

# Capital Funding for Primary Care NHS Dentistry

## Introduction

1. This paper sets out the arrangements for allocating the £100 million capital funding for primary care dentistry announced on 18 May 2006 and provides guidance for SHAs and PCTs on:
  - the types of dental services for which the funding is intended
  - examples of capital projects for which the funding could be used
  - criteria for investment
  - arrangements to ensure return on investment.

## Background

2. The NHS dental reforms which came into effect on 1 April 2006 give PCTs responsibility for commissioning NHS dentistry. PCTs have already received devolved revenue budgets of £1.7 billion (an increase of over £400 million since 2003/04) to commission services.
3. The Minister for Health, Rosie Winterton, announced on 18 May that the Department was making available £100 million capital funding to take forward infrastructure improvements for NHS primary dental services over the two years 2006/07 and 2007/08. This is intended to support dentists in modernising premises and equipment for patients and allow Primary Care Trusts to give greater financial support to help dentists establish new practices or expand existing surgeries.

## Method of allocation

4. The Department is allocating £40 million in 2006/07 and £60 million in 2007/08. This will be allocated to SHAs on a simple capitation basis (i.e. pro rata to the size of their local populations). SHAs are responsible for allocating the resources to PCTs, based on the SHA's assessment of where investment will secure maximum benefits for NHS dental services and the relative needs of the PCTs in their area.

## Types of services for which funding is intended

5. PCTs may use this capital funding to support investment in premises and/or equipment for:
  - independent contractors providing a significant level of NHS dental services under a General Dental Services (GDS) contract or Personal

Dental Services (PDS) agreement, whether they are an individual contractor, group practice, partnership or body corporate

- NHS-managed salaried primary dental care services
  - dental surgeries owned by the NHS and leased out to independent practitioners for providing NHS primary dental care services.
6. Where the investment is in NHS-owned premises or equipment, normal capital rules apply and PCTs are expected to make provision for the ongoing revenue consequences.
  7. Where capital funding is to be given to an independent contractor, the PCT may vire the relevant capital funds into revenue funding for this purpose, provided that the payment to the contractor will result in investment in a capital asset (see paragraph 14 below).
  8. The contract payments made to GDS/PDS providers for NHS dental services are intended to cover the expenses incurred in running the practice, including capital investment and net remuneration or profit. However, PCTs have the power, if they wish, to make additional grants to practices. This investment programme is designed to facilitate PCTs' increased use of these powers to support practices that will play a significant and continuing role in providing NHS dental services and enable them to improve further the service they offer to patients.
  9. Grants to independent contractors should normally be made on the basis of a shared investment between the PCT and the contractor, although PCTs may choose not to apply this principle for some low-value investments.

### **Potential uses of NHS capital funding**

10. PCTs should consider how the £100m capital funding can best be deployed. The key principles that should underpin such decisions are that the investment should:
  - improve the quality of the dental services provided to NHS patients
  - provide genuinely additional investment, over and above the investments that would ordinarily have been made (whether by independent contractors or by NHS organisations)
  - support and encourage continuing commitment to providing high-quality NHS dental services
  - help the PCT achieve its priorities for developing NHS dental services
11. Examples of the types of capital investment that SHAs and PCTs may wish to consider include:

- support for the capital costs involved in establishing new practices or new providers in areas where it is currently difficult to access services
  - support for the capital costs involved in expanding NHS services within existing practices
  - modernising practice facilities to improve NHS patient experience, including supporting specific requirements such as access for patients with disabilities
  - helping practices to ensure provision of high quality local decontamination facilities, for example by installing modern decontamination equipment (washer disinfectors)
  - developing enhanced training practices
  - improving IT infrastructure to provide additional or more accessible information or to improve patient access to services..
12. PCTs are encouraged, where possible, to discuss the use of these funds with Local Dental Committees.

### **Criteria for investment**

13. PCTs will wish to ensure that this investment is deployed in a way that provides the maximum long-term value and impact.
14. The PCT will need to satisfy itself, where appropriate in consultation with the District Valuer, that the proposed scheme represents value for money, and that the investment is in equipment or facilities and that the expenditure would normally be regarded as appropriate to capitalise under generally accepted accounting practices. If in any doubt, PCTs are advised to consult their auditors before agreeing a transaction.
15. In the case of grants to independent contractors, the main criteria that PCTs are likely to wish to take into account are:
- (a) evidence of continuing commitment to the NHS, i.e. excluding practices that do not have a significant NHS commitment or have notified patients that they intend to reduce their NHS commitments (see also paragraph 17 below)
  - (b) evidence that NHS patients will demonstrably benefit from the proposed investment.
16. PCTs may also wish to take into account the following additional criteria:
- (a) evidence of flexible patient access to the practice, e.g. willingness to provide access to new patients (where capacity permits), willingness to take referrals from patients who have contacted PCT access helplines,

flexibility in providing appointment slots across the normal range of practice opening hours

- (b) providing services for a full range of patients (unless the practice is a specialist practice)
  - (c) the current condition and suitability of premises .
  - (d) compliance with PCT clinical governance and quality assurance
  - (e) evidence that services are provided in accordance with NICE guidelines on patient recall intervals
  - (f) whether the practice has previously received, and used effectively, an NHS or other public sector grant
  - (g) opportunities for co-location with other primary care or social care services, particularly where the grants relate to the establishment of new services.
17. PCTs may wish to consider linking the level of any grant to the level of the practice commitment to the NHS. For instance, a PCT might choose to contribute:
- 33% of the total cost of the proposed investment for practices whose NHS work forms 50% or more of their activity, moving on a sliding scale to -
  - 66% of the total cost, where NHS activity forms 90% or more of activity.

Exceptions might be made for investment in smaller items of equipment or improvements, particularly where they contribute to a broader public interest such as improved decontamination services or access for patients with disabilities.

18. Where there is an outstanding dispute in relation to a GDS contract or PDS agreement, this need not prevent PCTs agreeing in principle to award a capital grant. However, PCTs are strongly advised not to commit bindingly to make payment to the contractor until the dispute has been resolved.

### **Arrangements to ensure return on investment**

19. In deploying NHS capital, PCTs have a duty to apply the guidance in the Government Accounting manual and the 27<sup>th</sup> June Treasury letter DAO(GEN)07/05 on proportionate recovery arrangements, which forsee the establishment of binding, enforceable agreement to protect the interests of the taxpayer.
20. In making grants to independent contractors, PCTs should ensure that the grant is tied to maintaining or developing NHS dental services over a

medium term period and recovering money to the extent this condition is not met.

21. For instance, a PCT might choose to specify that, once the capital scheme has been completed, the premises will remain in use for the delivery of NHS dental services and that the level of service provided (e.g. annual number of units of dental activity) will be at least equivalent to now:
  - for projects costing up to £50,000 plus VAT for at least 5 years, and
  - for projects costing over £50,000 plus VAT for at least 10 years.
22. The PCT would then specify that the contractor must repay a proportion of the grant should the premises cease to be used to provide NHS dental services, or if there is a reduction in the level of NHS dental services provided, before that 5 year (or 10 year) period of guaranteed use has expired. The repayable amount would, for instance, be:
  - $[\text{the amount of grant}] \times [\text{amount of time (in whole and part years) left}]$  divided by [5] or [10].

### **Next steps**

23. SHAs are asked to work with PCTs to agree the basis on which the SHA's share of the £100 million investment is allocated between PCTs.
24. PCTs are asked to develop the criteria to be used locally for deploying the capital funds and to allocate funds accordingly.
25. For any queries on this guidance, please e-mail:  
[dentalfinance@dh.gsi.gov.uk](mailto:dentalfinance@dh.gsi.gov.uk)