oral care consulting

A REPORT ON PROBITY ASSURANCE WITHIN THE DENTAL CARE SECTOR

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Table of Contents

Summary

Oral Care Consulting (OCC) Ltd was asked by the Department of Health and Children to produce a short report on the current status of probity assurance within the dental sector as undertaken by the Health Service Executive (HSE).

OCC were specifically asked to summarise the recommendations of the two previous reports on probity in the DTSS; to provide greater clarity on the statements surrounding probity made in OCC's report on the Public Dental Service of the Health Service Executive, and to advise on these consequences arising from the second term of reference and the possible nature of the financial risk exposure to overall DTSS expenditure.

The first report (2002) concluded that there was a lack of information on the magnitude of existing problems in the DTSS arrangements. Shortcomings in the definition of standards in both clinical and non-clinical areas were apparent, accountability within the system was also poor and the arrangements that existed to deal with perceived breaches in probity were inadequate.

The second report submitted in 2007 concluded that the HSE had made considerable progress following our recommendations to implement probity arrangements. In particular, many of the structural elements of a probity assurance system had been introduced including the establishment of an Examining Dentist scheme. The report identified a number of areas where further progress should be made over and above current performance. These would require resources both in terms of personnel and training.

The recent report of the Public Dental Service (PDS) highlighted the role that the PDS could play in probity assurance with specific reference to estimating the value for money elements of the service's work. However, due to other changes the level of probity assurance had declined, indeed was now substantially weaker when compared to the level found in 2007.

Although few data exist, based on work in alternative care systems OCC estimate at least ten per cent of payments are likely to be inappropriate. However, to achieve even this figure would require a substantial commitment on the part of the HSE, which it has failed to show since 2007.

Background, Terms of Reference and Outline

Introduction

Oral Care Consulting (OCC) Ltd was asked by the Department of Health and Children to produce a short additional report on the current status of probity assurance within the dental sector as undertaken by the Health Service Executive (HSE). The work would summarise the reports produced by OCC on probity and make reference to the initial work on developing probity assurance within the Dental Treatments Services Scheme (DTSS) as well as the more recent work reporting on the Personal Dental Service.

Terms of Reference

The terms of reference for the work are:

- to summarise the recommendations of the two previous reports on probity in the DTSS
- to provide more information on the statements surrounding probity made in OCC's report on the Public Dental Service of the Health Service Executive, and
- to advise on the possible financial risk exposure to overall DTSS expenditure

Outline of the present document

The present report is divided into three furthers sections. The first section provides a summary of the initial report that OCC undertook and submitted to the Department of Health and Children in 2002. OCC were subsequently contacted in 2006 by the Health Service Executive (HSE) to undertake a report on progress following the initial report. The findings of the work are summarised in section two of the present document. The third section deals with the second term of reference, namely the comments concerning probity in OCC's report on the Public Dental Service.

The Status of Probity Arrangements in the Dental Treatment Services Scheme (2002)

In 2000, as part of the a wider series of projects examining different elements of the oral health care arrangements in Ireland, Kings College London was awarded a contract to report on probity arrangements within the Dental Treatments Services Scheme (DTSS), one of two state funded dental delivery arrangements for adults. The work was undertaken over a period of 18 months and provided an outline of what was meant by probity; what an ideal model for ensuring probity would look like for a dental care system; the existing arrangements within the DTSS and, as a number of areas where shortfalls existed, suggestions on how this could be improved.

The report concluded that there was a lack of information on the magnitude of existing problems in the DTSS arrangements. This had implications for the management of probity risks as any developments to improve the system would have costs and without the quantification of the problem, the cost-benefit of any recommendations could not be assessed. Furthermore, shortcomings in the definition of standards in both clinical and non-clinical areas were apparent: while the DTSS contract provided an indication of what is expected of care providers, the standards were poorly defined. This presented difficulties when making judgments of the extent of any deviation from acceptable practice.

Accountability within the present system was also poor. While several bodies had roles to play in helping with probity assurance within the DTSS, there was a lack of clarity on the functions for the various bodies and poor managerial working arrangements existed. Finally, the arrangements that existed to deal with perceived breaches in probity were also inadequate.

The report went on to suggest a number of developments that could be implemented that would take forward the identified shortcomings. The first step required was clarification of policy within the Department of Health and Children. It was suggested that this must include the main principles that the system would adhere to which would subsequently help identify the work programme necessary to bring about incremental improvement to agreed levels and there after maintenance in face of a changing probity environment.

A suggested approach in the report called for the establishment of a steering group as a special management committee of the Health Board's Executive along with a probity assurance group; the latter group operating from within the GMS

Payments Board. Underpinning these was the need to improve the information systems both at a clinical level and through additional support and training for those charged with developing identified information requirements.

The Second Report on Probity Assurance Arrangements within the DTSS(2007)

In 2006, the Health Service Executive approached OCC to undertake an assessment of progress on probity following the publication of the earlier report. The specific terms of reference were:

- to review the minutes and material produced through the probity assurance arrangements to date,
- to assess progress that has been made and processes adopted concerning the 'cases' that the DTSS probity system have actively sought to pursue,
- to undertake an examination of the structural elements in the probity arrangements: the contractual agreements between the various parties; the arrangements for the provision of data to support probity, and; the examining dentist arrangements, and
- to analyse how data obtained through the DTSS arrangements are used.

The conclusions of the second report submitted in 2007 included that the HSE had made considerable progress since the publication of our initial probity report. In particular, many of the structural elements of a probity assurance system had been introduced including the establishment of an Examining Dentist scheme.

The report also identified that to develop matters further, probity assurance would require a number of elements to be put into operation. These included a valid database that would provide timely opportunities for relevant analyses over an extended period, a trained and calibrated examining dentist team and good collaborative working between the payment's agency, contracting agency and the probity unit.

OCC also suggested that a national arrangement was likely to be more cost-effective and efficient, not least due to the limited number and complexity of more serious probity cases. It also identified a number of areas where progress could be made over and above current performance but would require resources both in terms of personnel and training.

The key aspects still required included:

- ensuring that the former GMS Payments Board, now known as the Primary Care Reimbursement Service (PCRS), was integrated to a greater extent with the contracting arrangements for the DTSS than was then found. It was suggested that this included transferring the managerial accountability of the PCRS to the relevant service Directorate.

- The development of the then Examining Dentist Scheme (EDS) as a full time arrangement based within and managerially accountable within the relevant service Directorate. The report highlighted that this was a priority as without Examining Dentists (EDs) two major elements of a probity assurance mechanism were missing, namely the assessment of the qualities of treatment and diagnosis and that of the treatment provided.

- Strengthening the Specialist Unit. OCC's report suggested that working relationships between the dental element, other probity assurance arrangements and the PCRS are not conducive to an effective and efficient system and went on to recommend that the EDs should be incorporated into the Unit which should report within the relevant service Directorate and access to legal advice be made available as appropriate.

- OCC also suggested that a training needs analysis of the probity assurance system should be undertaken and the necessary expertise sought to help ensure that the system evolves.

- Finally it was strongly recommended that a continual reassessment of the contract between the HSE and the contractors based on any breaches identified within the current arrangements and following the necessary risk assessment would be undertaken.

Probity issues arising from the analysis and evaluation of the Public Dental Service of the Health Service Executive (2009)

In 2008, OCC was awarded a contract to assess the Public Dental Service of the HSE. In the report, the continued role that the PDS was playing in probity was identified. In addition to the their role in the DTSS, an additional report had examined the possibility of merging the DTSS and Dental Treatments Benefit Scheme (DTBS) schemes. With specific reference to the implications of the role that the PDS could play and costs arising from any merger it was suggested that:

"…until the proposed changes arising from the possible merger are made explicit and perhaps more importantly, the nature and extent to any probity arrangements within the new arrangements are defined for the modified delivery system, the impact on the PDS cannot be assessed."

Furthermore, the report also stated that:

"Any future assessment of the qualities of care including assessments of the efficiency, equity or value for money will require a substantial improvement in data handling and probity matters in general."

These statements were based on an assessment of the current activities of the PDS who played a key role in undertaking probity assurance through the monitoring of reports provided by the PCRS.

However, it was also apparent that a number of developments had occurred since OCC's second report on probity assurance progress that indicated that not only had the system failed to develop further but had actually failed to maintain the levels previously achieved. OCC would argue that the current levels of probity are very weak. Indeed, from information supplied to us, probity assessment has fallen below the level identified in the initial report.

No meetings have taken place of the PASOG during the past 2 years. There is currently no examining dentist scheme. OCC is unaware of any developments in PCRS to identify the risk exposure of the DTBS. Thus, not only has the progress that had been made stopped but due to the failure to build on the developments that occurred probity assurance will have been substantially weakened as the perceived deterrent element is now far weaker: contract holders are likely to perceive that the authorities do not place any value in the probity arrangements.

In the first report, we stated that:

"*The (periodic) review should be seen as an ongoing procedure probity assurance is a process that should be monitored and changed in the light of evolving circumstances*"

We pointed out that this applies to every part of the process (i.e. not just the contract review). Probity assurance is not a static process but a continual war against those who would make inappropriate use of (in this case) public funds. The fact that there has been very little work or activity, since the PASOG became inactive in early 2007, that PASOG did not meet or operate during 2008 and 2009, and the detailed Risk Assessment to guide further probity measures has not been actioned is ample clarification of our criticisms made in the PDS (2009) report.

In addition, we made the recommendation that a specialist team be set up in the then GMS Payments Board, (now Primary Care Reimbursement Service (PCRS). This has not taken place. The apparent lack of interest on the part of the PCRS to involve themselves in and support the analysis work needed has been identified as a critical inhibiting factor throughout the process. Indeed we understood that PCRS unilaterally withdrew from participation in PASOG.

The work undertaken by the Specialist Advisor when he operated within the PCRS identified the issues surrounding surgical extractions. However, this individual has now left the post and as far as we are aware, there is no clinical input into any assessment. As we highlighted in our first report, without this advice, probity assurance remains weak at best even assuming all other elements were functional.

With respect to the extent to which probity assurance is operating the key issue is first, did the HSE claw back any monies and second, what work or activities are ongoing? We have not been supplied with any information except that which infers that a sum in the region of €60k recovered, but not in more recent years. Two cases are currently under review by HSE West and funds may be recovered.

The key question that arises is how contract holders respond to these failings. The evidence submitted by the specialist function indicated that, although the behavior of targeted practitioners remained low initially, there was a significant rebound both overall and amongst the remaining practitioners to even higher levels once the checks had been removed. The importance of this is that if checks are stopped (a) it is more difficult to re-start and (b) it announces to the target population that no one is looking and so encourages inappropriate behavior.

It is difficult to assess the amount at risk in such circumstances but work in England and Wales suggests that, after operating a probity system for many years the raw risk (that is, before checks) of inappropriate payments being made is at least 8 per cent of the total expenditure. In a system with few if any checks such as that operated by the HSE, and boosted by apparent changes in the attitude of the authorities to such issues, a much higher rate, probably in excess of ten per cent would be expected.

It is also our understanding from the senior management in charge of the probity assurance project that they viewed it as a pilot that could be applied to pharmaceutical and medical payments where public expenditure is much higher. As such, OCC would argue that providing the issue of probity was taken seriously by the HSE and that the controls and development of the system as advocated in our second report were implemented substantial benefits would accrue.

References

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