

NHS DENTAL SERVICES: PATIENT CHARGE REVENUE

1. This paper sets out:
 - the main factors that may account for the lower than expected dental patient charge revenue (PCR) being reported for some areas
 - possible action for PCTs to consider to reduce risks to PCR
 - the support available from the NHS Business Services Authority (BSA) and NHS Dentistry Support Team.

Background

2. The average PCT (based on new configurations) has a gross budget for primary dental services of around £15.8 million, of which it was assumed around £4.2 million on average would come from patient charge revenue.
3. The main variables affecting PCR are:
 - the number of units of dental activity (UDAs) commissioned from dentists
 - the in-year UDAs actually delivered by dentists
 - relative numbers of UDAs for charge-paying and charge-exempt patients, together with the number of charge-exempt treatments given to patients who would normally pay charges.
4. Early data suggest that patterns of activity in this last area, together with additional factors set out below, are producing PCR pressures in some PCTs.

Proposed action

5. **Annex 1** contains a checklist of the main issues that PCTs could discuss with dentists to establish the reasons for unexpectedly low PCR and agree corrective action.
6. **Annex 2** sets out a suggested approach for SHAs and PCTs to use in forecasting their net expenditure outturn for dentistry, taking into account current PCR levels, potential changes to PCR (e.g. as new contracts come on stream), end-year accruals, and delays in committing gross expenditure where services are being re-commissioned. This will ensure that pressures are accurately reflected in overall financial forecasting.

Background

7. The data so far processed by the BSA show less PCR than would have been expected at this point. There are two main types of shortfall:
 - shortfalls in PCR where no activity – or lower than expected activity – is being reported, including where there are problems with data transmission

- shortfalls arising because reported activity includes an unexpectedly high proportion of charge-exempt treatment.
8. The first type of shortfall does not automatically mean an end-year pressure. Where activity is not being reported, the BSA does not know what charges have been collected and cannot make the appropriate deductions from monthly contract payments. Either there is a problem with reporting that, once fixed, will mean PCR can be deducted from contract payments. Alternatively, the contracted level of service is not being provided, in which case it is likely the gross contract payments for the year will have to be reduced. It is, however, essential to establish what is happening and what action to take.
 9. In the second scenario, a dentist might (say) have a contract value of £150,000 for which he is expected to provide 7,500 UDAs over the year, which is forecast to raise £40,000 PCR. So far the dentist has reported 3,000 UDAs (40% of the annual total), but a higher than expected proportion of these UDAs are charge-exempt and the charges generated are £12,000 (30% of the expected annual total). If this pattern is repeated over the course of the year, the dentist may deliver his contractual requirements but generate only 75% of forecast PCR.
 10. There are four groups of factors that could contribute to this kind of shortfall:
 - a) unexpected patterns in reported activity, in particular:
 - a shift in the relative proportion of charge-payers and exempt patients who are accepted for treatment, for instance because an increasing number of charge-payers are moving to private treatment
 - a high number of 'multiple' courses of treatment being given to exempt patients: this could reflect 'splitting' of courses of treatment or short recall intervals that do not reflect NICE guidance
 - a high incidence of charge-free treatments, including:
 - 'continuations' (where a course of treatment is completed and the patient needs unexpected further treatment within two months)
 - 'guaranteed' treatments (repair of dentures and other appliances)
 - an unusually high incidence of urgent treatments
 - b) allocations methodology: in calculating allocations in December 2005, the Department estimated the PCR that would be raised for a given level of gross expenditure in each PCT. This methodology has since been refined, for instance to reflect the late adjustments to dentists' UDA totals in February 2006, and it now predicts (all other things being equal) a 5% lower level of PCR than assumed in setting PCT allocations – although this is before taking into account the higher UDA values negotiated in many areas
 - c) PCT commissioning decisions: where PCTs agreed children-only or exempt-only contracts with dentists who had previously seen a mix of patients (or commissioned child-only contracts or orthodontic contracts using money recycled from closed contracts), this will have reduced PCR levels

- d) 'natural' flux: levels of PCR will always be subject to some small degree of flux, depending on the mix of charge-paying and exempt patients who come forward seeking dental treatment. This in turn will reflect factors such as numbers of people on Income Support etc.
11. It is difficult to disentangle these factors fully, but it is likely that the most significant factor is the shift in reported activity from chargeable to charge-exempt courses of treatment. The allocations formula made a small allowance for this, but so far the shift has been greater than assumed. This category is also the most susceptible to action by PCTs and dentists.

Checklist for NHS action

12. **Annex 1** proposes six main areas for discussion between PCTs and dentists:
- zero or low activity
 - late reporting of activity
 - patient mix
 - high incidence of multiple courses of treatment (particularly for exempt patients)
 - high incidence of urgent treatment (particularly for exempt patients)
 - high incidence of charge-exempt treatments.
13. The paper indicates:
- the data available to PCTs from the BSA to identify statistical outliers
 - the potential factors which may account for the unexpected service patterns and which will need to be examined with the contractor
 - potential action that could follow from discussion with the contractor
 - the support available from the BSA, including its Dental Reference Service.
14. The NHS Dentistry Support Team is available to support PCTs where SHAs request this.
15. In parallel, as part of its core ongoing work, the BSA will be continuing to check a sample of the data submitted by practices and, where there are clear anomalies, will take these up with the practices concerned. The Dental Reference Service (DRS) will (subject to the relevant PCTs' agreement) also visit a sample of practices with statistically unusual reporting patterns. If PCTs find, as part of their reviews, areas where DRS involvement would be helpful to them, they may wish to call the BSA Dental Practice Division Helpdesk on 01323 43350 to discuss how that help could be provided.
16. Where it becomes apparent from discussions between PCTs and contractors that treatment has been incorrectly reported, it is essential that PCTs discuss with the BSA how to correct the UDAs that are recorded as having been completed and/or the charge income that needs to be deducted.

Reviewing net expenditure forecasts

17. **Annex 2** sets out a structured approach to assess potential financial pressures. The bottom line is not forecast levels of PCR in isolation but rather forecast net expenditure, i.e. the forecast gross payments to dentists, less forecast PCR.
18. Gross expenditure will be affected by the speed with which PCTs have negotiated new or extended contracts to replace capacity lost through rejection of new contracts prior to 1 April and how quickly new services come on stream.
19. Levels of PCR for the year as a whole will be affected by the UDA levels agreed as part of new contracts. If current contracts have an average value of (say) £24 per UDA, but new activity is commissioned at (say) £20 per UDA, the new contract will, all other things being equal, generate proportionately more PCR. There is now considerable evidence that tendering for new services results in significantly improved value for money.
20. Annex 2 also sets out the adjustments that will be needed to financial forecasts to reflect end-year accruals and additional PCR that will be credited to PCTs' accounts to reflect courses of treatment that straddled the 1 April 2006 boundary.

Department of Health
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ANNEX 1

DENTAL PATIENT CHARGE REVENUE (PCR): ACTIONS FOR CONTRACT MONITORING

1. This document is designed to support PCTs in identifying factors at individual practice level that may be contributing to projected shortfalls in dental patient charge revenue and working with dental practices to take corrective action.
2. The six main areas recommended for discussion between PCTs and dentists to establish potential reasons for shortfalls in PCR are:
 - A. No reported activity
 - B. Low reported activity and/or late reporting of activity
 - C. Patient mix
 - D. High incidence of multiple courses of treatment (especially for exempt patients)
 - E. High incidence of urgent treatment (especially for exempt patients)
 - F. High incidence of charge-free items
3. For each of these areas, the NHS Business Services Authority (BSA) has supplied an analysis of statistical outliers to help PCTs identify and prioritise which issues to discuss with which contractors in their area. The reports cover 'general' contracts but not orthodontic or other specialist services.
4. PCTs can also request a more detailed report for individual practices, if they wish to see data at patient level to help better understand activity patterns. An annotated example of such a report is in the Appendix on page 13.
5. In each area, there are likely to be a number of potential reasons for unexpected reporting patterns, e.g. misunderstanding of regulations, mistakes in completion of forms, data transmission problems and so forth. It is important that PCTs take forward discussions with dental practices in a way that is open, participative and objective, in order to reach wherever possible a shared understanding of the contributory factors and agreement as to any corrective action needed.
6. When discussing data with practices, PCTs should bear in mind that:
 - practice data will be in 'real time' rather than based on the reporting cycle of the BSA, but this is unlikely to explain discrepancies between reported activity data and expected activity data unless there have been problems with data transmission
 - as part of its routine work, the BSA will in some cases contact practices to inquire about the data submitted or absence of data. It is possible that some of the issues flagged up in the BSA reports will have been resolved through discussion between the BSA and contractors by the time the discussion between PCT and contractor takes place. Equally, the BSA can follow up only a sample of cases, and PCTs should take primary responsibility for following up issues flagged in the BSA reports.

7. In reviewing the data processed in the first few months of the contract, the BSA has identified a number of refinements that can be made to the processing system to reduce the risk of inaccurate reporting and, by agreement with the Department, will be running a number of additional checks on the data already reported and processed. This does not detract from the value of the suggested discussions between PCTs and practices, but there may be some overlap between data identified as being anomalous by PCTs and practices and data subsequently corrected through these BSA checks. It is therefore all the more important that, where PCTs and contractors establish that treatments and/or patient charges have been incorrectly reported, PCTs – before taking any action – discuss with the BSA how to correct the UDAs and/or charge income reported.
8. NHS Primary Care Contracting (PCC) will be making available further advice for PCTs to support effective contract monitoring and will be running a series of national events with PCTs. However, it is strongly recommended that PCTs do not wait for this further guidance or the forthcoming events before discussing the areas above with 'outlier' practices.

A. NO ACTIVITY

Issue

Contractors are required to submit FP17 forms (or electronic equivalent) within two months of the date of completion of a course of treatment. There are still a significant number of contracts with zero activity reported. Without this data, the BSA cannot make PCR deductions from the contractor's monthly payments or credit the contractor with Units of Dental Activity (UDAs). Nor can the PCT make accurate forecasts of full-year PCR.

Some Trust-based schemes have also made few or no reports.

Data

The BSA has supplied lists of all contracts with zero reported activity. (This is part of a combined report that also covers exceptionally low reported UDAs.)

Action

If a contractor is completing courses of treatments but is facing technical difficulties in transmitting reports, urgent action is needed to resolve the problem. For advice on electronic data transmission, contact the BSA.

If a contractor is completing courses of treatment but not submitting reports (other than for technical reasons), the PCT will need to agree urgent action with the dentist to rectify this. Repeated failure to submit forms could constitute a breach of contract.

If a contractor is no longer providing NHS dental services, the PCT will need to close the contract, recover any excess payments already made to the contractor, and notify the BSA.

PCTs should also ensure that Trust-based schemes are making regular reports of activity and patient charge income.

B. LOW ACTIVITY/DELAYS IN REPORTING

Issue

Where activity is significantly below the level that would be expected at this point in the year, PCTs need to establish urgently the reasons for this. This may include a longer than expected time lag between completing and reporting courses of treatment.

Data

The BSA has supplied lists of all contracts with:

- exceptionally low reported UDAs compared to the annual contracted level. (This is part of a combined report that also covers contracts with zero activity.)
- contracts with a high proportion of FP17s submitted more than two months after the latest date of treatment.

Action

If a contractor has completed much less work than expected in the first part of the year, they and the PCT need to establish whether the shortfall is likely to be made up in the second part of the year and – if so – agree an appropriate action plan.

If a contractor does not expect to complete the contracted level of NHS work over the year (within the permitted tolerance of 4%), the PCT and contractor will need to agree an appropriate reduction in contract payments. They will also need to establish whether the under-delivery is for temporary reasons (e.g. a dentist at the practice who has left and not yet been replaced), or whether the contract value (and corresponding UDAs) will need to be reduced on a recurrent basis.

If a contractor is completing treatments but delaying submission of forms, the PCT should discuss the issue with the contractor and agree remedial action.

PCTs also need to ensure that Trust based schemes are reporting fully.

C. PATIENT MIX

Issue

In some cases, PCTs and dental practices have agreed that the practice may restrict services to children or more generally to charge-exempt patients, or may prioritise these groups. However, if there is no agreement of this kind in the contract, dentists are contractually required to accept patients for treatment without discrimination between charge-payers and charge-exempt patients.

If there has been a significant reduction in the proportion of courses of treatment given to charge-paying patients, this could reflect:

- fewer charge-paying patients coming forward and/or being accepted for treatment; and/or
- little change in the underlying mix of patients, but a change in the relative frequency with which charge-paying and charge-exempt patients receive courses of treatment (see section D in this Annex).

There may be an expected reason for changes in the underlying patient mix, e.g. an expansion in the service provided by the practice and a deliberate attempt to target increased capacity at areas of greater deprivation. If, however, there is a significant and unexpected reduction in the underlying patient mix, the PCT should establish the reasons for this with the dentist.

Data

The BSA reports indicate where there are low proportions of adult charge paying patients.

In most cases, PCTs should be able to compare these proportions with data on former GDS contracts or PDS pilots. We are, however, considering ways of producing a separate report on this.

If the current proportions differ significantly from previous patterns, and if there are no significant differences between charge-payers and exempt patients in terms of the incidence of multiple courses of treatment (see item D), this means that fewer charge-payers are seeking treatment and/or are being accepted for treatment, or that some patients who are liable to pay charges are being recorded as charge-exempt.

Action

The PCT and practice should establish the reasons for the change in patient mix. The PCT and practice may need to review the practice's procedures for accepting patients. If there is a risk that the practice procedures give greater priority to exempt patients, the PCT and practice should agree changes to these procedures.

If a practice is known to be actively promoting private care, the PCT may wish to check with the practice that, in doing so, the practice is not misrepresenting the type or quality of service available to NHS patients. For further advice see the Primary Care Contracting advice at www.pcc.nhs.uk/dental.

D. MULTIPLE COURSES OF TREATMENT

Issue

Except where the criteria for 'urgent treatment' apply, a patient who is accepted for treatment should receive an examination and assessment, following which the dentist will provide all the care and treatment needed. This should be set out on the patient treatment plan (FP17DC). The patient should then be asked to re-attend at an interval of 3, 6, 9, 12, 15, 18, 21 or 24 months depending on his or her oral health (in accordance with NICE guidelines).

Re-attendance within six months is likely to be restricted to a relatively small number of patients who have an unexpected dental problem during this period or who have specific risk factors (e.g. multiple risk factors for the onset of periodontal disease) which warrant a 3-month recall. Frequent recall for scaling and polishing is not in line with NICE guidance and may indeed be harmful to dental health. The full NICE guidance can be found at <http://www.nice.org.uk/page.aspx?o=CG019&c=dental>.

Dentists should not be providing a second course of treatment if it is to address dental problems that have been identified – or should reasonably have been identified – during the first course of treatment. For instance, if a patient receives an examination and is asked to return at a later date for a scale and polish (e.g. by a hygienist), this constitutes a single course of treatment. Similarly, if a patient receives a filling and is asked to return at a later date to have a second filling (or other treatment) done, this constitutes a single course of treatment.

Where multiple visits are incorrectly reported as multiple courses of treatment, this will reduce the level of service provided by the contractor over the course of the year and provide poor value for money. If, in addition, multiple courses of treatment are given disproportionately to charge-exempt patients, this will cause a PCR pressure.

Data

The BSA reports show practices with high numbers of multiple courses of treatment.

PCTs can request detailed reports on individual practices from the BSA (the reports have to be individually requested as they contain confidential patient data).

Action

PCTs should clarify the regulations and identify why the data are showing a high number of multiple courses of treatment, e.g. do practice staff understand the regulations, are forms being filled in correctly, and are there any problems with data transmission?

If it is established that UDAs have been over-reported, the PCT and the contractor will need to agree adjustments to the recorded activity. The PCT will then need to discuss the processing of this with the BSA before taking any action.

Where the data suggest that high numbers of patients are being recalled within a short space of time, PCTs may wish to review practice procedures and, where necessary, agree an action plan to improve compliance with NICE guidelines.

E. URGENT COURSES OF TREATMENT

Issue

The new contracts allow for 'urgent treatment' in what should be limited circumstances where a dentist judges that immediate treatment is needed to relieve severe pain or to prevent significant deterioration in the patient's oral health.

Urgent treatment attracts 1.2 UDAs, but the patient charge is £15.50 (the same as for a Band 1 course of treatment that attracts 1.0 UDAs). A higher than expected level of urgent treatment therefore leads to less PCR (per UDA) than in the model.

Where urgent treatments form one or more of the 'multiple' courses of treatment given to patients (see Section D in this Annex) and if this disproportionately affects charge-exempt patients, this will contribute to pressure on PCR.

The definition of 'urgency' relates to the patient's presenting condition, not the way in which the appointment is made. If the patient's condition does not meet one of the two criteria (i.e. immediate treatment needed to relieve severe pain, or to prevent significant deterioration in oral health), any examination/treatment provided to the patient should fall into one of the usual three Bands and attract 1, 3 or 12 UDAs.

There are some reports of dentists only agreeing to see new patients on the basis of an initial 'urgent treatment'. This would be a clear misapplication of the regulations.

For further guidance, please see the urgent treatment Factsheet (7B) at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4124337&chk=beZed2 (you may also find this via <http://www.dh.gov.uk/dental> and following the links to local commissioning guidance and advice for the NHS).

Data

The BSA reports show the incidence of urgent treatments.

PCTs can request detailed reports on individual practices from the BSA, including the incidence of urgent treatments by charge-paying and exempt patients (the reports have to be individually requested as they contain confidential patient data).

Action

In some cases, a high incidence of urgent treatments may be expected, for instance where a PCT has arranged with a contractor to hold open access slots for patients needing urgent care.

In other cases, PCTs should discuss a high incidence of urgent treatments with the practice involved to establish the reasons for this, e.g. do practice staff understand the regulations, and are forms being accurately completed?

If there is lack of agreement between PCT and contractor regarding the appropriateness of urgent treatment, the PCT can ask the BSA to request and examine record cards for the patients involved.

F. CHARGE-FREE ITEMS

Continuations of treatment

The charge regulations provide that, where a course of treatment is completed but a charge-paying patient then needs further treatment within two months, the further treatment is provided at no charge to the patient (but the dentist receives the appropriate UDAs). This was designed to cover what should be a minimal number of cases where the dentist has completed all necessary care and treatment, but (say) a patient unexpectedly returns within two months with a fracture in another tooth.

Initial data, however, show much higher than expected numbers of claims for continuation of treatment, in many cases for patients whose initial course of treatment was only Band 1 (i.e. examination, scale and polish etc).

Charge-free repair or replacement of certain restorations

There has also been an unexpectedly high number of UDAs claimed for repair or replacement of restorations, which are provided at no charge to the patient.

Prescription-only treatments

Where a patient assesses a patient and issues a prescription but carries out no other treatment, this attracts 0.75 UDAs and no patient charge. Such treatments should be rare. An excessive number of such treatments will put pressure on PCR.

Data

The BSA exception reports show practices with a high incidence of:

- continuations of treatment
- free repair or replace treatments.

The exception reports do not include data on prescription-only treatments, but this is included in the monthly reports already submitted to PCTs.

PCTs can request detailed reports on individual practices from the BDA (the reports have to be individually requested as they contain confidential patient data).

Action

If a contractor is reporting an unusually high number of charge-free items, the PCT should discuss the matter with the contractor to establish the reasons for this trend, and ensure that the regulations are understood and being correctly applied.

Further advice on 'continuation' cases, repairs/restorations and prescription-only treatments is available on the Primary Care Contracting website at <http://www.pcc.nhs.uk/dental> (then follow contract monitoring link).

Appendix

This report may be requested from the BSA for contracts where routine reports indicate the need for more detailed information

Processing information grouped by level of activity and patient details

*****/0001

This report contains details of the processing we have undertaken for this contract. It includes instances where details on FP17s have been amended - these can be identified where a record with type amendment + "contra record" exists with the same details as a not amended record. For reporting totals of FP17s on a monthly basis negates the previous record.

Patient Unique Identifier	Combined Patient Charge Band	Treatment Acceptance date	Treatment Completion date	Exemption Type	Type of Amendment	FP17's with these details	Total FP17's from this contract for patient
Patient 1 16-11-1965 00:00:00 Male	Band 1	14/04/2006	21/04/2006	Tax Credit	Not Amended	1	6
Patient 1 16-11-1965 00:00:00 Male	Band 2	19/04/2006	19/04/2006	Charge Payer	Not Amended	1	6
Patient 1 16-11-1965 00:00:00 Male	Band 1	24/04/2006	12/05/2006	Charge Payer	Not Amended	1	6
Patient 1 16-11-1965 00:00:00 Male	Band 1	16/05/2006	06/06/2006	Charge Payer	Not Amended	1	6
Patient 1 16-11-1965 00:00:00 Male	Band 1	25/05/2006	10/07/2006	Job Seekers Allow	Not Amended	1	6
Patient 1 16-11-1965 00:00:00 Male	Band 1	29/06/2006	25/07/2006	Charge Payer	Not Amended	1	6
Patient 2 12-05-1978 00:00:00 Female	Free-Prescription	03/04/2006	26/04/2006	Expectant Mother	Not Amended	1	5
Patient 2 12-05-1978 00:00:00 Female	Band 1	19/04/2006	19/04/2006	Expectant Mother	Not Amended	1	5
Patient 2 12-05-1978 00:00:00 Female	Free-Prescription	26/04/2006	09/05/2006	Expectant Mother	Not Amended	1	5
Patient 2 12-05-1978 00:00:00 Female	Free-Prescription	19/07/2006	01/08/2006	Expectant Mother	Not Amended	1	5
Patient 2 12-05-1978 00:00:00 Female	Band 1	01/08/2006	01/08/2006	Nursing Mother	Not Amended	1	5
Patient 3 10-08-1953 00:00:00 Female	Urgent/Occasional	11/05/2006	30/05/2006	Charge Payer	Not Amended	1	6
Patient 3 10-08-1953 00:00:00 Female	Band 1	11/05/2006	30/05/2006	Charge Payer	Not Amended	1	6
Patient 3 10-08-1953 00:00:00 Female	Free-Arrest of Bleeding	11/05/2006	31/05/2006	Income Support	Not Amended	1	6
Patient 3 10-08-1953 00:00:00 Female	Free-Removal of Sutures	18/05/2006	05/06/2006	Income Support	Not Amended	1	6
Patient 3 10-08-1953 00:00:00 Female	Free-Prescription	19/05/2006	19/05/2006	Income Support	Not Amended	1	6
Patient 3 10-08-1953 00:00:00 Female	Band 1	22/05/2006	22/05/2006	Charge Payer	Not Amended	1	6
Patient 3 10-08-1953 00:00:00 Female	Band 1	05/06/2006	02/08/2006	Charge Payer	Not Amended	1	6
Patient 4 28-07-1932 00:00:00 Male	Band 1	25/05/2006	22/06/2006	Income Support	Not Amended	1	5
Patient 4 28-07-1932 00:00:00 Male	Band 3	07/06/2006	16/06/2006	Charge Payer	Not Amended	1	5
Patient 4 28-07-1932 00:00:00 Male	Band 1	12/06/2006	29/06/2006	Charge Payer	Not Amended	1	5
Patient 4 28-07-1932 00:00:00 Male	Free-Denture Repair	15/06/2006	08/07/2005	Charge Payer	Not Amended	1	5
Patient 4 28-07-1932 00:00:00 Male	Band 1	22/06/2006	21/07/2006	Charge Payer	Not Amended	1	5
Patient 5 08-03-1998 00:00:00 Female	Band 1	09/05/2006	12/07/2006	Under 18	Not Amended	1	4
Patient 5 08-03-1998 00:00:00 Female	Urgent/Occasional	09/05/2006	12/07/2006	Under 18	Not Amended	1	4
Patient 5 08-03-1998 00:00:00 Female	Band 1	18/05/2006	18/05/2006	Under 18	Not Amended	1	4
Patient 5 08-03-1998 00:00:00 Female	Orthodontic Claim	27/05/2006	27/06/2006	Under 18	Not Amended	1	4

Overlapping dates for different courses of treatment

6 courses of treatment started for the same patient within 11 weeks

Check for unusual patterns of charge free items

Inconsistent charge categories

Few courses of treatment that require a treatment plan

If the contractor does not enter the sex of the patient the system defaults to female

Check orthodontics is in the contract, frequency of claims overall, age of patient being assessed

BSA Report
This can be requested by PCTs from the BSA for practices where regular reports indicate a need for more information

ANNEX 2

CHECK LIST FOR PREPARING OUTTURN FORECASTS OF NET RESOURCE EXPENDITURE ON DENTISTRY

1. This note is designed to support SHAs and PCTs in monitoring and forecasting net expenditure on dentistry.
2. PCTs will need to take into account a number of factors when assessing their likely net resource expenditure outturn. The data provided to SHAs and PCTs by the NHS Business Services Authority (BSA) will not on its own provide the full picture, because:
 - PCTs will need to accrue at the end of the financial year for patient charge income associated with treatment carried out during 2006/07 but not likely to be reported by dentists or recorded by the BSA until after 1 April 2007
 - the BSA data excludes the cost of, and any patient charge income collected within, any Trust-led primary dental services funded from the PCTs dedicated dental budget
 - BSA data will not anticipate any changes to contract payments, or additional contracts not yet registered or active, that PCTs may be planning.
 - PCTs will be credited by the BSA with a small amount of additional charge income to reflect a 50% share of PCR for courses of treatment that began before 1 April 2006 and were completed after 1 April 2006. Because dentists reported this PCR against their old GDS payment claims for the partial treatment given up to 31 March 2006, no charge income will be shown in the BSA's activity reports for treatment after 1 April.
3. PCTs could build up a more complete forecast outturn through the following steps
4. For GDS/PDS contractors who moved to new contracts from 1 April:
 - Identify the full year gross expenditure commitment. This needs to take account of contract payments, all approved additions to contract payments, and other costs such as employers' superannuation contributions. Costs should reflect the full year (12 month) payment commitment, bearing in mind that only eleven cash payments are likely to be made within the financial year as contractors are generally being paid one month in arrears (former PDS pilot practices which retained their former monthly pay dates may have only a part month's cash payment still outstanding at the year end)
 - if it is clear that agreed activity is not going to be delivered and there are clear justifications for reducing contract payments, adjust gross expenditure accordingly
 - record patient charge income to date

- extrapolate patient charge income for remaining months on the basis of the most recent two or three months data, unless there are special local circumstances which suggest a different representative period is appropriate
 - add [X] for an end-year accrual for patient charge income that the PCT can reasonably anticipate has been collected but not yet reported. A general rule of thumb might be to allow for a 1.5-month time lag in the recording of charge income, but DH will be issuing PCTs with current data on the average time lags specific to their area by 26 October 2006. This will take into account the impact of the BSA's monthly scheduling cycle. (Guidance on compiling the end year accounts in the 2006/07 Manual for Accounts will also be reviewed with the National Audit Office and the Audit Commission to ensure that it reflects the new dental service and charge income arrangements.)
 - add an element for the 50% share of patient charge income on treatments that began before 1 April 2006. Provisional data suggest that this additional PCR will represent an average credit for each new PCT area of between £20–25k. It is expected that the BSA will be able to incorporate the appropriate credits in PCT cash reports by December 2006 when processing of old GDS claims should be complete.
 - deduct adjusted charge income from adjusted gross expenditure.
5. For new contracts where activity has already started:
- as per 4 (above), but adjusted for the number of months during the year in which services will be provided, and without the 50% share of patient charge income on treatments commenced before 1 April 2006.
6. For new contracts yet to come on stream:
- as per 4 and 5 (above), but assess average PCR per UDA for contracts in (4) and (5)
 - apply this multiplier to the agreed UDAs for the new contract to estimate likely patient charge income
7. Forecast gross costs for any Trust-led primary dental services funded from the PCT's dedicated dental budget and deduct actual and forecast PCR generated within those services.
8. Identify if any of the gross costs include the cost of approved vocational trainees (i.e. the trainee's salary cost, the accompanying trainer's grant, and the relevant temporary service contract addition awarded to the host practice, for vocational trainees approved by the relevant Postgraduate Dean). Check if the appropriate VT funding allocation has been requested from, and confirmed by, the Strategic Health Authority.
9. Compare net costs identified at 4 + 5 + 6+ 7 (above) with net allocation (plus VT supplementary allocation where appropriate).