Practice Management Forum

The Bedfordshire PDS Orthodontic Pilot

C. J. R. KETTLER, B.D.S., F.D.S.R.C.S., M.ORTH.R.C.S.(ENG)

Specialist in Orthodontics, Bedford, Clinical Lecturer in Orthodontics, Eastman Dental Institute, 15 Foster Hill Road, Bedford, MK40 2ES, U.K.

Abstract. *Throughout the 50-year history of the NHS, the Government has sought to cash limit the GDS. PDS (Personal Dental Services) pilots represent another attempt at cash limiting and a new system for delivering dental services in NHS practice. The development of the Bedfordshire Orthodontic PDS pilot is described. The basis is the prioritization of orthodontic services to child patients with the greatest oral health need through a cost and volume contract with the local Health Authority. A brief outline of the Bedfordshire PDS contract is given. The experiences of the first 9 months of the PDS pilot are related.*

Index words: Personal Dental Services, Orthodontic Pilot, General Dental Services, Providers, Specialist Practice.

Introduction

On 1st October 1998, five orthodontic practitioners in Bedfordshire left the General Dental Services (GDS) of the NHS and joined the Bedfordshire PDS (Personal Dental Services) Orthodontic Pilot. We are contracted directly with our local Health Authority, Bedfordshire Health.

Brief History

For nearly 50 years the government has sought to cash limit the GDS with measures such as prior approval, patient's charges and a ceiling on earnings. The Dental Rates Study Group (DRSG) worked within a fixed size 'dental pool'. The Schanschieff Report (Schanschieff, 1986) in 1986 recommended an index of occlusion for use by the DEB in deciding whether or not to give prior approval to an orthodontic estimate. The Occlusal Index Committee 1987 under the Chairmanship of Professor J. Moss (Moss *et al*., 1987) recommended that an Index of Orthodontic Treatment Need could be used by the DEB. The Index of Orthodontic Treatment Need (IOTN) and the Peer Assessment Rating (PAR) (Brook and Shaw, 1989; Richmond *et al*., 1992) were developed in response at Manchester and Bristol Universities.

The GDS 'New Contract' in 1991 was another attempt at cash limiting through Child Capitation and Adult Continuing Care. the first year of the New Contract resulted in an overspend of £200 million. This caused a 7 per cent fee cut in 1992 and a 'Fundamental Review of Dental Remuneration' by Sir Kenneth Bloomfield (1992) (Bloomfield, 1992). He said: 'A la carte' conditions would be easier to deliver at a local level; the national dental budget could be disaggregated to FHSAs; and a new system would be better delivered at a local level. There could be a new approach through specific contractual arrangements for a finite number of patients.

In 1993, the House of Commons Health Select Committee looked at Dental Services (House of Commons Health Committee 1992–93) and said 'the perception of dentists of an NHS fee as the NHS price for a treatment plays a major part in binding them to the treadmill'. They recommended the use of indices of treatment need, better targeting of resources and reward for professional effort.

Launch of PDS Pilots

In July 1997, the DoH sent out a 'Dear Dentist' letter outlining their proposals for Personal Dental Services Pilots. This was followed in September by the 'Guide to Personal Dental Services (PDS) September 1997'.

The essential features of the PDS are that:

(1) it is entirely voluntary and dentists should not be worse off financially;
(2) it is based on local contracts to meet local needs;
(3) the dentists will be providers and performers;
(4) the patient charges must be the same as in the GDS;
(5) the funding is primarily from sums equating to current GDS payments to the dentists.

At last the DoH were looking at the issues raised by Bloomfield. They were saying to dentists 'If you can think of a better way of delivering dental services in your local area tell us about it and we may give it a trial. You can do it for the same money as you are earning now.'

Two years earlier, Sue Gregory, Consultant in Dental Public Health for Bedfordshire asked the local orthodontic practitioners to work with her to pilot a local arrangement for orthodontic services. We were ready to go as soon as the DoH issued their invitation. We immediately set up a 'Steering Committee' comprising the two local Consultant Orthodontists, the Bedfordshire CDS Director, the five GDS practitioners limited to orthodontics and three GDPs with a special interest in orthodontics.

We defined our local problems as:

(1) a local shortage of orthodontic manpower;
(2) long waiting lists for orthodontic assessment and treatment;
(3) a positive incentive in the GDS fee scale to treat mild cases and use unnecessary appliances;

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(4) it is difficult and uneconomic to refuse NHS treatment to mild cases;
(5) patients most in need of orthodontic treatment are kept waiting by those with a low need;
(6) we make a multitude of petty fee claims;
(7) we must seek prior approval for most treatments;
(8) there are sanctions on permitted treatment, e.g. functional appliances;
(9) there are time bars on the timing of patient visits for reviews an retention;
(10) we must wait until the end of treatment for major payments;
(11) we receive very variable monthly payments.

The Bedfordshire PDS Contract

The participants, the so called Providers are, three full-time orthodontic practices and two part-time orthodontic practices in Bedford, Biggleswade, Dunstable and Leighton Buzzard.

We submitted an 'Expression of Interest', which was approved in January 1998. There were two elements to our proposals. We will limit orthodontic treatment to patients in IOTN Dental Health Component (DHC) 4 and 5. We will also accept DHC 3 if the Aesthetic Component exceeds Grade 5. All patients must be under 18 years of age at the start of treatment. (This condition removes the requirement for patient charges). We said that, as our patients in the PDS have a greater treatment need, they also have a greater treatment difficulty and we must reduce our case load. As it is difficult to control when treatment is completed, our treatment volume is measured by treatment starts.

The other element of our proposal was to greatly increase the number of new patient assessments with the object of reducing new patient waiting lists and to prioritise patients according to need and urgency. We do not want patients with a low treatment need to have to wait a long time to be told that we cannot provide them with treatment under the NHS.

Our intention is to see our referrals quickly and to identify those who need to be treated urgently, those who need treatment, but not urgently and those who do not need treatment for dental health reasons at all. Cash limiting is implicit in the way the PDS is funded.

After our 'Expression of Interest' was accepted we had to develop our 'Business Plan'. For guidance we received the 'Guidance on making a proposal to Pilot Personal Dental Services' and a draft version of Personal Dental Services, Guidance on Establishing and Running Pilots. We attended two meetings with the NHS Executive and two meetings with the Dental Practice Board (DPB).

We wrote our own contract within the 'Guidance' to discuss implementation. We will do only orthodontics on patients under 18 at the start of treatment. We have a simple 'cost and volume contract'. We must see a specified number of new patient assessments per year. This number is based on the average number of our new referrals in past years. We must start a specified number of active treatments each year. This number is based on past performance but reduced because of the perceived greater average treatment difficulty of patients with a greater treatment need.

Payment is from Bedfordshire Health funded by the DoH from the GDS pool. Payment is in a fixed monthly sum equivalent to the gross fees received in our last year in the GDS enhanced by recent increases in GDS fees. Payment is made by the Dental Practice Board (DPB) who make appropriate deductions for superannuation. The payment and volume for each Provider is similar, but different. There are no patient charges except for replacement appliances.

Monitoring is conducted by the DPB, but we make no fee claims. Every patient must sign an NHS form just once. We make electronic data interchange (EDI) transmission to the DPB by computer of each new patient assessment, each treatment start and each treatment completed or discontinued. We also transmit each patient's IOTN score before treatment. Probity is conducted by the DPB and the Dental Reference Service, just as in the GDS. If a patient is unhappy with their IOTN assessment they may appeal to the Dental Reference Service. There is a requirement for Audit and we do PAR on every treatment completed in the PDS.

Bedfordshire Health is advised by the DPB every month of our transmissions of assessments, treatment starts, and completions. We are allowed to deviate from our contract volume at the end of the year by 5 per cent. Over performance on one part of the contract compensates for under performance on the other part, but over performance is not funded and under performance is penalized.

All the Providers attended a 3-day calibration course in Occlusal Indices by Professor Stephen Richmond in September 1998. Two evening courses on IOTN and PAR were held locally and every Bedfordshire dentist received the Occlusal Indices pack to encourage dentists not to make inappropriate referrals.

The duration of the Pilot is for 3 years. It is subject to 3 months notice by the DoH, the Health Authority or the Provider. It is to be reviewed annually and there will be increases in payment in line with those in the GDS.

At new patient assessments, if there is an urgent need for treatment, treatment is started now. If there is a non-urgent need for treatment, the patient goes onto a prioritized treatment waiting list. If there is a need for treatment, but the patient is not ready they are put on review or the referring dentist is asked to re-refer at a more appropriate time. If there is no dental health need for treatment the patient is refused treatment.

Patients who can't have NHS treatment are told they have no great dental health need for treatment, so they do not need treatment. If they really want treatment they can go to a GDS dentist in Bedfordshire who is not in the Pilot, go to a GDS orthodontist outside Bedfordshire, go to a Dental School, or they can ask to be treated under private contract.

The Benefits of PDS

The advantages to the DoH are that we are now cash limited. There is prioritization by the local purchaser, but not by the government. It represents a response to Bloomfield and it is an exploration of other systems of remuneration. The advantages to Bedfordshire Health are that it is in line with the Health Authority strategy for the best use of

local resources and it allows the Health Authority to prioritize local services. It is cash limited and the Health Authority has gained considerable political kudos. Any dentist may set up a GDS orthodontic referral practice in Bedfordshire and need not join the PDS Pilot. However, the Pilot has obvious attractions and as the Pilot is already set up and running, it might attract new orthodontists into the area.

The advantages to the Provider are that we remain independent contractors. We have a guaranteed fixed monthly NHS gross income. We make no fee claim and have no fee per case. We have no prior approval and no limitations on what we can do or how often we see our patients. We are making the most appropriate use of our resources. There is no financial disadvantage in discontinuing cases and there is no financial disadvantage in accepting transfer cases since they count as a new treatment start. Our contract is by personal negotiation with the local purchaser who has the best interests of the local area at heart.

The disadvantage to the Provider is that we have a fixed monthly gross income, but we can control our profits by the way we manage our patients and our practice. We have lost the protection of national negotiation by the GDSC and we run the risk of having to return to the GDS with a reduced case load of more severe cases. If we want to take a partner or associate as an additional Provider we must negotiate additional funding first.

Joining the PDS

Orthodontists who like the freedom to work as much or as little as they like in the GDS, will not want to join a fixed sum contract. If their practice is mainly NHS with a relatively static gross income, and they want to get off the GDS 'treadmill' and treat patients as they need, without the problems of the GDS Regulations, the PDS might be the way to do it. The Tom Farrell Lecturer at the 1998 DPB Conference, Joe Rich said: 'Is the GDS part of the NHS? Can it ever be a true part of the NHS whilst dentists continue to be used as sub-contractors? It may be that GDS dentistry has to change to become a true part of the NHS. If that happens it will indeed mark the end of the beginning. Perhaps Personal Dental Services will be the vehicle to produce this change.' (Report of the DPB Conference, 1998).

Before considering joining the PDS, read 'Guide to Personal Dental Services Pilots under the NHS' (Woodeson, 1998a) and 'Personal Dental Services, Guidance on Establishing and Running Pilots' (Woodeson, 1998b). Both can be obtained from: the NHS Responseline 0541 555 455. Think about what you want to achieve for yourself and what you have to offer. There is no need to copy the Bedfordshire model. The PDS is about 'local solutions to local problems'. You may have a better solution to your local problem. Talk to your local Health Authority because without their support you may have difficulty. Talk to all the local orthodontists because the more of you who join in, the better. Dentists who have never worked in the GDS and have no past GDS earnings may join the PDS if they can show that they would otherwise be joining the GDS. The PDS funding comes from the GDS pool and new funding is available.

Four 'expressions of interest' for orthodontics were approved for development of their Business Plan for the second wave of PDS Pilots to start on 1st October 1999. However none of these has been accepted for the final stage of development of their contract and will not start this year. A third wave of PDS Pilots will start in October 2000. It is clear that, for a Pilot to be accepted, the local Health Authority and Providers must all be happy with the proposals, it must be affordable within the existing limited budget for existing services and any proposed growth, it must be related to local need on an IOTN basis and ideally it should improve access to orthodontic provision where there is an unmet need. The 'Guidance on Making a Proposal to Pilot Personal Dental Services' says 'Work covered by a PDS contract may not be provided under the GDS by the same Provider'. This seems to mean that you must leave the GDS completely when you join the PDS. That is what we did in Bedfordshire. In fact, you can mix GDS and PDS work in the same practice and this is happening in some other PDS Pilots. For instance, some practices treating children in the PDS and adults in the GDS. One Pilot is providing general anaesthetics under the PDS and the extractions under the GDS. You must accurately differentiate GDS work from PDS work. In a small area, such as orthodontics, it is possible to define part of orthodontic services as different from the rest. What you define as PDS work can only be done in the PDS.

Progress so Far

All our GDS treatments have been discontinued and transferred to the PDS for completion. After 9 months we have seen large numbers of new assessments and created prioritized treatment waiting lists. Seventy-five per cent of new assessments have been in need of treatment. However, many are too early for treatment, and are now on review or re-referral. The new patient waiting list has actually become shorter. The volume of new referrals has gone down too and it seems that fewer inappropriate referrals are being made.

We are testing the hypothesis that parents who have children with malocclusions only want them to have orthodontic treatment because it is free on the NHS. Very few of those patients not in need of treatment have expressed interest in private treatment. Some are asking their GDP for referral elsewhere for NHS treatment. What is surprising is how pleased many of them are when they are told there is no dental health need for treatment.

We are also testing the hypothesis that orthodontists in practice only treat mild malocclusions. Of the patients we transferred under treatment from the GDS, three-quarters would be eligible for treatment in the PDS.

We have a much better view of the NHS. We are no longer bound by the GDS regulations. We are not looking all the time on how to earn fees. We may use any appliances we want without having to justify the need. We may take radiographs when we want to. We can set our own recall intervals. We can simply treat patients as we think best. We have all the clinical advantages of a salaried appointment, but we remain independent practitioners.

All the Providers meet together with the Health Authority every 3 months. These meetings are invaluable

in solving minor problems, and in fostering continuing good understanding between the Providers and our Purchaser. We are well on the way to completing the contract volume for the first year.

The Future

We will have a new contract at the end of September. We will be seeking an increase in payment in line with the GDS for a reduced number of new assessments and an increase number of treatment starts. The treatment waiting lists will continue to become longer, but we do know what is on the lists and the need and urgency of each patient. As most of our referrals have been in need of treatment, the number of referrals will probably not decline much more.

Conclusions

The development of our PDS pilot has been an interesting and challenging exercise. All the Providers are very happy with the result. Our contacts with the DoH have taught us that the DoH is very concerned about the increasing cost of GDS orthodontics, and not just about the recent cases of fraud. There are potentially large changes looming for GDS orthodontists. The DoH is keen to extend PDS orthodontics because it is cash limited. The Bedfordshire orthodontists can recommend the shelter, security and satisfaction of the PDS.

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