2006/07 budgets for primary dental care services
   - the importance of proactive communications for patient and the public.

2. As you will know, it is essential that PCTs agree new contracts with dentists by 31 March at the latest to ensure service continuity from 1 April - and by 28 February to ensure no delays in dentists receiving their first monthly payments under the new arrangements.

3. I appreciate that the next two months will involve intensive work for PCTs in successfully implementing these reforms, and I am grateful for the commitment being shown in SHAs and PCTs.

2006/07 budgets and patient charge income

4. The dental budgets for 2006/07 notified to SHAs and PCTs on 8 December take into account the 19% growth in net investment since 2003/04 and include a further 4% growth to reflect the further expansion in General Dental Services (GDS) and Personal Dental Services (PDS) this year and to promote further improvements in access. There will be a further allocation on top of this for 2006/07 pay and prices after the Pay Review Body has made its recommendations.

5. Some SHAs and PCTs have raised concerns about the assumptions we have made (in these net allocations) about levels of patient charge income under the new arrangements. In some cases, these concerns are based on the shortfall in patient charge income experienced this year in PDS pilots.

6. In this context, it is worth re-emphasising the following points:

   - PDS charge income in 2005/06 is no guide whatsoever to the income received in 2006/07
   - the fall in PDS charge income this year stems largely from the current charging system (which is based on individual items of service) and the much greater than expected reduction in items of service under PDS

- for 2006/07, there will be an entirely new system of patient charges based on courses of treatment rather than individual items and a new system of contract monitoring (for both GDS and PDS) also based on courses of treatment – the system of 'Units of Dental Activity'
- in projecting charge income, we have not made stretching assumptions about the service levels (i.e. the number of Units of Dental Activity) that will be agreed in new contracts. For GDS, we have allowed for the 5% reduction in Units of Dental Activity to which GDS dentists are entitled. For PDS, we have assumed that Units of Dental Activity will be on average 20% below the levels provided by GDS dentists (in the relevant PCT) during the Oct 04 – Sept 05 reference period
- we have allowed for the likelihood that the Units of Dental Activity actually delivered during 2006/07 will fall slightly short of the contracted level, and we have allowed for some reduction in the proportion of treatments given to charge paying patients (although we advise PCTs not to contract for any significant shift in local provision at this stage).

7. In other words, the patient charge income shortfalls that many PCTs have seen this year do not carry forward into 2006/07, provided that the relatively conservative assumptions we have made about Units of Dental Activity are borne out in the contracts that PCTs agree with dentists – and assuming no significant change in mix of patients.

8. In this context, I would be grateful if you could reinforce with PCT colleagues responsible for negotiating new contracts the importance of exercising responsibility in agreeing new service levels. In some cases, there will of course be reasonable grounds for varying the GDS contract values and/or Units of Dental Activity notified by the Dental Practice Board at the end of November 2005. However, we are already aware of cases where PCTs have made unwarranted concessions (e.g. to reflect factors that were already taken into account in these contract values) or have made changes that are not legally permitted.

9. To support PCTs further in this area, the NHS Primary Care Contracting website now includes a guide to some of the key mistakes to avoid in agreeing new service levels and contract values – see www.pcc.nhs.uk/89.php. I would be grateful if you could ensure that PCT commissioners take this advice into account in agreeing remaining contracts.

10. We are aware that some PCTs are considering holding back reserves from their dental allocations to cover the risk of patient charge shortfalls. This is likely to have the perverse effect of actually generating a shortfall, given that it will mean commissioning fewer Units of Dental Activity and therefore foregoing patient charge income. It is also important to bear in mind that PCTs' dentistry allocations cannot be used for other purposes. If a PCT's budget is unlikely to be fully spent on dentistry, the Department will discuss with the SHA how to re-allocate the shortfall to other PCTs.

11. As set out in the finance factsheet that accompanied these allocations, we would strongly encourage SHAs and PCTs to implement risk-sharing arrangements, rather than hold money back for patient charge income.

Communications with patients and the public

12. We will next month be issuing to each PCT a set of leaflets and posters and a communications toolkit to use in explaining the dental reforms to the public. These communications materials focus on the new system of patient charges, the significance of local commissioning of dental services, and the NICE guidelines on patient recall intervals. We will also be making this material available to national patient/consumer representative groups.

13. I would be grateful if you could ensure that all PCTs use these materials to communicate actively with their local populations to explain the significance and the benefits of the dental reforms.

14. We are aware that in some areas there has been misleading information about the reforms (particularly the new system of patient charges) placed in dental surgeries or publicised in other ways. This has led to some PCTs, supported by their SHAs, taking early steps to explain the new system to the public and to local stakeholder, in order to set the record straight and to help prevent unnecessary concerns among patients.

15. To support SHAs and PCTs in proactive communications of this sort (before next month's communications toolkit is issued), we have this week made available to all SHAs and PCTs the near-final copy of the material for the national poster and leaflets. Please make sure your communications lead is aware of these resources which will be published via www.nhscommslink.nhs.uk on an ongoing basis from this week.

Conclusion

16. I would be grateful for your continuing support during this essential preparatory period in:

- completing contract negotiations by 31 March at the very latest and 28 February wherever possible
- helping provide reassurance that this year's shortfalls in PDS charge income do not carry forward into 2006/07
- ensuring that PCT commissioners exercise responsibility in agreeing new service levels and contract values
- ensuring proactive communications with patients and the public to explain the significance and benefits of the dental reforms.

Margaret Edwards
Director of Access