

KEY WORDS

NHS dental contract, grey areas, urgent treatment, private treatment

LEARNING OBJECTIVES

- To appreciate the complexities of the 2006 NHS dental contract in England and Wales
- To understand the important clauses that give rise to different interpretations
- To understand how to manage the complexities of the NHS dental contract

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GREY MATTERS: 2006 AND ALL THAT

ABSTRACT

The article is intended to put the current NHS dental contract in England into context and identify areas where there has been confusion about interpretation of certain clauses. The article describes these as grey areas and provides a rationale for logically interpreting these issues, such as urgent treatment, mixing NHS and private treatment and defining what a course of treatment is.

These are the views of the authors based on significant personal experience of the contract, both as practitioners and as dento-legal advisers.

Background

The Department of Health launched reforms to NHS dental services in April 2006 in England and Wales against a background of widespread discontent with the previous arrangements. There had previously been no fundamental change to the system that was originally set up in 1948. The 1990 General Dental Services (GDS) contract introduced a system of capitation and continuing care payments (20% of the contract) to encourage the practise of preventive dentistry, and dentists had to offer all treatment necessary to secure and maintain oral health.

Until 2006, dentists were paid largely on a fee-per-item basis which incentivised treatment provision but did little to encourage prevention. A number of reports had been critical of the remuneration system, including Tattershall (1964), National Audit Office (1984), Schanschieff (1984), Bloomfield (1992), the Health Select Committee (2001) and the Audit Commission (2002).

Following the 2001 report from the Options for Change working group,

it was the Health and Social Care (Community Health and Standards) Act 2003 which paved the way for major changes to dentistry.

2006 Contract

On 1 April 2006, having been postponed from October 2005, the so-called new contract was introduced (nGDS). It was a transformational change designed to:

- support access improvements
- provide dentists with the stability of an agreed annual income in return for an agreed level of patient care
- simplify patient charges by banding courses of treatment rather than payment for individual items.¹

The metric that is the unit of dental activity (UDA) and the introduction of targets was roundly criticised with Lester Ellman (2007) noting in particular that the contract was “not helping dentists nor patients”. The House of Commons Select Committee in 2008 condemned elements of the contract.

The proposals for reform started in 2011 with over 70 pilot sites selected to test new ways of working. Many of these morphed

- National Health Service (Performers Lists) Amendment Regulations 2005

We present some of the more frequently arising issues and offer a perspective on interpretation of the contract clauses in relation to these.

What treatment is available under the NHS?

There are two types of contracting arrangements with the NHS:

- **Mandatory services contract**
- **Additional services contract**

The mandatory service contract requires contractors to provide the following (Clause 76):

- examination
- diagnosis
- advice and planning of treatment
- preventative care and treatment
- periodontal treatment
- conservative treatment
- surgical treatment
- supply and repair of dental appliances
- the taking of radiographs
- the supply of listed drugs and listed appliances
- the issue of prescriptions.

The list is not self-limiting (in contrast to the Statement of Dental Remuneration in the pre-2006 era) and this in itself creates ambiguity that we describe as “grey areas” which lie at the heart of the dento-legal discussions.

There is also requirement to provide urgent treatment, but the contract clearly states that it “does not include additional services.”

The additional services include advanced mandatory services (which include complex oral surgery, complex periodontal treatment and complex endodontics), dental public health, domiciliary, orthodontic and sedation services.

The question arises over what is considered to be “complex” or when it comes to, say, endodontic procedures. Part 1 of the GDS contract clarifies the meaning of advanced mandatory services as “any primary dental service that would

fall within the services described in clauses 74 to 76, but by virtue of the high level of facilities, experience or expertise required in respect of a particular patient, the service is provided as a referral service.”

Additional services are commissioned and paid for separately from the base mandatory services contract and will be subject to different monitoring arrangements.

What is a course of treatment?

The definition can be found at the start of the regulation in a section called “Interpretation”:

Course of treatment

- a **an examination of a patient, an assessment of that patient’s oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment;**
- b **the provision of any planned treatment (including any treatment planned at a time other than the time of the initial examination) to that patient up to the date on which**
 - i **each and every component of the planned treatment has been provided to the patient, or**
 - ii **the patient either voluntarily withdraws from, or is withdrawn by the provider from treatment, by, unless the context otherwise requires, one or more providers of primary dental services, but except that it does not include the provision of any orthodontic services or dental public health services.**

The definition draws attention to the fact that it is the examination and assessment that triggers a course of treatment – rather than the particular intervention itself which merely falls into the designated band.

What treatment is available under the NHS?

The dentist is required to provide all “proper and necessary dental care and treatment which the patient is willing to undergo” (Clause 74: Mandatory service contract) and includes everything that is needed “to secure the oral health of the patient” (Clause 47.4). They have to do so with reasonable skill and care (Clause 40).

into prototypes that continue to test new models of care. At the time of writing, there are 102 prototypes which include three in the Community Dental Service and we await a final decision on the date of implementation of the reformed contract and hope for what the Nuffield Trust and the Health Foundation² say is vital, that being “...a speedy and effective rollout of a contract that genuinely focuses on prevention of poor dental health...” Until that time, the current contract remains in force with all its challenges.

Grey areas

We live and work in a VUCA times – the acronym (originally a US military term) stands for volatile, uncertain, complex, and ambiguous and it will not be long before it permeates into our professional parlance.

The Merriam-Webster dictionary defines grey areas as “an area or situation in which it is difficult to judge what is right and what is wrong.” Risk, uncertainty and ambiguity reside in grey areas; it is evidenced by the number of dento-legal inquiries, cases, discussions and debates arising from the 2006 contract over the last decade. Some have been resolved, others remain defined by oft-divided opinion.

There are a number of key documents that guide us in this grey world. They are:

- National Health Service (General Dental Services Contracts) Regulations 2005
- National Health Service (Dental Charges) Regulations 2005
- General Dental Services Statement of Financial Entitlement Dec 2005
- National Health Service (Performers List) Regulation 2004

return some time later, a new course of treatment would be started and they would be required to pay further charges depending on the band of treatment that requires completion.

What treatment is covered by guarantee (free replacement)?

Whilst the term “guarantee” is frequently used in the context of free replacement, it does not feature in the GDS contract.

There are some treatments which are “guaranteed” for one year following the date of placement. These are “any filling, root filling, inlay, porcelain veneer or crown”. Treatment provided is “a banded course of treatment for the purposes of calculating the number of units of dental activity”.

There are some exceptions. The obligation to repair or replace these items is not transferable between contractors. It is however transferable amongst performers who are linked to the same contractor. Other exceptions are where:

- the restoration was intended to be temporary in nature
- a different form of restoration was more appropriate to secure oral health, but the patient nevertheless requested the restoration to be provided
- in the opinion of the contractor, the condition of the tooth is such that the restoration cannot satisfactorily be repaired or replaced, and different treatment is now required
- the replacement is required as a result of trauma.

If the conditions are fulfilled, dentists are entitled to claim the relevant UDAs, 3 or 12 and the patient is not required to pay.

When may I claim for urgent treatment?

There have been a number of cases when dentists have been targeted for alleged inappropriate claims relating to urgent treatment.

Consider a patient who attends in pain and the diagnosis of irreversible pulpitis. The dentist carries out a pulp extirpation as an urgent intervention to relieve the patient’s symptoms. The patient then returns at a subsequent visit for root canal therapy. The two questions that arise are:

- 1 Is the visit when pulp extirpation takes place part of a Band 2 course of treatment? If it is, then then the dentist will claim 3 UDAs after the treatment is complete.
- 2 Alternatively, if the pulp extirpation is considered for the relief of pain as marked as urgent treatment, can the dentist submit a Band 4 claim (urgent claim) and then claim a further 3 UDAs for the course of treatment that will follow and include the root canal therapy?

The answer lies in the definition of urgent treatment which is:

- **“urgent treatment” means a course of treatment that consists of one or more of the treatments (urgent treatment under Band 1 charge) that are provided to a person in circumstances where:**
 - a prompt course of treatment is provided;
 - because, in the *opinion of the contractor, that person’s oral health is likely to deteriorate significantly, or the person is in severe pain by reason of his oral condition;*
 - **and treatment is provided only to the extent that is necessary to prevent that significant deterioration or address that severe pain.**

The italics are ours but indicate the qualifying criteria for the appropriate claiming of this item. Note also that it is the dentist’s assessment of the severity of the pain, not the patient or the receptionist who books in the patient, or the likelihood of deterioration that establishes the essential criteria for claiming.

The NHS dental charges regulations which outline what can be claimed as urgent treatment under Schedule 4 include a range of items but limit them to extraction of not more than two teeth and not more than one permanent filling, for example.

The issue of whether an examination is required in order to justify a Band 2 or 3 claim has been the subject of a number of legal challenges, some at the NHS Litigation Authority and others at judicial review in the Appeal Court.

In the Powys case³ the question revolved around the word “examination” in the definition above of “a course of treatment”. The absence of an examination being claimed led NHS England to believe that they are entitled to discount any Band 2 or 3 claims where an examination has not been done, recorded or claimed, and seek repayment of any related fees.

The judge agreed that, although the meaning of the word “examination” must be assessed in reference to the context in which it is being used, this is not inconsistent with a “default” meaning of full mouth examination. The fact remains that “examination” is not defined at all in the regulations. The Court of Appeal found that there was nothing in the wording or in the machinery of the GDS contract which deprives a dentist of all entitlement to payment where he has failed to carry out a full mouth examination.

What is meant by continuation of treatment?

Where treatment is required within two months of the previous CoT and it falls in the same or lower band, this is provided under continuation arrangements. It is free of charge to the patient and the dentist is able to claim UDAs.

High incidences of “continuations” are monitored closely because they fail to deliver the patient charge revenue that would normally be collected in non-continuation cases.

Whilst the regulations allow for a patient to return within two months to have further treatment free of charge, NHS England have identified this as a potential method of “gaming” and it is monitored for this reason utilising the 28 day re-attendance process.⁴

Our experience suggests that some practices may decide they do not want to claim these treatments even when they are entitled to do so because they have been previously flagged up as “outliers”. This is an interesting example of behavioural change driven (unintentionally) by inquiry rather than by regulation. It adds a further dimension to the “grey areas” narrative. It is an example of the principle of nudge⁵ – where the beneficiary is NHS England.

When do I submit my claim for a patient who has failed to return for completion of treatment?

The so-called two-month rule relates to the submission of the claim within two months of completing or terminating a course of treatment. If the patient has failed to return, ticking the "incomplete treatment" box will ensure that even if the form is sent more than two months after the patient's last attended appointment, the claim is accepted and a counted towards the annual target.

Can I claim for replacement dentures or orthodontic appliances?

The NHS allows dentists to provide replacement "dental appliances" which are bridges and dentures as well as orthodontic appliances. The patient is expected to pay a fee towards that unless they can demonstrate hardship. The claim is made under Regulation 11.

How can I mix NHS and private dentistry?

Dentistry is unique in the wider NHS in allowing dentists to treat patients under NHS as well as private contract at the same visit, during the same course of treatment and even on the same tooth. Clause 58 is clear in that it is permissible for the Contractor, "with the consent of the patient, to provide privately any part of a course of treatment or orthodontic course of treatment" but must not "advise a patient that the services which are necessary in his case are not available from the Contractor under the Contract" or "seek to mislead the patient about the quality of the services available under the Contract".

The use of the word "mislead" presents a challenge. Consider a situation where a patient is provided with a set of complete dentures. The "private" may include more natural looking teeth and other design features that improve the appearance of the denture but not impact the fit. If a dentist describes these additional features and explains the benefits (largely cosmetic) then the patient is free to choose.

The choice architecture remains intact because the patient is offered dentures under the NHS. The question arises: is the dentist "misleading" the patient? To use the definition in the Cambridge English dictionary, is the dentist "causing someone to believe something that is not true"? The answer would seem obvious and yet there have been cases where such allegations have been made against dentists.

A patient leaflet produced by the NHS, reads: "Your dentist should not suggest that private treatment is better than NHS treatment". Does the discussion about additional benefits of a private denture suggest that the private denture is "better" and therefore breach what is written in the patient leaflet?

It is easy to see why mixing is like walking a tightrope because it is so easy to be knocked off balance by the wind of inference.

The obligation not to mislead patients about the availability of treatments on the NHS is clear. All treatments under the NHS dental charges regulations are available on the NHS, but the FP17DC form clearly states that patients may wish to have private work as an "alternative" to the NHS option. It states: "The dentist will discuss these options with you so that you can make an informed choice". The phrase "will discuss" reads like an imperative and a necessary one in an age where patients are free to choose.

The FP17DC makes it clear that: "There are some treatments (mainly cosmetic) that are not normally available under the NHS, and you may choose to have these provided privately. You may also choose to have some treatment provided privately as an alternative to NHS treatment". This statement appears on the front of the form and we believe that it is important to draw the patient's attention to it when mixing private and NHS treatment to avoid the patient misconstruing the dentist's motivation in offering a choice. Some patients may also have unrealistic expectations because they have been advised by others that 'everything' can be provided on the NHS.

Hygienist treatment

An emergent issue relates to offering patients the services of a hygienist only privately. This is fraught with problems. If patients need periodontal treatment, they are entitled to receive it under the under NHS if that is their wish. Dentists may, of course, offer a private option as an alternative. The offer itself does not breach any guidelines or regulations, but the risks manifest when a patient asks "What is the difference?" any response linked to quality of provision, or a suggestion that the hygienist will spend "more time", or that the hygienist is a "specialist" is difficult to defend from a dento-legal perspective.⁶

Where the intervention is solely limited to stain removal, it may be considered to be a "cosmetic" intervention, then the risks are significantly lower.

The *Which?* website offers the following advice to patients: "If your dentist suggests a scale and polish or a trip to the hygienist, make sure you understand whether it's clinically necessary or not. If treatment is clinically necessary, you should be able to have it on the NHS without an extra charge".

It is interesting to note that in its 2002 Report,⁷ the Audit Commission pointed out that, according to scientific evidence, straightforward scaling and polishing "does not keep most people's teeth and gums healthy". It cited evidence from 2001-2002 when 11% of GDC expenditure was on this item alone.

Interestingly a recent Cochrane report⁸ concluded that there was little or no difference between regular planned scale and polish treatments compared and no scheduled scale and polish for the early signs of gum disease (gingivitis or bleeding gums; plaque deposits; and probing depths or gum pockets). There was a small reduction in calculus levels, but it was uncertain if this is important for patients or their dentists.

In the December 2009 CDO Update, Goss et al provide an early indication of the challenge:

CDO Update, December 2009

The PCT has recently received an increased number of queries from NHS patients being asked to pay private charges for a scale and polish, which would normally be included as part of the Band 1 course of treatment. This treatment is usually carried out under the NHS by either a dentist or a hygienist/therapist.

If a NHS patient clinically requires a scale and polish, then you must offer the patient that treatment under their NHS treatment plan.

Any discussions with the patient must be clearly documented on the clinical records along with some justification for the basis of the intervention. The GDC also has ethical guidance in standards for the dental team,⁹ which relates to mixing NHS and private treatment.

1.7.3 states: You must not mislead patients into believing that treatments which are available on the NHS (or equivalent health service) can only be provided privately.

1.7.4 states: If you work in a mixed practice, you must not pressurise patients into having private treatment if it is available to them under the NHS (or equivalent health service) and they would prefer to have it under the NHS (or equivalent health service).

How do I treat high-need patients?

One of the unintended consequences of the 2006 contract is the challenge of treating high-need patients whose disease experience and history requires multiple

complex interventions. In a payment system where interventions are bundled, this leads to the time-quality-money trilemma.

It is not possible for all three outcomes to be achieved when high-need patients are being treated. Quality care requires quality time – often at the practice's expense. Many dentists will make this sacrifice in the interests of their patient, but the architecture of the system is clearly flawed, and the risks of sub-optimal care are self-evident.

One solution is to consider a phased approach to treatment planning. This was advocated in *Understanding NHS Dentistry*¹⁰ and the clinical merits of this approach were referenced in this text.

The first stage may comprise urgent treatment for pain relief. The next stage provides stabilisation of any progressive disease or conditions which may become acute (e.g. temporarily restore very carious teeth, remove necrotic pulps or extractions). A further assessment would identify risk

factors, and initiate preventive measures, and the patient's response will then determine the next stage(s) of care.

The Office of the Chief Dental Officer issued guidance¹¹ in early 2018, confirming that this is an appropriate way to manage high-needs patients. There are some provisos such as phased treatment may consist of up to three courses of treatment; all these CoTs will usually be completed within a 12-month period. This approach is welcomed and abstracts some uncertainty from the grey zone.

Future direction

Much of the uncertainty in the grey relates to complex care, high-need patients and lack the incentives to prioritise prevention. It is heartening to note that the reform proposals appear to address these concerns.

A number of commissioning documents¹² have been published, setting out these criteria with the stated purpose of ensuring equity of access for patients and to ensure high quality is delivered for the right patient at the right time and in the right environment.



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For example, the delineation of complexity is represented by three tiers:

Level 1 This includes procedures/ conditions managed by a clinician commensurate with a level of competence at the end of one year of Foundation training programme.

Level 2 This reflects a level of complexity which requires the clinician to have enhanced skills and experience who may or may not be on a specialist register.

Level 3 This requires a clinician to be registered with the GDC registered specialist level or be a consultant.

There are a number of complexity indices with criteria for assessment for a number of specialities. For example, Muthukrishnan et al (2007) note that such an approach “could also be used to identify the most appropriate setting in which a patient should receive treatment and to allow correlation with treatment outcomes”.

The *Restorative Dentistry Index of Treatment Need Complexity Assessment*, published by the Department of Health and Clinical Effectiveness committee of the RCS, offer complexity codes for:

- Periodontal treatment assessment
- Root canal treatment assessment
- Fixed prosthodontics treatment assessment
- Removable prosthodontics treatment assessment.

Townsend¹³ notes that: “The index would appear to provide a robust tool for inclusion as one of a ‘basket of indicators’ when contracting special care dental services.” The same principle holds true for future contracting in the GDS.

The British Society of Periodontology also has guidance relating to the complexity of periodontal diseases.¹⁴

With the commissioning of Tier 2 services,¹⁵ the Department of Health has, by default, determined what is included within mandatory services and what falls under advanced mandatory services. This has some significant unintended service issues and presents some medico-legal challenges too.¹⁶

The phased treatment approach is integral to the care pathways which underpin the contract reform¹⁷ and have been tested in both the pilot and prototype practices.

The oral health assessment (OHA) determines the patient’s risk status for four domains:

- 1 caries
- 2 periodontal health
- 3 tooth surface loss
- 4 soft tissue health.

Patients are assessed for risk using the traffic light approach – red, amber or green – for each of these domains. Clinical and other data input triggers the algorithms that determine the risk status which impacts what advanced care is available to the patient.

To be eligible for the advanced care, the patient’s oral environment must be suitable and stable, then the treatment is clinically feasible and beneficial.

The criteria have been and will be developed in collaboration with specialist societies.

Example

A patient who is assessed as high-risk (red) for caries or periodontal health will not be entitled to immediately access advanced care on the NHS unless the risk factors are controlled, and the patient’s risk status is lowered. Previously and in the present contract, any treatment which is not available to the patient under the NHS, may be offered privately.

In a scenario where the treatment is available but not appropriate in the light of uncontrolled risk factors, the option to by-pass the pathway and veer into private dentistry may be less defensible because the clinical pathway is evidence-based and applicable more widely than just in the NHS.

Clinical care pathways can never mandate treatments in all cases. Individual patient factors may require the pathway to be overridden, but this is likely to be the exception rather than the rule. The patient’s entitlement to have that treatment on the NHS will be clear and offering it privately may create some ethical and legal grey areas. The current guidance includes advanced care pathways for endodontics, metal base dentures, indirect restorations and advanced periodontal care. Minor oral surgery will be added in due course.

The literature¹⁸ suggests that clinicians have mixed attitudes towards a pathway approach, partly because of the perception that it threatens clinical autonomy and leads to the standardisation of provision and removed what Jones describes as the “artistic aspect of practice”.

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