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Health Committee

Dental Services

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Written evidence

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Written evidence

Memorandum by the Department of Health (DS 01)

NHS DENTAL AND ORTHODONTIC SERVICES

EXECUTIVE SUMMARY

1. I am pleased to have this opportunity to set out where we are on NHS dental services—the achievements to date and the plans for further improvement.

2. The first thing to note is that our record on dentistry is strong:

— England is a leader within Europe in improving oral health: according to the WHO database, our twelve year olds now have the best oral health in Europe, measured by decayed, missing and filled teeth.

— We are expanding the dental workforce by increasing the numbers of dentists in training by 25% (170 extra undergraduates). The new cohort will start to graduate from 2009. Two new dental schools opened in autumn 2007—in Plymouth and Preston. Dental Care Professionals (DCPs), who support dentists in their work have increased by 300%.

— This Government is committed to increasing access to NHS dental services and is continuing to provide both increasing financial investment and support for the NHS in growing and developing dental services.

Changes in dental needs since 1948

3. In looking at the challenges ahead and the rationale for the changes made to the dental system, it is important to remember the level of change there has been in dental need and demand since the NHS dental service began in 1948.

4. In the immediate post war years NHS dentistry served a nation with generally poor oral health, large amounts of untreated decay and therefore with extensive treatment requirements. A large proportion of the adult population were toothless (edentate). As recently as 1973, 40% of the population had no natural teeth. The NHS dental system set up in 1948 reflected a world where those with teeth typically needed complex treatment for extensive decay and those without required full dentures.

5. From the early 1970s onwards developments in dental care and particularly the spread in the use of fluoride toothpaste have meant that an ever-increasing proportion of adults retain their teeth into old age. By 1998, fewer than 13% of the adult population were edentate. If the trend has continued that figure is probably now just 6% (adult dental health surveys are carried out every 10 years or so). Decay rates had fallen in all groups (although there remains a marked gap between socio economic groups).

6. Over the last decade or so, patients' focus has moved from simply ensuring their teeth are healthy and pain-free to an ever-stronger desire that they should also be cosmetically pleasing. This presents new challenges about where the boundaries should lie between clinically needed treatment—available for all who want it from the NHS—and purely cosmetic treatment, which most would agree need not necessarily be offered on the NHS.

Our vision

7. Against the background of these changes in need and demand for dental care, our overarching goals for dentistry are now to:

— Improve oral health yet further and address inequalities, by bringing the health of those in poorest oral health closer to that of those in the best oral health.

— Ensure we steadily increase the number of patients who have access to accessible, safe, appropriate NHS dental services for all clinically needed care.

— Ensure that patients who continue to use private care—whether for clinical or purely cosmetic treatments—receive care that is regulated to the same high standards to which we already hold the NHS.

Rationale for Dental Reforms

8. The system set up in 1948 was provider and treatment driven. Dentists decided on the level and location of services, and under payment per item of service the more treatment delivered and the more complex that treatment was, the more the dentist earned. NHS dental charges were introduced in 1951 for charge paying adults (those under 18, or in receipt of income support or pregnant are exempt from all charges). Charges were based on individual items of service.

9. From the early 1990s, the inherent risks of a provider driven system that left dentists to decide where and what level of service should be available became apparent. As dentists drifted away from the NHS, service commissioners had no powers to seek alternative providers. The access difficulties that resulted, the legacy of which we are dealing with today, are well known.

10. The incentive to deliver complex restorative treatment was a good fit for a nation in poor oral health but an increasingly bad fit as decay rates declined. Dentists complained of being on a treadmill that allowed no time for preventive as well as restorative treatment.

11. The charging system became increasingly confusing for patients. By 2005–06 there were over 400 possible charges with a maximum possible charge of £389.00. Patients reported being often unable to tell from the charge whether they had had private or NHS treatment—and for very complex treatment—finding charges prohibitively expensive.

12. The system was as frustrating for dentists as it was for patients. The fee per item system left little time for preventative work. Dentists and patients welcomed the greater scope for a preventative approach the capitation system piloted through personal dental services pilots (PDS) offered.

13. However, as with any pure capitation system you have the opposite challenge from a fee per item system—how to ensure that as well as preventative advice patients also receive enough active treatment. The new system aimed to address the risks of both pure capitation and pure fee per item systems by offering dentists a pre agreed annual income but one which included pre agreed levels of activity.

14. The reforms made three key changes.

— First and most fundamentally, they gave Primary Care Trusts (PCTs) power to commission services to meet local needs.

— They radically simplified the charging system into just three payment bands, leaving little room for confusion on what is private treatment and what is NHS, and slashing the maximum total charge in half.

— They removed the exclusive focus on active treatment—basic courses of treatment now include diagnosis and any preventative treatment clinically indicated ranging from simple scale and polishes to fluoride varnishes.

15. In the new system Units of Dental Activity (UDAs) provide a language for discussion of expected activity. It is important to be clear though that they are not the exclusive measure of performance or quality—specialist services including sedation, Out Of Hours services, domiciliary care and open access slot payments are all outside the UDA system.

16. For mainstream contracts, PCTs are free to agree local variations to payment as long as they are within the national legislation. For example some PCTs have chosen to pay a premium to practices setting up in areas where new patients are likely to need extensive remedial work. By agreement, these will tail off as the surgery restores the patients' oral health (and therefore treatment need and cost per patient reduces).

Conclusion

17. Many challenges remain but the first eighteen months have demonstrated beyond doubt that the new system is workable and working. Access has been broadly stable across the transitional period at national level. Access problems that developed over many years cannot be resolved overnight but already patients in particularly hard-pressed areas have felt the benefit. The transition from the old system has been particularly challenging for the profession and we do not underestimate the degree of culture change it has required.

18. The progress made—and particularly the fact that even in the inevitably hard first year dentists delivered 95% of the activity contracted for—is a tribute to those working on the front line. Many challenges remain, particularly to reassure dentists that while the new system has rightly moved control from providers to commissioners it is one in which those committed to NHS dentistry can flourish with a new certainty about their future. However the first 18 months have demonstrated that the new system is workable and provides a stable foundation for building robust services.

Areas of Particular Interest Identified by the Health Select Committee

19. The rest of this memorandum sets out in more detail the impact of the reforms on the areas the Committee have identified as of particular interest.

The role of PCTs in commissioning local dental services

20. The new system created for the first time in the history of the NHS a statutory duty on PCTs to ensure the provision of primary dental services to meet local need. Combined with the devolution of dental budgets to PCTs this revolutionised the system of dental services putting it for the first time on a similar footing to other mainstream NHS services.

21. PCTs are now empowered to assess need and develop services against those needs. Existing dentists were rightly given strong protections during the period of transition—not least a guarantee that their pattern of service or remuneration would not be changed (unless they agreed) for three years post reform. From April 2009 when the transitional period ends PCTs will have even greater ability, working in partnership with local dental providers to shape services to meet local needs.

22. PCTs have gone in eighteen months from, effectively glorified payment agents to full-scale commissioners of dental services. They have been supported in this transition by the national Primary Care Contracting team (PCC). PCC are a team of experienced NHS managers their programme ranges from hands on support to individual PCTs to a wide suite of guidance available to all dental commissioners. The full range of guidance is available at http://www.primarycarecontracting.nhs.uk/89.php

23. There is no doubt that taking on a full commissioning role during a time of wider organisational change presented PCTs with a significant level of challenge. Some PCTs are further ahead than others. Notable front runners include Tower Hamlets which has tailored services to meet the needs of a particularly deprived population through innovative use of outreach services delivered by local high street and salaried dentists.

24. Generally the first year saw a focus on getting the basics of the transition right and ensuring services delivered for patients through the critical first year. As commissioning matures and commissioners and providers get to grips with the system, PCTs are in the process of moving from contracting to true commissioning—designing services tailored for local needs rather than the original national inevitably somewhat rigid model.

25. It is notable that despite the national rhetoric, relationships between the profession and NHS are generally strong at local level. A Local Dental Committee (LDC) survey carried out at the height of dental concerns just after the new system had launched found that the majority of Committees reported good relationships with their local PCT even at that very early stage.

Patients' access to NHS services

26. The key gain of the new system is the ability to stop the previously relentless decline in access in a system where access was driven by business decisions made by individual dentists. The first 18 months have seen access stabilise—despite the need to re-commission services for around 900,000 people (those affected by the 4% of activity previously delivered by the one in 10 dentists who decided not to join the new system). The latest figures show numbers of patients seen at over 99% of service levels pre reform.

27. The main gains through this year have been at local level. Some previously very hard-pressed areas have seen nothing less than a transformation of access for local people. Milton Keynes, the Isle of Wight and Gloucestershire have seen particular successes in addressing long standing access issues.

28. At national level we expect services to grow as new services come fully on stream. The NHS is now commissioning more service than before the reforms and as services and performance mature, we should see a matching increase in services delivered. The Government is committed to growing access year on year.

29. But the NHS also needs to get much smarter at putting dentists with availability together with patients looking for a dentist. A dentist can take on new patients only when their current appointment book allows, whether or not they work in the NHS or only offer private care. This fact of high street dental life can lead to a feeling among the public that NHS dentists are scarce even in areas such as London where the reality is that supply actually outstrips uptake of services in many localities.

30. In these areas, the problem can be as much that patients cannot easily locate those practices that do have availability than one of overall local shortage. It is crucial that patients have a quick uncomplicated way of identifying local practices and, if they then have difficulty in finding one able to take them on, accessible help from the PCT.

31. This is why we have taken action to ensure that patients find the process of finding out whether there are local dentists taking on new patients increasingly simple. Many PCTs are already providing dedicated help lines. These have provided popular with patients and very effective in ensuring that when new capacity is made available those patients actively seeking care are made aware of the new service.

32. Nationally patients can find information on dentists via NHS Direct and NHS Choices. The information on NHS Choices has recently been strengthened by adding a telephone number for each PCT for people having difficulty finding a dentist to ring. This should drastically reduce the number of contacts individuals make before finding a suitable dentist.

33. We are currently consulting with the NHS on proposals to extend the NHS logo and identity to NHS dental practices. Historically dental practices have not had a high NHS profile. This, depending on the outcome of the consultation offers the opportunity for committed NHS dentists to badge their services more clearly as part of the wider NHS family.

The quality of care provided to patients

34. It is worth stating that patients are entitled to expect to receive, as of right, high quality dental care from dental professionals. We all take it as a given that an individual medical professional will deliver care to the highest professional standards and the dental profession and the NHS expects no less from dentists.

35. Concerns have been raised about the reduction in length and complexity of treatments seen since the reforms. However, we believe that this is broadly speaking an appropriate response to the greater clinical freedoms the new system has delivered—evidence that dentists are indeed off the drill and fill treadmill.

36. But it is essential that the NHS and practitioners can demonstrate that local patterns of care are appropriate to local treatment needs. In areas of poor oral health for example one would expect to see complex treatment forming a higher proportion of all treatments than in an area with better oral health and therefore less decay.

37. This is why we are introducing an enhanced clinical data set which will provide information which commissioners and providers can use to check care is appropriate to need. This core data set, which will be in place from 1 April 2008 has been broadly welcomed by patient groups, the profession and representatives of dental laboratories.

38. The new system is one of averages. It depends on dentists moving from the culture of a piece work system to one where the cost of treating one patient is offset by another needing little or no intervention. Some dentists have found this more challenging than others.

39. Outright malpractice, deliberately under treating patients for financial gain is rare. Dentists as ethical professionals have of course a duty to provide all care required—most would be shocked by suggestion they would under-treat to make an illegitimate profit at the expense of their patients, the NHS and taxpayers.

The extent to which dentists are encouraged to provide preventative advice and care

40. There was a consensus that the old general services contract was inappropriately focused on active treatment. The new contract has preventative advice included in Band 1 course of treatment. Dentists have expressed concerns that there is no explicit preventative "item of treatment". In our view, this is a hangover from the old way of thinking where every action had an individual price tag.

41. The calculation which set levels of UDAs required to deliver the same income as under the old system (for dentists moving from the old to new system) deliberately required 5% less active treatment to free up the time required for preventative care. In practice and as expected further time has been freed up by the marked reduction in length and complexity of courses of treatment.

42. The PDS pilots demonstrated that dentists are extremely keen to provide more preventative care. However, it also highlighted the lack of available evidence about what preventative treatment is actually effective. The Department has now produced a tool kit, "Delivering Better Oral Health" which provides for first time objective evidence on what preventative care works. The tool kit has been sent to all NHS dental practices and is also available on line at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078742

43. But, important as it is to ensure dental professionals have the time and materials to provide effective preventative treatment, we need to remember that all the evidence is that population level changes in oral health status are driven by factors outside the dental surgery.

44. The introduction of fluoride in toothpaste has been the key factor in delivering the markedly reduced decay in younger people. Fluoride toothpaste was introduced from the early 1970s onwards. It is sobering to remember that before this, dentists—despite their best efforts—were largely a disease service.

45. Fluoride toothpaste has not however reduced the variation in oral health between different socio economic groups. To date the only factor with a transformative impact on oral health across the social groups is the fluoridation of water. Data from oral health surveys which draw comparisons between areas with fluoridation schemes and those where no fluoride is added to the water supply, show that fluoridation is capable of countering the association between dental disease and social deprivation.

46. The government is committed to reducing inequalities in oral health. This is why the legislative framework governing fluoridation has been amended to give communities with high levels of dental decay a real choice of having their water fluoridated. If, after conducting consultations a Strategic Health Authority (SHA) finds that local people are in favour, it may require a water provider to fluoridate the water supply.

Numbers of NHS dentists and the numbers of patients registered with them

47. As at 31 March 21,041 dentists were listed on NHS contracts open at that date. This about the same as at 31 March 2006 although the new figures contain around 500 dentists employed directly by the NHS who were not included in the previous figures.

48. However, it is important to bear in mind that for dentistry pure headcount data, as this is, is a particularly weak indicator of levels of service. Most dentists combine private and NHS activity but there is no way of telling from the headcount whether an individual listed spends 10% or 100% of his or her time on NHS care.

49. A much stronger measure is whether PCTs can find providers to deliver commissioned activity and in turn, whether those providers can recruit dentists to deliver the clinical care.

50. One of the most striking features of the last year has been the improvement in the availability of providers looking to deliver NHS dental activity. In contrast with previous years, PCTs which have gone to tender have often had multiple bids to select a preferred provider from.

51. The new system has freed patients from the requirement to register with a particular dentist. Patients are therefore not nationally recorded as belonging to an individual practice or dentist as they were before (although most practices will continue to run practice "lists" just as they did before registration was introduced in 1990). Numbers of patients in regular contact with NHS dental services continue to be monitored through the count of the number of patients seeing an NHS dentist one or more times in any 24 month period.

Numbers of private sector dentists and the numbers of patients registered with them

52. Headcount information on dentists who currently work entirely outside the NHS has never been collected by the Department. Such dentists are not required or expected to make returns on patients they see privately. Similarly, dentists are not required to report details of patients receiving entirely private care to the centre. We can make some estimate of the level of private dental activity. This suggests around three quarters of all courses of treatment are delivered in NHS and a quarter privately.

53. Historically patients receiving private treatment have not had the same level of protection against clinical error as those receiving NHS treatment. This was particularly true where the dentist was operating outside the NHS system.

54. Action is in hand to provide stronger quality assurance for the NHS and for the first time to regulate the private sector.

The work of dental care professionals

55. Dental practices are now able to use dental care professionals—dental therapists, dental hygienists, orthodontic therapists and dental nurses—more flexibly and efficiently. This results from:

- legislative changes which have empowered the General Dental Council to introduce mandatory registration for Dental Care Professionals (DCPs) replacing restrictions on the range of their duties with a general principle that DCPS may practise within the competencies they have acquired through training and experience; and
- the replacement of the item for service system of remuneration with the local commissioning that allows dental practices to organise its workload to make full use of the skills of its staff.

56. These changes have brought challenges on the use of dental hygienists where the changes in recommended recall intervals recommended by National Institute for Clinical Excellence (NICE) and improvements in oral hygiene have reduced the clinical need for scaling and polishing. Most dental schools now provide a joint dental therapist/hygienist training course with opportunities for existing dental hygienists to undertake top-up courses in dental therapy.

Dentists' workload and incomes

57. The new contracts were aimed at freeing up dentists to deliver the care that was clinically indicated. The new arrangements have reduced the workload required of dentists while maintaining their income levels. The new system has, for contract holders, created stability of income alongside an increase in total income:

- The regular payments made to providers under the contracts give a guaranteed monthly income for pre-agreed levels of work across the whole year.
- The information published by the Information Centre in October on changes in patterns of treatment shows dentists are on average carrying out simpler and shorter courses of treatment—reducing workload and expenses.
- Existing general dental service (GDS) dentists had a 5% cut in the number of courses of treatment required (for same contract value) on transfer to the new contracts.

58. The new dental contracts also provide dentists with the long-term financial security they did not have under the old item of service system. GDS contracts are open-ended and allow dentists to agree their services and delivery pattern with PCTs along with any necessary variation to allow for staff changes etc. This provides a regular income stream every month, a month in arrears: a major improvement on the previous system where claims had to be submitted and agreed after the conclusion of the course of treatment with payment taking another four weeks on average. This improves cash flow and financial planning and significantly reduces the cost of working capital. It also allows agreed activity to be planned across the financial year to allow for holidays, training etc.

59. Dentists and the NHS have also asked us to provide a better indicator of clinical workload. We have taken account of these issues and have recently announced our intention to enhance the data provided by dentists to give a better indication of the clinical workload: although it will remain a relatively simple system to use and administer. This is intended to begin in April next year and should answer many of the criticisms from the profession that the current system does not allow for fair comparisons between practice workloads.

60. Although the transition period for the new contracts and the associated guarantees for dentists and ring fencing arrangements for PCT dental budgets were set at three years from April 2006, we do not expect any major changes to take place at the end of this period. PCTs and their dental providers should be building up long term, mutually beneficial working relationships. PCTs are highly unlikely to sever service contracts, provided there has been no serious breach of contract requirements or service standards.

61. The main significance of the three-year period is that, during this period, money from contracts that lapse through retirement, dissolution of practices, etc has to be used by the PCT to re-provide more dentistry. This gives real stability; neither before nor after the transitional period can a PCT unilaterally reduce the remuneration given to a provider.

The recruitment and retention of NHS dental practitioners

62. One of the main concerns about the new system as it was set up was whether enough dentists would join to ensure a viable service. In the event nine out of 10 existing dentists decided to sign the new contract. One of the earliest and most striking gains of the new system was that contrary to expectations in the dental world the new system had a galvanising effect on would be providers of NHS services.

63. The one in 10 dentists who left represented around 4% of all activity. (This reflected the fact that those who left were on average those with least commitment to the NHS). This 4% was fully re- commissioned at national level within six months of the launch of the reforms. PCTs, initially to their considerable surprise, have continued generally to find no shortage of takers when they are in a position to offer additional NHS activity.

64. The experience of the first 18 months suggests there is a strong appetite among many dentists to expand their NHS practice—the new commissioner led system means that for the first time expansion is not the random by product of a business decision but can be managed and targeted on areas of shortage.

65. For hard pressed NHS commissioners it was startling to find, after years of having to seek dentists from overseas that they were in a buyers' rather than sellers' market. This was equally salutary for dentists.

66. There is no room for complacency on the recruitment and retention of NHS dentists which is why we have expanded the training so significantly. Nor do we underestimate the residual concerns many providing NHS services still have about their place in the new system. But by no stretch of the imagination can we say there is a current crisis of recruitment or retention in terms of supply of dentists wanting to provide NHS services. This is the first time in many years this could be said and is no small first achievement for the new system.

Department of Health

6 December 2007

Memorandum by Dr Jillian Pritchard (DS 02)

I am a consultant in GU/HIV Medicine working at St Peter's Hospital, Chertsey, Surrey.

Provision of dental care for HIV positive patients is a very difficult matter. A few years ago we had a community dentist who was able to provide a good free service for these patients. Many have poor dental health and require extensive work. It is self evident that poor oral health has a significant deleterious effect on their general health. Referral of this sort also had a greatly beneficial effect of allowing patients to declare HIV status without any fear of disclosure. Dentists, especially private dentists, anecdotally are not great fans of HIV positive patients. At present I have a number of patients who cannot afford private dentistry because they do not work and others who would not attend a private dentist for fear of the consequences of disclosing HIV status.

We need a good provision of NHS dentists and especially dentists who work in the trust setting where they can readily treat patients who for reasons of HIV or other stigmatising condition do not currently fit into the system.

Dr Jillian Pritchard

15 October 2007

Memorandum by Mrs H Diane Martin (DS 03)

I welcome your inquiry into NHS dental and orthodontic services, because I feel very demoralised by the current state of affairs. I qualified in 1981 and I have always worked in general practice providing care for NHS patients. Until this new contract was imposed I had considered my work to be appreciated and well rewarded. Now I feel there are major problems with the service and the remuneration.

The reforms were sold to us as a means of improving work balance by removing the "treadmill" of piece work, and to improve our ability to practice preventive dentistry, ie; advising to improve dental health rather than just treating disease. As far as I am concerned the connection between "work done" and "pay earned" is just as close yet not as fair, and there is a negative incentive to practice preventive dentistry.

1. Under the old contract some dentists provided large volumes of complex work attracting huge gross payments which translated to 12 UDA's per course. Under the new contract they were allocated the same gross but can now provide just one crown per course and easily achieve their target UDA's. And more annoyingly they now have a reduced laboratory bill and thus are earning more money for doing less work. Why did no-one think to make laboratory bills part of the equation?
2. We were told how many UDA's we were to provide for the same gross earned the previous year, yet there was no way we could check if that figure was correct. Now we are striving to achieve a target which is totally unrealistic, and for which the goals keep changing. Our interpretation of the rules differs from those of the PCT and the Practice Board in Eastbourne. We do not know how the Bands were allocated historically, whether the difference between Band 2 and 4 could be applied accurately by someone looking at old claims, not knowing the circumstances under which the patient attended on each individual visit. Over a year the accumulated score can alter considerably if more courses were allocated as Band 2 rather than as Band 4. Now we are committed to achieving an inflated target.
3. I feel the target is also inflated because under the old contract we were able to make a separate claim for each child we saw who required an orthodontic examination. Thus our historical gross included this value but now under the new contract there is no possible way to earn the equivalent UDA value, so to make-up for this discrepancy we have to squeeze more patients into the time available.
4. Achieving Band 3 for most regular patients is quite easy but they are subsidising those patients who have neglected their teeth. If a patient needs a number of fillings we have to try and squeeze as much treatment as possible into each visit, as each visit after the first means no UDA's are being earned for that time. Doing a lot of work in one visit is not ideal. Historically treatment could be split, for example extracting a tooth, waiting for healing then adding onto a denture. This would have given two Band 3 courses, however now the patient pays for a Band rather than for the actual treatment we have to hold the first course open and only gain one Band 3 for the same work undertaken. Again making it harder to achieve targets.
5. There is a considerable problem with patients not keeping appointments. Under the old system we were able to make a charge, this helped encourage patients to attend and made up for loss of earnings. Now we are told there is no loss of earnings as a result of a patient failing to attend, but there is a potential for claw back at the end of the year if targets are not met. It is impossible to make-up lost time in a day, once an appointment is not used it is wasted time. A no show means no UDA and reduced earnings indirectly.
6. I have had to reduce my target of UDA's (hence my gross) to make the target reasonable, or rather to make my daily workload manageable. I have to earn 25 UDA's per day, this doesn't sound a lot about 4/hour. But if most patients are in the middle of a course on some days my total could be as little as 8, so I have to make the rest up on other days. The pressure is immense. I can afford to give a patient just 15 minutes for a full examination, scale and give advice. Where is the time for prevention?

Mrs H Diane Martin

12 November 2007

Memorandum by David G Hillam (DS 04)

DENTAL SERVICES

Executive Summary

Following closure of three dental schools in the 1980s, there is now a shortage of dentists to manage the increasing demand and need from an aging population requiring complex dental treatments (restorative and periodontal). Good preventive care, such as can be provided by hygienists, could reduce the need for simple treatments. However, current trends are for the training of more dental therapists to perform these more simple treatments, at the expense of hygienist training. Furthermore, the duties of therapists are extending to permit much of the work of the general dentist and there are moves for them to work independently. Quality of care will ultimately suffer if therapists are allowed to work as independent "dentists" with only 102 weeks training. The numbers of hygienists should be increased, not reduced. At present one of their roles is advice on smoking cessation. This could be formally extended to include dietary and other advice on obesity and on alcohol intake.

The submitter of this written evidence was a Consultant in Restorative Dentistry specialising in periodontology (diseases of the gums and supporting structures of the teeth) for 25 years, a post that was combined with Directorship of a training school for dental hygienists. He is also a former General Secretary and President of the European Federation of Periodontology and former President of the British Society of Periodontology. Other positions he has held include Clinical Manager of a Dental Hospital, chairmanship of the national Panel of Examiners for dental hygienists (GDC) and membership of numerous dental advisory and other committees at local and national level. He retired from active practice in 2001.

Evidence

1. The parts of the committee's remit that I wish to comment on are:
   (a) The work of allied professions, (dental hygienists and therapists).
   (b) The extent to which dentists are encouraged to provide preventative care.
   (c) The quality of care provided to patients.

Background

2. Up to the late 1950s, there were two training programmes for dentists, a four-year course leading to the LDS qualification in addition to 4.5-year and five-year programmes leading to the more academic BDS qualification. The LDS was phased out in favour of the, longer, more comprehensive courses.

3. Dental hygienists were introduced by the RAF during the war, followed by an experimental civilian scheme in the 1950s. This proved to be a success and national training programmes began throughout the UK in the 1960s and 1970s. Approximately 200 were trained each year. Their work includes the treatment of periodontal diseases (these rival tooth decay as a cause of tooth loss), the prevention of all oral diseases, taking radiographs, etc. Their course of training is currently two years long (minimum 90 weeks study[1]).

4. Also in the 1960s, when levels of decay in children were very high, therapists were introduced to do simple restorative and preventive treatments for children.

5. Towards the end of the 1960s, the introduction of fluoride toothpastes reduced levels of decay over the next decade and it was feared that there would be an over-supply of dentists. As a result, three UK dental schools closed in the 1980s despite some of us warning that the British public had become accustomed to restorative dentistry (as opposed to extractions and dentures) and the aging population will require more complex, difficult restorative work to maintain their heavily restored dentitions. This proved to be true, and at the present time there is a large need and demand for crowns, root canal treatments, bridges, implants, etc. Not only this, but with more teeth being preserved, more teeth are exposed to the risk of periodontal diseases leading to a greater demand for hygienists and dentists.

Recent Trends in the Delivery of Dental Care

6. There has been an expansion of the role of therapists so that they are now permitted to undertake most of the more routine tasks of dentists after only 2.25 years training (minimum 102 weeks study[1]). Their work is no longer restricted to children and they are now permitted to work in all areas of dental practice.

7. There is a lack of clarity on what therapists are permitted to do, causing confusion to therapists and dentists alike. In addition to "*simple*" procedures, the GDC states that they must "*Have a knowledge of advanced restorative techniques for both dentitions*", ie children and adults. "Knowledge" is defined as "*A sound theoretical knowledge of the subject but may only have limited clinical/practical experience*"[1].

[1] GDC Publication. Developing the Dental Team. Curricula Frameworks for Registrable Qualifications for Professionals Complementary to Dentistry (PCDs). September 2004.

Furthermore, the same document states "*there should be no barrier to prevent PCDs* [including therapists] *expanding their range of skills" and they are "Permitted to practise in respect of those responsibilities for which they have received education and training . . . and for which they have received authorisation from a registered dentist*". It would appear from this that therapists may practise the whole range of dentistry, so long as they convince themselves and a dentist that they have received training and are competent.

8. Moves are now afoot to allow diagnosis/prescription by hygienists and therapists and for them to be allowed to set up independent practice. Indeed, the regulations have already been changed that will ultimately enable them to set up their own businesses. As a result, I foresee the possibility of a grade of "dentist" appearing in the "High Street" with training of only 102 weeks. (Compare this with the phasing out of four-year trained dentists referred to in paragraph 2 above.)

9. The training of therapists is being progressively combined with that of hygienists. There are now very few places for the training of hygienists only.

10. The recent scarcity of dentists has brought with it the need to import dentists from overseas, the training standards of whom are not monitored by the GDC in the same way as home-educated dentists. Many of the countries from which we import these dentists cannot afford the exodus of their personnel. I believe that we should be exporting our skills to less well-developed countries, not vice versa. Also, the GDC's Fitness to Practise hearings seem to be dominated by overseas trained dentists who have failed to match up to expected standards.

Possible Consequences

11. I fear that the quality of care provided to patients is in jeopardy because of the short training of operating dental personnel (hygienist-therapists) and the need to import overseas dentists whose training has not been monitored by the GDC.

12. The risk is enhanced because of lack of clarity in the regulations. There is no longer a "red line" that must not be overstepped. I believe there will always be unscrupulous practitioners who will be tempted to work beyond their level of competency and the situation will be impossible to police.

13. There is taking place a serious reduction in the number of dental hygienists who play such a major role in the prevention of oral diseases. This is to be deplored.

Motivation and Job Satisfaction of Dentists, Hygienists and Therapists

14. I believe that the profession tends to attract two main personality types. They are, of course, not mutually exclusive but are a guide to those aspects of their occupations that provide greater job satisfaction:

Type 1. Perhaps the more traditional type. They are motivated by an attraction to the practical aspects of dentistry; intricate fillings, crowns, bridges, implants, aesthetic improvements to the teeth. The "precision engineering" aspects.

Type 2. These are motivated by a more "biological" approach; prevention, the treatment of gum diseases, care of the soft tissues of the mouth and the general health of the patient.

15. I believe that the current trend towards therapists is attractive to Type 1 individuals, perhaps those that cannot achieve the requirements to become dentists. This trend is at the expense of hygienists (Type 2), many of whom do not want to perform the extended duties of a therapist but who gain their job satisfaction by successfully treating periodontal diseases and motivating patients to prevention rather than by undertaking restorative treatments.

16. There is anecdotal evidence that some applicants for hygienist-therapist courses do not want to do therapy, but are forced into it because of the lack of places for hygienist training. Also, there is a high demand from preventively-minded dentists for the very limited supply of hygienists, not therapists. It could be argued that their preventive methods are so successful that they do not need therapists to undertake simple work.

What is needed?

17. Diversion of resources to ensure that the UK has sufficient, well-trained, general dental practitioners to undertake most of the increasing amount of complex work needed for the aging population (restorative and periodontal), and also to encourage more preventive dentistry.

18. Improved referral services for cases of advanced periodontal diseases, by introducing consultant posts in periodontology, fully supported by hygienists. The present Consultant in Restorative Dentistry has to cover; restorations, root canal therapy, bridges, implants, dentures, etc. (Type 1), as well as the whole range of periodontal diseases (Type 2). It is just not possible to keep up with all the new knowledge and maintain expertise in all these areas of dentistry.

19. Expansion of the numbers of dental hygienists, sufficient to provide a comprehensive dental prevention service to the whole population as well as supporting the general and specialist dentist in the treatment of periodontal diseases. If preventive services improve sufficiently, there will be less need for therapists. In other words, there should be a reversal of the current trend to train therapists at the expense of hygienists.

20. Amongst other duties, the work of hygienists includes:

(a) The removal of calcified bacterial deposits firmly attached to teeth within deep gum pockets where gums have detached from teeth following bone loss. This is technically a difficult, time consuming task and can only be done at its best by people whose skills are maintained by spending a high proportion of their time doing it.

(b) The giving of preventive advice to patients on thorough tooth cleaning (especially important and difficult in patients with periodontal diseases).

(c) The application of solutions to teeth to prevent decay and also to treat tooth sensitivity.

(d) Giving advice on smoking cessation. (Smoking is linked to oral cancer.)

(e) Giving dietary advice for the prevention of decay.

21. This could easily be extended to include:

(a) Dietary and other advice on obesity.

(b) Advice on alcohol intake.

22. The training of all groups (dentists, hygienists and therapists) must include experience in all environments where they may practise in future. At present, there is a trend for training to be predominantly (in some cases exclusively) in "outreach". In this environment, students are not exposed to difficult, referred cases and may be less able to recognise or cope with the treatment needs of this group of vulnerable patients, or to provide adequate support to consultants, without additional training.

D G Hillam BDS, MDS, FDSRCS

October 2007

Memorandum by the British Endodontic Society (DS 05)

NHS DENTAL AND ORTHODONTIC SERVICES

The British Endodontic Society (BES) welcomes the opportunity to submit evidence to the Health Select Committee inquiry into the new GDS and PDS contracts. Root canal treatment is a therapy aimed at preventing or treating apical periodontitis, a prevalent disease process caused by infection of the root canal system within a tooth. The complexity of root canal treatment varies from a straightforward single root canal to complicated molar teeth with four or five root canals. This is precise and fine work which requires time in order to achieve a quality result, the instruments are also costly and disposable. Many practitioners have made a significant investment in equipment (eg magnification loupes, microscopes, electronic devices to help measure the length of teeth, endodontic motors etc) in order to carry out this treatment to modern standards.

The dental health of our younger population has improved, however the restorative and endodontic needs of older adults are likely to increase. This reflects the fact that people are retaining an increasing number of teeth for longer. In 1998, 50% of middle aged adults in the UK had teeth with fillings (Pine et al, 2000). There will be an ongoing need for complex restorative care of this aging population, despite a younger, healthier cohort following through. Future decennial surveys of adult dental health will be important in monitoring this trend.

The 2001 Health Committee report raised several important issues in regard to dental provision, including access to NHS Dentistry and the remuneration system. The introduction of the nGDS contract April 2006 saw significant changes in the way NHS dental services were commissioned. The British Endodontic Society is concerned that the introduction of the UDA monitoring system does not recognise the time, skill and expense of providing root canal therapy procedures.

BACKGROUND, QUOTED FROM THE 2001 HEALTH COMMITTEE REPORT

> "Para 27 under quality of care considered written evidence from one GDS dentist regarding details of the low success rate of NHS endodontic (root canal) treatment (10%), as measured against European radiographic standards. He noted additional costs to the service this sub-standard care imposed and discussed the reasons why it occurred, which he ascribed to the lack of time and the use of ineffective and out dated techniques and materials. His comment sums up the problems:"
>
> "What is required is more time and the use of adequate equipment that is expensive, neither of these can be funded by the very low NHS fees."
>
> "Para 28. The DoH did not accept that there was hard evidence to suggest that the quality of NHS dentistry is not up to the standard they expect. They pointed to the regulatory system; the comprehensive inspections undertaken each year by the Dental Reference Service, and the introduction within the GDS of clinical governance and clinical audit. In response to the evidence quoted above, Dame Margaret Seward, the Chief Dental Officer, told us;"
>
> "the report . . . actually was saying that the way the filling was put into the root canal failed against European endodontic standards and, as you quite rightly quoted, [the success rate] was 10%. What it did not actually say was that the whole root filling had failed, it was the way that the root canal had been filled with the material. As we call it. In the report it did admit that the technical quality of the root filling does not necessarily affect the outcome. There are a million canals root filled and we do not have great numbers of them failing."

THE BRITISH ENDODONTIC SOCIETY COMMENTS

We believe Dame Margaret is referring to the survival rate of teeth treated by root canal therapy in the NHS, such information has not been available until recently. Lumley, Lucarotti and Burke (submitted for publication) have demonstrated a 74% survival rate of teeth treated by root canal therapy in oGDS without any further intervention over a ten year period. This work demonstrates the value of such therapy to patients and the NHS. Although considerably higher than 10% this figure does remain 23% lower than survival rates reported through the Delta insurance scheme in the USA, an alternative remuneration system (Salehrabi R, Rotstein I. 2004).

All parties are concerned about quality of care and outcome for the patient. A GDS dentist in 2001 raised the issue of low fees in regard to root canal therapy which can be complex and time consuming to deliver. The nGDS contract has seen significant changes in the way dentists are remunerated moving from fee per item to a contract with a PCT monitored against a number of UDAs which are calculated from bands of treatment. Root canal therapy may be performed as part of a band 2 or band 3 course of treatment and is completed by definitive restoration of the crown of the tooth. In the current monitoring system the dentist receives the same number of UDA's for restoring the tooth regardless of whether a root canal filling has been placed or not. Root canal therapy involves preparation and disinfection of the root canal and placement of a root filling. This will normally take between $\frac{1}{2}$ and $1\frac{3}{4}$ hours in routine cases depending on tooth position. More complex tooth anatomy and heavily infected teeth require more time. The British Endodontic Society suggest that this additional time and care is not recognised under the current UDA monitoring system.

This situation has been compounded by the recent introduction of single use instruments which places an additional financial burden on the nGDS dentist.

Many infected teeth can be retained by root canal therapy, the alternative way of rendering patients dentally fit is to eliminate pain and remove infection by extracting the tooth. The preliminary results of the dental treatment band analysis in England from April to July 2007 demonstrate that there has been a reduction in approximately 45% of adult courses of treatment that contain a root-filling episode from 2003–04 to 2007 and an increase in extractions.

The British Endodontic Society is concerned that the UDA monitoring system does not appear to recognise the placement of a root filling and that the introduction of single use instruments may result in teeth which could be reasonably saved being extracted. Extraction is a simpler procedure, takes less time and has the same recognition under the UDA monitoring system. Extraction of a tooth and replacement with a single tooth partial denture carries four times the recognition (12 as opposed to three UDA's), takes less time to deliver but does involve laboratory work.

In summary the British Endodontic Society requests the UDA monitoring system be reviewed in and modified in order to recognise the time and skill required to perform root canal therapy in nGDS to appropriate standards.

Professor PJ Lumley
President British Endodontic Society

December 2007

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Memorandum by CHALLENGE (DS 06)

NHS DENTISTRY

Executive Summary

1. This submission, produced by CHALLENGE argues that while many of the principles underlying the reform of NHS dental services were to be welcomed, the manner of their introduction has been seriously flawed. In particular, key areas of the reforms have been introduced without the necessary preparatory work and forward planning.

In consequence, the new arrangements have failed to provide many of the important benefits that the DoH wished to achieve: there are growing inequities in access to care; the quality assurance mechanisms are woeful, and there are few, if any data to answer the specific questions that the Health Committee wishes to investigate. Furthermore, as numerous external agencies have highlighted, considerable risks remain.

The PCTs are, in the majority, ill equipped to handle local commissioning of NHS dentistry largely due to the lack of data on which to base any commissioning decisions, growing inequalities in care arrangements, a lack of quality assurance arrangements, and a growing likelihood of unemployment for expensively trained dental personnel.

We conclude our submission by offering our ideas on a positive way forward to try to resolve the many difficult issues facing the parties involved. In order to help those with limited time to spare our conclusions are outlined in the next part of this paper.

Proposals

2. CHALLENGE would argue that reforms to the previous NHS dental service were required and, providing sensible proposals with an open dialogue are introduced, a new arrangement could work with the support and good will of all sides.

3. The attitude of all parties needs to be moderated. The increasingly personal fighting that has been raging for the last 20 months must cease and a semblance of peace must be restored if progress is to be made. The Health Committee might wish to promote a new working relationship between the Department of Health and the dental profession. That relationship is, according to many commentators, irretrievably damaged. For the good of the population's oral health that situation cannot be accepted, efforts must be made to rebuild it.

4. The present arrangements have led to a polarisation of the parties. The factions should meet in public and discuss their problems afresh but based on a clear understanding of what is to be achieved. If the dental profession can be convinced that real improvement is the goal this move could herald real progress.

5. The NHS must once again be seen as a "a good employer" or "a trustworthy contracting partner" if the downward spiral of NHS dentistry is to be reversed. This may require some acknowledgement of past errors and a new policy direction.

6. PCTs need staff who will be capable of commissioning dental services in an appropriate manner. The current programme of training and education is weak and the low priority given to dentistry by PCTs means that few staff have remained in position for sufficient time in order to develop a working relationship with the dental providers.

7. The payment system needs to be completely overhauled. The work undertaken in Personal Dental Services (PDS) pilot sites from 1998–2005 needs to be revisited and the perceived failures ironed out. The PDS contracting model came from an earlier report "Options for Change" that was widely supported by the profession. Going back to that model and that report would be seen as a very positive step.

8. The new contracts were introduced with many legal features that favoured the PCT to the detriment of dentists working under NHS regulations, those issues need to be addressed sensibly and modifications agreed.

9. The issue of patients' charges need to be re-examined. Cost remains the biggest single barrier to accessing care. Alternative mechanisms for raising revenue to fund dental care should be explored.

10. New funding arrangements that make best use of allied professionals easier in general practice, especially where dentists are difficult to recruit, should be created.

An introduction to CHALLENGE

11. CHALLENGE is a dental political pressure group (formed in October 2006) seeking to persuade the Department of Health to alter the way that NHS dentistry works. Our members do not believe that NHS dentistry is working for patients and it is certainly not supporting the many thousands of dentists who would still like to work for the NHS.

The three founder members of CHALLENGE are:

Eddie Crouch, Secretary of Birmingham Local Dental Committee, Chairman of the Annual Conference of Local Dental Committees 2008 and an orthodontic practitioner in Birmingham.

John Renshaw, former Chairman of the British Dental Association (2000–06) and general dental practitioner in Scarborough.

Ian Gordon, Chairman of Tees Local Dental Committee and a general dental practitioner in Teesside.

We have sought help in the writing of this response paper from Paul Batchelor, Consultant in Dental Public Health and University Lecturer.

Background to this enquiry

12. The current contracting arrangement for the provision of NHS dentistry has been in place for 20 months but it is still causing severe problems. In many places patients are unable to gain access to NHS care and dentists are still leaving the NHS for the private sector. The situation has been investigated many times recently by several important bodies.

13. The Prime Minister (Tony Blair) in 1999 stated in a Party Conference speech that he would make sure anyone who wanted to could see an NHS dentist. The Health Committee itself, under then Chairman, David Hinchliffe, looked into access to NHS dentistry in 2001, the Audit Commission looked at NHS dentistry in 2002, the Office of Fair Trading looked at private dentistry in 2003 and the National Audit Office looked at NHS dentistry in 2004. Following the external assessments, new contracts were introduced supposedly to support dentists providing NHS dentistry. However, the problems have not been solved; there have been patient focused reports on NHS dentistry from the Citizen's Advice Bureau, the Consumers' Association and the Patients' Association.

COMMENTS ON THE HEALTH COMMITTEE'S INQUIRY

14. CHALLENGE welcomes the opportunity to submit evidence to the Health Committee and to comment on the principles underlying the reforms of dental services that were introduced in April 2006 and in particular the extent to which the changes have been consistent with the principles.

15. The benefits for patients outlined by the Chief Dental Officer at the time were:

- to improve access to NHS dentistry;
- to improve oral health; and
- to reform and improve NHS dental services.

16. To achieve this, the Department of Health proposed to introduce new working arrangements and ensure a fair deal for dentists and their teams. The benefits for the dental team included:

- more time to be spent with patients;
- more time to allow improved quality;
- less bureaucracy; less work pressure;
- the ability to plan and invest in their businesses;
- integration with the NHS National Programme for IT; and
- a chance to modernise premises with the help of the NHS.

17. Using these objectives, our submission will address the nine key points in turn that the Committee wishes to explore. In addition, CHALLENGE will also comment on the future issues that will need to be addressed if the overall objective of a fair and equitable NHS dental care system is to operate within England.

Comments on the Nine Key Issues Outlined in the Health Committee's Terms of Reference for this Inquiry

The role of Primary Care Trusts in commissioning dental services

18. Low staff numbers, inexperience and high rates of turnover amongst PCT personnel have to date produced widely variable success in managing NHS dental services. There is clear evidence to show that relinquished contracts are not being rapidly re-commissioned and important commissioning decisions have been influenced by internal PCT budget considerations. There is a lack of transparency within PCTs to allow an assessment of dental expenditure, or indeed on commissioning arrangements. Bureaucratic processes vary widely, even in similar localities, with a postcode lottery affecting policy and service delivery. There is suspicion of favouritism and a lack of openness in commissioning procedures, "preferred providers" receiving favourable treatment, with the winning factor often declared to be "value for money" but the criteria used being obscure and, in particular, the patients' voice is absent.

Numbers of NHS dentists and the number of patients registered

19. While the number of NHS contracted dentists has risen, as has been highlighted in other reports, this does not necessarily equate to overall increased capacity. There is a lack of accurate and sophisticated data on the whole time equivalent (wte) workforce. In reality, the NHS has no idea how many dentists actually work in the service.

Patients no longer "register" with an NHS dentist. The new contracts abolished registration. Many patients find this a real mystery. They still value and regard "registration" as a most important feature of NHS dentistry.

The new measure of patient activity is the number of patients who have been seen in the last 24 months. Given that the new arrangements have only been in place for 20 months that data are invalid. What data do exist highlight a considerable growth in the non-NHS sector suggesting increased inequalities.

Numbers of private sector dentists and the number of patient registered with them

20. Estimates vary and no data are held centrally but survey work undertaken by CHALLENGE suggests that there may be as many as 2,000 wholly private practitioners in England and they, along with the many thousands of practitioners who provide a mixture of NHS and private treatment, may be providing privately funded care for as many as 7.5 million patients.

The work of allied professions

21. Allied professionals may be able to make a contribution under the new arrangements but currently the numbers of such trained professionals are relatively small. We would wish to split the allied professions into two categories: clinical operators and non-clinical operators. For the clinical operators, namely dental hygienists (4,000) and therapists (400 qualified in 2006), due to their small numbers and the current structure of dental premises, the opportunities for benefits through their increased adoption are limited. Furthermore, the only major review of the cost-effectiveness of their employment showed few if any financial benefits. The other allied professionals, especially dental nurses, are crucial to the efficient and effective running of dental practices. However we would wish to draw to the attention of the Committee that, due to the General Dental Council's new registration requirements for dental nurses, there is a growing risk that many practices will be unable to comply fully with the necessary requirements and may even have to cease delivering care in July 2008. Currently less than 8,000 of the notional total of 40,000 dental nurses are registered and therefore compliant.

Patients' access to NHS dental care

22. We wish to break this issue into two separate questions. First, can a patient find an NHS dentist willing to take them on when he or she wants one and, second, if an NHS dentist can be found, will that dentist be willing or able to provide the kind of treatment the patient needs?

The answer to the first question is that NHS access remains patchy. If you live in Bradford or Teesside you will probably find access fairly easy. If you live in Epsom or Winchester you will not be so fortunate. This is yet another NHS postcode lottery. In some areas, like Birmingham, where access was never a problem under the old system, there have been signs of an access problem for the first time.

The second, new and additional access problem—the availability of appropriate forms of treatment through NHS arrangements—is a direct result of the introduction of the new contracts in April 2006. There is growing evidence of a substantial alteration in prescribing patterns within the NHS. The pattern of the changes would suggest that patients are getting inferior care with less and less advanced work being carried out.

The quality of care provided to patients within the NHS

23. The present arrangements have completely removed the most cost-effective quality assurance mechanism that existed anywhere in the world. NHS dental contracts are now monitored solely by counting Units of Dental Activity (UDAs) with no capacity for the quality of the treatment to be assessed or rewarded. The Department of Health wanted simpler courses of treatment, but there is no evidence to suggest that simpler treatment is the kind of service patients need or want. No part of the new contract allows additional rewards for dentists who provide quality care with quality treatment planning appropriate to patient needs.

The extent to which dentist are encouraged to provide preventive care and advice

24. The new dental contract includes preventive care within band 1 of the UDA linked payment system. This band encompasses examination, basic scaling and any appropriate diagnostic tests such as radiographs, so there is no additional reward for preventive care. The contract was introduced with an alleged 5% reduction in treatment targets (UDAs) to allow dentists more time with patients and to provide more preventive care. In reality, inflated output targets and inaccurate conversion of previous treatment patterns into UDAs have not reduced dentists' workloads at all and prevention is not being supported. Many practitioners are finding that their output targets are not being reached, some 47% having fallen short in the 1st year.

Dentists' workload and incomes

25. The evidence on dentists' workload has been badly damaged by the new contracts. We no longer know how much work is being done by NHS dentists although the numbers of patients accessing care remains roughly the same. Anecdotally, dentists claim they are doing more NHS work than ever to meet their imposed UDA targets but it is impossible to find a way to verify these claims. Evidence recently brought to light from DoH data shows that 47% of NHS dentists failed to reach even their 96% minimum output target for the year 2006–07. This would indicate—as has often been alleged—that UDA targets were deliberately calculated higher than was sensible prior to the new contracts coming into force.

Dentists' incomes are equally difficult to establish. Data published recently shows good income figures but the sample is narrow and badly skewed, reflecting the earnings of single-handed practice owners whose incomes may be derived from a variety of sources. This is a very strange sample to use and it has been criticised previously. Extrapolation from this data across the whole profession is very dangerous in statistical terms.

The closing down of the old system and the introduction of a new system has created a bubble of practice turnover but this will not be repeated as contract values and UDA values come under pressure and expenses rise.

The recruitment and retention of NHS dental practitioners

26. Recruitment of dentists to the NHS is now limited by national and local fixed budgets. PCTs find themselves with too little cash and too many demands on it. New recruits to the service have to go cap in hand and bid for a share of a limited pot. Once dentists do enter the NHS they find the work unrewarding in professional terms with the emphasis on the simplest form of treatment that will cost the least to put the patient's immediate problems right. This is bad news for someone coming into the profession to exercise their newly acquired skills to the best advantage for the population. Opportunities for long term professional development are severely limited within the NHS.

Conclusions

27. The new arrangements for NHS dentistry have failed to improve the service to patients. The reasons for that are simple for all to see. Contract managers working within PCTs do not have the time, the ability or the capacity to make the most of the opportunities that the new contracts offer.

Dentists have been forced into new contractual arrangements they would never have agreed to if they had been given any real choice, they have been forced to reduce the quality of the service they offer, to work harder than ever and to accept poorer working conditions. Many of them find the lure of the private sector to be very powerful. They can find there the freedom of professional expression and the ability to provide a wide range of modern treatments simply denied to them and their patients within the NHS.

This combination of weak NHS management, disillusioned and disheartened professional staff and inflexible working arrangements is a massive disincentive for all the parties involved. As always in situations like this, it is the patients who are caught in the cross fire and they find themselves on the receiving end of a poorer service that is patchy at best and comes to them at greater cost than before.

The only party that seems to see nothing but good in the current situation is the Department of Health and their judgment is highly questionable.

John Renshaw BChD MFGDP FDSRCS

December 2007

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Memorandum by The London Regional Group of Local Dental Committees (DS 07)

DENTAL SERVICES

1. *Summary*

1.1 The London Regional Group of LDCs agrees with the London Assembly's findings that "only half of Londoners regularly visit an NHS dentist, meaning that oral disease and decay are common".

1.2 The LRG also agrees with the London Assembly that "much more work is needed to ensure Londoners are well-informed and able to access dental care that meets their needs".

1.3 The LRG agrees with the London Assembly that "Low uptake of dental care is an important public health issue for London, as people who do not attend a dentist regularly are more likely to have untreated dental problems and disease, which can impact on other aspects of their health."

1.4 The LRG agrees with the London Assembly that "The reforms have introduced measures that could actually reduce access to NHS dentistry" and "Some dentists . . ..because no new money was available . . . . . had to close their doors to NHS patients . . ..."

1.5 The LRG agrees with the London Assembly that "in future, the Department of Health should base PCTs' funding allocations on local needs assessments, rather than historical provision".

1.6 The LRG maintains that to improve quality dental services for Londoners, it is essential to address the limiting factors listed in this paper. Dentists feel that when they raise these issues "nobody is listening".

2. *Who we are*

The London Regional Group of Local Dental Committees includes representation from Local Dental Committees throughout the whole of London, ie the NHS London Strategic Health Authority area. Each Local Dental Committee represents the dentists in their respective Borough.

3. *Low morale of dentists*

Local Dental Committee representatives throughout London hear constantly and consistently that dentists are demotivated and disheartened by the new dental contract.

They feel that the new contract was imposed with no meaningful consultation. The "Units of Dental Activity" scheme was not piloted.

4. *Uncomfortable pressure to perform Units of Dental Activity*

We hear every day comments from dentists such as "I used to enjoy my job, but now when I arrive at work I feel under pressure to carry out the requisite number of Units of Dental Activity and I feel this distracts me from concentrating on looking after my patients and doing what is best for them."

5. *Threat of money being "clawed back"*

Dentists call us in distress because their PCT insists on part of their earnings from the past year being repaid to the PCT, if they have not carried out the requisite number of fillings and other treatments. It was never explained to dentists prior to the introduction of the new contract that the relationship between their earnings and their dental interventions would be so strictly linked.

We are aware of many examples of dentists falling short of their UDA (units of dental activity) targets through no fault of their own (eg changing patterns of patient attendance) yet the PCTs have no sympathy for such circumstances. This creates a demotivating and depressing culture for dentists.

6. *Dentists who are able to walk away from the NHS are doing so*

We have many examples of this. There are young recently qualified dentists who have decided to change career because of the new contracts; some dentists nearing retirement have chosen to retire early because of it, and some have decided to reduce their time in NHS dentistry because they have become disillusioned.

7. *Dentists are feeling overwhelmed by the extent and duplication of "monitoring" of their professional lives*

PCTs are sending ever increasing numbers of compulsory questionnaires, systems of monitoring quality and quantity of dental work, statistical record-keeping, and audits etc. Whilst most of these are not unreasonable in themselves, the cumulative effect becomes too heavy a burden on dentists, and often requires them to spend their evenings and weekends completing paper work, which is a further demotivating factor.

8. *Additional regulatory responsibilities are not resourced*

Dentists are supportive of high standards of infection control, radiation protection, control of substances hazardous to health, etc. However when more onerous requirements are imposed, the increased cost represents an effective decrease in dentists' earnings, unless properly resourced. For example, the latest infection control requirements necessitate the purchase of additional equipment, and longer times spent by staff that is not recognised by Units of Dental Activity.

These additional costs represent a pressure on dentist's personal income.

9. *Primary Care Trusts wish dentists to treat more patients for the same money*

We are aware of situations where dentists have withdrawn from working within the NHS, and where PCTs have recommissioned the resultant shortfall in activity at a much lower cost.

Whilst we recognise PCTs have an obligation to achieve value for money, this is often emphasised above the need for high quality patient care.

10. *The new contract's intention to "improve the working lives of dentists" has not figured highly in PCTs' thinking*

We are not aware of many, or any dentists who feel that the new contracts have improved their working lives, despite this being one of its stated intentions.

11. *Preventative dental work not recognised by the new contract*

The incentive within the new dental contract is to achieve the correct number of Units of Dental Activity, which do not emphasise preventative work, nor oral health education, nor general health improvement. Whilst dentists embrace a preventative approach, this is not recognised in their contracts. The London Regional Group of LDCs agrees with the London Assembly in concluding that "The Department of Health should look at including preventive care in the way PCTs manage and monitor dental contracts and consider whether dentists should be financially rewarded for providing preventive advice."

12. *Restrictions on dental activity*

The Regional Group of LDCs is concerned to read in the London Assembly's report that 205,000 adults in the capital may never visit a dentist.

Whilst only 51% of Londoners went to an NHS dentist in the two years to March 2007, dentists are consistently being told by their PCTs that there is no scope for growth, and practices with imaginative ideas to increase access are being actively discouraged from implementing them, as PCTs wish to contain dental activity within the limits of the year before last.

Dentists who carry out dental activity in excess of their allocated target are not being funded for this.

Some PCTs (notably Bexley) used funding intended for Access Quality and Choice in dentistry for other purposes, without public consultation. The Secretary of State for Health and the Department of Health were asked to intervene but refused.

The London Regional Group of LDCs agrees with the London Assembly in its conclusion that "The Department of Health should base PCT's dental funding allocations on what local people need, rather than basing it on what has been provided in that area in the past".

13. *Dentists are being pressurised by PCTs not to prioritise the most needy patients*

Children and adults who are exempt from NHS charges are among the most in need of dental help.

Yet PCTs require dentists to ensure that a certain proportion of the patients they treat are sufficiently well off to pay for their own NHS treatment, in order to maintain the PCT's financial balance. We know of dentists who have been told that unless they see a higher proportion of paying NHS patients, they will have their contract capacity curtailed. This attitude tends to increase rather than reduce socio-economic inequalities.

14. *UDA targets are being imposed too rigidly*

Dentists find it almost impossible to ensure that they achieve exactly the required number of fillings and other interventions over a 12-month period. We maintain that providing dentists achieve within 10% of this target, they should be allowed to address the under or over achievement during the following year. But this is not happening.

15. *Dentists are being financially disadvantaged by patients who fail to attend appointments*

Prior to the introduction of the new contracts, dentists were allowed to make a small charge to patients who failed to keep appointments. This was an excellent incentive to remind patients of their appointments, and avoided them having to be "struck off" for non-attendance. Since the new contract dentists have been prevented from carrying out such incentive programmes, and as a result many appointments are unused, which in turn affects the achievement of UDAs, and can lead to financial penalties to dentists. We maintain that it is often the patients from the most deprived backgrounds who find it hardest to remember appointments, and dentists should not be disallowed from running an incentive scheme to discourage "Did not Attends".

16. *Dentists are out of work because of the financial limitations on NHS dentistry in London*

For example, when dentists finish their vocational training, there are no NHS dental jobs for them.

Dr Henrik Overgaard-Nielsen

December 2007

Memorandum by John Mills (DS 08)

DENTAL SERVICES

1) My name is John Mills. I worked in a mainly NHS dental practice for over 40 years, but have recently retired, which allows me to give an opinion which is not biased by motives of personal gain. However my wife works in the management of a dental corporate body, so I have continuing interest and knowledge. The observations made here are anecdotal, without statistical basis. However they are relevant observations about the development and introduction of the New Dental Contract, introduced in April 2006, and its effect on dentists, patients and the provision and quality of NHS dental care. Most of these observations relate to finance, but then dentists in practice are running businesses!

2) It is essential to understand how the New Contract evolved and how it works in order to understand why it is failing to deliver the increase in availability; however it is a complex area to comprehend fully.

3) It is also essential to understand that the only income that a GDS practice receives from the NHS is from the Contract Value, as described below, (or from the fee per item under the previous system). They do not receive a salary or any contribution to the running costs of their dental practices, which are typically around 50% of gross practice income. The only income that the dentist receives is the "net profit" from the running of the dental practice.

4) Although there was a consensus view that the existing GDS contract had many shortcomings, there was no great demand for change, certainly not for very radical change. Although the previous contract favoured treatment rather than prevention, the "fee per item" system did give a direct link between work done and reward (piecework!) and a mechanism for reflecting variations in expenses (eg. price of gold or recent requirement to regard root treatment instruments as single-use) through the periodic review of the fee scale by the DRSG.

5) A new alternative, the PDS system was piloted on a small scale, then rolled out more widely before it had been properly evaluated. This was the basic model used in development of the New GDS contract.

6) It was evident at an early stage that the new contract was being developed entirely by the DoH and that input from professional organisations or individuals was not welcome. Both BDA and GDSC were disenfranchised from the development work.

7) The new contract seemed to have only three key aims:

a) Organisation and control of GDS treatment was to be devolved to PCTs which would have a responsibility for provision of NHS dental care within their areas.

b) The PCTs would be given a fixed budget for this purpose, based on historic cost. This budget would be "ring-fenced" for dental treatment until April 2009, after which the PCTs have the discretion to divert part of their dental budget to other areas of perceived need.

c) The new patient charging system was to be simple for patients to understand and was required to raise at least the same amount of revenue as the old system. The existing system was linked to the fee per item scale, such that patients paid 80% of the cost of their treatment up to a maximum of £360. This seemed fair and was not complicated for dental practices, especially as most are computerised. For patients it was actually no more complicated than understanding the till receipt from the supermarket.!

8) Above items 7a and 7b resulted in the "Contract Value" which was allocated to each "provider". This was calculated by reference to NHS income in 2004–05 (Test Year"). The need to measure the quantity of treatment provided in exchange for the contract value resulted in the concept of the UDA (Unit of Dental Activity, or as it is unaffectionately known, the "udder").

9) Using data supplied by the DPB, the level of treatment activity in the test year was established and converted into UDAs. This was linked to the contract value, thus giving a monetary value to the UDA for each dentist or practice. A new unit of currency had been created! The UDA values varied widely between practices and PCT areas. The range is as low as £13 to above £30. Average £19–20. PDS practices, having recorded relatively little treatment during the test year, had very high UDA values.

10) Dentists would be expected to achieve their target number of UDAs annually in order to maintain their contract value. Shortfall would result in reduction in the contract value whereas over-achievement of UDAs would not produce any addition to the contract value.

11) The problem of patient charges was difficult to resolve. A committee eventually recommended a three tier system.

Band 1: £15.90 Simple treatment (eg. exam, xray & scaling)
Band 2: £43.60 More complex treatment. (eg. Including filling(s).)
Band 3: £194.00 Complex treatment. (including any treatment incurring laboratory charges. But including all necessary treatment)
This over-simplified system has resulted in serious anomalies.

12) Having adopted this simplistic approach to charging patients, the truly fatal error was to use it as the basis for calculating UDAs for dentists. Thus remuneration for dentists became based entirely on a patient charging system that was intended only to be so simple that an idiot could understand it.

13) Thus the treating dentist is rewarded with UDAs as follows:

Band 1 : 1 UDA
Band 2 : 3 UDAs
Band 3 : 12 UDAs

14) This is where the anomalies arise, as follows:

(For this exercise, regard a UDA as worth £26 for dentist X and £15 for dentist Y)

Band 1

Patient A: requires only a simple check up.
Patient pays £15.90 Old system approx £4 Not very happy
Dentist X receives 1 UDA Worth £26. Old system £5. V. Happy!
Dentist Y ditto £15 ditto Happy

Patient B: requires check up, scaling, 4 xrays
Patient pays £15.90 Old system approx £20 Happy
Dentist X receives 1 UDA = £26. Old rate £30+ Not too happy
Dentist Y ditto = £15 ditto Very unhappy

Band 2

Patient A Requires check up + 1 small filling
Patient pays £43.60 Old rate approx. £12.00 Very unhappy
Dentist X gets 3 UDAs = £78 Old rate £14.00 Deliriously happy !
Dentist Y ditto £45 ditto Very happy

Patient B Only attends when in serious trouble!.
Requires check up, 6 xrays, scaling over 2 visits, 12 large fillings.
Patient pays £43.60 Old rate, perhaps, £120+ Happy
Dentist X gets 3 UDAs = £78 Old rate perhaps £150+ Unhappy
Dentist Y ditto = £45 ditto V.Unhappy

Band 3

Patient A — Regular patient with excellent dental health, but fell and knocked front tooth out. Requires only a temporary partial denture, for 3–6 months. (May have bridge subsequently)
Patient pays £194.00 Old rate £50 Angry
Dentist X gets 12 UDAs = £336 Old rate £65.00 Embarrassed!
Dentist Y ditto = £180 ditto Slightly embarrassed.

Patient B — Irregular patient with multiple problems.
Requires examination and complex treatment planning, multi-visit to hygienist for gum problems, 15 assorted fillings, 3 root treatments, 5 crowns, 1 bridge & metal partial denture.
Patient pays £194.00 Old rate £360 Patient happy.
Dentist X gets 12 UDAs = £312 Old rate £900 Very unhappy
Dentist Y ditto = £180 ditto Suicidal!
In this case, the laboratory costs alone, borne by the dentist from within the 12 UDA value (£336 or £180), would most probably exceed £350! Thus dentist Y would suffer an immediate loss of £170. But in addition a course of treatment of this complexity might easily take 20+ hours of surgery time.

15) Under the previous system, the patient charge (subject to the £360 maximum) and the reward to the dentist were both directly related to the treatment carried out. Under the current regime, this link has been broken. In some cases, the patient pays more than the cost of the treatment. In other cases, the dentist receives less than the basic cost of providing the treatment.

16) The representatives of the DoH, including the CDO, will state that although the system has changed, dentists are actually receiving the same remuneration. However the major changes were intended to result in totally different uptake of treatment and to improve access to NHS dentistry for those who did not previously have access. So treatment patterns have changed. As the DPB has been disbanded, there is no longer a satisfactory mechanism for recording and measuring the type and quantity of treatment provided, only a crude UDA count. So the DoH presumption is not only flawed, but cannot be verified.

Summary

17) The anomalies described above have resulted in distortion of treatment patterns. Dentists are discouraged from treating patients with extensive dental problems or needing any laboratory work eg. crowns and bridges. Dental laboratories have experienced a major drop in business.

18) There is nothing in the new contract to encourage a preventive approach.

19) In 2009 the PCTs will be free to direct the "ring-fenced" dental budget into other areas of healthcare.

20) The "New Contract" requires urgent re-consideration, in full consultation with the profession. In its present form it is fatally flawed!

John Mills, BDS., DGDP

December 2007

Memorandum by the British Orthodontic Society (DS 09)

DENTAL SERVICES

This is a submission from the British Orthodontic Society (BOS), which represents the interests of specialist orthodontists in primary care, secondary care, the university teachers, community orthodontists and dentists with a special interest (DwSIs) in orthodontics and the provision of best possible orthodontic care.

1. Introduction

1.1 Orthodontics is the branch of dentistry concerned with growth of the face, development of the teeth and bite, also of the prevention and correction of problems with the teeth and bite. Ideally patients are treated during pubertal growth (in their early teens), when facial growth is most active.

1.2 The introduction of the new contract in April 2006 has been satisfactory for many established orthodontists. On many fronts it represents a considerable improvement on the old GDS contract. The BOS is pleased to have contributed constructively towards the structure of the new PDS contract.

1.3 A key change has been the introduction of the Index of Orthodontic Treatment Need (IOTN) into NHS practice. IOTN differentiates between dental health needs and cosmetic improvements. The BOS supports the implementation of the IOTN as a selector for NHS treatment as an appropriate way to ration limited financial and manpower resources. The introduction of IOTN removes a group of patients whose need for treatment is low and are < IOTN 3.6—all above this in Groups > 3.6, 4 and 5 are considered severe enough to require treatment under the NHS.

1.4 From a provider/practice's point of view there is no doubt that the regular monthly payment arrangements, paid one month in arrears, have been helpful in having a balanced cash flow within practices. This compares to the large monthly fluctuations of old—often paid up to two years after a patient's treatment commenced.

1.5 From a Primary Care Trust (PCT)/ Local Health Board (LHB) point of view, the fixing of Calculated Annual Contract Values (CACVs) also offers significant advantages in managing local dental budgets. The principles of local commissioning are to be welcomed. This assumes that appropriate "needs assessments" are carried out and funding levels are in place to address any additional need.

2. The Role of PCTs in Commissioning Orthodontic Services

2a) *Establishment of CACVs and local budgets*

2a.1 Orthodontist's and general dentist's contract activity was set, using gross GDS earnings during the historic period October 2004 to September 2005. This was the baseline used to establish CACVs for providers and set local budgets for PCTs/LHBs. As in general dentistry, orthodontists were remunerated at the end of a course of treatment and so were paid in arrears. In general dentistry, this principle worked well as a means of establishing a CACV, because earnings over a year were a good reflection of activity. However, this principle does not apply well to orthodontics as many courses of treatment take two years.

2a.2 As a result, income received by an orthodontic practice under the GDS actually reflected its activity up to two years previously. In the case of new practices, this effectively meant that the practice received little money at all for the first 18 months to two years.

2a.3 The DoH effectively capped funding at the 2003–04 level with small annual increases. Since 2003–04 much growth has taken place which is not reflected in historic earnings. Funding has been capped at a level considerably lower than current activity. (See appendix A)

2a.4 At a practice level, this had disastrous consequences for newly established and growing practices who were only offered very low or even zero contract values, despite the fact that many patients were in treatment. Following advice from the BOS, this problem had been recognized by the DoH who stated in previous correspondence to the PCTs; (Gateway Document 4449: Paragraph 7.5) "It is important to reassure new orthodontic practices that, when the reforms are introduced, the value of work commenced under the general dental services but not yet completed and therefore not reflected in payment history, will be reflected in the practice's contract value."

2a.5 In summary—as a result of this flawed system for setting local budgets, funding was capped at a level which reflected activity up to two years before the baseline period. New practices were given inadequate contracts, often leading to loss of an NHS resource.

2a.6 As local "needs assessments" were not taken into account, the funding remained in areas that were already well provided and areas of inadequate funding were not improved. Though PCTs understood the nature of the problem, they were powerless to act, as their budgets were set before any negotiations or "needs assessment" could take place.

2b) *Needs assessment of orthodontics*

2b.1 PCTs have a duty to assess and provide for the local dental health needs in their area, including orthodontics and to make appropriate provision to meet these needs.

2b.2 Historically, most large scale studies[2,3] looking at treatment need, agree that approximately 30% of children need orthodontic treatment on health grounds. Up to 50% of children have an IOTN score of 3.6 or above; these figures are supported by the 2003 National Dental Health Survey[4]. The prevalence of objective need for orthodontic treatment has remained consistent over the last 30 years.

2b.3 The Department of Health document "Strategic Commissioning of Primary Care Orthodontic Services" (Gateway document 7105), Para 4.5 states: "In planning orthodontic services, PCTs should be aware that the 2003 National Child Dental Health Survey found that 35% of 12 year olds are likely to have a need for treatment."

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[2] PH Brook, WC Shaw. The development of an index of orthodontic treatment need. *European Journal of Orthodontics*, 1989 Aug; 11(3):309–20

[3] CD Stephens. Standing Dental Adisory Committee—report of an expert group.

[4] Chesnutt I, Pendry L, Harker R, The Orthodontic Condition of Children *from* Children's Dental Health in the UK 2003, *Office of National Statistics*, London December 2004

However, Para 4.5 also states: "Not all parents and children agree with a professionally assessed need and conversely, a small proportion feel, that treatment is needed when clinically no need is recognised. The 2003 survey estimated that 58% of the parents of 12 year old children with a clinical need felt that their children did not need orthodontic treatment."

2b.4 The presumption that 58% of parents or children feel they do not wish treatment means that the patients with a known orthodontic problem may not have the opportunity of being given appropriate specialist advice.

2b.5 To illustrate the problems resulting from such an approach, two clinical examples are presented. Specialist orthodontists know that if patients have upper front teeth protruding more than 9 mm, there are known long term risks of damage through trauma for approximately 50% of these patients. This data is derived from previous dental health surveys. A second example is that of patients with palatally misplaced canines—we know that in 14% there will be resorption and damage to adjacent incisor roots.

2b.6 We therefore question the reduction of need from 35% to 15% as recommended by the DoH. We understand that patients must not be forced to have treatment, but they should be fully informed of the risks and benefits of treatment and allowed to give informed consent to treatment after a consultation.

2b.7 A local "needs assessment" is an excellent proposition, as long as the local providers are involved in discussions with the PCTs. The BOS feel this should be based on the identified 35% with a great need for orthodontic treatment derived from the 2003 Child Dental Health Survey.

2c) *Managed clinical networks*

2c.1 The BOS believes that the most appropriate way to manage referrals in the interests of the PCT, patients and the specialist providers both in primary and secondary care, is through joint consultation in Managed Local Orthodontic Clinical Networks (MCNs). The MCN should include all the local orthodontic specialists, DwSIs, a representative of the PCT, preferably the dental lead and a representative of the Local Dental Committee (LDC).

2c.2 The aims of the Local Orthodontic MCN are to:

- Co-ordinate the local provision of orthodontic care in conjunction with the funding agencies (PCTs or equivalent).
- Ensure the highest standard of orthodontic care is provided by the local orthodontic workforce.
- Develop short, medium and long-term strategies with regard to maintenance and development of orthodontic provision.
- Assure access for patients to the most appropriate orthodontic care.
- Enhance communication between providers.
- Act as a source of advice on orthodontic provision.

2c.3 All BOS members have been strongly advised by the Society to establish local MCNs and work closely with their PCTs.

2d) *The 18 week rule in secondary care*

2d.1 The introduction of the 18 week rule and other changes to secondary care provision will disturb the local balance of orthodontic care.

2d.2 Dental services provided by undergraduate dental students in teaching hospitals are exempted from the 18 week rule. This exemption has not been applied to postgraduate orthodontic students. Current postgraduate training programmes provide pre-selected patients to the supervised care of trainees at the beginning of their training. Implementation will mean that orthodontic trainers cannot hold waiting lists of suitable patients for trainees. The consequence is that fewer patients will be taken on for treatment in areas with a postgraduate course.

2d.3 There is no requirement to apply the 18 week rule in primary care and without doubt hospital waiting lists will be transferred from secondary care specialists to primary care specialists. The areas with long secondary care waiting lists are often areas with low provision in primary care.

2d.4 The MCN therefore has a vital role in co-ordinating care across all the local providers in consultation with the PCTs, which reflects the variation of provision around the country.

2e) *DwSIs in orthodontics*

2e.1 Dentists with a special interest in orthodontics (DwSIs) provide orthodontic care, in appropriate circumstances. Currently they work in specialist practices in primary care under the supervision of a specialist, or work in areas of need with the link of a consultant specialist in secondary care. DwSIs are best suited to take on cases under the supervision of a specialist, especially in an area of low population density that cannot logistically support a specialist practice.

2e.2 Planned replacement of DwSIs has not been given appropriate attention by PCTs. In the long term, there are key DwSIs in areas of need who on retirement have no obvious means of replacement. Careful planning is required to train new DwSIs in such areas of need. Strategically placed DwSIs will need someone to be targeted locally, to be supported financially in their training. There is then a need for a planned hand over of an orthodontic contract with PCTs, to the newly trained DwSI.

3. Numbers of NHS Orthodontists and the Numbers of Patients Registered with them

3.1 There is an under-supply of orthodontic treatment provision in the UK due in part to a dearth of specialist trained orthodontists. As a country, the UK is 15th out of 17 countries in Europe in terms of orthodontic provision. There is currently one orthodontist per 73,000 people. Germany and Austria top the table with 1 per 30,000. Only Spain and Turkey are worse off.

3.2 The UK three year postgraduate orthodontic training programme is recognised as one of the best in the world, but the number of UK students in training is inadequate for national needs, as a consequence of chronic under-funding over several decades.

3.3 We have no accurate figures as to the numbers of registered patients with specialist orthodontists and DwSIs in orthodontics, because this is so varied, but many colleagues have capacity to take on more NHS cases for treatment, if contracts were increased.

4. Numbers of Private Sector Orthodontists and the Numbers of Patients Registered with them

4.1 There are very few exclusively private orthodontic practices in the UK, such as there are, are mainly in London. However, with the changes in orthodontic provision following introduction of the new contract, this is increasing. The exclusion of cases < IOTN 3.6 from NHS treatment, has increased the number of patients who wish private care. Increasing orthodontic waiting lists, caused by limitations imposed by the new contract levels, is also contributing to more private practice treatment.

4.2 In the 2007 BOS survey, specialist members estimated that they are treating 15% of their patient numbers privately and that 58% of practices have growing numbers of private patients. Previously, the estimate is that most practices would treat approximately 5% of private patients.

5. The Work of Allied Professions

5a) *Orthodontic therapists*

5a.1 The first two courses for orthodontic therapists have begun this year in Leeds and Bristol; they will be a very important part of the future skill mix. We look forward to engaging in discussions as to the best way to work with orthodontic therapists in specialist orthodontic treatments in primary and secondary care. Inevitably this will require a review of the means of funding such new additions to the work-force.

5b) *Orthodontic technicians*

5b.1 As with technical provision in general dentistry, there are fewer orthodontic appliances being manufactured by orthodontic laboratories. There have therefore been a number of redundancies in orthodontic labs and rather poignantly at this year's British Orthodontic Conference; the prize for the best young laboratory trainee was awarded to a young trainee who had been made redundant just before the Conference!

6. Patients' Access to NHS Orthodontic Care

Uneven orthodontic provision

6.1 The historic differences in orthodontic provision, around England and Wales have been perpetuated. Areas of good provision remain well served, but those areas with poor orthodontic provision still have low contract levels of orthodontic care. This is often made worse by the fact that these areas are also poorly served for general dental care and as a consequence, (DwSIs) in orthodontics often have their orthodontic contracts converted into general dental contracts further reducing the level of orthodontics.

6.2 Approximately 35 orthodontists complete three years of publicly funded postgraduate specialist training in orthodontics every autumn and look for employment in the NHS. Because of the reduction in orthodontic contracting, many new specialist post-graduates cannot easily find work in the National Health Service. There are opportunities to employ these newly qualified specialist orthodontists in the areas of poor provision, but growth funding is not being provided to facilitate this.

7. The Quality of Care Provided to Patients

7.1 Orthodontics has a very robust measure of outcome in the Peer Assessment Rating (PAR), which has been in use for nearly 20 years. The quality of orthodontic treatment outcome will be reviewed at two levels.

7.2 The Dental Practice Division of the BSA have an orthodontic group who will be required to randomly check practices who take on >200 patient starts each year. There is a local peer review process which is the joint responsibility of the PCTs and the MCNs. The MCNs are committed to ensure the highest standard of orthodontic care is provided by the local orthodontic workforce.

8. The Extent to which Orthodontists are Encouraged to Provide Preventative Care and Advice

8.1 There are a number of areas in which early orthodontic intervention can prevent a more serious problem developing. The BOS believe that every child should be seen by a specialist orthodontist to assess the orthodontic treatment need. There has been a reduction in the quantity of orthodontics taught to undergraduate dental students. Advice from an orthodontist is often required.

8.2 In the context of general dentistry however, prevention is not an area in which orthodontists have a major role. All involved in orthodontic care will encourage patients to use the highest standards of oral health to reduce the possibility of damage to the teeth. Patients will not normally be taken on for orthodontic treatment if they have poor oral health or have active caries.

9. Orthodontists' Workloads and Incomes

9.1 As stated earlier the new contract gives better cash flow, but a significant number of specialists have spare capacity to take on more patients for treatment.

9.2 From the DoH point of view, a principal objective of the new contract was to contain the expansion of the NHS service which was responding to patient demand without any control. This limitation has now been achieved in orthodontics at a level, two years previous to April 2006.

9.3 Under the new contract, there is no provision for establishing new practices by an enterprising practitioner who sees an area of treatment need. There is no provision for expanding a practice with growing waiting lists, by recruiting a new provider or orthodontic therapist. This perpetuates the uneven distribution of orthodontics around England and Wales as stated in section 6.

9.4 A survey of BOS members in February 2007 found:

- 50% of orthodontic practices were in a steady state because of fixed volume NHS contracts but
- 58% were experiencing a growth in their number of private patients
- 55% of practices were experiencing an increased demand for private treatment for children and
- 30% of practices believed this was due to a lack of NHS provision
- 30% of practices had waiting lists for new patient assessments of treatment need in excess of 21 weeks and
- 30% had waiting lists in excess of 40 weeks for patients in need of treatment before treatment could be started.

9.5 The new contract has achieved the Government's objective of containing the supply of NHS orthodontic treatment but this ignores the demand. It is leaves patients in certain areas of the country without NHS care.

10. The Recruitment and Retention of NHS Orthodontic Providers

10.1 Recruitment of dentists to specialist orthodontics remains high, orthodontics is a specialist area with a great deal of interest to many newly qualified dentists. The problem remains that there is a need for additional funding for training.

10.2 Retention of orthodontic specialists within the UK remains good. If contract values reduce significantly, this might change.

11. Executive Summary

11.1 The BOS is satisfied with the nature of the PDS agreement. We are pleased that we have been able to play an active role in the development of the contract.

11.2 The use of historic earnings has been an inappropriate way of establishing contract values in orthodontics. This has resulted in national and local funding levels being capped, well below the level of activity at the start of the new contract. Areas of low provision have remained low. Many new or growing practices have been given inadequate contract values leading to inability to provide NHS care despite demonstrable need and mounting waiting lists.

11.3 Appropriate "needs assessment" should have been carried out before the implementation of the new contract and the establishment of local budgets.

11.4 The new arrangements perpetuate the inequality of orthodontic provision around England and Wales.

11.5 Training numbers for specialists remains low and there are not appropriate means of training and replacing strategically placed DwSIs. The BOS welcomes the advent of orthodontic therapists to the workforce.

11.6 As local commissioning becomes established, increased co-operation between PCTs, primary and secondary care providers is necessary to ensure that local need is met as efficiently as possible. The BOS feels that the establishment of local MCNs involving all orthodontic providers and PCTs are the key to realising this goal.

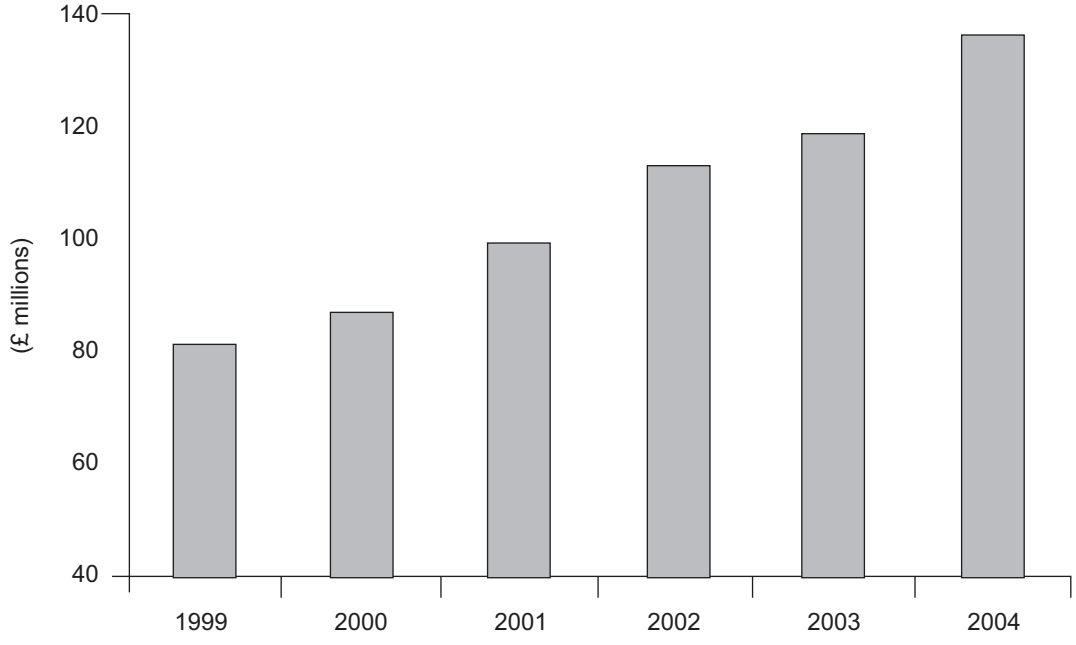
12. Index of Abbreviations

BOS	The British Orthodontic Society	LHB	Local Health Board
BSA	Business Services Authority	MCN	Managed Clinical Network
CACV	Calculated Annual Contract Value	MOrth	Membership in Orthodontics
DoH	Department of Health	NHS	National Health Service
DwSI	Dentist with a Special Interest	PAR	Peer Review Assessment
EU	European Union	PDS	Primary Dental Services
FDS	Fellowship in Dental Surgery	PCT	Primary Care Trust
GDP	General Dental Practitioner	RCS	Royal College of Surgeons
GDS	General Dental Services	UK	United Kingdom
IOTN	Index of Orthodontic Treatment Need		

December 2007

APPENDIX A

If GDS had continued with the old funding system, orthodontic payment in 2007–08 would probably be a fairer reflection of activity in the year 2006–07 than the 2006–07 payment itself. There has been an upward trend for annual expenditure on orthodontic treatment since 1992. In the year ending March 2004, the annual expenditure on orthodontic treatment under the GDS increased by 14.3% from £119.0 million the previous year to £136.0 million.



Graph based on Dental Practice Board statistics

It is reasonable to assume that the general trend would have continued had the old GDS contract remained in place and by 2007–08; it is likely that a significant increase would have been seen on the 2004 figures, possibly in the region of 20%–30%.

Memorandum by Sandwell Local Dental Committee (DS 10)

DENTAL SERVICES

1. Dentists have always enjoyed a good relationship with their patients. Indeed it is a fundamental requirement in order to do the job. There has to be a high trust environment and the number of long-term patient/clinician relationships that do prevail supports this.

2. The new GDS contract appears to have been designed to disrupt this relationship as shown by the following evidence.

(a) The Chief Dental Officer was quoted on Radio 4's You and Yours as saying that patients wanting to see a Dentist should contact the Primary Care Trust and NOT Dental practices. Dentists provide dental treatment not PCTs.

(b) On Midlands news television in an item on the new contract, one of the presenters said that it was important to have a good trusting relationship with a regular Dentist as you would with your Doctor or even your hairdresser. West Midlands Strategic Health Authority were then quoted as saying that "Patients need to get used to not seeing the same Dentist each time they attend." That does not support the further development of the Patient/Dentist relationship.

3. There are other areas where we believe that the new contract is causing problems and not delivering its stated aims.

Dentists can no longer sell their NHS practices to whom they choose. They cannot even give a value for the practice as the PCT have complete control over the contract. In all sales of which we are aware in our area, the PCT have reduced the contract value.

There is no guarantee that the PCT will award a contract to a purchaser if it is contrary to their plans. Funding is likely to be squeezed in 2009 when ring fencing of the Dental budget ceases and contracts may be trimmed accordingly. A practice owner will have built up the practice over many years taking mortgages and financial risks to provide an NHS service. The PCT have made no investment and provided no service. In 1948, the Government bought out the goodwill of General Medical Practitioners. Dentists' goodwill has been stolen.

4. The Unit of Dental Activity (UDA) is an ill conceived and artificial construct. It delivers no health gain and is only a measurement of quantity. It is even a poor measurement of that, when complicated and time consuming treatments such as root canal therapy attract the same UDA value as the simplest of fillings. There is no recognition of or reward for quality in this system. Instead we have a new treadmill based on hitting a target number of UDAs. We believe that the targets are artificially high, but we are not allowed to challenge the methodology that produced the targets. The new system encourages Dentists to concentrate on achieving UDA targets or risk financial penalty. The contract could be withdrawn by the PCT as a Dentist is in breach if the target is not met. Patient care is not addressed by this system and may well suffer as a consequence.

5. In the run up to the Contract, Practices were informed by the PCT that all the UDAs generated by all the Dentists in a Practice would count towards the Practice UDA total. Eight months into the contract a notice was posted, on a not well advertised DoH website, that this was no longer the case. Information of this significance should be made available by the PCT. Not all Practices have Internet connections. It now appeared that UDAs generated by first year qualified Dentists (Vocational Dental Practitioners) would not count towards the Practice total. This is unfair and inequitable. A VDP is a Dentist providing patient services like other Dentists. It is plainly wrong to discount this Dentist's UDA total after two thirds or the year. In one local training Practice the year-end UDA total was 104% of target if the VDP's UDAs were included. Without those UDAs the Practice achievement was 92% of target. Consequently the Practice now has to repay some £36,000.

6. The CDO spoke of "a basket of measures" around year-end negotiations and that UDAs need not be the sole measurement. Quality issues such as good Clinical Governance should be taken into account. Not in Sandwell. The PCT have offered that Practices can make up any UDA shortfall in the second year. This is often not feasible as it only increases the treadmill effect.

7. This contract was meant to improve working conditions and to free up time for Dentists. Not in Sandwell. Dentists report that they are working harder than before the contract came into force and that there is no free time dividend.

8. Regular patients, who are far and away the majority in Sandwell, are financially penalised by the new system. They will generally receive occasional intervention; the odd lost filling or crown, rather than extensive treatments. The amount they now pay is over 100% greater for crowns and around 200%–400% greater for a filling. Perversely, high need infrequent attendees get huge value for money for extensive treatment within a neglected mouth. These patients only generate the same number of UDAs as a patient who needs a single treatment item within the equivalent treatment band. If a Practice takes on several of these high needs patients it runs the risk of being unable to reach its UDA target.

Time is a vital factor under the new contract. If a patient needs several fillings over four appointments lasting two hours in total, three UDAs will be generated. The general target for an individual Dentist is six or more per hour every hour. So there is an immediate time and UDA deficit. Time is impossible to make up.

9. Patient charges collected by many local Dentists show a significant increase from the period before the new contract. However, the PCT have not collected as much revenue from patients as they expected. This is entirely the fault of whoever designed and engineered the contract at the DoH. If you impose a completely untried system that has not been piloted or tested, as the DoH have done with the Dental contract, it cannot be a complete surprise to discover major problems.

10. Dentists were promised that the new contract would simplify matters for patients and dentists, offering a guaranteed regular income for less clinical work in an atmosphere of clarity. This has not been the case. End of year reconciliation between payments made to Practices and UDA achievements have led to clawback and adjustments well into the following year. Should a Practice hit the target early there is no incentive to continue an NHS service for the remaining time as it actually costs the Practice to provide this out of what is now a finite budget. Needs could be addressed under the old system but not now.

11. We were promised the opportunity for increased prevention, but this is impossible to carry out if UDA targets are to be met. There is simply no time to practise prevention.

12. The scrapping of the Seniority payment mechanism seems to be cruel and petty. It has long been recognised that the output of older Dentists declines. The Seniority payment system sought to redress that balance and to reward years of dedication to the NHS.

13. Superannuation calculations are a nightmare, especially if adjustments have to be made at year-end. Even PCT finance officers do not seem to understand the system fully.

14. There is a definite shift in relations between the PCT and Dentists. It has become a master and servant arrangement, which mirrors the situation between the DoH and our BDA negotiators. Our locally democratically elected BDA representatives inform us that the DoH approach is extremely unpleasant and dictatorial.

We do not find the PCT unpleasant, but they do dictate and if put into a position where a decision is necessary, will ignore the possibility of local discussion with the profession and follow the DoH hard line.

15. Finally, the new system has managed to introduce rationing and waiting lists to NHS Dentistry for the first time. Perhaps this brings us into line with the wider NHS!

If the Select Committee is interested in improving NHS Dentistry, we would urge them to revoke this new system and to work with the profession to seek out a proper way forward.

16. Summary

Sandwell LDC believes that the new Dental contract has satisfied none of the criteria that it hoped to achieve. Working conditions for Dentists have not improved and the promised benefits for patients have not materialised. There is no incentive for Dentists to carry out preventative treatments and the fear of financial penalties is dictating the way Dentists practise, with the treadmill of chasing UDA targets being the priority.

This submission is made after consultation with local Dentists and on behalf of Sandwell Local Dental Committee.

Dr D M Gingell
Chairman

Dr D Cooper
Secretary

December 2007

Memorandum by Dr Ashish Dhopatkar (DS 11)

NHS DENTAL CONTRACT REGARDING THE EFFECTS OF IMPLEMENTATION OF THE CONTRACT ON ORTHODONTIC SERVICES

Orthodontics is the branch of dentistry that looks at and manages irregularities of the teeth and jaws. Treatment aims to correct dental and jaw abnormalities and provide the patient with a healthy and well functioning dentition for the future. The ideal time for dealing with such problems is usually in children between the ages of approximately 11–14 years of age.

Executive Summary

— My full name is Ashish Avinash Dhopatkar and I wish the Commons Health Select Committee looking at the implementation of the new NHS dental contract to be aware of and take into account how the changes have affected many orthodontic practices in the country which have been classed by the Department of Health (DoH) as new or growing practices for the purposes of transition to PDS from the old contract.

— I am aware that the committee cannot look into individual cases but I make this submission to highlight the effect that the national framework set up by the Government for implementation of the changes has had on new and growing orthodontic practices using my case as an illustration.

— I have personally and unsuccessfully disputed the treatment of my practice and therefore its local child population through the NHS Litigation Authority (NHSLA) and via an application for Judicial Review but I have been unable to make any progress which would allow my practice to continue to provide the level of service which is clearly required in my area.

— I am also aware that many specialist colleagues faced with similar situations have instead opted to leave the NHS completely which, in a specialty that had already been identified by the most recent Government commissioned workforce survey as having a manpower shortage, must be considered an undesirable consequence and a mismanagement of available resources.

— I submit to the committee that in the transition to the new PDS contract the DoH essentially created an environment where all "new or growing" orthodontic practices were classed as providing services which were surplus to the requirements of their local child patient population whether this was the reality or not. This was brought about by providing PCTs charged with commissioning appropriate service levels in their area with virtually no flexibility in their budgets to account for and correct miscalculated contract values for growing orthodontic practices which were based on unrepresentative historical data.

— I therefore submit that PCTs such as mine, Birmingham East and North (BEN PCT), in such circumstances, failed to discharge their duty to commission services based on an assessment of the needs of the local population.

— The consequences in Birmingham have included: longer waiting times for treatment, children unable to get treatment from a local orthodontist even when there is one available and specialists who had been committed to NHS service provision and who had been trained using NHS funding being forced to consider leaving the NHS and being actively prevented from providing a service despite a need.

— I believe the implementation of the contract has sadly failed many children who deserve and require excellent quality NHS orthodontic treatment. I therefore welcome the Commons Health Select Committee's review of the new NHS dental contract and would be happy to provide further evidence if required.

1. Background

I am a qualified dentist and a registered specialist in Orthodontics. I qualified with my dental degree (BDS) from King's College London in 1992 and am a Fellow of the Dental Faculty of the Royal College of Surgeons of England (FDS RCS, 1995). I completed an MSc in Orthodontics at King's College London in 1998 and a PhD in Orthodontics at the University of Birmingham in 2006. I have carried out an approved specialist orthodontic training programme at King's College London which led to the clinical specialist qualification (MOrth) of the Royal College of Surgeons of Edinburgh (1999). This qualification allows me to be registered as a specialist on the General Dental Council's specialist register. I have also completed further clinical training up to NHS Consultant level which is assessed by the Intercollegiate Specialty Fellowship Examination of the joint Royal Colleges of Surgeons (FDS Orth, 2003). I am currently a part time Clinical Senior Lecturer and Honorary Consultant at the University of Birmingham, School of Dentistry. Previous research I have carried out is referenced in the PDS contract in relation to monitoring standards.

1.1 I own the practice known as Sutton Orthodontic Centre at 27 Coleshill Street, Sutton Coldfield, Birmingham, B72 1SD. The practice falls within the boundary of the current Birmingham East and North PCT ("the PCT") area. The practice was first established and set up in 2001 and was fully funded in its initial period by the NHS because the area was identified as having a need for orthodontic provision. The number of patients in need of treatment in the area and length of waiting times were both high. This is still the case today.

1.2 I took over this practice and have been running it since February 2005. Prior to this Sutton Orthodontic Centre was experiencing considerable management problems of which the PCT was well aware. When I took over the practice, the waiting list for treatment was approximately 18 months. Before the dental contract changes introduced in April 2006 I had turned around this practice and reduced waiting times to 6-8 weeks. In the process I also increased the number of patients seen and receiving treatment at the practice. Throughout this period I used the now mandatory Index of Orthodontic Treatment Need (IOTN) criteria to prioritise need and treatment was not offered inappropriately. This is important to point out because the Government in its defence has stated that they have taken their stance with growing practices to avoid funding practices who were starting inappropriate or unnecessary treatment in an area where their service was not required, presumably for financial gain. Unfortunately whilst taking this hard line approach against what they clearly consider rogue practices, they completely failed to devolve any additional funding to PCTs to help fund ethical but growing practices in areas where their service was required (despite the sentiments

outlined in the above letter). As a result my PCT needed to make a case that they did not need our service in order to justify their not commissioning our ongoing service at the level it was just before the contract changed in April 2006.

1.3 Sutton Orthodontic Centre between February 2005 and March 2006 provided an improved service to patients and referring dentists alike and this was reflected in the steady increase in the number of referrals to the practice, a trend which has since been maintained. We had in that period also been able to support local hospital departments such as Good Hope, Burton and the Birmingham Dental Hospital where waiting times for treatment were already high before the contract changed and we helped provide earlier treatment to children who would have otherwise been on those waiting lists for some considerable time. The new contract has had the effect of driving up waiting times even further, because capacity in practices such as mine has been drastically cut. The average waiting times in those local hospital departments now for treatment is over 3 years.

2. The Nature of the Problem

I entered into a Personal Dental Services (PDS) Agreement ("the contract") which was served upon me on 24 March 2006 in respect of the provision of orthodontic services in the Birmingham area. A dispute arose between myself and the PCT relating to what is called the CAAV (the calculated annual agreement value of the contract) which is too low and incorrect in the light of my patient caseload and the local population's orthodontic needs.

2.1 The ongoing contract values, namely the CAAVs, for orthodontic practices in the new PDS arrangements have been calculated by looking at payment history for the practice from Dental Practice Board (DPB) records in the index period (October 2004 to September 2005). As I only took over the practice in 2005 this essentially meant that my CAAV was calculated based on the first 6 months of my practice being set up. This is clearly unfair as no new practice is likely to start generating representative payment records in the first months of operation. Furthermore, for orthodontic work in the old General Dental Services (GDS) contract there was a huge time lag between undertaking treatments and receiving payment. The bulk of the payment was not made until treatment was completed which for an average case takes 18 months. Clearly therefore my CAAV did not include any completed case payments at all—only start of treatment assessments in the main which is a small proportion of the cost of orthodontic treatment. As a result my CAAV was far too low to continue providing anything like an adequate service level to local children.

2.2 Although the payment history did not show this, the practice was providing a far more considerable and valuable service to the local population in the run up to the new contract. This fact has since been confirmed by the so called "close down" figure which was the value of the work in progress at the practice on 1st April 2006 which the NHS had not yet paid the practice for. The total value of this work transpired to be nearly 10 times the calculated CAAV. This shows quite clearly that the commitment of my practice to the NHS and the local service it was providing before the contract changes had been grossly undervalued by the methodology used by the PCT under direction by the Department of Health (DoH). The DoH has acknowledged that the methodology for calculating the CAAV was flawed in this respect (Hansard 1st March 2006 Part 10) but does not point out that all remedies suggested to PCTs in such cases merely involved methods of "paying off" the practice in question to finish the existing case load rather than by enabling the PCT to fund additional service where there was a need. This is because virtually all funding devolved to PCTs was already spoken for in terms of previous historical service levels and there was no facility at all for additional funding for PCTs unless they diverted this from other services within their own budgets. The DoH seem to have been working under the assumption that any practice that was growing or new in the run up to the new contract was not likely to be providing a valuable service that needed to be maintained in the long run and failed to provide PCTs with enough flexibility to enable this in the event that it was actually necessary. It is also clearly inaccurate to state that there was no practicable way to get more up to date data for new practices as these data were readily available from the DPB or directly from the practice if they had wanted to use them.

2.3 Therefore my practice, in common with many others caught in this DoH trap, has been severely disadvantaged by the DoH's decision not to take into account the value of work already approved and under way in the GDS for which payment had not yet been received in the index period. This is despite the strong assurances by the Department of Health previously that they would take into account the currently unpaid work when calculating ongoing contract values.

2.4 According to DoH guidelines a PCTs decision to commission or otherwise "additional services" from practices where the adopted methodology resulted in an undervalued CAAV needed to be underpinned by a Needs Assessment exercise to determine their local population's needs. A relatively small uplift was offered to my practice and presented as an adjustment for an undervalued CAAV in the first instance. Unfortunately this uplift bears no resemblance to the local needs situation and the PCT has not to date explained why it felt this was the appropriate level to commission from us. In addition the PCT also applied a lower unit of treatment (UOA) value to this additional work and this essentially means that my practice has to do more work for the same funding as everyone else commissioned to carry out orthodontic work in the BEN PCT area, including dentists with no specialist qualifications at all. I submit that the PCT did not undertake sufficient consultation of the needs of the community prior to making its decisions regarding my practice

and that these decisions were based purely on the allocated funding devolved to the PCT budget in the immediate run up to the new contract. In defence of this statement I would submit the following evidence (all of which was also submitted to the NHSLA):

2.4.1 The practice which I took over in 2005 was actually set up and funded by the NHS in 2001 following a needs assessment exercise which showed a need for increased specialist orthodontic service provision in the area. If the practice had been managed differently from the start then by the time the new contract was brought in it would have been well established and have been treated more fairly by the transitional arrangements. However, the available DPB data show that the practice only started fulfilling the objectives for which it was set up following the management change in 2005. During the intervening time there is certainly no evidence that need for the service had reduced in the area—in fact all available waiting list data show that the need for our service was actually greater in 2005-2006 than in 2001.

2.4.2 The PCT in its defence against my case to the NHSLA initially represented a draft and incomplete needs assessment as a finished work in order to show that it had commissioned appropriately. As far as I am aware this document has still not been finalised but certainly was not in a state to inform the PCTs decisions in March 2006. The current document at that time was the document which led to the practice being set up in the first place.

2.4.3 The Consultant in Dental Public Health who is charged with providing advice to the PCT was instrumental in my decision to take over the practice in 2005 as she advised me at the time that this was an area of need and this is supported by the fact that she also re-iterated this in a letter supporting our plans to expand the practice in July 2005. Furthermore the draft document which the PCT submitted to the NHSLA in actual fact showed an inequality of service provision in Birmingham and that my PCT in particular has under-commissioned orthodontic services for its local population. This was simply not addressed by the NHSLA.

2.4.4 I also submitted evidence to the NHSLA that showed that the PCT did not seem to know exactly how much orthodontic provision it had commissioned. I provided testimony from dentists whom the PCT stated were providing the service in my area but by the dentists' own admission this was not the case.

2.4.5 Finally but perhaps most importantly, I provided representative testimony to the NHSLA from a parent of a patient of my practice who had been told by PCT representatives that if my practice could not provide the treatment they could be redirected to another practice by the PCT—but all alternative practices suggested were in fact a long way from the patient's home and were in-fact within another PCTs borders. Is this not tantamount to an admission by the PCT of failure to provide the necessary local service to its population.

3. Summary

I have tried to illustrate with reference to my own case how orthodontic service provision in some areas has been jeopardised as a result of the way the new PDS contract was introduced. I believe that very similar arguments and reasoning have been used to justify such decisions by PCTs across the country and that these decisions stem from the lack of funding flexibility provided to PCTs by the DoH in the transitional arrangements to the new contract. As a result it seems that it is at least possible that PCTs may have been making commissioning decisions without proper consultation and without due regard to the needs of the local population. I have provided the committee with some evidence in this respect in relation to my own area. In addition it is interesting to note that even the DoH was referring to the incomplete and highly controversial needs assessment exercise carried out in Birmingham as a completed work and an example of good practice at a time when this work was still in draft form. Furthermore the actual findings of that draft assessment were also being misrepresented to justify the commissioning decisions.

3.1 A major consequence of these decisions has been that waiting times for treatment have drastically gone up. For example, in the case of my practice the methodology adopted to determine our contract and therefore our activity level basically reduced our activity level from approximately 500 cases (which was the number in active treatment at the practice at the point of transition) to approximately 80 cases per year. Also as a result, children are having trouble finding orthodontic treatment locally and specialists who had recently moved into an area where their services were required but have suffered due to the transitional arrangements for new practices were forced to consider leaving the NHS or to try and provide a service in hampered and increasingly stressful circumstances.

3.2 I believe the implementation of the contract has sadly failed many children who deserve and require excellent quality NHS orthodontics. I therefore welcome the Commons Health Select Committee's review of the new NHS dental contract and would be happy to provide further evidence if required.

Dr Ashish Dhopatkar
PhD BDS MSc FDS MOrth FDS(Orth)

December 2007

Memorandum by Stephen Day (DS 12)

NHS DENTAL SERVICES

SUMMARY

Root canal treatment is a complex and time consuming procedure which presently unfairly receives no remuneration with Units of Dental Activity (UDA) within the new contract. It is a worthwhile procedure for the patient enabling them to retain teeth and possibly avoid the inconvenience of a denture. It is unclear whether the Department of Health wishes dentists to carry out this procedure out as opposed to an extraction. It is a factor that dentists consider as to whether to continue with the new GDS contract. The matter of root canal treatment standards was raised at the Health Committee Inquiry in 2001 and since then no progress has been made at all. The new contract gives no guidance or protocols for treatment and no UDA award to carry out the procedure as opposed to extractions of teeth which carry a UDA value of three UDAs.

1. I write with reference to the sections being considered covering "Patients' access to NHS dental care" and the "Quality of care provided to patients".

2. The provision of root canal treatment was discussed at the previous report of the Health Committee into "Access to NHS Dentistry" published 27 March 2001. Little progress in this area of dental care has been made since then, despite the assertion made by Lord Hunt in paragraph 111 of the report. He agreed to Mr Brand's suggestion that the quality of root canal treatments be tracked to see whether the outcomes are different from those published in a survey by Professor Dummer in the Dental Practice Board magazine Dental Profile in 1997–98. This reported that only 10% of root canal fillings assessed by the Board met the requirements of the European Endodontic Society guidelines. I am not aware that the Department of Health assessment was ever carried out. With the introduction of the new contract the situation has gone into reverse in that there are no protocols for root canal treatment at all now and no way of recording how many are being carried out under the new contract. There is no guidance for practitioners as to what is required in root canal treatment techniques for practitioners and given the number of foreign dentists coming into the country it is important that they should know what is expected of them when practising in the UK. We have recently received guidance on preventive care for children so why not root canal treatments for the acute, painful problems involving the root canal systems of teeth. These problems are a very common occurrence for patients in dental practice. If not treated properly patients return at a later date costing more money to correct or eventually have the tooth extracted, possibly unnecessarily involving the overstretched secondary care agencies.

3. There appears to be confusion with some members of parliament about what treatments are available within the General Dental Services, indicating that root canal treatment is not one of them, although the profession has not been advised about this. Alan Johnson MP, in his letter to the Sunday Telegraph on 4 November 2007 stated that types of root canal treatment "are not available on the NHS" and Anne Keen MP in her recent letter to Labour MPs stated that "the new contracts . . . encourage dentists to carry out less complex and invasive courses of treatment". Root canal treatment would fall into the category of complex treatment.

4. As a practitioner working within the GDS, trying to balance the problems of the provision of clinical care for patients needs with the financial problems of running a business, it is frustrating to have to provide time consuming root canal treatment at a loss. No Units of Dental Activity (UDAs) are awarded at all for any root canal procedure. Some teeth, such as molars, can take 2 hours of time to treat and in addition we have to dispose of the instruments used within the root canals at each visit (at least two visits would be common). Some courses of treatment could include more than one root canal treatment, with no additional UDAs allowable under the new contract, even though there is extra expense with the mandatory one-time use of the instruments to prevent the possible spread of Creutzfeldt-Jakob disease. Each visit (likely needing two) could cost in the region of £30-40 for a molar and not much less for other smaller teeth. If the tooth concerned is a visible one, an extraction with a denture replacement, instead of a root canal treatment, would be awarded 12 UDAs (or 13.2 if seen as an emergency at a previous visit). The denture would likely cost about the same to have made as the unrewarded costs of the root canal instruments used if a root canal treatment had been carried out to save the tooth. This presents an unfair dilemma for the dentist. Do they carry out time consuming, tooth saving root canal treatment for the patient (and not impose on them the life time need to wear a denture) for no remuneration, or receive 12 UDAs for the easy and quick option of an extraction and make a denture? I do not know whether this happens or not but it is a factor considered when dentists are considering their position with regard to committing to the new contract or not. The NHS Information Centre dental statistics show a reduction of 45% in adult courses of treatment involving a root filling from 2003–04 figures to 2007 (April to July) and an increase in extractions.

5. The new contract could sadly disadvantage children involved in an accident with their front teeth in the present, unbalanced situation just described. Should a tooth be knocked out or severely displaced the options would be to either remove the tooth and commit the child to a plastic denture and collect the 13.2 UDAs for not much more than $\frac{3}{4}$ hours work, or spend a considerable number of hours saving the tooth over a period of weeks to months with root canal treatment (having to dispose of the costly instruments

during the process) for zero UDAs; 3 UDAs would be awarded only for a filling provided at the end, the facial appearance saving root canal treatment would have no UDA value. The child could well be spared the crippling effect for them of a denture for the rest of their life with careful root canal treatment.

6. In the report of the Health Committee in 2001 (para 98), Mr D Hinchliffe MP identified that "there is a tension between independent contractor status, the private business interests and the community interests and the service interests". This present contract, instead of making NHS dental practice more appealing by addressing those stated problems, has made them more extreme. The problems with root canal treatment and the new contract, that I hope I have highlighted, have accentuated these conflicting interests and there has been no improvement since 2001. In fact the situation has become far worse. Clinical decisions with the new contract are now geared, in terms of UDA payments, to the quick-fix solution instead of quality based solutions. It is very sad.

Stephen Day
Dental Practitioner

December 2007

Memorandum by the British Fluoridation Society (DS 13)

DENTAL SERVICES

1. Despite an overall improvement in dental health over the past 30 years, tooth decay remains a significant public health problem in parts of the UK. Inequalities in dental health remain wide with children living in the poorest communities continuing to suffer unacceptably high levels of tooth decay.

2. The purpose of the 2006 Dental Reforms was to provide patients with easy access to high-quality and clinically appropriate dental services.

3. The Health and Social Care (Community Health and Standards) Act 2003 extended PCTs' remit to assessing local oral health needs and commissioning the appropriate services to tackle long standing oral health inequalities.

4. Furthermore, for the first time NHS General Dental Practitioners were given the opportunity to focus on prevention and health promotion, as well as treatment as part of their NHS contract.

5. Historically, uptake of dental services has been a classic example of the inverse care law—those in greatest need make least use of the service. Clearly PCTs now need to be very skilful in their commissioning of dental services to redress the balance.

6. However, even with better provision of primary dental services including the provision of oral health promotion, it is likely that inequalities in oral health will persist for many years to come.

7. Water fluoridation is the single most effective public health measure available to health authorities to reduce unacceptably high levels of tooth decay, and reduce oral health inequalities.

8. Importantly, water fluoridation would significantly reduce the need for dental general anaesthetic for tooth extraction in children. (See attached chart comparing general anaesthetics in non-fluoridated Greater Manchester with fluoridated Birmingham and the Black Country.)

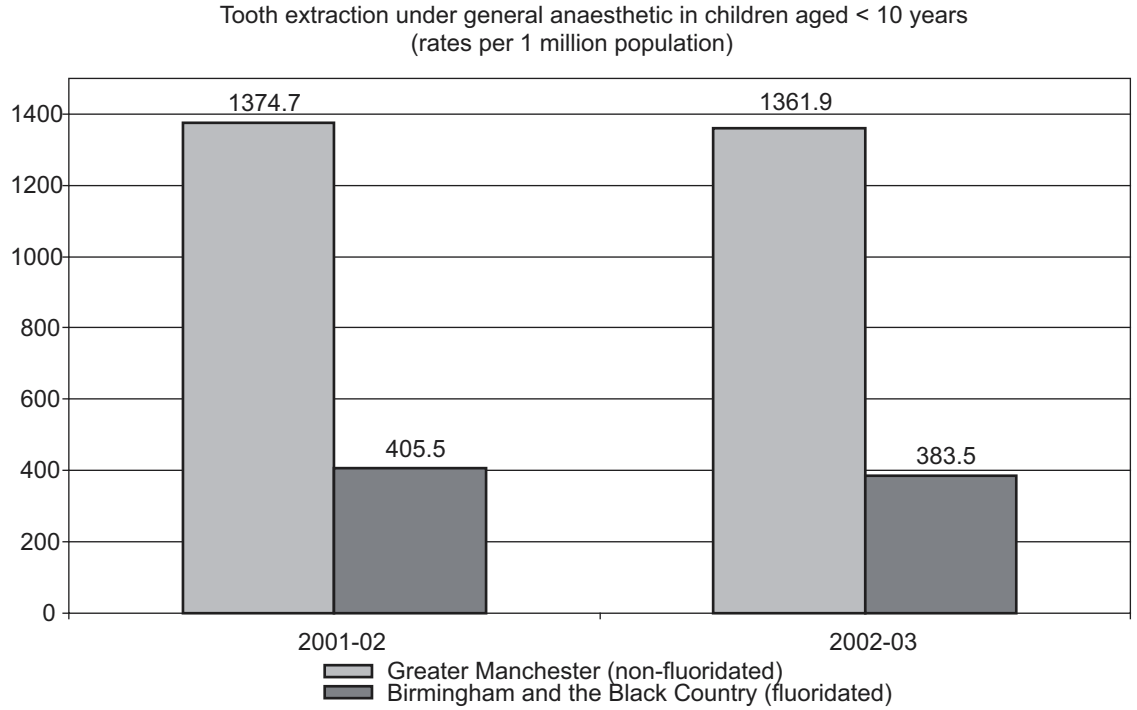
9. In November 2003 Parliament, with substantial majorities in both houses, supported the Government's proposal to correct the legislation (in England & Wales) so that water companies were no longer able to veto NHS decisions about water fluoridation. (Water Act 2003 Section 58(2) http://www.opsi.gov.uk/acts/acts2003/20030037.htm)

10. Four years after the new legislation no new schemes have been implemented, and only one PCT, Southampton, has requested its SHA to undertake cost and feasibility studies. The SHA and PCTs in Greater Manchester, where dental health is among the worst in the country, originally mapped out a timescale suggesting that in Spring 2007 the PCTs would have sufficient information—in terms of mapping water distribution and caries levels, and cost-effectiveness—to decide whether or not to ask the SHA to undertake a formal fluoridation consultation. However, there is no indication as yet that the NHS in the North West has any firm timetable for a fluoridation consultation.

11. Elsewhere, there has been little information in the public domain to suggest that other PCTs might be actively considering fluoridation as part of their oral health policies. These delays are unacceptable.

RECOMMENDATION

12. We strongly urge the Health Select Committee to recommend that where the need has been established—for example in the North West of England and Yorkshire—health authorities will consult communities with a view to implementing new fluoridation schemes without delay.



Source: Hansard 1 Nov 2004: Column 134W .

Michael A Lennon OBE
Professor of Dental Public Health, University of Sheffield, and
Chairman, British Fluoridation Society

4 December 2007

Memorandum by Dr Paul Batchelor (DS 14)

NHS DENTISTRY

1. Summary

2. This submission argues that while the previous arrangements for the delivery of National Health Service (NHS) dental care had shortcomings and many of the principles underlying the reforms were to be welcomed, both the content and the manner of the present arrangement's introduction were flawed. In particular, the assessments of the shortcomings of the previous arrangements were unsound and the risks associated with the new system inadequately identified. In consequence, the current arrangements have failed to address the issues that the Department of Health (DoH) wished to see dealt with.

3. Due to shortfalls in the monitoring arrangements of the present system, it is not possible to provide the data required to ensure probity to the previous level nor to answer many of the questions that the Health Committee wishes to investigate. The quality assurance mechanisms that previously existed have been disbanded and the replacement arrangements are feeble. What data do exist, particular those obtained from independent sources external to the NHS highlight growing inequities in access to care. The considerable sums spent on recruitment and education represent poor value for money as the workforce planning methods used are wholly inappropriate: unemployment within the dental profession is a real possibility, this despite the continued access problems. Furthermore, as external agencies have highlighted, considerable risks remain.

4. The policy decisions taken by the DoH to help ensure that the dental needs of the population are met are flawed. The DoH has failed to provide a coherent vision of how dental care can be provided to the population through cost-effective, efficient and sustainable arrangements. In consequence, the very issues that the Government wishes to see addressed, namely improving access and a reduction in the inequities in disease levels have not occurred and will not do so under the current arrangements.

5. To address this problem, a sound analysis of the actual extent and reasons for the identified issues must be undertaken. This includes a review of the workforce proposals and a modified remuneration system that adopts incentives to reduce inequalities, encourage effectiveness and promote quality.

6. Introduction

7. The present submission is based on my areas of activity as an academic and consultant. I have had considerable experience of working and analysing dental care arrangements in the United Kingdom (UK) and abroad. This has included examining the usage of dental services by the population and factors associated with service usage, workforce planning, funding of care and developing quality assurance arrangements. I have acted as an advisor to a number of agencies that have been involved in examining dental care policy including the Office of Fair Trading, National Audit Office, Dental Workforce Review Team and Options for Change Working party within the UK, In addition I have acted for a number of agencies abroad including the Health Service Executive and the Competition Authority in Ireland, the World Health Organisation and as an advisor to a number of other foreign national health bodies.

8. The rationale given to support the introduction of the present NHS dental care arrangements is centred on a long history of reported failings. All have suggested problems with the previous delivery arrangements but from differing perspectives. The reports include: the Schanschieff Report (1986), examining the possibility of over prescription; the Bloomfield Review (1992), regarding payment mechanisms; the Audit Commission (2002) and the Office of Fair Trading (2003), exploring the manner in which the dental "market" operated, and; the National Audit Office (2004), dealing with the risks of the current arrangements.

9. Numerous consumer group reports have also been published. All reiterate a common theme surrounding the delivery arrangements, in particular, perceived difficulties in accessing dental care. The Government itself has also examined dentistry, perhaps the two most pertinent being a previous Health Committee (2001), dealing with access to NHS dentistry and the Public Accounts Committee (2004), examining the management of risks of the then proposed dental contract.

10. The success or otherwise of the present care arrangements need to be based within a framework to help identify the extent to which the reforms could provide benefits for patients and the public at large. The goals of the current system included the need to improve three elements: access to NHS dentistry, oral health and NHS dental services. The precise definition of NHS dentistry has not however even been made.

11. The main proposals to achieve the goals included a number of benefits for those working within the system including more time being spent with patients, not least to help improve quality, less bureaucracy and work pressure, the ability of the profession to plan and invest in their businesses, integration with the NHS National Programme for IT (NPfIT), and opportunities to modernise premises.

12. Using this framework the specific issues that the Health Committee wish to examine will be explored.

13. Factual Information

14. *The role of PCTs in commissioning dental services*

15. To date, very little commissioning of dental care has occurred; PCTs have simply contracted with providers working under the previous arrangements. Some secondary and primary care is being commissioned where previous contractors have left the NHS system. While theoretically the idea of local commissioning of dental care may work, in practice the difficulties are enormous. Not least, PCTs require sound data both of dental need and reliable service data from all sectors of the dental delivery system. These include all primary care arrangements, including the non-NHS sector and the secondary care sector. These data then need to be analysed to provide a valid interpretation and subsequently, to develop an appropriate contract to commission care to best meet both the present needs and those likely into the near future. There is a lack of such expertise; in certain sectors the experience is non-existent. Data on non-NHS activity are absent as are those covering clinical disease and other relevant measures for the vast majority of the resident population.

16. PCTs also have a considerable number of activities in differing fields of healthcare to undertake. The priorities given to developing a cadre of informed and capable staff to deal with dental matters has historically been poor. There is a lack of transparency in most financial flows meaning that it is impossible to verify claims by either the DoH or the provider side on actual resource allocation. The methods being used to ascertain the patients' voice within the system are equally pathetic. As such, the PCTs role is currently very weak.

17. *Numbers of NHS dentists and the number of patients registered*

18. The number of dentists contracted to provide NHS care has risen. In March 2006, the last data capture point of the old arrangements, there were 18930 dentists (principals, assistants and trainees with at least one open contract) working within the primary care NHS dental system. Currently, the number of NHS dentists, defined as "performers", is 21111. The latter figure is a cumulative figure: the precise number currently working will be smaller. Perhaps more importantly, this does not equate to whole time equivalents and in consequence data are largely meaningless. It is the overall capacity that is important. At present there are no such data. Indeed, NHS service data will not be available for some time to allow any meaningful comparisons between the previous and current arrangements, if ever.

19. The new arrangements mean that an individual no longer "registers" with an NHS dentist. Patient "usage" is based on the number of individuals who have been seen within the previous 24 months. Given that the new arrangements have only been in place for 20 months the data include individuals attending under the old arrangements. The limited data that do exist and which are supplied to PCTs suggest that, to date, there has been no major change in the number of patients seen.

20. *Numbers of private sector dentists and the number of patient registered with them*

21. No data are held to provide the number of patients seen under non-NHS arrangements and as previously highlighted, the term "registration" is at best vague. The non-NHS sector consists of a wide variety of care arrangements ranging from individual agreements between a dentist and a patient through to more organised care plans, the largest of which is Denplan. The number of patients seen through the latter arrangement is probably in the region of 1.5 million: the data are commercially sensitive. Published work suggests that the total number of patients reported accessing for a non-NHS check over the last 12 month period for which data are available is in the region of 7.5 million individuals. This represents a doubling over a 10-year period to over 14% of the population. However, the Committee should also be aware that many individuals also receive care through non-NHS arrangements despite being an NHS patient. Furthermore, there is a considerable social gradient in non-NHS usage with nearly twice the percentage of the higher socio-economic groups attending for non-NHS care when compared to the lower socio-economic groups.

22. *The work of allied professions*

23. The new arrangements have made little, if any differences to the possible contribution that allied professions could make. With the exception of dental nurses, the present numbers of such trained professionals are relatively small in comparison to the number of dentists. The clinical operators, namely dental hygienists and therapists, the former consisting of approximately 4,000 registered individuals, the latter approximately 400, form a small proportion of the total operator workforce. There are currently over 30,000 registered dentists with current projections adding over 1,000 new graduates each year. The number of projected new hygienists or therapists each year is 120. Due to their small numbers and the current structure of dental premises, many being single surgery premises, the opportunities for benefits through their increased adoption are limited. Furthermore, the only major review of the cost-effectiveness of their employment showed few if any financial benefits.

24. Dental nurses are however crucial to the efficient and effective running of dental practices. However the Committee should be aware that, due to changes in registration requirements, there is a growing risk that many practices will be unable to comply fully with the necessary requirements and will have to cease delivering care in July 2008 if they wish to remain legal. Less than 8,000 of the notional total of approximately 40,000 dental nurses are registered and therefore compliant at the time of writing this submission.

25. *Patients' access to NHS dental care*

26. Simply because an individual can access dental care under the NHS, this does not necessarily mean that any subsequent care is provided under NHS arrangements. The issue from a patient's perspective involves two distinct questions: can an NHS dentist be found, and, if yes, will any care required be carried out under NHS arrangements?

27. First, access itself to an NHS contractor remains variable. Numerous reports continue to highlight the problems. The registration arrangements for dentistry have always been different to those for medical care. Historically individuals who wish to ensure access to dental care have needed to attend irrespective of whether they have any clinical need with a continued reduction from, recently, 15 months to nothing under the current arrangements. The key question for policy makers is to what extent do those wishing to access care have a clinical need, not whether they feel they need to attend to ensure access. If the medical sector operated in the same way, there would be similar problems as found in dentistry.

28. The second issue centres on the availability of treatment through NHS arrangements. There is growing pool of data to show substantial changes in prescribing patterns within the NHS. This is almost certainly due to the changes in the incentive arrangements. The pattern of the changes would suggest that patients are getting inferior care, for example extractions as opposed to root canal treatments unless they are willing to have the care provided through non-NHS arrangements. Given the costs, this is almost certainly increasing the level of health inequalities.

29. *The quality of care provided to patients within the NHS*

30. The changes introduced following the implementation of the current arrangements have completely reduced the levels of quality and risk assurance arrangements for NHS dental care. The changes have seen the dismantling of the most cost-effective and efficient quality assurance mechanism that existed anywhere in the world. The current arrangements, largely the counting of Units of Dental Activity (UDAs) against a predetermined annual target and a record check on a small number of dentist selected patients, are more or less useless for ensuring the quality of treatment.

31. *The extent to which dentist are encouraged to provide preventive care and advice*

32. Although the new arrangements have included the possibility for the provision of a preventive care element there are no additional rewards to undertake such activities over the previous arrangements. The incentive system adopted has merged a number of elements together, for example the examination and the cleaning of teeth, with the preventive "package". In consequence, there are no financial benefits to the dental provider to actual provide the preventive element. Furthermore, the DoH have no knowledge of the extent to which it has been undertaken due to the poor data capture arrangements.

33. *Dentists' workload and incomes*

34. Data on dentists' workload are sparse and, as highlighted previously, knowledge of the extent to which dentists commit to providing NHS care is absent. Data released following a request under the Freedom of Information Act show that nearly 50% of NHS dentists failed to reach the minimum output target for the first year of the new arrangements. Due to the lack of information on the actual content of activity, comparisons to previous working arrangements are impossible.

35. Recent data suggest that dental incomes are on average £100K but the methodology used to acquire the data, in particular the sampling arrangements, is highly questionable. In consequence, extrapolation from these data across the whole profession is likely to be very misleading. Data on the income of dentists working outside the NHS shows earnings to be remarkably similar but earned through treating fewer patients. This suggests that one determinant in retaining the NHS workforce lies not necessarily with financial incentives, but through reducing their workload.

36. *The recruitment and retention of NHS dental practitioners*

37. Recruitment of contracts and hence indirectly, dentists to the NHS is now limited by national and local fixed budgets. In 2009 this restriction will be removed. However, if historical data can be relied upon, PCTs have found themselves with declining dental revenues in real terms that have coincided with increasing demands from all health sectors. The real issue is to what extent will a PCT wish to commission dental services given all the other health demands made upon it, and subsequently, what contractual agreements will it establish and with who.

38. What data are available suggest that NHS dentists find work professionally unrewarding. There is an emphasis on the simplest forms of treatment that cost the least to address the patient's needs. This is hardly conducive to entrants into the NHS to exercise their skills to the best advantage for the population. Opportunities for long-term professional development are severely limited within the NHS.

39. Recommendations for Action

40. The reform of NHS dentistry should be based on dealing with the two main problems: access to and inequalities in oral health. The poor analysis of what data are available and the lack of insight by policy makers have lead to care arrangements that are failing the public. Access to NHS care should be improved and inequalities in health need to be reduced. The arguments to support the current emphasis on the development of local based contracting and a substantial increase in the workforce are highly contentious.

41. The increase in the workforce, with a projected requirement of over 5000 new dentists by 2011 has been derived using a workforce model that is inherently flawed. The model contains calculations based on numerous assumptions that are wrong. Furthermore, the overall policy is likely to be unsustainable given the projected costs and, more importantly, it fails to address the underlying causes of the access issue. Of equal importance is that the proposed increase in the number of dental personnel will increase the overall costs of the system substantially. While this may be acceptable if the benefits included improved levels of oral health and a reduction in oral health inequalities, neither of these is likely to be achieved.

42. The failings are as of a direct consequence of the deficiency in making an accurate diagnosis of the problems within the care system. The problem in access is as of consequence of: an increase in the numbers trying to access the system and at the same time dentists moving away from the NHS. Simply increasing the numbers of care providers will fail to alter the trend towards non-NHS provision and will prove extremely costly. Furthermore, the increase in numbers is likely to lead to over treatment, the provision of which is of questionable value.

43. Due to the fragmentation of the delivery system when combined with the totally inadequate monitoring arrangements, poorly constructed remuneration system and the shortage of dental public health expertise at a local level, accountability to Parliament is substantially weakened.

44. To address the growing problems a proper analysis of the dental care arrangements and the true reason for the perceived problems must be undertaken. The solution must centre on ensuring that practice is evidence based and that clinical governance is used to ensure that the care meets the quality standards. The delivery system needs to change to appropriate objectives to meet the needs of the population. The payment system should discourage inappropriate intervention and reorient efforts to improving effectiveness and quality. The most appropriate arrangement for achieving this should centre on capitation based payments with long-term registration arrangements.

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December 2007

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Memorandum by the Oxfordshire PCT Patient & Public Involvement Forum (DS 15)

NHS DENTAL AND ORTHODONTIC SERVICES

IMPACT OF THE REFORMS ON DENTISTS AND MEMBERS OF THE PUBLIC: EVIDENCE FROM SURVEYS IN OXFORDSHIRE

Executive Summary

1.1 Members of the southern group of the Oxfordshire PCT Patient & Public Involvement Forum undertook two independent surveys in October 2007 in order to assess the situation for patients, public and dentists in Oxfordshire.

1.2 The evidence provided for the Select Committee in this report supplements that contained in the National Dentistry Watch Survey Report from the Commission for Patient and Public Involvement in Health but reflects locally expressed views only.

1.3 The report highlights the serious concerns articulated by Dentists and the public in Oxfordshire on the adverse effects of the reforms on the dental health of many people. Dentists are particularly angry about the Units of Dental Activity (UDA) banding system that acts as a disincentive to patient needs-based treatment in some cases, and frequently fails to cover real costs.

Members of the public are primarily concerned about restricted patient access to NHS dental services and the inability of some people to find an NHS dentist at all. People are angry about the high cost of both NHS and private dentistry, particularly people in lower income groups.

On behalf of patients and public, members of Oxfordshire PCT Patient & Public involvement Forum are particularly concerned about the discriminatory effect the reforms have had on access to dental treatment for persons with low incomes and those with high dental needs.

1.4 The report also notes the high number of dental practices providing NHS care, albeit frequently combined with private practice, and the high levels of satisfaction expressed by NHS patients about the treatment they receive.

2. Impact of the Reforms: Evidence from Survey of Oxfordshire Dentists

The Forum found that 94% of responding dental practices offer both NHS and Private treatment.

However, 59% of responding dentists believe that the quality of NHS dental care has been compromised by the reforms, and 73% believe that it is inferior to dental care provided in private practices.

2.1 *Impact of the reforms on NHS dental service provision in Oxfordshire*

73% of responding dentists indicated they have serious concerns related to the Contract, and none feel satisfied with it.

Issues raised include difficulty in maintaining standards of treatment, the loss of clinical freedom to address individual needs, the unhelpful nature of restrictions placed on the numbers of patients that can be accepted and the shortfall in remuneration received for the use of high quality materials as indicated by patient need, all of which are seen as disadvantageous for patients. Patient need is seen as secondary to meeting targets imposed by the system.

For some dentists, full NHS provision has become financially unviable, with financial survival forcing a change either to part time or full private provision. Only a very few dentists take an altruistic approach, indicating that they view discriminatory treatment provision as unacceptable, and therefore choose to provide equal quality of care for both NHS and private patients through supplementing the shortfall through their private practice income.

A number of dentists see private practice as the only way to enable them to update equipment and materials used.

2.2 *Impact on NHS service provision of the Units of Dental Activity (UDA) banding system*

Dentists made many adverse observations about the UDA system. Pressure is placed on dentists to reach their UDA target; this is likely in many cases to result in the quality of treatment being offered to be reduced.

The UDA system is seen to encourage a "treadmill" target-driven service. The treatment bands penalise dentists prepared to take on patients with high dental needs. Dentists are effectively penalised for taking on patients with a history of poor oral health on the NHS as these patients cause dentists to miss their UDA targets.Some practices are restricting treatment based on UDA values such as crowns and bridges.

Complex treatment on the NHS attracts the same UDA value as some quick simple treatments. One example given of this financial disincentive is the situation where remuneration for providing twenty fillings to an individual within a single course of treatment is the same as if providing one filling only. Thus, in some practices, treatment is now being staged, ie necessary treatment delayed, to make it financially viable for the dentist.

A further point raised concerns the lack of continuity in the contract arrangements after 2009 which compromises the ability of dental practices to plan future services.

2.3 *Impact of the reforms on the ability to provide quality care to patients*

Dentists expressed a number of concerns relating to the quality of care they are able to provide under the current Contract.

Some dentists are finding it more difficult to provide adequate NHS dental care. It appears that high quality treatment is not valued as the Reforms make it more difficult for dentists to give adequate care through imposed financial disincentives.

Dentists cannot afford to provide high quality materials and laboratory work where needed for NHS patients, unless they subsidise their NHS work with private work.

Some dentists no longer accept new child patients due to impossibility of maintaining standards of prevention, conservation and laboratory work. These issues potentially pose more adverse outcomes for patients.

The ability to upgrade equipment and materials is also compromised by the reforms. Equipment and material upgrades are commonly entirely dependent on the ability to subsidise from private practice incomes.

Concerns are also being expressed about the potential adverse impact of the reforms on some people's general health through reduction in ability to access dental treatment and preventative initiatives.

2.4 *Negative incentives for dentists arising from the Reforms*

The reforms are seen to provide an incentive for dentists to provide the cheapest, shortest treatment rather than the most appropriate, with a potentially negative impact on patient care. For example, the current system encourages tooth extraction rather than restoration/root canal treatment and provision of spoon dentures rather than bridges.

The system also makes dentists unwilling to register patients with poor oral history as limits on UDAs available to the dentist, and the UDA banding structure does not encourage the care of patients at high caries risk and/or with multiple treatment needs. In some cases, fillings are being postponed for 6 months in order to gain remuneration that better covers the costs.

Dentists believe that the system may discourage some patients from seeking a regular check-up.

The impact of the reforms on children's dental health is a major concern. Inevitably, children who require a lot of treatment are less likely to be accepted by dentists, who will effectively be out of pocket if they treat them properly. This is especially true of children with high decay rates and children requiring root canal therapy as the 3 UDAs allowed for either 1 restoration or 15 means these patients pose a disproportionate drain on limited resources.

2.5 *Impact of the reforms on Patients' access to NHS dental care*

All responding practices tried to offer appointments at times which were convenient to patients (including early, late, or Saturday morning). 83% provide a practice leaflet to keep patients informed.

Dentists are aware of patients complaining that there are very few NHS dentists who accept new patients. Dentists are also concerned that patients with high treatment needs may have difficult finding a dentist willing to do multiple items of treatment.

Concerns were expressed that some practices have been given much larger contracts than they can treat well but many continue registering patients and not providing regular care. But some practices are severely restricted in the number of patients they are able to treat under the contract; in some cases their contract is too small to deal with the demand for NHS services.

It was also suggested that waiting lists are growing due to increase in demand/need but there is no commensurate growth in NHS provision.

2.6 *Impact of the reforms on provision of preventative care and advice*

Some dentists said they no longer accept new child patients due to impossibility of maintaining standards of prevention. The reforms give little time or incentive for preventive work or dental health education for children. One dentist who would ideally like to spend more time with children to educate them in regard to their oral health said that they do not have any extra time to set aside to achieve this.

Whilst hygienist services are recognised by the profession to be an important preventative measure, under the reforms these are being denied to people on low incomes who cannot afford to access them now.

2.7 *Impact of the reforms on specialist service provision*

The reforms disallow growth potential in delivery of NHS specialist services.

Orthodontics is an area of real concern in terms of reduced access and long waiting times. The reforms are seen to effectively operate a rationing system.

2.8 *Impact of the reforms on Dentists' workloads*

While over two thirds of dentists surveyed say they have a reasonable workload, others consider their workload to be excessive in terms of "endless waiting lists and huge pressures", "a paperwork mountains that fills every lunch break and some evenings", "pressure to achieve UDA targets" and "having no tea break, no lunch break, starting at 8 in the morning and not getting home until after 6. Paperwork requires working on at weekends".

One dentist points out that they "are a dental surgeon and this is what they do best".

2.9 *Impact of the reforms on private dental service provision in Oxfordshire*

The majority (94%) of responding dentists provide combined NHS and private services and many have been forced to take up private work to maintain the viability of their practices.

2.10 *Finally*

It is clear that only a minority of dental practitioners are able to make the current system work to their advantage but it is questionable whether all patients receive an adequate deal in these circumstances. Securing an acceptable level of income (over and above practice overheads) requires an unacceptably swift throughput of patients. This inevitably compromises the dentist's ability to accept those who have complicated dental needs. Current policy is likely to favour shorter rather than longer treatments and is potentially open to abuse. Those on very low incomes who do not qualify for exemption are doubly disadvantaged by the introduction of the new contract. Even when they secure access to an NHS dentist, the costs of some treatments are prohibitive for those not exempt and at the least anomalous for others. Private care is not an option for many, and some people are either going without dental care altogether, or declining elements of treatment needed because of cost. The dental health of children may now be satisfactory, but will not remain so unless a better service at a more attainable cost can be introduced.

3. Evidence from Members of the Public

3.1 *Patient access to NHS dental care*

31% of the 384 people surveyed by the Forum were current NHS patients, 54% were private patients and 14% not registered with any dentist. 3% of NHS patients have to travel over 100 miles to see a NHS dentist.

Amongst the private patients, almost half have been unable to register with an NHS dentist although they wish to do so, and many of these people find the cost of private dentistry excessive in relation to their means.

Some private dentists continue to treat the children of private patients on the NHS, and with the lack of NHS places available, this locks parents into the private system in order that their children can receive dental care.

Finding an NHS dentist in Oxfordshire is a major issue for many people. The procedure for finding an NHS dentist is complex and fraught with misinformation. Many people follow this tortuous path only to fail.

People with high treatment needs are uniquely disadvantaged; even if they can afford to use an NHS dentist they are not welcome as their treatment uses too many units of dental activity which both disadvantages other patients and leaves dentists out of pocket. This also applies to same-day access to emergency treatment where units of dental activity are confined to a daily quota that cannot be exceeded.

Some patients entitled to free treatment during pregnancy are having to pay for dental treatment due to lack of NHS places.

7% of respondents have had to resort to self-treatment at some point.

3.2 *Quality of care provided to patients in Oxfordshire*

Although a few members of the public did identify some quality issues relating to NHS dental treatment they had received, 90% of patients receiving NHS dental care in Oxfordshire say they are happy with the treatment they receive. The shortage of NHS places remains a key issue in Oxfordshire.

4. Conclusion

This Forum believes that the Reforms were introduced with insufficient consultation with patients" groups, insufficient regard to the principles of good dental practice, insufficient consideration of ethical principles and public health interests. Insufficient consideration is also evident of the impact of the Reforms on children, people on low incomes and other disadvantaged groups. The inadequacies and anomalies of the UDA system have resulted in sub-standard dental health provision for many people in Oxfordshire. A more effective contracting system is required that addresses some of the adverse impacts of the current Contract on patients and public in terms of preventive measures and quality and availability of treatment including rationalisation of payments to dentists. The aim should be to promote high levels of both dental and general health in the whole population.

There is a huge swell of public anger reacting to this lack of availability of NHS dental services, and indeed a concern that the current NHS contract discriminates against the dental needs of those who are on low incomes and those with high dental needs. Many dental practitioners are also angry and disillusioned with the reforms.

The procedure to find an NHS dentist who will agree to take patients is seen to be so complex and so dependent of the state of a potential patient's mouth and teeth, that the system discriminates against older and less advantaged people who may not have the means, the energy or the determination to find out how to proceed.

Within such a utilitarian system where individual patient need is secondary to the needs of all patients on a dentist's caseload, inevitably the reforms in their current configuration place many individuals at higher risk of both oral and general health problems. Also, with the associated reduction in dental health promotion activity and reduced access to preventative treatments, Forum members are concerned for the future dental health of those least able to access dental services if further reform of the current system is not enacted.

5. Recommendations for Action

Members of the Oxfordshire PCT Patient & Public Involvement Forum recommend that the Committee agrees the following areas for action:

To revise and update the present dental contractual arrangements to allow:

- A more patient-focused, rather than cost focussed philosophy within existing funding constraints.
- A system where extra funding can be accessed in cases of high dental need.
- Better and easier access to NHS dentistry for all who wish to use it.
- More flexibility within contracts to enable dentists to use their clinical judgement in cases where individual needs may vary.
- Better and swifter access to orthodontic treatment for children.
- A higher level of dental health promotion activity, both individually and in the wider public arena.
- A root and branch review of the current UDA system that takes realistic account of practice overheads and allows more flexibility in choice of treatments and materials.
- A more flexible charging system for patients that more closely reflects the value of dental treatments received.

Copies of the Oxfordshire PCT Patient & Public Involvement Forum's full reports on their Dentist and Public Surveys are available on request from the Forum.

Marion Judd (member)
Oxfordshire PCT Patient & Public Involvement Forum

December 2007

Memorandum by Brian Bird (DS 16)

Dentistry Provision in Devon

Report prepared by Brian Bird on behalf of the PPI Dental Working Group led by Mrs Marjorie Brace

Preamble

Prior to the formation of the Devon PCT in the autumn of 2006, NHS Dental Services and funding were managed by the various "Locality" PCTs. Involvement by the PPI varied from a watching brief to inclusion of representation in the SH & WD PCT Dental Contract Implementation Group. The Government promised access to the service for all over five years ago, but this has remained low and generally less than 30%.

The promise of an improved service and access following the changed procedures operative from April 1st 2006 has not been seen to be a complete success by either the dentists or the public, but for different reasons. Pilot schemes were run in cooperation with dentists on the proposed changes, with plans to change from GDS contracts to the new PDS ones.

These changes guaranteed the supporting dentists significantly higher incomes for providing full time NHS services (designated as 10 half day sessions/week). At April 2006 this was expected to pay them £80,000 plus a further £80,000 for Admin/Surgery costs etc. The Trust has confirmed that the figures quoted are averages based upon a quote by the Health Minister—dentists who moved from GDS to PDS did not get a pay rise to the above levels, their contract sum was based upon their historic NHS earnings.

The dentists, we believe, recognised that GPs were being offered better deals and that not accepting a complete NHS contract was going to be more lucrative. In fact many dentists opted to treat only children or children plus benefit seekers, excluding other adult patients with potential for greater income generation as private patients. These dentists just informed those patients that they were de-listed as NHS patients.

However the PCT has said that the only restricted contracts which were agreed by PCTS reflected existing practice arrangements ie changes which had been made before the contract was introduced. It has been Devon PCTs policy to award new contracts to provide services for all groups of patients. No contracts restricted to particular patient groups have been awarded since the new contract was implemented.

The PCTs, with approval of the DOH, took the easy way out and allowed discriminating contracts, both GDS and PDS, to operate. This has led to excluding the majority of people who are paying or have already paid for over 40 years into the National Insurance Scheme.

The effect on this group of citizens is a public disgrace, with the lower paid and pensioners unable to access and pay for dental care. The Commission for Patient and Public Involvement Dentistry Watch report confirms these views.

Who Pays What?

The DOH needs to provide information on how they arrived at the present charges to the public. The present charges appear to be realistic and easily understandable. However, the lowest charge, that for inspection and cleaning, meant just that. It is not being implemented as dentists invariably charge extra for cleaning, using their dental hygienists and Denplan contracts to charge extra.

The basis on which Units of Dental Activity (UDAs) was calculated and payments made was, in our view, flawed. Our representative on the DCIG raised concerns at the time that the payment of £25/UDA was not soundly based. This payment has been questioned elsewhere as well as the case for additional UDA payments to be reviewed and paid at significantly lower rates.

Overseas Dental Recruitment

The foreign dentists, with few exceptions, have been well received locally. Our concerns are that with open short term contracts operative, they can quickly revert to private practice, which some are reported to have done already. This needs to be confirmed as millions of pounds have been spent on recruitment.

Access to Services

The PPI Forum and members of the public believe that the Government has no real evidence, in spite of increased numbers of dentists, that access has significantly improved across the South West, which was below 30% prior to April 2006. Any claims by the PCTs and Ministers that almost all the public has access to NHS dentistry cannot be substantiated. No accurate statistics can be arrived at from the information gathered and reported by the "Information Centre for Health and Social Care" and endorsed by the Devon PCT.

Dental Financing

The basis of Government funding, we believe, needs to be subject to closer independent scrutiny.

Firstly, that adequate and equitable funding is made available for all residents wishing to use the service. Until sufficient dentists provide a non-discriminatory service, the Government needs to consider providing vouchers for treatment by private dentists in the UK or within the rest of Europe.

We are frequently asked why is it that non-UK nationals (illegal entrants and visitors) can obtain free treatment as benefit seekers, while payers into the system are excluded. Perhaps this level if discrimination needs to be tested in the European Court of Human Rights.

Report to the DCC Health Overview and Scrutiny Committee 22/10/2007 by the Devon PCT Primary Care Manager (appendix 1)

We wish to table this report (appended) to illustrate the latest position in Devon and comment as appropriate.

Dentistry Spend

The reported shortfall, we believe, can safely be attributed to the ready acceptance of discriminatory contracts, as already explained. It is noted that other factors that may contribute to the shortfall include under-performance against contract and closure contracts.

Dental Manpower

The number of dentists employed does not reflect the sessions they actually work for the NHS.

Patients Accessing NHS Dentistry

The method of generating the statistics gives little clue to the total percentage of patients accessing treatment. The 24 months' figures do not recognise the difference between the number of patients treated and patient visits which can be markedly different. This method of calculation glosses over the shortcomings, which the PCT recognises in the last sentence of Dental Manpower.

Recruitment of Dentists

Based on the increased numbers from June 2006 (330) to March 2007 (360), you would have expected more patients to be treated in the period under review. Again, perhaps a reflection of part-time participation in providing NHS service.

Developments 2007–08

These are sparsely placed and the waiting lists still long. Locally orthodontic service is poor. Oral Health is only being practiced for private payment.

The Way Forward

The PPI Forum and public welcome the renewed proposed Government initiatives to improve the service and access.

Conclusions

It may well be that our experiences of inadequate NHS Dental Services in Devon are reflected in many other rural counties, with promises that have failed to materialise to date.

The Devon PPI Forum Dental Group would be prepared to appear before the Health Select Committee to present our case and input a balanced view on behalf of the public, whose wider views have been reported in Dentistry Watch.

Brian Bird
Devon PPI Forum member

APPENDIX 1

NHS Dentistry in Devon

Report to the Devon County Council Health Overview and Scrutiny Committee

Introduction

In April 2006, the new NHS dental contract was implemented across England, replacing the national General Dental Services contract which had been in place largely unaltered since 1948. The new regulatory framework for primary care dental services, introduced a number of important changes which included, new contract arrangements which were based upon moving away from the item of service system, the removal of the registration system, devolvement of the national dental budget to Primary Care Trusts, a new simpler system of patient charges, new National Institute of Clinical excellence (NICE) guidelines on recall intervals for patients.

The new contract arrangements were successfully implemented across the six PCTs that constituted the area now covered by Devon PCT. In line with the national position approximately 4% of dentists across the county chose not to accept the offer of a new contract. In addition to contracts for general dental services to be provided, agreements were also in place for the provision of orthodontic services, sedation, domiciliary visits and urgent dental services.

Dentistry Spend

During the first three years of the dental contract the funding for NHS dentistry is separately allocated to PCTs and does not form part of the PCTs unified budget. This enables the Department of Health to ensure the spending commitments to NHS dentistry are delivered and can be demonstrated. The table below sets out the PCT allocation for NHS dentistry. The dental budget is made up of two separate elements, being the allocation received from central government and the income received through patients charges.

	Allocation from DoH £000s	*Patient Charge Expectation £000s*
2006–07	24,055	8,452
2007–08	25,517	8,817

Whilst the allocation from the Department of Health is a known sum, the patient charge income was unknown and based upon the assumptions made by the Department of Health's figures and had not been tested under the new system. In the first year of the contract the actual income received from patient charges was £6,578,000 representing a significant shortfall against the funding anticipated within forecasts. Significant patient charge income shortfalls have been reported across many PCTs and has reduced the overall level of funding available for dental services.

Dental Manpower

The table below shows the number of dentists who are currently working under open contracts within the PCT area.

	June 2006	*September 2006*	*December 2006*	*March 2007*
Number of Dentists on Open Contracts	330	341	342	360
Dentists per 100,000 population	45.1	46.6	46.8	49

Source: The Information Centre for Health and Social Care.

Whilst the statistics show an increase in the number of dentists under contract within Devon PCT it does not take account of the amount of time each dentist devotes to treating patients under NHS arrangements. A whole time equivalent figure is not available for the amount of time spent undertaking NHS dentistry.

Patients Accessing NHS Dentistry

Prior to April 2006, patients were registered with a specific dentist for NHS treatment and dentists NHS list sizes were used to indicate the number of patients who were regularly accessing NHS dental care. Patient registration was removed with the introduction of the new contract and has been replaced by a measurement of the number of patients who access NHS dentistry in any 24 month period. The table below provides the number of patients registered at 31st march 2006 and the new patients treated measure:

	March 2006	*June 2006*	*September 2006*	*December 2006*	*March 2007*
Patients Registered	344,962	n/a	n/a	n/a	n/a
Children Treated	101,197	101,113	101,552	101,629	102,167
Adults Treated	263,533	262,960	263,576	265,876	269,394
Total Patients treated in Previous 24 month period	364,730	364,073	365,128	367,504	372,011

Source: The Information Centre for Health and Social Care.

The PCT has consolidated the differing arrangements which existed for patients to access an NHS dentist into a single contact point which can be accessed by telephone, letter or by e-mail. This central contact point enables patients to register their name with the PCT and be allocated to a local dental practice as further NHS spaces become available. During the first year of the new contract improvements in access have been achieved through additional investment which has supported new dentists in practices, in Torrington, Barnstaple, and Chulmleigh, new practices have been established in Exeter and in Salcombe. This has allowed the PCT to be able to offer patients who have been on the waiting list a NHS dental service. Whilst information is available through the NHS website, NHS Choices and through NHS Direct, there is more work which needs to done in this area, particularly regarding the accessibility, and accuracy of information to the public about dental services.

In addition to routine dental care there are established arrangements in place to provide access to urgent dental care. During normal hours, patients can gain access to urgent dental care through their own dental practice, all practices have daily emergency appointments available and are usually able to see a patient on the same day or within 24 hours of making contact. For those patients who do not have access to a regular dentist there are Dental Access Centres or salaried dental services provided by the PCT providing urgent care. Services are available in Exeter, Barnstaple, and Newton Abbot within Devon.

An Out of Hours dental service is provided by Devon Doctors, providing call handling and advice on managing a dental condition on weekday evenings and access to an emergency dentist in Exeter, Barnstaple, Newton Abbot and Plymouth at weekends.

Developments During 2007–08

The first year of the new contract has seen significant change for patients, the NHS and for dentists. The PCT has continued to work with dental practices to review performance under their contract to ensure the best use of public funds is achieved and to further improve access for the public. In June 2007, new practices were opened in Exmouth and Okehampton with a total of four extra dentists. Further improvements in access are being planned for Exeter and Crediton, with existing practices increasing their NHS workload. Another new dental practice has been approved for Tavistock and this is expected to open by the end of 2007.

Since June 2007, 6,435 patients have been allocated an NHS dentist, with access being secured in Exeter, Crediton, Newton Abbot, Exmouth, Okehampton, Torrington, Chulmleigh, Barnstaple, South Brent, Kingsbridge and Salcombe.

There are now 7,700 patients on the PCT waiting list and the PCT will continue working with dentists to ensure those patients can be offered a NHS dental service as more spaces become available through the planned developments mentioned above.

Oral Health Strategy

The development of an oral health strategy for Devon is viewed as a key requirement to take forward and inform the commissioning of oral health services in Devon. The strategy will contribute to the strategic review of Health Services across Devon. The strategy is in the early stage of development which is being led by the PCT Oral Health Advisory and will be shared with stakeholders as part of a consultation process.

Andrew Harris
Primary Care Manager
Devon Primary Care Trust

22 October 2007

Memorandum by General Dental Practitioners from the Coventry Local Dental Committee (DS 17)

Dental Services

The role of PCTs in commissioning dental services

Primary Care Trusts (PCTs) often do not try to understand the working pattern of Dental Practices but try to impose their own management agenda. This is often because they do not have any Dental knowledge themselves.

PCTs should have a Consultant in Dental Public Health to give them advice, but in Coventry there is no such person in post.

PCT Officers often have the attitude that as long as Units of Dental Activity (UDAs) are delivered, they are not bothered how this activity is delivered.

The new contract is failing the requirements of high needs patients.

Commissioning mechanism is not transparent, as practices with General Dental Service and Orthodontic contracts were unfairly treated in not allowing for similar number of patients to be treated prior to the change.

PCTs are often sitting on the money rather then spending it on patient care, in instances where a practice may not utilise its total UDA allocation.

PCTs tend to assume that the work output will be uniform day in day out without recognising that patient through put can vary for any number of reasons.

PCTs need to recognise that the quality of dental service provided has to be taken into consideration as well as some quantitative measurement, rather then penalising practices financially if they are not delivering the total UDAs.

PCTs need to recognise that they are relying on the goodwill of dentists who have invested very heavily in their practices to deliver high quality of dental service.

Orthodontic Service is suffering, as this service needs to be commissioned properly.

There is no Consultant in Orthodontics support available.

Numbers of NHS dentists and the number of patients registered with them

Under the new contract, dental patients are not registered with any practitioner.

Previously dentists were paid a nominal fee for registering patients and the dentist was responsible for providing that patient continuing care as well as providing emergency care.

Although the number of NHS dentists may have increased, the amount of work done has decreased.

Number of dentists has been recruited from abroad. They are not familiar with the NHS system and therefore require further training in order to obtain Vocational Training number. Therefore the quality of service provided will be affected.

Orthodontic dental services are also in chaos as practices, which previously could provide orthodontic service and still can provide NHS Orthodontic care are being forced to abandon patients because of their small orthodontic contract values. These practices are being asked to have waiting lists, where none existed before and if the circumstances are suitable there is still no need for waiting lists.

In Coventry, we do not have a Consultant in Orthodontics and therefore no Consultant Orthodontic support available to General Dental Practitioners.

Therefore patient needs cannot be adequately assessed.

Number of private sector dentists and the number of patients registered with them

In Coventry about 15% of practices have gone private after the contract came into being. Therefore patients are being forced to receive private dental care, whereas before 1st April 2006, patients were able to obtain NHS treatment at these practices.

Therefore there is a question mark as to whether access has improved or deteriorated.

The work of allied professions

Under the NHS, very few Hygienists employed. The contract is not very conducive to employing Hygienists or Therapists.

Patients' access to NHS dental care

In some areas of Coventry, access seems to have improved as dentists are advertising for dental patients.

However there are other parts of Coventry where practices have gone private and therefore patients in those areas will have difficulty getting NHS dental care unless they are willing to travel.

The way Dental Charges are levied tends to put patients off dental services as sometimes a patient may need only a small filling and they are having to pay a same charge as someone having ten fillings.

PCTs also look at the dental charges as a way of increasing their revenues.

The quality of care provided to patients

Under the new system, complex treatment needs are not being addressed. Some nervous patients would benefit from use of sedation techniques. However as these techniques are time consuming and require further training and investments, there is no incentive under the new contract to provide these services. Therefore quality of care provided has deteriorated.

As mentioned earlier, orthodontic treatment is not easily available to patients and therefore quality of care has deteriorated. There is very little incentive to provide preventive dental care.

Health gains and quality indicators or number of patients treatments satisfactorily completed should be measured rather then Units of Dental Activity.

Dental activity should be to do with improvement in oral health of patients rather then just measuring fillings or extractions.

General Dental Practitioners are better placed to look after patients rather then PCT administrators, as there numbers seems to be increasing all the time just to monitor statistics and create unnecessary paperwork. Therefore inspiring to improve quality of care is not present in the new contract.

The requirement to come close to target is very difficult, as the treatments should not have to be tailored just to meet the right target.

The extent to which dentists are encouraged to provide preventive care and advice

As mentioned earlier, there is very little incentive in the new contract to provide preventive care and advice. There should be incentives to reduce the decay experience of the public by use of oral health promotion techniques, fluoridation applications, and fissure sealant applications.

If these encouragements take place then better use could be made of Hygienists and Therapists.

Dentists' workloads and incomes

Dentists are highly trained professionals and they are best placed to deliver a high quality appropriate and effective dental care to the public. It seems fewer dentists are doing more work.

If a dentist sets out to provide a high quality dental care to all his or her patients, the dentist may not achieve the targets set. Therefore the dentist is financially penalised which seems so unfair for a person who is trained to put the interests of his patient first.

Dentists would like to be paid for providing higher quality of dental care.

It is high time that PCTs should stop looking at treatments, which generate patient charge revenue only.

Continuing education is very important for any professional person and therefore protected learning time should be there in reality rather then just on paper.

Every Dental Practice should be provided with sufficient resources, so that all staff and dentists can be adequately remunerated and the patients can receive the dental care in the best safe environment.

Under the new system, it is very difficult to set up a new practice. This would also reduce the choice for patients.

The recruitment and retention of NHS dental practitioners

There is no recruitment of practitioners. If practitioners do not provide sufficient patient charge revenue, there is no security of employment. Recruitment is likely to decrease, as fewer newer practices will open.

Vocational Training is inadequate under new contract and trainees get less experience compared to before April 2006. Trainees on completing their course cannot stay with same practice and therefore there is no continuing care relationships with patients.

Retention of practitioners could be improved by providing facilities for postgraduate course participations.

W Sidhu BDS (Sheff) MCDH (Birm) DDPHRCS (Eng)
Honorary Secretary for Coventry LDC

December 2007

Memorandum by Sarah Elworthy (DS 18)

COMMENTS ON THE NEW DENTAL CONTRACT

1. Summary of the Main Points

In my opinion the new dental contract is unable to provide patient centred effective dental care for children because:

1.1 The UDA does not measure effective patient centred care;

1.2 The "banding" system for payments does not reward dental practices for effective patient centred care; and

1.3 The PCT does not have the ability and structure to work with dental practices to set appropriate financial and clinical targets to achieve patient centred effective dental care.

2. Introduction

I am a general dental practitioner of 20 years experience. I own a small three surgery practice in the market town of Cranbrook in Kent. The practice was established 12 years ago. We treat adults as private patients. Children under 18 years of age are offered NHS care. We achieved IiP status in 2000 and the BDA good practice scheme in 2001

The practice mission statement of "integrity, choice and value" underpins our objective of providing effective patient centred, evidence based dental care. We feel we have achieved this under the new dental contract. However we have been unable to achieve our UDA target and are under threat of significant financial penalties. This will means we will have to compromise our standards of care or opt out of providing NHS care for children. I would like the committee to understand why the new contract is failing our practice and therefore our patients. I hope this may be of some use in sorting out the current debacle.

3. Our objectives for NHS Care

To provide the appropriate care and advice to minimise and treat dental disease, and to provide the skills and knowledge to remain dentally fit for life.

4. Strategy

— Effective prevention advice to our patients and their parents from pregnancy onwards.
— Provision of effective preventative treatments ie fluoride varnish, fissure sealants.
— Early detection of dental disease with appropriate but minimally invasive treatment.
— Patient friendly appointments to encourage regular attendance and efficient treatment.
— Fast access to emergency care to minimise distress and maximise treatment success.
— Education in dental health to the wider community.

5. Implementation

Careful consideration of the DoH reports *NHS Dentistry: Delivering Change by the CDO* (England) July 2004 and the *Framework Proposals for primary dental services in England from 2005* gave us encouragement that the above strategy would be valued by the NHS.

Training of current staff and engagement of therapist to provide effective team to support the dentist

We engaged with the PCT well in advance of the new contract to ensure the PCT supported our aims

We utilised our IT systems for information on patient numbers, treatment needs and surgery hours

We utilised our IT system for efficiently and effectively providing flexible appointments, quality control and audit

Support from the PCT in funding via the new contract, and other direct grants from Government initiatives for training and investment in dental surgeries and Oral Health Educators.

6. Advantages of the New Contract

6.1 An adequate regular monthly income has given us the financial security to continue successful and effective strategy for child dental health in Cranbrook.

6.2 The removal of fee per item has given us the flexibility to prioritise surgery time and care to those with greatest need.

7. Disadvantages of the New Contract

7.1 *The wrong measuring stick (UDA)*

The UDA measures treatments provided. It does not measure effective or patient centred care. We have increased the number of children that we care for before the new contract. We continue to conform to the principles of best practice as laid down by NICE and The Royal College of Surgeons We have provided a better level of service and equivalent surgery hours as we did before the new contract. We provide treatment that prevents dental disease, reduces repeat procedures and reduces referrals to (costly) secondary care. Unfortunately this is not valued and does not equate to the required levels of UDA's. If the government wants the PCT's to be responsible for the provision of dental care that is sensitive to patients needs a more appropriate measuring stick is required.

7.2 *Banding; a disaster for patient centred care*

The system of banding discourages dentists from taking on new patients with high dental needs, as greater surgery time for multiple treatments is not rewarded financially. The UDA's can be maximised by forcing patients to book appointments spaced two months apart. We prefer to see children promptly if they need treatment thus limiting disease progression. We want to encourage attendance and so offer convenient appointments after school and increase availability in the school holidays. Most children are dependant on their often busy, working parents to ensure they attend for dental care.

7.3. *Poor management*

The PCT's need to have a good understanding of dental practice in order to work effectively with dental clinicians. The PCT's need to have clear objectives and strategies. These need to be effectively communicated to the dental clinicians. I have had a number of meetings with various PCT managers. Their level of knowledge on dental practice appears to be limited to their own (limited) dental experiences. Factual knowledge on the dental needs for the area appears negligible, and they have no obvious strategies or objectives other than in terms of the UDA and rewarded by the "banding" system. Although I can appreciate the desire to promote competition between dental practices in tendering for contracts, it is the patient care that will suffer if the measured 'units' are not appropriate for the patients needs.

7.4 *Finance*

Our successful dental care has resulted in increased demand from parents for NHS children's dentistry at our practice.

Increased demand has not been met with increased funding. We have spare capacity and would be very happy to provide more NHS care for children. We would be able to work our surgeries more efficiently if we could expand our NHS care for children. The framework proposals 2005 encourages PCT's to support larger more efficient practices that utilise therapists,hygienists and oral health educators. We are saddened that the dental health of the children on our waiting list is being further compromised by these restrictions. Is this because we are in a reasonably affluent area and the PCT do not consider it necessary?

7.5 *Removal of patient register*

No registration results in lack of continuity of care. Building up a good long term relationship with the patient (and for children, with their parents too) is a major part of effective preventative dental care.

7.6 *Conflict of interest*

The PCT appears to have two conflicting roles. To manage the provision of dental care, and to award the contracts for the provision of dental care for all the NHS providers in the area. I cannot imagine a business situation where a manager is working for multiple business that are in competition with each other for contracts issued by the managerial staff. Combined with targets that are not sensitive to patients needs

7.7 *Private/NHS partnerships*

There appears to be reluctance for mixed practices. However with limited funding and regional socio-economic variations this would be something to be harnessed rather than ignored.

From my experience most dentists do not opt for private dentistry for purely financial gain but to enhance patient care and regain professional satisfaction.

7.8 *Clarity*

Can the government (or rather the tax payers) afford to provide dental care for the whole population? Should the politicians decide the priority groups, and the funding available? The managers and clinicians can then set realistic and achievable objectives for the provision of adequately funded dental care for those groups.

8. Conclusion

I sincerely hope this brief over view is helpful to the committee. We have provided the dental care that the DoH proposed in their reports and implemented the new contract in the same spirit. We have succeeded in providing effective patient centred care. We have not achieved our UDA target and have been threatened with significant reductions in funding.

Sarah Elworthy BDS

December 2007

Memorandum by the British Dental Association (DS 19)

NHS DENTAL SERVICES

1. Executive Summary

1.1 The new dental contract has failed to meet the Government's own success criteria for the future of NHS dentistry, as set out in the Department of Health (DH) report *NHS Dentistry: Options for Change* and which was widely supported by the profession.

1.2 Despite its stated aims, the new contract has both failed to free dentists from the workload "treadmill" and to allow time to provide the preventive care that is essential to reduce the oral health inequalities which still exist across the country.

1.3 A prevention-based system could be delivered if the NHS contract used a range of quality-based performance indicators rather than sole reliance on a single flawed output measure. Instead, dentists are facing financial penalties derived from untested targets.

1.4 Patient groups, dentists and the Government's own figures reveal patients still face problems finding NHS dental care. Confusion also exists over the "registration" of dental patients, which was abolished by the reforms. Clarity is required over what is meant by "access" to dental care and the impact on the nation's oral health of a new system which seems to work against continuity of care for individual patients.

1.5 Primary care trusts (PCTs), now responsible for the local commissioning of dental services, must be given the resource required, in both funding and expertise, to fulfil their new role effectively and meet the oral health needs of their communities. Strong working relationships should be developed between primary care trusts and dentists to enable them to plan how to meet these needs.

1.6 The majority of dentists work in a mixed economy, providing both NHS and private care. The relation between the two is complex with many practices effectively using private income to subsidise NHS work. The private market is now growing and set to expand further. Dentists who move towards private practice are prompted by the opportunity to spend more time with individual patients and focus more on prevention, and do not experience significant increases in income.

1.7 To date, dentists have propped up NHS dentistry by virtue of their professional relationships with patients. However, the target-driven nature of the new contract, which fails to encourage prevention, threatens the continuity of care. The financial penalties and uncertainty faced by many dentists puts the future of NHS dentistry at risk.

2. *Introduction and Background*

2.1 The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its 23,000-strong membership is engaged in all aspects of dentistry including general practice, salaried services, the armed forces, hospitals, academia and research, and includes students.

2.2 The new dental contract impacts on dentists in all areas of the profession. The focus of this evidence is principally on general practice, but also has consequences for salaried primary dental care services. This evidence applies equally to general dental services and personal dental services contracts which, in contrast to their equivalents in primary medical services, are almost identical.

2.3 The House of Commons Health Committee last reported on NHS dentistry in 2001. The committee called for a new, long term strategy for NHS dentistry, reporting that the system of remuneration in the general dental service at that time was the main factor for dissatisfaction among both professionals and patients.[5] Following that report, the DH and BDA worked together on *NHS Dentistry: Options for Change,*[6] a report which considered radical options for modernising NHS dentistry. The DH and BDA's key aims for reform were to:

— move towards locally commissioned and funded services, responsive to local health needs;

— experiment with different ways for paying dentists; and

— place prevention at the centre of dental care.

2.4 Consensus exists among the dental profession and patient groups that these aims are not being met. The Government's own data demonstrates that its reforms are failing to meet important aspects of its own success criteria.

2.5 The fundamental cause of the failure of these reforms remains that which was identified by the committee in 2001: a system of remuneration which is directly and indirectly causing dissatisfaction among both professionals and patients and hindering the provision of prevention-focused dentistry.

2.6 The BDA welcomes the Secretary of State's commitment to make public health the priority of the DH, but is concerned that these reforms will stall positive progress to promote good oral health and tackle health inequalities, which continue to blight the health chances of the most disadvantaged groups.[7]

3. The Role of PCTs in Commissioning Dental Services

3.1 The BDA supports the development of dental services to meet the needs of local patients. Providing services based on assessment of local communities' needs, allows longstanding health inequalities and "dentistry deserts"[8] to be addressed.

3.2 To commission dental services successfully, PCTs must have the right resources, in terms of both funding and expertise, and engage with local dentists and patients. However, the varying success with which PCTs have been either willing or able to do this has resulted in a new postcode lottery of NHS dental provision. The difficulty faced by some PCTs when commissioning dental services results from their commissioning budgets being based on previous spending levels. Therefore, areas which were historically under-funded before the new contract continue to be so.

3.3 The BDA has called for the Government to allocate full dental budgets for PCTs so that they are no longer reliant on patient charge revenue. In the first year of the new contract, PCTs were required to collect approximately 25% of their dental commissioning budget via payments from patients who must pay for NHS dentistry. However, in 2005–06 patient charge revenue was £159 million (26%) lower than expected by the DH.[9] PCTs were forced to cover this deficit by a combination of commissioning less dentistry than they otherwise should have and by implementing inflexible performance targets for dentists. Reliance on patient charge revenue ensures that PCTs' dental commissioning budgets remain unpredictable for future years.

3.4 The funding predicament faced by PCTs comes in the wider context of the chronic under-funding of NHS dentistry. The proportion of the NHS budget spent on dentistry in England is now lower than it was in 2002–03, at only 2.8%.[10] Unless the Government invests additional funding into NHS dentistry the only source of further growth to meet demand is through the private sector.

3.5 The National Audit Office warned in 2004 that PCTs would need "to develop new expertise in dentistry" given that they had "little experience of high street dentistry".[11] The development of effective working relationships with local dental committees and local dentists is a crucial part of addressing this requirement. The BDA is playing a proactive role in providing advice to support this process, a contribution recognised by the DH.[12]

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5 *Access to NHS Dentistry*, report of the House of Commons Health Committee, 2001, paragraph 22

6 *NHS Dentistry: Options for Change*. Department of Health, 2002.

7 According to a survey of five year olds conducted by the British Association for the Study of Community Dentistry, there is a seven-fold difference between PCTs in England with the best dental health and those with the worst. By the age of five, more than a third of British children have suffered tooth decay, missing teeth or fillings; in some parts of the country as many as three-quarters of children are affected.

8 *Gaps to Fill: CAB Evidence on the First Year of the NHS Dentistry Reforms*. Citizens' Advice, 2007

9 According to figures published by the Department of Health, 23 August 2007, patient charge revenue only generated £475 million instead of the expected £634 million, resulting in a shortfall of £159 million in the dental budget. The NHS Dental Statistics for England 2006–07 are available from the Information Centre for NHS and Social Care.

10 NHS Primary Dental Care expenditure data for 2006–07 provided in a parliamentary answer. NHS data from the NHS Operating Framework for 2007–08

11 *Reforming NHS Dentistry: Ensuring Effective Management of Risks*; National Audit Office, 2004, page 8 and Part 2

12 Barry Cockcroft, Chief Dental Officer for England, Speech to BDA Conference, May 2007

3.6 The expertise of consultants in dental public health is also vital for effective strategic commissioning. The recent loss of a number of consultant posts is therefore of great concern. This loss of dental public health capacity also undermines the Secretary of State's elevation of public health to the top of the national agenda, and his recognition that this is "pivotal" to reducing health inequalities.[13]

3.7 It is vital that PCTs, having drawn on these resources, publish plans on how they intend to reduce health inequalities and improve the oral health standards of their communities.

3.8 To commission effectively, PCTs also need information about the oral health of their patient cohort. The Adult Dental Health Survey, carried out every ten years by the Department of Health, is an invaluable tool to monitor populations' oral health—and indeed will be essential to evaluate the impact of the current reform programme. The BDA is calling for the funding of the survey, which has been delayed a year, to be secured.

4. Numbers of NHS Dentists and the Numbers of Patients Registered with Them; And the Numbers of Private Sector Dentists and the Numbers of Patients Registered with Them

4.1 When considering the relationship between NHS and private care, it must be recognised that the vast majority of dentists work in a mixed economy. It should also be noted that since 1 April 2006 a patient can no longer be registered within the NHS.

4.2 The vast majority of general dental practitioners make available to patients a combination of NHS and private care. The Options for Change report acknowledged that this model of mixed provision should be welcomed: "private dentistry contributes to patient choice, provides dentists with options and independence and delivers those treatments that the Government does not wish to finance".[14]

4.3 Analysis of DH data suggests that the value of the private dentistry market is now at least equal to that of NHS provision and that it is continuing to expand.[15] The 2005–06 report of the review body on doctors' and dentists' remuneration showed that in most practices there was cross subsidy of costs between private and NHS work. General dental practices are independently managed businesses that contract to provide services for the NHS. Unlike general medical practitioners, dentists have to buy their own premises, buy their own equipment and employ their own staff. This report demonstrates that, in effect, the income from private treatment is keeping NHS practices in business.[16]

4.4 According to the DH, there are now 570 fewer dentists holding NHS contracts in England than there were prior to the introduction of the new dental contract. However, the BDA believes the real loss to the NHS since April 2006 is approximately 1,000 dentists.[17]

4.5 A further indicator of change in the current dental market is the rise in the number of patients who have joined private capitation schemes to pay for their dental care. To take just one example, Denplan, one of the UK's largest providers, has seen a 30% increase in patient registration since 2004.[18]

4.6 Patient registration was first introduced to NHS dentistry as part of the contract reforms in 1990. It was abolished as part of the 2006 reforms. BDA members are told by their patients that they greatly value a long term relationship with their dentist. The BDA is concerned that the loss of registration may have an adverse effect upon the continuity of care received by patients. The 2006 contract has created a system that favours episodic, pain-relief oriented treatment rather than promoting disease prevention. We discuss the number of patients accessing dental services in section 6.

5. The Work of Allied Professions

5.1 Major changes are underway in relation to Dental Care Professionals (DCPs) with the advent of regulation bringing additional responsibilities and accountability. The BDA has strong links with the DCP associations, and welcomes and is committed to the development of the wider dental team and the professional growth of individual team members.

[13] "The Healthy Society", Speech in the House of Commons, Rt Hon Alan Johnson MP, Secretary of State for Health, 12 September 2007

[14] *NHS Dentistry: Options for Change*, Department of Health, 2002.

[15] *The UK Dentistry Market Development*. Market and Business Development, 2007. The health intelligence company Laing and Buisson reached similar conclusions in 2003.

[16] DDRB supplementary evidence, analysed and published in the BDA "Policy Bulletin", August 2005

[17] According to the DH, at 31 March 2007 there were 21,041 dentists performing NHS dental services in England. The BDA argues that the comparable figure for pre-April 2006 would be approximately 22,073. This is derived by taking the old England and Wales general dental services figure of 21,254, a number supplied by the Dental Practice Board. Welsh GDPs are then subtracted, which is approx 1,031 (source: BDA Wales). But we then incorporate the BDA estimate of 1,200 salaried dentists in England and 650 VDPs. This calculation suggests a net loss of 1,032 NHS dentists.

[18] Denplan currently has 1.8 million registered patients, compared with 1.3 million patients three years ago, an increase of approximately 30%. Information from the Denplan Media Centre.

5.2 Dental nurses have always played an essential role in the dental team. A wider group of professionals, including therapists and hygienists, also have positive contributions to make. However, their potential is not being fully realised because of the cost pressures within NHS general dental practice (discussed at section 8, below). In addition, DCPs and dentists share many of the same concerns about the viability and stability of NHS dental practices.

6. Patients' Access to NHS Dental Care

6.1 The BDA urges the Department of Health to define what "access" to NHS dental care should mean. The BDA argues that the new system favours sporadic and discrete treatment episodes rather than long term continuing care for those patients seeking a regular treatment pattern.

6.2 Even taking the DH's reductive interpretation of access, the April 2006 reforms have failed to improve access for patients to NHS dentistry. The latest figures from the DH show that over a 24 month period—the maximum recommended period between dental examinations[19]—27.8 million patients accessed NHS dental services.[20] This is a reduction of 266,000 patients since the 2006 reforms.

6.3 In March 2007 the BDA published the results of a survey of dentists' experience of the new general dental services contract. Eighty-five per cent of respondents said that the new contract had not improved access to NHS dental services for patients, 88% said that access to orthodontic services had not improved and only 10% were able to take on new patients.[21]

6.4 Research conducted by patients' organisations reinforces these concerns. Citizens Advice states that patients still face significant problems finding a dentist.[22] Market research published by Which? also shows significant regional variation in the availability of NHS dental care, with an average of just a third of practices across England taking on new NHS patients.[23] The most recent Wanless review on healthcare spending shows public satisfaction with NHS dentistry to be lower than for all other NHS services, with a decline of 20 percentage points between 1998 and 2005.[24]

6.5 The pressures in general dental practice have also led to increased demand on the salaried primary dental care services and on dental hospitals. A BDA survey of clinical directors showed that 87% of services were experiencing increased waiting times for specialist care due to these additional referrals.[25] These services are often designed specifically to treat patients with special or complex treatment needs; any disruption therefore risks creating difficulties for patients in the greatest need of care.

6.6 It has been at least seven years since the Government conducted even a rudimentary assessment of the unmet need for dental care. It found then that two million patients who wished to receive NHS dentistry, were unable to do so.[26] The BDA believes this underestimates the size of the current problem. The Healthcare Commission's national patient survey in 2005 found that 69% of patients not registered with an NHS dentist would like to have been.[27] This equated to approximately 15 million people.

7. The Quality of Care Provided to Patients; And the Extent to which Dentists are Encouraged to Provide Preventive Care and Advice

7.1 Dentists want to provide high quality care for patients within a prevention-based system, as proposed in Options for Change. Yet patients' quality of experience is now threatened by the time pressures on dentists generated by the new target-driven system.

7.2 These contract reforms have introduced a new system for measuring the performance of NHS dentists. A target for the number of units of dental activity (UDAs) a dentist or practice must perform annually is written into each contract. For simple procedures, such as a check-up, dentists are awarded one UDA; work that also involves intervention, such as fillings and root canal treatment is worth three UDAs; and dentists are awarded 12 UDAs for work that also necessitates laboratory involvement such as bridge-work or dentures.

7.3 There are significant anomalies within this system, which result in it being more complex and unfair than the above description would suggest. Dentists earn the same number of UDAs regardless of the number of items of treatment provided within a course of treatment. For example: a patient requiring one filling would fall into the Band 2 course of treatment, earning for the dentist three UDAs. A patient requiring four fillings and root canal therapy would fall into the same band, also generating for the dentist just three UDAs.

[19] *Dental recall: recall interval between routine dental examinations*, National Institute for Health and Clinical Excellence, 2004.
[20] *NHS Dental Statistics for Quarter 1, 2007*, Information Centre for Health and Social Care
[21] BDA survey of members, March 2007
[22] *Gaps to Fill: CAB evidence on the first year of the NHS dentistry reforms*. Citizens' Advice, 2007
[23] *Check-up on NHS Dentistry: dental contracts one year on*, Which?, March 2007
[24] Wanless, D. *Our Future Health Secured? A review of NHS funding and performance*. King's Fund, 2007, page 223.
[25] BDA survey of clinical directors, September 2006
[26] *Modernising NHS Dentistry: Implementing the NHS Plan*, Department of Health, 2000, par 2.17
[27] Survey of patients: primary care trust, Healthcare Commission, 2005, page 17.
ONS data shows the population of England to be 50.8 million. The Healthcare Commission found that 43% of patients were not registered with an NHS dentist; of those, 69% wanted to be. This equates to approximately 15 million people.

7.4 As well as appearing arbitrary, this system of performance measurement fails to promote a more preventive approach to care because of the pressures on time it creates. A recent report from the London Assembly called on the DH to "consider how it could revise the current NHS dental contract so that preventive care is built into the way PCTs manage and monitor dental contracts and should consider whether dentists should be financially rewarded for providing preventive advice".[28]

7.5 One of the Government's stated aims of the reforms was to get dentists off the workload "treadmill" to allow additional time for preventive care. The last official study into general dental practitioners' workload showed that a fully committed NHS dentist worked 43 hours per week, in that time seeing 140 NHS patients.[29] In a survey of dentists' attitudes to the 2006 reforms, 82% strongly disagreed with the statement that "the new NHS contract has removed the treadmill effect". For fully committed NHS dentists this figure was 88%.[30]

7.6 The UDA is more than a performance indicator: it is the principal unit of currency of the new contract. Anything less than 96% of UDA performance may lead to serious repercussions for NHS dentists. Data supplied by the NHS following a freedom of information request showed that in 2006–07 almost half of dental contractors actually failed to provide the required number of UDAs.[31] The proportion of dentists who met their UDA target was only 20%, if those who performed additional unfunded NHS services—ie at their own expense—are also included.

7.7 BDA research found some areas where PCTs have taken a constructive and sensitive approach to dentists missing their UDA targets; but others did not. The variability of PCTs' approach is illustrated by the research, which found that of practices that had not achieved 96% of their target in the first year of the new contract, almost 40 per cent faced clawback of money already paid by their PCT. Just over 35% said that their PCT had insisted that the uncompleted UDAs be performed in the 2007-08 contract year.[32]

7.8 The BDA is aware of clawback where dentists' work rate has remained unchanged from previous patterns; some of these cases involve clawback of tens of thousands of pounds. To take just one example: a fully-committed NHS dentist in the Wirral felt forced to close his practice having been required by his PCT to pay back £20,000.[33]

7.9 The BDA supports the DH's oral health plan, *Choosing Better Oral Health*,[34] and the "prevention toolkit" that derives from it. But the reality is that when dentists spend additional time with patients to explain about oral hygiene, nutrition and disease prevention they do so at the risk of missing their UDA requirement or by disproportionately increasing their clinical working time.

7.10 The BDA has consistently argued that the UDA is a flawed measure, which was untried and untested before implementation, and has called on the Government to scrap it as the sole indicator of performance. It supports the Department of Health's advice to PCTs to include factors such as oral health, access, quality and patient experience in dentists' contracts. This approach would enable PCTs to develop and agree contracts with dentists and practices that reflect the needs of patients in their area.

7.11 It appears from two reports that the contract reforms have resulted in a change to the complexity of NHS courses of treatment.[35] According to the DH "the new contractual arrangements were designed to encourage simpler courses of treatment, where clinically appropriate, with less complex and invasive procedures".[36] These preliminary changes to treatment complexities should be seen in the context of the majority of dental contractors missing their UDA targets, as discussed above.

8. Dentists' Workloads and Incomes; The Recruitment and Retention of NHS Dental Practitioners

8.1 The implementation of the new contract has prompted many dentists to question their future in NHS dentistry. BDA research shows that, a year into the reforms, dentists were more concerned than ever about their long term future in the NHS.[37] Dentists' concerns relate to the target-driven nature of the new contract and how this influences their clinical practice and the financial security of practices.

8.2 The BDA argues that issues around recruitment and retention can only be addressed by tackling the faults in the new contract and safeguarding future funding levels for NHS dentistry.

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[28] *Teething Problems: A Review of NHS Dental Care in London*, London Assembly Health and Public Services Committee, November 2007. page 21.
[29] *Review Body on Doctors' and Dentists' Remuneration; Supplement to the 31st Report*. Office of Manpower Economics, 2002, pages 69 and 100.
[30] BDA survey of members, March 2007
[31] BDA analysis of information supplied by the NHS Business Services Authority showed that 47% of dental contractors failed to provide at least 96% of the contracted number of units of dental activity.
[32] BDA survey of local dental committees and PCTs, August 2007
[33] The case referred to was that of Dr Clive Morgan, of Greasby in Wirral PCT.
[34] *Choosing Better Oral Health: An Oral Health Plan for England*, Department of Health, 2005.
[35] *NHS Work Stabilised at All Time Low*, the Dental Laboratories Association, 2007.
Dental Treatment Band analyses: England 2007, Information Centre from Health and Social Care
[36] *NHS Dental Reforms: One year on*, paragraph 4.6. Department of Health, 2007.
[37] BDA survey of members, March 2007. This showed that 57% of dentists were less confident about the future of their practice than they were two years previously. This compared to only 27% when asked that same question in 2002.

8.3 Dentists have been moving away from the NHS since the early 1990s, a trend which the 2006 reforms have exacerbated. This movement is manifest in individual dentists leaving the NHS entirely and others changing the balance of their practice to carry out a greater amount of private care. Information from the NHS highlights the extent of the shift towards private dentistry.[38] Using NHS earnings as an indicator of commitment, the percentage of total NHS work fell from an average of 47.6% of earnings in 2004–05 to 41.9% in 2005–06, a fall of 5.7%. The largest reduction was for dentists aged under 35, whose NHS earnings as a percentage of total earnings fell by 20.7%. Analysis of the attitudes of senior dental school students suggests that the future dental workforce expects to spend a smaller proportion of its time delivering NHS dentistry. The supply of NHS dental hours could be further reduced by these students' intention to take longer career breaks to raise children and earlier retirement than the current workforce.[39]

8.4 The reason for this shift towards private practice is not to earn more money. Data from the DH suggests private dentists are more able than NHS dentists to invest in their practices, in terms of the ability to pay for modern equipment and premises.[40] The same DH data demonstrates only a small difference in earnings between predominantly NHS and predominantly private dentists, of approximately 6%. Instead, the BDA's research identifies that dentists move away from the NHS in order to spend greater time providing prevention-based care to their patients.[41]

8.5 In terms of recruiting new NHS dentists, a survey of last year's vocational dental practitioners—newly qualified dentists—found that by the summer, more than one in five had still not managed to secure employment for the coming year; this is three percentage points up on the same time 12 months before.[42] Among those that had yet to secure a job, many reported that their lack of experience was a key factor hampering their search for employment. This is symptomatic once again of the new target-driven UDA system which strongly favours productivity over a focus on prevention.

9. Oral Evidence

The BDA would be pleased to give oral evidence to the committee if it would be helpful to the inquiry.

British Dental Association

December 2007

Memorandum by Castle College (DS 20)

DENTAL SERVICES

A) Executive Summary

1) The concerns raised in this submission relate to the reduction in the prescribing of Dental Custom Made Dental Appliances manufactured for patients of Dentists, through UK dental laboratories by UK Dental Technicians. As regulated members of the UK dental team, Dental Technicians are extremely concerned that their livelihood and role is being lost from the highly skilled Dental Care workforce. This appears purely due to a change in prescribing by NHS dentists when "working the new contract system" rather than related to patients needs.

2) The effect has so far appears to be:

i. Loss of UK jobs in Dental Technology within these private small medium enterprises.

ii. Individuals moving out of their highly specialised Dental Care Profession role and a loss of fully competent dental technicians from the UK workforce.

iii. A future need to any increase the provision of NHS appliance prescribing is likely to be fulfilled by pan-world supply of custom made dental devices, thus increasing imports.

3) Only local data is available regarding the effect on dental technicians within the Oral Health care team, as little or no information is collected centrally and they are seen as non NHS employees. But are expected to respond to the "Team Ethic" of dentistry.

4) We would welcome the opportunity to present orally at the evidence sessions.

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[38] *Dentists' Earnings and Expenses Report 2005–06*, The Information Centre for Health and Social Care:
[39] Stewart F, Drummond J, Carson L, Theaker E: *Senior Dental Students' Career Intentions, Work-life Balance and Retirement Plans*, British Dental Journal, 2007, 203 (5) 257–264
[40] *Dentists' Earnings and Expenses Report 2005–06, The Information Centre for Health and Social Care*
[41] BDA Private Practice survey, 2002
[42] BDA survey of vocational dental practitioners, June-August 2007

ISSUES RAISED

B.1 *The work of allied professionals (Dental Care Professionals—DCP's)*

a) Dental Technicians have seen their work load adversely affected by a dramatic downturn in the NHS prescription requests for Dental Appliances, since the April 2006 contract introduction. Some Dental Laboratories have therefore gone out of business.

b) This has both been; (1) reduction in the number of appliance making requests, and (2) a reduced content in NHS appliance prescriptions ie more single items requested.

c) There is local evidence that the types of appliances requested under the NHS has also changed and this is seen as requests for more low priced alternative appliances.

d) Dental Technicians are not part of the NHS, but are an integral part of the dental team.

e) There has been a downturn in employer recruitment of new trainees in many areas.

f) Loss of UK Dental Technology jobs followed the introduction of the new contract, but no government body appears to record such movement in specialist labour.

g) The apparent marketing of appliance to Non EU based dental laboratories is likely to further decimate the UK based Dental Laboratory industry.

B.2 *Patients Access to NHS Dental Care*

a) It would appear that NHS patient access to Custom Made Dental devices has been reduced since the introduction of the April 2006 contract—records in SME's.

b) Generally a reduction in the type, volume and actual numbers of NHS appliances seen.

c) The change in prescribing since April 2006 might be attributed to;

(1) Over prescribing in previous years—N.B. What evidence is available of such?

(2) Reducing the prescription value during the initial phase of the new contract, or

(3) Dentists limiting prescribing of custom made dental devices to control cash flow out of the dental practice to maintain their own financial stability.

B.3 *The quality of care provided to patients*

a) Limiting the types of custom made dental appliances offered under the NHS could for that proportion of the general public who rely on the NHS for their dental care severely limit options offered. Is approx 40% of UK population registered with an NHS dentist?

b) The changes in prescribing of custom made dental devices is concerning, if patients are only being offered one restoration at a time, when three or four are required. This might also be a consent issue.

B.4 *The recruitment and retention of NHS dental practitioners*

a) Dental Technicians are currently registering to be part of the Oral Health Care team.

b) Dental Technicians training is highly specialised and related to dedicated appliance constructing skill competences (ref: Skills for Health—National Occupational Standards).

c) Initial training takes 3+ years, on which to build enhanced special skills. An ability to manufacture a wide range of appliance requires years of dedicated personal training and development. These skills have little relation to other vocational skills sets.

d) Low recruitment for part time training is now a factor, as employers working for the NHS are concerned at a reducing NHS prescription value. Some are therefore looking towards novel cost reduction or production of dental appliance elsewhere eg China.

e) There has been a steady closure of training establishments for Dental Technician throughout the UK. Some educational providers have maintained their dental technology provision by marketing to international students or solely to UK Hospitals.

f) Retention of dental technicians within the Small Medium Enterprises who manufacture custom made NHS dental appliances is mainly dependant on a continuation of prescription requests for NHS work.

Tony Griffin
Director of Health Science and Manager of the School of Dental Care Professionals

December 2007

Memorandum by the Oral Health Task Group of Lancashire County Council's Adult Social Care and Health Overview and Scrutiny Committee (DS 21)

DENTAL SERVICES

1. Executive Summary

1.1 Lancashire County Council's Adult Social Care and Health Overview and Scrutiny Committee considered submissions on the subject of "Access to NHS Dentistry" at its meeting on 4 September 2007. The submissions included a report from a consultant representing the three Primary Care Trusts in Lancashire on the implementation of the new NHS Dental Contract, a contribution from a practising NHS dentist, and public consultation outputs from the Life in Lancashire Citizen Panel and responses to media requests for public experiences and perceptions.[43]

1.2 Members of the Scrutiny Committee were concerned that the reports they received indicated there was cause for concern about oral health standards in Lancashire. To further investigate the subject a Task Group of elected members was established who made the decision to provide a submission to the Health Select Committee regarding oral health in Lancashire, in order to contribute to the national debate.

1.3 This memorandum represents the views of the Oral Health Task Group which includes County Councillors Terry Aldridge, Miles Parkinson, Mike Calvert and Stephen Sutcliffe and Wyre District Councillor Ramesh Gandhi.

2. Recommendations

2.1 The NHS Dental Contract should be re-examined in light of the potential limiting effect of Units of Dental Activity on delivering preventative care and advice.

2.2 A public education campaign should be delivered on the benefits of good oral hygiene from an early age, particularly targeting children and young people, and to promote accessing dental care for preventative rather than remedial treatment.

2.3 PCT commissioning should deliver investment into preventative treatment and advice to deliver good oral health.

2.4 The new system of dental charge bands should be publicised to address the public perception of free dental care for all.

2.5 PCT commissioning should provides appropriate and equitable service provision taking into account urban and rural needs and barriers to access such as deprivation which can limit mobility and travel horizons.

2.6 The NHS should ensure that enough trainees enter the system to sustain and raise the number of Dentists.

3. Introduction

3.1 Lancashire has a population of 1.1 million people experiencing on average lower levels of oral health than nationally.

3.2 Lancashire County Council's Adult Social Care and Health Overview and Scrutiny Committee comprises fifteen county councillors and 12 co-opted councillors representing the district councils of Lancashire, and enables closer two tier working to consider social care and healthcare developments across the county.

3.3 Members of the Scrutiny Committee were concerned that the reports they received indicated there was cause for concern about oral health standards in Lancashire. To further investigate the subject a Task Group of elected members was established who made the decision to provide a submission to the Health Select Committee regarding oral health in Lancashire, in order to contribute to the national debate.

3.4 The following information comprises evidence considered by the Oral Health Task Group with concern and recommendations for the attention of the Health Select Committee.

4. The role of PCTs in Commissioning Dental Services

4.1 The PCTs in Lancashire have begun the process of developing Oral Health Strategies. The strategies include oral health assessments, actions to improve oral health and actions to improve services. Central Lancashire PCT has published its Oral Health Strategy, whilst North and East Lancashire PCTs are in the process of developing theirs.

[43] Life in Lancashire Wave 19—Dentistry in Lancashire (2007) Corporate Research and Intelligence Team, Lancashire County Council. NHS Dentistry Consultation (2007) Corporate Research and Intelligence Team, Lancashire County Council

5. Numbers of NHS Dentists and the Numbers of Patients Registered with them

5.1 It is the understanding of the task group that dentists no longer hold "registers" of patients following the implementation of the 2006 reforms. This may have led to confusion amongst patients and longer waiting times for appointments.

5.2 As part of their investigation, the Overview & Scrutiny Committee commissioned a survey. The survey was distributed to the "Life in Lancashire" Citizen Panel, which is demographically representative of the population in the county. Results are weighted to reflect this. The public perception as identified through the Life in Lancashire Citizen Panel shows that more than three-quarters of all respondents (78%) think it is difficult to register with an NHS dentist, nearly half (47%) are dissatisfied with the availability of NHS dental services, half of respondents (52%) said they are registered as NHS dental patients.

6. Numbers of Private Sector Dentists and the Numbers of Patients Registered with them

6.1 The Life in Lancashire Citizen Panel found one in three people were private patients. These people were most likely to be from the AB socio-economic groups. The majority of people who are registered privately said it was because their dentist stopped providing NHS cover (72%).

7. The Work of Allied Professions

7.1 The Task Group was concerned that patients recommended for a protracted period of care with an allied professional such as a hygienist or orthodontist would be deterred by the cost.

8. Patients' Access to NHS Dental Care

8.1 The Life in Lancashire Citizen Panel found that one in five people don't have a dentist at all. One in 12 respondents has tried to register with an NHS dentist in the last year, going up to 21% for those without a dentist. Half of the respondents who have tried to register with an NHS dentist in the last year are still unregistered with a dentist (48%) with the main problem experienced being that there were no NHS places available locally (70%). NHS patients have to travel shorter distances than private patients with half of those from socio-economic group DE living within a mile of their practice.

8.2 The Task Group noted that patients were not prepared to travel very far for a dentist and that this was affected considerably by the level of deprivation experienced by the individual.

8.3 Many patients use Dental Access Centres for remedial treatment as they do not have a regular dentist. Such treatment would not take into account general oral health concerns or provide preventative advice or treatment. It is unclear whether those who use Dental Access Centres are satisfied with being able to have emergency treatment when necessary or whether they would prefer to access a general dental practice for preventative treatment and advice.

8.4 There is a concern about the accuracy of the waiting lists for dental practitioners as to whether they reflect the true number of patients or individuals representing families without a dentist.

8.5 The task group felt that further consideration should also be given to the needs of vulnerable population groups and more accessible service provision appropriate to their needs.

9. The Quality of Care Provided to Patients

9.1 The Task Group considers that NHS dentists provide a good remedial service to patients. However there is not enough effort put into preventative advice for good oral health.

10. The Extent to which Dentists are Encouraged to Provide Preventative Care and Advice

10.1 The Units of Dental Activity are not considered to allow for preventative care and advice to be administered. There were particular concerns that in areas of deprivation and poor levels of oral health, UDAs did not allow NICE guidance on dental recalls to be followed as there was insufficient time to work with more complex cases and in areas of poor oral health.

11. Dentist Workloads and Incomes

11.1 An individual General Dental Practitioner raised concerns with the Committee about the Units of Dental Activity allocated within a NHS Dental Contract and their potential to limit capacity. The case was presented that the number of UDAs within the specific practitioner's contract were not sufficient to fill their normal working week and that the dentist effectively had spare capacity to treat patients that was not contracted by the PCT. It was noted that patients with poor oral health would take up large portions of UDAs thereby reducing the overall number of patients that could be seen by a particular Dentist. It was of

concern that this could potentially be a disincentive to treating patients with poor oral health. As there was no further funding available from the PCT to commission the additional capacity, effectively this individual dentist only worked part-time and could not treat additional NHS patients.

11.2 There was a perception that some NHS Dentists experienced considerable workloads leading to lengthy waiting times for patient appointments. This delay could contribute to the perception that NHS Dentists are hard to access in an emergency.

12. The Recruitment and Retention of NHS Dental Practitioners

12.1 The Task Group was concerned NHS dental practitioners were becoming private practitioners as a result of the new NHS contract, and that this was chiefly due to a combination of the financial constraints and a reduced ability to provide care offered by the contract.

12.2 There was additional concern that dental practitioners recruited from outside of the UK were only staying short term and that trainee dentists did not intend to stay within the NHS due to the financial constraints of the contract and the burden of study costs.

13. Recommendations for Action

13.1 The NHS Dental Contract should be re-examined in light of the potential limiting effect of Units of Dental Activity on delivering preventative care and advice.

13.2 A public education campaign should be delivered on the benefits of good oral hygiene from an early age, particularly targeting children and young people, and to promote accessing dental care for preventative rather than remedial treatment.

13.3 PCT commissioning should deliver investment into preventative treatment and advice to deliver good oral health.

13.4 The new system of dental charge bands should be publicised to address the public perception of free dental care for all.

13.5 PCT commissioning should provide appropriate and equitable service provision taking into account urban and rural needs and barriers to access such as deprivation which can limit mobility and travel horizons.

13.6 The NHS should ensure that enough trainees enter the system to sustain and raise the number of Dentists.

December 2007

Memorandum by the Socialist Health Association (DS 22)

PRIMARY CARE DENTAL SERVICE

The Socialist Health Association was founded in 1930 to campaign for a National Health Service and is affiliated to the Labour Party. We are a membership organisation with members who work in and use the NHS. We include doctors and dentists and other clinicians, managers, board members and patients.

Our members are involved in a wide variety of consultation and involvement processes in health and social care. We are particularly concerned that dental services are available to all who need them and that they contribute to improved oral health and reduce inequalities. This submission is made on behalf of the Association. The sections relate to the issues identified by the Health Select Committee.

The Role of PCTs in Commissioning Dental Services

— In April 2006 PCTs were not, for the most part, able to decide what dental services to commission to meet locally identified local needs. They were, rightly, obliged to offer contracts to existing dental practices based on the amount of NHS activity and NHS earnings by the practice during the reference year. This facilitated an element of stability for dental practices.

— Overall some 4% of NHS capacity was lost through practices refusing the new contract, although many of the practices that rejected the contract were largely private and had a comparatively small NHS base.

— One of the advantages of the new dental contract has been that if a dentist reduces his/her NHS commitment, or "goes private", the funding is not lost but is retained by the PCT which is then able to recommission dental services to replace that which has been lost and it can decide what services to provide to meet the needs (as opposed to demands) identified in the local oral health needs assessment and oral health strategy.

— PCTs, however, realised early in the year that the level of Patient Charge Revenue (PCR) that they had been advised by the Department of Health that they could expect, was not going to materialise. This seems to have been an error in the calculations that the Department of Health had made in setting the levels of patient charges, which were supposed to provide the same income as the previous year ie a level playing field. It had been made clear that it would be the PCT that carried the risk if PCR fell short. This resulted in some PCTs deciding not to recommission all of the lost capacity in order to offset some of the shortfall in PCR.

— Dental service utilisation is a classic example of the inverse care law, where those with the greatest oral health needs often receive less dental treatment than those with much lower levels of need. Dental practices are frequently concentrated in more affluent areas where dental needs are less and private transport more available. The PCTs now have the opportunity to commission services to provide a more equitable provision.

— PCTs have had to build expertise in commissioning dental services very rapidly and have succeeded in doing so to varying extents. All PCTs should have regular oral health needs assessments and produce oral health strategies as the basis for commissioning plans. It is essential that all PCTs have access to specialist dental public health advice in order to commission services which are based on needs rather than just demand and which will contribute to improving oral health.

Numbers of NHS Dentists and the Numbers of Patients Registered with them

— The number of dentists with an NHS contract at the end of the first quarter (ie 30 June 2006) was 19,385, that is one dentist to 2,602 population. At the year end (31 March 2007) there were 21041 dentists with an NHS contract, a dentist to population ratio of 1:2397 (source NHS Information Centre).

— Registration with an NHS dentist was introduced in the early 1990s in order to pay dentists for a continuing commitment, including out of hours cover, for patients. The period of registration was initially up to two years but was subsequently reduced to 15 months. The responsibility to provide out of hours cover has now been transferred to PCTs and patients no longer have NHS registration with a dentist, although dental practices are encouraged to have their own lists of patients which they consider are "their patients".

— Recent guidance from the Institute of Health and Clinical Excellence (NICE) has recommended that six-monthly check-ups, which was appropriate when oral health was poorer, was no longer appropriate for everyone and that dentists should assess the best interval for individual patients according to their needs and risk status. NICE recommended that the longest interval between check-ups should be 24 months. Dental attendance is now measured by the number and proportion of patients who have attended a dentist within the previous 24 months.

— As at 31 March 2006, a total of 28,144,599 patients had attended within 24 months (55.8% of the population). At 31 March 2007, this figure was 28,097705 (55.7% of the population). There had thus been a small reduction in the number of people who had seen a dentist. However, bearing in mind the initial lost capacity and the fact that it took a while to recommission the lost service it might have been expected that a greater reduction would have been seen. We would hope that there might be an increase in 2007–08.

— Although the proportion of adults who had seen a dentist within 24 months fell from 51.7% to 51.5% the proportion of children increase slightly from 70.6% to 70.7% (Source NHS Information Centre).

Numbers of Private Sector Dentists and the Numbers of Patients Registered with them

— Most dental practices have both NHS and private patients, whilst a small number are exclusively NHS or exclusively private. It is also possible for dentists to mix NHS and private treatment in a single course of treatment, for example to provide a white filling in a back tooth at the request of the patient. We have no knowledge of the numbers of patients treated privately.

— Whilst we are content for patients to chose to pay privately for treatment if they wish to do so, we are concerned that some patients are "forced" to pay privately, or join one of the private capitation type schemes, because they think that they will be unable to receive dental care under the NHS.

The Work of Allied Professions

— We support the continued development of a team approach with the dentist leading a team of dental care professional (dental therapists, dental hygienists, dental nurses etc). Further developments of appropriate skill mix is supported.

Patients' Access to NHS Dental Care

— Most PCTs have established dental advice lines to assist patients obtain NHS dental care. In most PCTs there are adequate out of hours arrangements for patients who need advice and/or treatment at night, weekends or Bank Holidays. Many PCTs have commissioned urgent slots in dentists' appointment books for patients who need urgent treatment and who do not have a regular dentist. We commend such practice to PCTs that have not already commissioned such arrangements.

— We are concerned that the media reports of large numbers of patients being unable to receive NHS dental care does not accord with information from PCTs. One possible reason for this dichotomy is that too many patients are unaware of the PCTs' dental advice lines and are not making use of the service established by PCTs to help them find an NHS dentist. We are also aware that some PCTs have not updated the information about available services on a regular basis. PCTs should do more to publicise these services and ensure that the information available to patients is kept up to date.

The Quality of Care Provided to Patients

— During the first year of the new contract the PCTs have concentrated on ensuring that the quantity of dental care was maintained. We are very strongly of the opinion that it is essential that PCTs now give a greater emphasis on the clinical governance / quality aspects of the service and how this might best be performance managed.

— Before April 2006 the UK had, probably, the best database in the world of what treatment dentists carried out. It is regrettable that the minimum data set now collected from NHS dentists is now so minimal that PCTs only know what treatment band of treatment has been provided. We understand that the Department of Health is planning to require more information on the treatment provided from April 2008.

The Extent to which Dentists are Encouraged to Provide Preventative Care and Advice

— One of the principles behind the changes was to make NHS dental care more preventive oriented. There is, however, no measurement of what preventive treatment and advice is undertaken, although we understand that the expanded data set from April will include information on the application of fluoride varnish treatments.

— The Department of Health, in conjunction with the British Association for the Study of Community Dentistry, has recently published a Prevention in Practice Toolkit, which has been sent to all dental practices. It is essential that PCTs monitor the extent to which practices include prevention in their dental care. This must be part of the quality performance management agenda.

— In May 2007 the Department of Health published Smokefree and Smiling which set out guidance on how members of the dental team should be involved in smoking cessation activities, ranging from brief intervention advice (30 second) and, where appropriate, referral to Stop Smoking Services by all practices, to a higher level of individual advice where members of the dental practice had undergone smoking cessation training. PCTs need to monitor smoking cessation activities (and also advice on chewing tobacco, which is common in some Asian communities, and which is a major factor, together with excessive alcohol, in causing oral cancer)

— Dentists see patients who may not go to their GP because they consider themselves to be healthy. Some dental practices perform other health checking procedures such as taking blood pressure. Consideration needs to be given to whether this should be more common and how such additional activities could be remunerated.

— It must be recognised that the provision of NHS dental care services is one aspect of improving oral health. PCTs also need to provide or commission community based oral health promotion programmes eg water fluoridation, other fluoride use such as fluoride varnish programmes, fluoridated milk programmes, dental health education programmes in schools, anti-natal sessions etc. The successful implementation of such preventive programmes, in conjunction with practice-based prevention will reduce the future need for treatment.

Dentists' Workloads and Incomes

— The number of Units of Dental Activity (UDAs) for which GDS dental providers were contracted to deliver was based on the historical pattern of provision at that practice, reduced by 5%. It was somewhat more complex for providers that were previously Personal Dental Service Pilot practices as they has already reduced the amount of treatment provided. Modern dental practice puts emphasis on a minimal intervention approach ie to do only what needs to be done and adopt a preventive approach to reducing future dental disease.

— Dentists who delivered the UDAs for which they were contracted and paid had their contracts rolled over. If the number of UDAs was 96% of the contracted level they could agree with the PCT do have a contract that required the same number of UDAs plus the shortfall from 2006–07. If they provided less than 96% it was a matter for PCT / provider discussion whether the PCT would reclaim the excess funding or whether additional UDAs would be required in the current year.

— Clearly the PCT has a duty to ensure that the tax-payer receives what the dentists contract to deliver, whilst at the same time being reasonable in understanding the reasons why some practices under-performed and giving them the opportunity to make up the shortfall. We are concerned that there are anecdotal stories of some PCTs being unreasonable but it has to be recognised that they are custodians of the public purse.

— Those living in the most deprived areas have, on average, much poorer oral health than those living in more affluent areas. It needs to be recognised that practices in areas with the most disadvantaged communities are likely to have to provide more treatment within Bands 2 and 3 than practices in richer suburbs. There are two ways of dealing with this differential. One would be to divide Band 2 (3 UDAs) into two with more UDAs awarded where a larger number of fillings needed to be provided (patient charges could remain as they are or set at two differential levels). However, it is already possible for PCTs to set the payment to the dentist per UDA higher where dental needs are greatest in order to recognise the greater amount of treatment that has to be undertaken for each UDA. The expanded dataset to be introduced from April 2008 will facilitate this process.

The Recruitment and Retention of NHS Dental Practitioners

— As already stated most of the NHS capacity that was lost through dentists rejecting the new contract has now been replaced, and some PCTs have commissioned additional capacity using some of their general funding. It is understood that those PCTs that have sought tenders for replacement services have had no shortage of interest. It is important that PCTs recognise that the lowest bid may not provide good value for money if the quality of the service they provide is poor. We have already stressed the importance that needs to be given to further developing the performance management of quality.

— The three year transition period ends in 2009. In order to maintain the confidence of the dental profession it needs to made very clear, both by the Department of Health and the PCTs, that NHS dental services will not suffer a cutback when the ring-fencing of the dental budget ceases in 2009.

Other Issues

1. *NHS Information technology*

Dental practices are still not linked to the NHS IT systems. Indeed not all dental practices are computerised. This results, for example, in delays in dentists obtaining medical histories from, and sharing information with, GPs when necessary, delays in referrals to hospital from dentists, difficulty in PCTs and others communicating with dental practices. Medical practices have received financial assistance from the NHS to ensure that they are integrated into the NHS IT systems. We believe that it is important that dental practices are also part of the NHS electronic communication systems.

2. *Prison dental services*

Over the past few years there has been an improvement in the prison dental services. However, the level of service varies from prison to prison. We recommend that Strategic Health Authorities should performance manage the prison dental services in their region and take steps to ensure that PCTs implement improvements where the prison dental services do not match services generally available to the community.

3. *Water fluoridation*

Mention has been made above to water fluoridation. It is now over three years since parliament passed the fluoridation clauses of the Water Act 2003 and yet only one PCT has asked its PCT to undertake public consultation on implementing new fluoridation schemes. Although there have been improvements in the general level of dental health there remain totally unacceptable inequalities with those in the poorest communities and those from certain ethnic minority groups having the greatest amount of dental disease. Fluoridation is the most effective community measure to improve the dental health of children and adults, and in the medium / long term will reduce the need for expensive dental treatment. Ministers should ensure that all PCTs and SHAs review the need for fluoridation without delay and, where the need for fluoridation is established, use the new legislation to consult their local communities on possible fluoridation proposals.

December 2007

Memorandum by the NHS Workforce Review Team (DS 23)

DENTAL SERVICES

1. Executive Summary

- The reforms to the dental contract have created opportunities that should have positive benefits for the service, patients and dentists alike, through improved access to NHS dentistry, reduction of health inequalities and promotion of a more evidence based, preventative approach to dental care.
- The success of these reforms relies on meeting the oral health needs of the local population alongside partnerships with dental service providers including dentists and other dental professionals.
- The Workforce Review Team (WRT) believes that it is too early to comment on many aspects of the impact of these reforms.
- Primary Care Trusts (PCTs), who may be focused on other priorities, need to be able to access appropriate independent expert advice to support and drive these improvements as they move away from contracting and focus on commissioning.
- WRT recommends that greater use should be made of a "basket of indicators" that monitor dental services and capture oral health, access patient experience, alongside weighted measures of activity.
- More thought needs to be given to ways of dealing with those dentists who reach their targets early.

2. Background

2.1 The Workforce Review Team (WRT) is a national body working on behalf of the NHS in England, primarily to support workforce decision making within the 10 strategic health authorities. WRT's core role is to review in detail the supply of and demand for the healthcare workforce across all specialties and professions, and to advise on the most practical and effective use of resources. It employs expert professional advisors from the healthcare professions, including dentistry. This intelligence and WRT's relationships with key dental stakeholders enable it to have a strategic overview of the dental workforce and its challenges.

2.2 It currently works through a service level agreement with the Department of Health (DH) and provides valuable workforce information to key stakeholders including DH, strategic health authorities (SHAs), employers and commissioners. Profiles of healthcare workforce groups are published on the www.healthcareworkforce.nhs.uk portal.

3. The Impact of the Reforms on the Role of PCTs in Commissioning Dental Service

3.1 Initially, in their new roles, PCTs have focused on continuation of existing services ("contracting"), but increasingly are commissioning new and additional dental services informed by local oral health needs assessments.

3.2 PCT dental budgets are based on a test period that took account of patients' charges. In the event of a shortfall in forecast patient charge revenue, there is a risk that PCTs' commissioning budgets are effectively reduced as they underwrite these shortfalls.

3.3 These new obligations place increasing pressure on PCTs to have appropriate dental public health advice and a competent, knowledgeable commissioning team.

3.4 Paradoxically, concurrent changes to PCT and SHA configurations have led to a loss of dental expertise at many levels, which risks undermining the dental services commissioning process.

3.5 WRT believes that PCTs will need to retain a focus on improving the working lives of dentists and their teams in order to secure services and maintain access for patients.

4. The Impact of the Reforms on Numbers of NHS Dentists and the Numbers of Patients Registered with them

4.1 WRT has commissioned a report[44] which comments on the lack of descriptive literature on successful workforce planning in relation to healthcare (WRT 2007). Consideration should be given to a range of measures that demonstrate a dental service that is clinically effective and promotes best practice.

4.2 There is a challenge in analysing information on numbers of dentists and patients because data collected before and after 1 April 2006 cannot be directly compared.

[44] "Who does workforce planning well?: a Rapid Review for the Workforce Review Team"; Warwick Institute for Employment Research; D L Bosworth, R A Wilson and B Baldauf; November 2007

4.3 When comparing the numbers of NHS dentists on 31 March 2006 (21,111) and 31 March 2007 (21,041), it would appear that there has been little change in numbers. There are a number of other significant factors that should be considered when making assumptions about the impact of reforms on dentist workforce supply.

4.4 The number of dentists on the General Dental Council (GDC) register with addresses in England on 31 March 2006 was 24,935 and on 31 March 2007 was 26,105. A factor in this increase is international recruits from both within and outside the European Union. These extra dentists provide predominantly NHS dental care.

4.5 Analysis of available data from the Information Centre (IC) suggests that the number of patient visits to dentists measured over a two year period has remained relatively stable since the introduction of the new contract.

4.6 The number of dentists is not an indication of activity, which may be monitored through a range of indicators including weighted measure of courses of treatment using units of dental activity (UDAs) and units of orthodontic activity (UOAs).

4.7 WRT suggests that any assessment of primary care dentistry should take account of primary dental care provided by dental care professionals.

5. The Impact of the Reforms on the Numbers of Private Sector Dentists and the Numbers of Patients Registered with them

5.1 Data on private sector dentistry is poor.

5.2 Based on early feedback from some PCTs, the number of dentists providing purely private dental care is likely to have increased since the introduction of the new dental contract. However, this will have had very low impact on local access because those extra dentists are mostly ones who had small NHS commitment, and because PCTs were able to replace these lost services.

5.3 As with mixed and NHS dental practices, private dental practices do not normally have registration lists.

5.4 In the light of reported experience, WRT believes that patients are most likely to migrate to private care because of a wish to stay with the dentist of their choice or because they are unable to access NHS dental care, rather than because they have a specific wish to have private dental care.

6. The Impact of the Reforms on Work of Allied Professions

6.1 Data on dental care professionals (DCPs) remains very poor, but is expected to improve with the arrival of mandatory registration in July 2008.

6.2 PCTs may commission dental services from registered DCPs acting as providers.

6.3 Effective deployment of DCP skills creates the potential to free up dentists' time.

7. The Impact of the Reforms on Patients' Access to NHS Dental Care

7.1 WRT believes it is important to ensure that we measure:

- opportunities for access;
- subsequent real activity increases; and
- improvements in oral health including addressing oral health inequalities.

7.2 WRT believes it is too early to say whether there has been increased access to NHS dental care.

7.3 The reforms have created significant opportunities to improve access (including equality) to NHS dental care because PCTs can retain funding and reinvest in dental services whenever a contract is relinquished.

8. The Impact of the Reforms on the Quality of Care Provided to Patients

8.1 WRT believes that it is too early to assess the impact of these reforms on the quality of care provided to patients. A robust primary care dentistry clinical governance framework is already in place.

9. The Extent to which Dentists are Encouraged to Provide Preventative Care and Advice

9.1 Changes to recommended recall intervals should free up time and enable dentists to spend more time on prevention and health promotion. It is the view of WRT that there is a risk that this may not happen without appropriate monitoring, incentives and realistic and achievable targets.

10. The Impact of the Reforms on Dentists' Workloads and Incomes

10.1 Because of the changes in measuring activity and reporting, it is not possible to meaningfully assess the impact on workloads.

10.2 Data from the IC suggests that the number of interventions by dentists has decreased. This is in line with aims of the reforms, which aspired to fewer interventions, freeing up more time for a preventative approach.

10.3 Dentists who have not achieved their agreed targets may be subject to recovery of payments which will affect their salaries. WRT suggests that PCTs and dentists need to work together to monitor and manage activity effectively.

11. The Impact of the Reforms on the Recruitment and Retention of NHS Dental Practitioners

11.1 Dental performers list regulations mean that older dentists and overseas graduates who have not undertaken dental vocational training (VT) nor can demonstrate equivalent experience, must undertake a period of training before joining the list. As practices become more familiar with these new regulations, more opportunities should become available for these dentists. Most deaneries provide "Introduction to the NHS" courses to support new (non-VT) entrants to the NHS, which includes EU qualified dentists.

11.2 WRT considers it too early to assess the full impact of these reforms on the recruitment and retention of NHS dental practitioners.

11.3 Because dental services are now commissioned to meet local needs, recruitment and retention initiatives for NHS dental practitioners will be driven by local demand.

11.4 Nonetheless this must be considered in the context of the national picture. The combination of significant expansion of dental undergraduate places, increased numbers of dental therapists and continued migration of overseas qualified dentists into the UK, poses a risk of over-supply of the primary care dental workforce.

NHS Workforce Review Team

December 2007

Memorandum by Denplan (DS 24)

DENTAL SERVICES

1. Executive Summary

1.1 Denplan welcomes the House of Commons Health Select Committee inquiry into dental services and the chance to contribute to it.

1.2 The Committee's terms of reference focus on the impact of the dental reforms made in April 2006. In this written submission to the Committee, Denplan aim to consider these terms of reference in the wider context of the future of the entire dental care sector. We aim to address how the under-lying aim of dental care provision should be framed in order to achieve a high quality of preventive, comprehensive and inclusive dental care in the long term, and the implications of this on a sustainable model of dentistry which can be created going forward.

1.3 We believe that private dentistry is an important part of dental provision in the UK. It can serve to complement, rather than compete with, NHS dentistry by providing additional options for patients and by helping to reduce the costs of running a modern dental surgery. The capitation approach of Denplan also incentivises both patients and dentists to achieve and maintain dental health, and discourages "episodic" dentistry. Any further reform to the dental system must take the complementary role of the private sector into account.

1.4 We have set out how we feel that the current system puts the wrong emphasis on short term care provision whereas a long term vision based around preventive care and oral health could improve efficiency, and reduce the need for surgery. Firstly, the system must allow the outcome of dental care to be measured in such a way as to ensure that oral health is demonstrably maintained and improved. Secondly, the system does not align the best interests of the dentist and the patient. It may incentivise patients to "save up" their problems, whilst dentists see themselves as financially discouraged from caring for those with the greatest dental needs. It encourages "episodic" dentistry. Thirdly, the current system does not encourage the dentist or the patient to focus on preventive care which would give the patient a much better chance of avoiding major disease and treatment and would save considerable resources, making dental provision more sustainable in the long term.

1.5 Finally, we believe that the current system is not sustainable in the long term and we feel that the failure of successive reforms have demonstrated this. Therefore we have set out both short term and long term proposals for a more sustainable model of dental provision in the UK.

1.6 We feel that we have significant experience to contribute to the on-going debate around dental provision in the UK and would be pleased to give oral evidence during the inquiry should you wish us to do so.

2. Company Profile

2.1 Denplan was founded by two dentists, Dr Stephen Noar and Dr Marilyn Orcharton in 1986 around the principle of a capitation payment system, rather than dental insurance. The dentists aimed to create an alternative approach where the best interests of patients and dentists were synonymous: prevention-based capitation. In this approach, patients would know in advance the reasonable sum they would pay for their dental care needs, whilst dentists would have a sound and regular income allowing them to invest in their teams, their practice and their development. Over 20 years on, our main product is the capitation based plan, Denplan Care; although we also provide other financing products as well as support services including professional development and training, quality assurance and risk management, complaints handling, marketing and business advice.

2.2 In 2007, Denplan works with over 6,500 dentists and has 1.9 million patients registered, of whom 90% are contracted individually to their own dentist, the remainder being served under employer-arranged plans. Over the past 20 years, most Denplan member dentists have retained a balance of private (fee-paying) and NHS patients. Our internal research shows that the "average" spread of patients in a Denplan practice is as follows: 39% capitation, 40% private fee-paying and 21% NHS.

3. Policy Sphere Experience

3.1 As a pioneer of dental provision and the largest private sector provider in their field, Denplan endeavour to remain engaged with policy makers and we feel that we have much to add to the on-going debate about the future of dentistry. Denplan's objective is the support of ethical, high quality, preventive-based private dental care through appropriate funding mechanisms, where the dentist remains in control of his/her practising circumstances. We believe that, whilst the issue of NHS dental reform does not affect Denplan specifically, a healthy NHS dental system is important for dentistry in the UK and encourages patients to take responsibility for managing their own oral health.

3.2 We gave oral evidence to the Health Select Committee in 1993, in the aftermath of a previous NHS contract reform, and written evidence to the inquiry in 2001 when we were positively commended and acknowledged in the subsequent report[45]. In 2002, we participated in the "Options for Change" work published by the Department of Health and which was widely cited as the principal forerunner of the current reforms[46]. We have also commissioned research over the years into the provision of dentistry, notably from Demos (1996 and 2000), York Health Economics Consortium (2003), and Office for Public Management (2005).

4. How Public and Private Dentistry Coexist in the UK

4.1 The Health Minister, Ann Keen MP, recently estimated that around nine million people seek private dental care[47]. However, industry commentators believe that the private dental market is worth up to £3 billion overall in the UK[48] and Information Centre (NHS) figures note that more than half of the income of the practice-owning dentists, for whom they have information, is derived from private treatment (51% in 2004–05; 58% in 2005–06).[49] Overall, we estimate that the NHS contributes between 50% and 60% by volume and 40%—50% by value of the total dental market.

4.2 The majority of dentists—as evidenced by the NHS information statistics cited above—work in a "mixed NHS and private" model. The option that a dentist has to devote a proportion of their time to providing private dentistry is often a vital factor in enabling them to continue to provide NHS treatment to those patients who need it. The statistics suggest that this position is now becoming polarised, with more dentists working almost wholly in one sector or the other.

[45] House of Commons Health Select Committee (2001) *Access to NHS* Dentistry Summary of Recommendations (a)
[46] Department of Health (August 2002) *Options for Change*
[47] Rt Hon Ann Keen MP, Parliamentary Under Secretary of State for Health (12 September 2007) speech to Primary Care Trusts
[48] Market & Business Development Dentistry Market Research Report (June 2007); Laing and Buisson Dental Market Report (2003)
[49] NHS Information Centre: Dentists Earnings survey, (September 2007)

4.3 Our internal experience is that the cost of running a contemporary dental surgery, which complies with the plethora of modern regulation and legislation, averages out at around £160 per hour. This is similar to the figure recently confirmed by the British Dental Association (derived from Scottish government estimates).[50]

4.4 Private dentistry is sometimes characterised as being "in competition" with the NHS, however many dentists see mixed practice as a logical solution to these business needs in the provision of good quality care for all their patient population.

4.5 We strongly believe that a comprehensive (all necessary treatment) and inclusive (for all the population) system of primary dental care delivery cannot be provided by the public sector alone. The spread of available public finance simply cannot stretch to cover identified dental demand. Unidentified dental need is yet another issue.

4.6 The polarisation of practice which the current reforms are engendering will not best serve the interests of the public, the Government or the profession. We therefore believe that it is very important that a more holistic approach is taken when considering further and future reform and that the likely impact of any change on the entire dental profession and industry, and the ability of a dentist to provide mixed NHS and private care must be considered.

5. How can Dental Provision be Improved in the UK?

5.1 We feel that there are some fundamental elements the 2006 dental reforms did not address, which would bring about significant improvements in the way in which care is given and managed, and which would significantly strengthen the long-term viability of the dental system. Firstly, the system must allow the outcome of dental care to be measured in such a way as to ensure that oral health is demonstrably maintained and improved. Secondly, the system does not align the best interests of the dentist and the patient. It may incentivise patients to "save up" their problems, whilst dentists see themselves as financially discouraged from caring for those with the greatest dental needs. It encourages "episodic" dentistry. Finally, the current system does not encourage the dentist or the patient to focus on preventive care which would give the patient a much better chance of avoiding major disease and treatment and would save considerable resources, making dental provision more sustainable in the long term.

i. *Lack of health measurement within system distorts the focus of care*

5.2 We believe that a major flaw in the current UDA system is that it intrinsically encourages the dentist to focus on the short term outcome of the course of treatment, whereas the long term health of the patient is in fact the only real indicator of how successful the care provided has been. Although details of specific treatment provided under NHS care will once again be identified by dentists on claim forms from April 2008, there is no measurement of the effectiveness of dental care delivered. There therefore needs to be a better measurement as to how dental health can be achieved and the dental system needs to be able to accommodate this. Health gain seems to us to be the most obvious choice when measuring the effectiveness of dental care.

5.3 Other than the decennial Adult Dental Health survey, no good measure exists of the oral health of the population at large, nor in individual areas or contracts, although widespread inequities in the prevalence of common dental diseases are acknowledged.[51] Measurement of the oral health of 12 year olds, whilst a good international measure, is a narrow one.

5.4 Within Denplan's capitation approach, both patients and dentists are incentivised to achieve and maintain dental health. Under Denplan's Excel programme, oral health is measured and monitored by both dentist and patient. This measurement system has been externally reviewed and is based on the academic model originally intended for the (then) Dental Practice Board.[52] The Public Accounts Select Committee and the National Audit Office both drew on essentially the same index for their reports.[53] A similar measurement system would enable the long term oral health of patients to be tracked and would therefore encourage care geared towards the improvement of long term health.

ii. *The patient's relationship with their dentist*

5.5 It is widely believed amongst industry commentators that the current attention to access and the effects of the UDA target system, along with recent guidance from NICE that patients who do not need treatment should only be seen by a dentist once every two years, may be encouraging episodic dentistry, and discouraging relationship dentistry.

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[50] British Dental Association (November 2007) *Better Health, Better Care, response from the British Dental Association*

[51] See for example: London Health Observatory *Oral Health Overview* http://www.lho.org.uk/viewResource.aspx?id=9570

[52] Burke FJ and Wilson NH (1995): Measuring Oral Health: an historical view and details of a contemporary oral health index (OHX). *Int Dental J* 45(6): 35–70

[53] House of Commons Committee on Public Accounts (July 2005) *Dept of Health—Reforming NHS Dentistry* HC167: Recommendation 12.

5.6 Statistics (such as those quoted by the NHS and in Parliamentary answers) on "access" consistently fail to distinguish between these types of dental demand, as distinguished from dental "need". It is of course desirable to have need translate into demand, but consistently, some 20%–30% of the population do not believe that they have cause to visit regularly, whilst others visit only infrequently[54]. This of course affects the type of care that they receive and they miss out on the regular check ups which can catch any problems before the need for treatment arises.

5.7 Many patients do seek ongoing, preventive care and increasingly this proportion of the population—who value dental health and not merely the absence of current dental disease—is growing. This is despite their identification as the "worried well". These patients require and seek an ongoing relationship with their dentist—usually their dentist of choice and whom they have grown to trust.

5.8 Patient who choose episodic dentistry should have their needs met: both NHS and private systems can address these needs and, importantly, provide an opportunity to convince patients of the advantage of on-going regular and preventive care, should they wish to avail themselves of this. Those who do wish to do so should be encouraged to take individual responsibility for this, with state-aided funding for those who require it.

iii. *The value of preventative dentistry*

5.9 Unlike medicine, dentistry is principally about the management of two, almost entirely preventable, conditions: dental caries and periodontal disease. An opportunity therefore exists for a preventive approach to these conditions. Public health measures (including fluoridation and education) are important components, but on-going management and reinforcement at the individual patient level is also key.

5.10 For dental caries, the "tooth death spiral" suggests strongly that the avoidance of the first "surgical invasion" of a tooth (by the dentist's drill) is the most significant objective of preventive care. Minimal invasive techniques are the most likely to prolong tooth life.[55] Periodontal disease requires, for the most part, intensive personal monitoring and meticulous care (by both patient and the dental team), although it probably presents a serious risk to only a proportion of the population. Identification of the at-risk is an important task, since links with diabetes, heart disease and the damaging effects of smoking have been shown.

5.11 Good evidence-based dentistry is expensive to provide, both in terms of facilities, equipment, materials, and whole-team professional development and training. Dentists have, in the past, invested significant amounts to secure this environment. Future funding cannot solely depend on state provision unless, again, major changes are made in budget allocations.

6. The Future of Dental Care

6.1 In the long term, we believe that a complementary approach to the provision of primary dental care, where both the public and private sectors work together, is essential for meaningful progress, the efficient use of public funds and the exercise of patient autonomy.

6.2 We believe that in order for the public provision of dentistry to be sustainable in the long term future, public health and the provision of urgent and "episodic" care would sit best with the public sector. Ongoing routine maintenance and preventive care would be best served by a responsible and ethical private sector, with assistance for those who are genuinely unable to afford it. Elective and cosmetic dentistry should rightly remain in the domain of the individual's choice and funding.

December 2007

Memorandum by Citizens Advice (DS25)

DENTAL SERVICES

Executive Summary

— Access to NHS dentistry has been an issue of longstanding concern to the CAB Service. Citizens Advice has therefore welcomed the fact that, under the April 2006 reforms, Primary Care Trusts (PCTs) now have a statutory duty to provide dental services to meet "all reasonable requirements".

[54] Bradnock G, White DA, Nuttall NM *et al* (2001). Dental Attitudes and Behaviours in 1998 and implications for the future Br Dent J.190 (60–68)
[55] Elderton RJ (2003). Preventive (evidence-based) approach to quality general dental care. *Med Princ Prac* Suppl 1: 12–21

— However we regret that, although the key aim of the reforms was to improve access, no attempt was made to reduce the postcode lottery by targeting additional funding on those PCTs where access had traditionally been poor. We believe this is a key explanation for the failure of the reforms to deliver any growth in NHS dentistry since April 2006.

— CAB evidence from around the country continues to demonstrate serious access problems at the local level. Many people have gone without regular treatment, instead relying on emergency services when they are in pain. Others have felt they have no option but to seek private treatment even when this is not what they want or can afford.

— NHS charges can also be a barrier to access. There is a need for better promotion of the help available through the NHS low income scheme.

— In a recent CAB online survey, around a third of respondents who had received NHS treatment since the reforms, said they were not satisfied with their treatment. Some reasons given reflected a service under pressure. Others said that they had been incorrectly told by their dentist that necessary treatment such as scale and polish and root canal treatment were not available under the NHS.

— We are concerned that some PCTs with significant access problems may be adopting a narrow interpretation of their new duties, focusing on spending at the level of their ring-fenced budgets based on historic spend in the area, rather than on undertaking a comprehensive assessment of local need and commissioning to meet all reasonable requirements.

Introduction

1. Citizens Advice welcomes the opportunity to submit evidence to this inquiry. In 2006–07 bureaux in England and Wales dealt with 6,260 enquiries regarding dentistry, the main concern being the availability of NHS dentistry (34%).

2. Ever since the early 90's, bureaux have been reporting this problem and the concern of local people when they are unable to find a dentist. There can be no doubt that people see access to NHS dentistry as a priority—whenever a local dentist withdraws from the NHS or a new practice opens, the story usually finds it way to the front page of the local paper.

3. Citizens Advice has therefore welcomed the dentistry reforms introduced in April 2006, which had improvement in patient access as a key objective. We have particularly welcomed the fact that PCTs now have a statutory duty to provide dental services to meet "all reasonable requirements". This, together with clear statements from Ministers that the Government is "committed to providing NHS dental services for all those who wish to use them"[56] has rightly raised public expectations.

4. It is therefore very disappointing that Government statistics from the first 12 months of the reform showed no increase in the number of patients receiving NHS dental treatment but rather a slight fall. Moreover this fall appears to have accelerated in the first quarter of 2007–08. We believe that the key explanation for the failure of the reforms to improve access is that the ring fenced funding allocated to PCTs to deliver their new duty was not based on any assessment of local need, but rather on the historic spend on NHS dentistry in each area. This therefore perpetuated existing inequalities in access and has made it extremely difficult for those PCTs in the historically most under funded parts of the country to fulfill their new duty.

5. This submission is informed by case evidence submitted by bureaux since April 2006 and by two on line surveys. The first of these, to which 4,705 people responded, was carried out between May and October 2006 and focussed on people who had been unable to find an NHS dentist (access survey). The results were included in our 2007 report *Gaps to fill*[57]. The second survey carried out between August and November 2007, to which 341 people responded, provides some information on the experience of people who have had NHS treatment since the reforms came into effect (patient experience survey).

6. In our response we have focussed on those aspects of the inquiry on which we have evidence.

Patient Access to NHS Dental Care

7. A key objective of the April 2006 reforms was to improve access to NHS dentistry. It is therefore very disappointing that the statistics for the first year of the reform showed a reduction of 50,000 in the number of patients receiving treatment in the previous 24 months. This means there was no progress in meeting the needs of the two million patients who the Government estimates are unable to find a dentist. Moreover the most recent figures covering the first quarter of 2007–08 show a fall of over 200,000 in the number of patients receiving treatment, compared with the previous quarter. This suggests that even the more modest aim of ensuring through recommissioning that access does not deteriorate, is not being met.

[56] Ministerial conference speech, Commissioning of NHS dentistry: the future, 17 September 2007
[57] *Gaps to fill: CAB evidence on the first year of the dentistry reforms*, Citizens Advice, 2007

8. Nor has there been much progress in reducing the postcode lottery at the local level. For example in South East Central Strategic Health Authority (SHA) where access was already relatively poor, the percentage of patients seen fell from 51.4% to 49.8% over the 15 month period—a reduction of almost 56,000 patients. And within the SHA, falls were even greater amongst those PCTs with poorest access—in Surrey PCT numbers of patients seen fell from 47.1% to 44.2% and in West Kent PCT from 48.7% to 43.9% over the period.

9. Another way to assess the postcode lottery is to look at the number of dentists taking on new patients. In our CAB evidence report *Gaps to fill*, we analysed the data on the nhs.uk website, and this revealed huge differences between PCTs. Whilst in 22% of PCTs at least four in 10 dentists were accepting new charge paying adult patients, in another 26% of PCTs, no dentists were shown accepting this group of patients.

10. It has not been possible to update this analysis because the information is now presented differently on the website. Nor is information about the number of dentists with open lists publicly available either nationally or at PCT level. However bureau evidence from around the country continues to demonstrate serious access problems at the local level. People on low incomes living in rural areas appear to be particularly affected, often facing long and expensive journeys to reach the nearest available dentist. It is important to note that, unlike travel to hospital, there is no help available from the NHS low income scheme with travel costs to primary care services such as dentists, presumably on the assumption that these services will be available in the local community.

> A CAB in Northumberland reported a young mother on a low income, who needed emergency dental treatment. She had to travel 10 miles to the nearest available treatment centre, which was not easy with three children. She would have to take half a day's leave and therefore lose wages.
>
> A CAB in Hampshire reported an 87 year old woman who was enquiring about the possibility of finding a local dentist. She currently has to travel from her rural town to Southampton—a journey which she cannot manage on her own and therefore has to rely on her daughter. There used to be two NHS practices in the town but both have now gone private and the bureau has been calling on the PCT, to no avail, to replace the lost NHS service.
>
> A CAB in Kent reported a 77 year old client who had a broken tooth. She had been into bureau previously for debt problems and cannot afford a private dentist. To get to the nearest NHS dentist involved an 8 mile bus journey, followed by a train and then a walk.

11. From our access survey it was clear that patients faced limited options. The majority of respondents (64%) said they simply went without regular check ups or treatment. 9% said that, instead of adopting a preventative approach to their case, they relied on emergency dental services for treatment, including A&E, when a crisis arose. This was not always satisfactory as the treatment provided would often not deal with the underlying problem.

> A CAB in Surrey reported a woman in low paid work who had problems with wisdom teeth. There are no NHS dentists available but she couldn't afford to see a private dentist. She therefore waited until the problem was sufficiently severe that she could go to the emergency dentist at the local hospital. She ended up with an infected wisdom tooth and was given treatment and very strong painkillers which made her feel so unwell that she was off work for five days. She still has an ongoing problem needing further dental work.
>
> "I cannot register with a NHS dentist, so I had to go to an emergency one when I had an abscess. He told me my teeth were in a poor state, but seeing as he was only an emergency dentist, all he was allowed to do was treat the abscess. The dentist staff was fabulous; it's just that their hands were tied." (survey respondent)

12. 18% said they had felt forced to accept private treatment even when this was not what they wanted or indeed could afford.

> A CAB in Suffolk reported a client who had severe toothache at the weekend. There was no NHS dental care available in the area and he was referred to Great Yarmouth for treatment. He could not get up there and therefore went to a private dentist in a nearby town and had an extraction—costing £110.00. He wanted to know if there is any way he can get any help with this cost.
>
> A CAB in Hampshire reported a 79 year old client who had been unable to find an NHS dentist when her previous one ceased taking NHS patients. She finds travelling difficult and so feels she has no choice but to use a private dentist.

NHS Charges

13. 27% of dentistry enquiries to bureaux in 2006–07 related to NHS charges and it is clear from CAB evidence that these can also be a barrier to access. The structure of the charges was radically changed from April 2006 and Citizens Advice was represented on the Department of Health's Patient Charges Working Party which proposed the current structure. The advantages of the changes are that the structure is much simpler so that it is less easy for patients to be confused as to whether they are paying for NHS or private care. It is also welcome that the maximum charge has been reduced from nearly £400 to £194, and that the

flat rate structure goes some way to breaking the link between poorer oral health and higher charges. It is crucial that charges do not fall disproportionately on those with greatest health needs, thus deterring them from accessing the NHS services they need.

14. However the fundamental problem remains that NHS dental charges are significant. The review of charges was undertaken on a nil cost basis, with the requirement that the same proportion of revenue should be recouped through patient charges as under the previous scheme. This was despite the fact that there had long been criticism of the affordability of NHS dental charges, as discussed in our 2001 report *Unhealthy Charges*[58]. This found that the main reason why patients who had an NHS dentist had not had a check up the previous year was because they could not afford the cost.

15. Between August and November 2007, we included a questionnaire on the Citizens Advice website for people who had had NHS dental treatment since the April 2006 reforms. 77% of the 329 people who responded had paid for their NHS treatment (the rest were exempt). Of these, 42% said they found it difficult to meet the cost of this charge. This percentage reduced to 27% amongst those paying the Band 1 charge (currently £15. 90), but increased to 54% amongst both those paying Band 2 (£43.60) and Band 3 (£194) charges.

16. Help with charges is available for people on low incomes through the NHS Low Income Scheme. However the dental contract does not require dentists to provide any information about this scheme or to hold the relevant leaflets and claim form. As a result, bureaux often report that clients fail to claim for the help to which they are entitled. Recent MORI research undertaken for the Department of Health as part of their review of Help with Hospital Travel Costs, found that, of a sample of respondents all in social grade D and E (and therefore likely to be entitled to help) only 11% had heard of the NHS Low Income Scheme.

> A CAB in Norfolk reported a client who was on long term incapacity benefit with a weekly income of £81.35. He therefore assumed that he was entitled to free NHS treatment. He did not have his reading glasses with him and wrongly signed forms to get free treatment by ticking the box that he was receiving income support (IS). As a result he was charged a £79.50 penalty fee with an additional charge of £39.75 if the money was not paid within 28 days.
>
> The bureau found that the client should have been entitled to a small IS top up, which would have given him automatic entitlement to free dental care.

The Quality of Care Provided to Patients

17. Only 6% of CAB enquiries in 2006–07 were related to issues around the quality of care, suggesting that this is not such an issue of concern for patients as access and charges. We therefore specifically included a question in our 2007 patient experience survey about how satisfied they were with the treatment provided. 32% said they were very satisfied and a further 36% said they were fairly satisfied. However 32% said they were not satisfied with the treatment they received. Patients who had had Band 2 treatment were more likely to say they were dissatisfied (41%) than those who had received Band 1 (26%) or Band 3 (11%) treatment.

18. Many of the reasons given reflect a service under pressure, with patients saying they felt rushed, found themselves repeatedly seeing a different dentist or had to wait months for appointments.

> "I was told that I would have three fillings in the appointment I made but when I turned up on time my dentist was running late. When I finally went in he said he only had time to do one filling."
>
> " . . . The only practice that would take me on employs all locums."

19. Some respondents and CAB clients have also complained that they received incorrect information and were not given all the treatment needed on the NHS, as they are entitled.

> A CAB in Devon reported a client in her 70s and exempt from charges on grounds of low income. She had a tooth removed by an NHS dentist who then recommended that her teeth needed cleaning. However he wouldn't do this on the NHS and referred her for private treatment at a cost of £26.
>
> "A few days ago my husband was in a lot of pain. He went to our dentist who we have been with for many years (NHS). He was told he had an abscess and needed root canal treatment (band 2). He was told by our dentist that he couldn't afford to do the treatment on the NHS."

20. It is not easy for patients to check whether what they are told by their dentist is correct, or indeed to know how to challenge such practices when they do occur. And as long as access problems continue, patients are in a vulnerable position. Few will want to risk taking up the issue with the practice itself, for fear of jeopardising the dentist/ patient relationship or even being removed from the list altogether.

> A CAB in Surrey reported a client who made a complaint about her experience of poor treatment from her dentist. The dentist then told her she was not wanted as a patient. She is currently in pain but has been unable to find an alternative NHS dentist.

[58] *Unhealthy charges: CAB evidence on the impact of health charges*, Citizens Advice, 2001

The Role of PCTs in Commissioning Dental Services

21. Undoubtedly from the PCT perspective, April 2006 was not an auspicious time to take on new duties in relation to the delivery of NHS dentistry as many were still coping with the consequences of reconfiguration which took place in Autumn 2005. In addition many faced the need to manage significant budgetary problems over 2006–07. Then the initial challenge was to cope with recommissioning the dental activity from those dentists who decided not to sign the new contract.

22. During the winter of 2006–07 Citizens Advice contacted 40 PCTs which appeared from the nhs.uk website to have the poorest access. The responses from these PCTs highlighted two issues of concern.

23. Firstly PCTs appeared to be adopting a narrow view of their new duties. Rather than commissioning services to meet the reasonable requirements of their area, they were only recommissioning lost activity where a dentist withdrew services and so spending only up to their ring fenced budget, regardless of its adequacy. Thus one commented that "action that the PCT has taken will ensure that the ring fenced dental allocation is fully spent on providing an equitable access for local residents".

24. This is also reflected in the more recent experience of local bureaux, several of whom have undertaken their own surveys of local demand in order to demonstrate to the PCT the need for additional dentistry in the local area. Interestingly, despite the fact that many dentists have been critical of the new contract, PCTs have not said that they have a problem in finding dentists prepared to take on NHS work. Rather the barrier to improving access appears to be inadequate PCT budgets.

25. The second issue was that some PCTs appeared to be basing their estimates of need for services on the number of enquiries to their dental helpline or the numbers on their waiting list. But this assumes everyone in need of a dentist is aware of these resources and has used them in their search for a dentist. Responses to our access survey suggested very differently, with only 19% replying that they had contacted their PCT or their PALS as part of their search, although this is usually the way to access the waiting list and helpline. Only one PCT said they were considering undertaking a local patient survey in order to accurately assess local demand for NHS dentistry.

26. We also believe that PCTs need to do more to increase public awareness of their new responsibilities with regard to NHS dentistry and make sure people know the best way to find a dentist. Recent changes to the NHS Choices website have increased the visibility of the local PCT dental helpline number. However even amongst respondents to our on-line access survey, who by definition were web users, only 52% used the website in their search for a dentist, so it is clearly important that other publicity strategies are used. Some PCTs have displayed posters in key areas such as GP surgeries and libraries, informing people about how they can get help with finding a dentist, but this practice is not universal. This becomes particularly important in circumstances where a dentist is withdrawing from providing NHS services, and so large numbers of patients in a local area will be looking for an alternative provider.

27. It is also important that mechanisms are put in place so that patient satisfaction with their treatment is fed into the PCT contract monitoring process.

Conclusions

28. It is extremely disappointing that, 15 months after the dentistry reforms were introduced; Government statistics are still showing a decline in overall access to NHS dentistry. We believe that a key reason for this failure is that those PCTs which had poorest access before April 2006 were not given any additional funding to help them fulfil their new duties to meet all reasonable requirements. As a result, at PCT level, inequalities in access have only been entrenched by the reforms.

29. Given the serious financial budget constraints which many PCTs faced in 2006–07 it is perhaps not surprising that many appear to have focussed only on spending their ring fenced budget. We believe that the priority now must be to address access inequalities through targeted additional funding before the three year ring fenced period ends in 2009. Otherwise it is very unlikely that the reforms will achieve their objective of providing NHS dental services for all those who wish use them.

December 2007

Memorandum by the Dental Laboratories Association (DS 26)

NHS DENTAL SERVICES

Executive Summary

The primary driver of the NHS Dental Reforms was to devolve the service to make it responsive to local need and address problems of accessing NHS care. Also, as stressed in the Department of Health's report on the reforms, One year on, they were intended to "shift the service away from the old system, which operated on a piecework basis (often described as 'drill and fill' treadmill) . . ."

In doing this we have seen a significant reduction, around 46%, in Band 3 treatments, treatments that repair the consequences of the "drill and fill treadmill". Moreover, the cohort of the population that need these treatments, who benefited from NHS dentistry, are going to make the greatest demand on dental care during the next 20–30 years but are in danger of being abandoned by the service.

1. The Problem

1.1 We begin our evidence by looking at what has gone wrong following the most fundamental change to NHS primary care dentistry in England and Wales since its inception, with the introduction of personal dental services (PDS), before considering the implications, if not addressed, and a possible way forward.

1.2 Our concerns are not only about the significant fall in the provision of Band 3 treatments (treatments requiring laboratory work like crowns, bridges and dentures) but also the quality of what is provided. Of the 480 or so fees under the old fee per item, general dental services (GDS), just over 40% involved laboratory work. Significantly, these accounted for around 8% of courses of treatment (CoTs), Band 1 (checkups, scaling and diagnostic procedures) 52% and Band 2 (fillings, root canal treatment and extractions) 40%.

1.3 However, NHS Dental Statistics for 2006/07, published by the NHS Information Centre (IC), show Band 3 treatments during the first year of PDS 50% lower than under the GDS, at 4% of CoTs. These treatments have probably settled at around 56% of what they were or 4.5% of CoTs. This was the level in quarters three and four of 2006–07, following a recovery from 2.2% at the beginning of the first quarter, rising to 3.7% by the end of it and 4% in the second quarter.

1.4 The reason for very low Band 3 CoTs during the early months of the PDS was that these courses of treatment generally take longer than others to complete. Also, and more significantly, there was a lot of activity, particularly in the provision of what were to become Band 3 treatments, during the final quarter of the GDS contract, as general dental practitioners (GDPs) attempted to provide these under fee per item of service, before the changeover to PDS.

1.5 The latter resulted in patients benefiting from lower patient charges for single treatments before the significant increases accompanying the PDS. The Department has exclusively focussed on the reduction in the maximum patient charge from £378 under the GDS to £189.00 during the first year of the PDS—the patient charge for Band 3 treatments. But for single treatments, like a porcelain jacket crown, the patient charge increased by 168%; a full or jacket crown in non-precious metal by 139%; a full upper or lower denture by 151%; and a full upper and lower set of dentures by almost 50%. Increases in price of these magnitudes will have significant effects on the demand for dental care.

1.6 This reduction in Band 3 treatments was identified in our surveys of dental laboratories, conducted at regular intervals following the introduction of the PDS and during the pilot schemes. In the first year, this showed an overall decline of 57% in units of Band 3 appliances supplied to GDPs in England and Wales, compared to increases of 15% in Scotland and 17% in Northern Ireland, both of which retained the GDS. For individual items, the decline ranged from 41% for non-precious metal crowns to 84% for chrome framed dentures. This was not matched by an increase in private work, which increased by just 18%.

1.7 Band 2 items also experienced a fall in demand, from around 40% of CoTs under the GDS to 30% under the PDS, again reflecting increases in patient charges for individual treatments. The patient charge for a Band 2 CoT was introduced at £42.40, which compared, for example, to a price of £7.75 for a simple, amalgam filling under the GDS, an increase of over 580%, and even when combined with an examination, included under Band 2, increased by 180%.

1.8 One of the consequences of a reduction in demand for Band 3 and, to some extent, Band 2 CoTs has been a significant shortfall in patient charge revenue, with knock-on effects for primary care trusts (PCTs). In NHS Dental Reforms: One Year On, the Department stated that patient charges were expected to raise around £600 million, although warning that "a number of PCTs, though not all, have been projecting lower than expected income from patient charges during the first year . . . the Department has increased funding allocations for 2007–08 to allow for slightly lower levels of patient charge income as a proportion of gross expenditure."

1.9 As it turned out, patient charge revenue was £475, a massive £125 million short of the £600 million assumed in the indicative gross allocations issued to PCTs. The Department had plenty of warning that this might happen from the PDS pilot schemes—we estimate that patient charge revenue from these were some £80 million short of the £190 expected, out of a total spend of £764 million in England and Wales.

1.10 As well as demand-side effects, there were also supply-side effects influencing the provision of band 3 treatments. If a patient needed multiple crowns, for example, and could afford the maximum charge, GDPs were quite willing to provide these under the GDS as their fee was not constrained—simply the number of crowns times the fee. Although the PDS contract value, target of units of dental activity (UDAs) and therefore value of UDAs were determined by a GDP's previous activity under the GDS, GDPs have been reluctant to provide multiple treatments as they incur higher direct costs for the same fee (12 x £UDA). This will be compounded after April 2009 when the dental budget is no longer ring fenced and UDAs begin to float.

1.11 Partial dentures have bucked the trend, with the Dental Treatment Band Analysis for England, published by IC, showing that within Band 3, CoTs containing partial dentures rose from 27.4% to 34.7%. Our surveys show that during the first year of the PDS, there was a 76% increase in the most basic partial denture—the single tooth denture.

2. Demand for Dental Care

2.1 The Department's mantra accompanying the introduction of the PDS and repeated to PCT commissioners at every opportunity since, has been prevention, prevention, prevention. The move away from intervention to prevention is appropriate for children—according to the World Health Organisation, UK 12 year-olds have the lowest levels of tooth decay in Europe. It is also appropriate for adults brought up post 1960's, who benefited from the introduction of fluoride toothpaste and a more preventative approach to dental caries. However, it is totally inappropriate for those born in the 1930's, 1940's and 1950's.

2.2 This cohort of the population was at high risk of developing caries and increasingly enjoyed access to dentistry through the NHS. Techniques universally favoured cavity preparation based on the principle of "extension for prevention". These patients had decayed teeth that entered into the "restorative cycle"—repeated placement and replacement of restorations, with progressive loss of tooth structure and weakening of the tooth. In short, those most likely to need Band 3 treatments under the PDS.

2.3 It is these patients, with their huge volume of restorations and expectations to maintain a natural dentition, who will have the biggest impact on the demand for dental care over the next 20–30 years but are in danger of being abandoned by the PDS. The question has to be asked can one fee, however it has been arrived at which, through time, will inevitably degrade, ensure that this cohort of the population receives the treatment it needs when it covers such a wide range of appliances and therefore costs?

3. The Solution

3.1 We do not, however, see a return to more fees for band 3 treatments as the way forward. Dentistry is unlike medicine in that there are often a variety of ways of restoring/repairing/replacing the dentition that differ in quality and cost. The problem of having a different fee for a procedure to reflect the laboratory component is no different to a specific allowance built into the fee as under the GDS—it inevitably becomes the maximum and the GDP has no incentive to involve the patient in decisions about what is used.

3.2 The patient is unaware of this cost minimisation pressure, nor of its significance in limiting options, even though there may be considerable choice available—choice about the aesthetic and durability of something that will be present in their mouth for some considerable time. This complete lack of transparency and consumer sovereignty is at variance with market efficiency and is particularly difficult to accept in a health care system where patient charges have been a feature since 1951, introduced, ironically, for dentures.

3.3 However, if, as we propose, the patient pays for the laboratory component and the NHS subsidises treatment, we will see the emergence of an enfranchised patient, making real and informed choices about the dental care they receive.

December 2007

Memorandum by the Dental Technologists Association (DS 27)

DENTAL SERVICES

- From 1 August 2008, dental technicians will be required to be on a recognised course, or to hold a current registrable qualification in dental technology.
- There will be an ongoing and increasing need for CPD, much of which will come at a cost to the individual.

— There will be an increased cost to employers with employees requiring time off to fulfil their CPD obligations and formal training where the individual is on a recognised course other than full time.

— Due in part to the effects of the new contract and forces in the dental technology market from overseas dental laboratories, UK laboratories will be wanting to move into developing a more specialised high tech and customer orientated service. This will generate the need for high end courses, for developing these skills, and to attract the higher calibre of student into taking up dental technology as a worthwhile career option.

I would like the Health Committee to take a fresh look at the funding of dental technology education nationally. Education for Scotland has made some steps in the right direction by starting a fully funded vocational training scheme for dental technicians and fund free CPD for Scottish technicians. Why is England so far behind in regard to this matter?

I would like to see this Health Committee put forward the kind of recommendations that would help build an inclusive and rewarding scheme to address all of the matters outlined above. To not only enable UK based dental technicians to meet their obligations under their registration with the GDC but help create world leading dental technologists providing world beating solutions to the wider dental team, and to patients.

Paul Mallett RDT
President

December 2007

Memorandum by the Dental Practitioners Association (DS 28)

DENTAL SERVICES

Introduction and Notes

1) The Dental Practitioners' Association (DPA) welcomes this opportunity to submit evidence to the Health Committee's Inquiry into NHS dental and orthodontic services.

2) The DPA (formerly GDPA) was formed in 1954 and is the largest body that represents dentists in general practice. It consists of 1,000 practices containing 2,500 "high street" dentists. Uniquely its Constitution requires that the fifteen members of the principal executive committee and the Chief Executive must be dentists.

3) Within a document of this length we regret it is not possible to go into any detail regarding what might be learned from variations on the old system (as in Scotland except see para. 50)) or the variations on the new one (as in Wales and shortly in Northern Ireland).

4) For the sake of clarity this document will adopt the usual convention of referring to the arrangements in England prior to 1 April 2006 as GDS and the subsequent system as new GDS (nGDS). Similarly the piloting of various treatment provision systems in the period leading up to April 2006 as PDS and the fixed-term contract extensions awarded to early adopters of the pilot schemes as nPDS.

5) Where this document refers to Primary Care Trusts (PCTs) this includes Local Health Boards, insofar as their contracting and commissioning functions are identical.

6) The lack of any reference to patients' concerns should not be taken as a failure to acknowledge the distress caused by gradual collapse of NHS dentistry. We expect that the many organisations representing patients will make their case elsewhere with our full support.

Executive Summary

7) Dentistry is a unique combination of academic, manual and business skills. Very few other professions require a combination of all three.

8) Much of the current public dissatisfaction with the NHS dental services can be traced to a general decrease in NHS activity by each dentist due to the disparity in terms and conditions between the NHS and private sectors.

9) The dental contract imposed in April 2006 is characterised by inefficiency, inflexibility and unfairness and has introduced a number of perverse incentives.

10) Dentists do not leave the NHS for financial reasons. They invest the extra profit in improving their quality of life by giving patients more time and using better quality materials and laboratory work. On average a private dentist earns £800 more each year than an NHS dentist.

11) The DPA sees a rôle for dentists as the leaders of clinical teams with ultimate responsibility for the patient's overall care. It is more efficient for dentists to be confined to those procedures for which only they are qualified.

12) The key to prevention in dentistry is to give the practitioner a stake in the savings made. For example, a dentist who reduces his workload by (say) 20% due to prevention must not suffer a drop in income of 20% (as under the present and previous systems).

13) Once UDA targets were reached, it made good commercial sense to bid for more UDAs and this has led to a fall in the value of UDAs reflecting their lack of content. We consider that the value of a UDA will fall somewhat until it approaches the cost of production, at which time it will rise consistent with free market conditions of excess demand over supply.

14) The DPA would welcome the return of some form of registration of patients. Dentists do not like to see their patients on an ad-hoc basis and patients like to know who their dentist is and what rights they have. It is also consistent with the preventive cohort system (see para. 46)).

15) The question of whether the new arrangements represent adequate value for the taxpayer should be properly and expeditiously put in front of the National Audit Office.

16) The Health Select Committee has no constraints and, having given oral evidence in the past, the DPA respectfully asks that it is called to give oral evidence on this occasion as an organisation which is representative in the main area of this Inquiry.

Evidence

17) Dentistry is a unique combination of academic, manual and business skills. Very few other professions require a combination of all three.

18) DPA members in primary care are self-employed subcontractors to the NHS. They own their own premises, employ their own staff and pay their own expenses. Subject to a three-month notice period they are free to do as much or as little NHS work as they wish. As a result, there are significant differences in their terms and conditions compared to salaried dentists and GPs.

19) In 1981, approximately half the current number of dentists on the General Dental Council register treated substantially the same population with no NHS access problems.

20) Much of the current public dissatisfaction with the NHS dental services can be traced to a general decrease in NHS activity by each dentist due to the disparity in terms and conditions between the NHS and private sectors.

The Role of PCTs in Commissioning Dental Services

21) Prior to April 2006 Primary Care Trusts and Local Health Boards cared little about the dental services provided in their area. They played a minor part in the administration of the system which included processing applications to join or leave the area and had a rôle in inspection and testing.

22) From April 2006 PCTs have held the primary dental care budget and as a result they are now interested in dental provision. The handing-off of dental contracts to PCTs has coincided with the closure of the dental budget. As a result PCTs have a strong disincentive to expand dental provision to that part of the population which does not normally attend. (See also Perverse Incentives, para. 60))

23) During the piloting of schemes prior to April 2006, the DoH indemnified PCTs against any shortfall in patient charge revenue (PCR). This indemnity was withdrawn for the scheme proper. As a result PCTs have a strong disincentive to extend the service into areas of high need which may have low levels of PCR. (See also Perverse Incentives, para. 60))

Numbers of NHS Dentists and the Numbers of Patients Registered with them

24) The DoH has finally accepted after many years that the number of dentists with NHS contracts bears no relationship to the volume of dental services provided[59].

25) Since April 2006 there has been no registration of patients. Any cipher (such as the number of patients who visited a particular dentist in the last 24 months and have not seen another dentist since) is likely to be highly malleable and to have been arrived at because it gave the answer that was required.

26) Registration, measured using the new yardstick, confers no rights on patients.

[59] "The numbers of dentists providing NHS services is a relatively weak indicator: it is the volume of services they provide for the NHS that is more important" DoH evidence to 37th Review Body, para. 6.11

Numbers of Private Sector Dentists and the Numbers of Patients Registered with them

27) All dentists in primary care (other than salaried dentists) are private sector dentists that sub-contract work from the NHS.

28) The proportion of turnover derived from private work is now greater than that from NHS work[60], but because private fee income per patient has stabilised at around three times that on the NHS, it is likely that NHS patients are still in the majority.

29) Dentists do not leave the NHS for financial reasons. They invest the extra profit in improving their quality of life by giving patients more time and using better quality materials and laboratory work. On average a private dentist earns £800 more each year than an NHS dentist[61].

The Work of Allied Professions

30) It is the DoH policy following from the Nuffield Report to hand off insofar as possible the routine care of patients to allied professions.

31) There has been an increase in the rôle of the allied professions in particular the hygienist/therapist which is the practitioner thought most likely to be able to assume the bulk of routine dental work currently carried out by highly trained and expensive dentists.

32) To this end registration and regulation of allied professions will be completed by July 2008.

33) The DPA sees a rôle for dentists as the leaders of clinical teams with ultimate responsibility for the patient's overall care. It is more efficient for dentists to be confined to those procedures for which only they are qualified.

Patients' Access to NHS Dental Care

34) The new contract was supposed to halt the drift of dentists away from the NHS. Every survey shows that it has failed to do so and that patients' access continues to deteriorate.

35) The abolition in April 2006 of charges for failed appointments was an ill-advised attempt to bring NHS dentistry in line with NHS practice. NHS dental patients accepted charges as reasonable and necessary for the proper operation of the appointment system and with very rare exception it worked reliably and well. It was a model for the rest of the NHS, not an aberration to be corrected.

36) The average dentist now loses time to the value of 600 UDAs (approximately £12,000 turnover) as a result. Failed appointments impede the access of other patients and result in underperformance. Fifty-two per cent of our practices report an increase in broken appointments averaging 35%.

The Quality of Care Provided to Patients

37) There is a common fallacy regarding dental work, which is that standards set by the General Dental Council ensure the uniform quality of dental work, whether provided on the NHS or privately.

38) The main differences between the quality of NHS and private work lie in the amount of time taken and the quality of materials and laboratory work. It is not true to say, therefore, that an NHS crown is the same as a private crown, only cheaper.

39) This misconception has led to many patients clamouring for NHS treatment on the grounds that it represents exceptional value for money. While that may be true, it is not for the reason generally assumed and once this is explained properly, far fewer patients choose NHS work.

40) It is incumbent upon any dentist to do the best possible job under the circumstances; however NHS constraints mean that the best possible job might not be the best job possible. In this, dentistry is no different from any other field of human endeavour.

The Extent to which Dentists are Encouraged to Provide Preventive Care and Advice

41) The mechanism of dental disease and the steps necessary to prevent it are well known. Prevention in dentistry works quickly, reliably and consistently.

42) Mechanisms exist in the private sector to deliver preventive care—in fact most third-party modified[62] capitation plans are built round such systems.

43) There is no reason so far as the DPA can see why NHS dentistry has not been modelled on an existing preventive system other than the DoH's aversion to implementing ideas that did not originate in-house.

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[60] Source: National Association of Specialist Dental Accountants, figures for April 2005-March 2006.
[61] Source: Information Centre for Health and Social Care.
[62] Third-party capitation plans are called "modified" because the risk that patients might suffer a catastrophic dental accident is subcontracted to an insurer.

44) A system of prevention in dentistry would produce oral health gains and financial savings much faster than could be expected in other medical specialities and would serve as a model for the NHS generally.

45) The key to prevention in dentistry is to give the practitioner a stake in the savings made. For example, a dentist who reduces his workload by (say) 20% due to prevention must not suffer a drop in income of 20% (as under the present and previous systems).

46) Prevention is consistent with registration, as a dentist must take responsibility for an improvement in the oral health of a cohort of patients and keeps a percentage of any savings made.

47) The so-called "5% reduction in workload" was more than swallowed up by increased administration and a greater than expected UDA target for children based on the false assumption that they all attend twice each year. In the current system no time is left for prevention.

48) To expect that a dentist will take time out of a target-driven system to carry out prevention is wishful thinking at best. Encouragement must come in the form of a system that rewards prevention, not exhortation.

Dentists' Workloads and Incomes

49) The arrival of local commissioning calls into question the purpose of a Review Body when there is no agreed national pay rate, no universal scale of fees and 153 different commissioning bodies in England alone.

50) The Scottish may still find a need for an across the board pay increase but they have departed in many other ways from a DDRB-led pay system for NHS dentists. Twenty per cent of Scottish dentists' remuneration is now paid by way of grants from an open-ended budget.

The Recruitment and Retention of NHS Dental Practitioners

51) The DPA accepts that NHS recruitment and retention do not give cause for concern if using the number of dentists with an NHS contract as the yardstick. It is motivation to work wholly or mainly within the NHS that is the problem.

52) Measures such as an increase in dental student numbers, overseas recruitment and the returning workforce are not expected to have a significant impact on NHS availability.

NHS Dental Reforms

53) The dental contract imposed in April 2006 is characterised by inefficiency, inflexibility and unfairness and has introduced a number of perverse incentives.

Inefficiency

54) The interpolation of a middle tier of management was an expensive, unnecessary and retrograde step. The desire to adopt a "command and control" attitude to the provision of public services owes much to a failed central Soviet style of management.

55) The question of whether the new arrangements represent adequate value for the taxpayer should be properly and expeditiously put in front of the National Audit Office.

56) Under the old system every dentist had a direct interest in cost saving. Under the new system an entirely different dynamic is operating, where expenditure is monitored at a level far removed from the activity.

Inflexibility

57) Under the old system a dentist could apply for permission to work in a PCT area and subject to a satisfactory application be in post within a very few weeks. Under the new system dentists may only apply where the budget exists and an application may have to be deferred until the next financial year. In the meantime the dentist may well apply elsewhere and a position may remain unfilled.

Unfairness

58) During the period for three years from April 2006 dentists will be paid a UDA value that is based on their historic earnings. Dentists that used to carry out many treatments per course will have high UDA values and dentists that used to carry out very few treatments will have low UDA values.

59) While the DoH maintains that historic treatment patterns will continue the DPA considers that this is most unlikely as dentists have in the past shown no hesitation to adapt to new ways of working. Dentists are having to meet identical targets for different contract values (even within the same practice).

Perverse Incentives

60) The number of complex treatments per course is dropping and this was flagged up as one of the intentions of the DoH in introducing the April 2006 contract. However the practitioner with a low UDA value and healthy patients will benefit much less from this effect than his neighbour.

61) Dentists with high UDA values benefit disproportionately by reducing their workloads. All dentists are discouraged from taking patients with high needs and chasing UDA targets conflicts with decisions based on clinical need. The disincentive to carry out complex treatments results in a de-skilling of the NHS workforce. These are a few examples of perverse incentives introduced by the new system.

62) Young dentists are now more likely to be delivering a core service of straightforward maintenance and not gaining a broad base of experience in their early years.

NHS Dental Reforms—One Year On

63) The notes below refer to a selection of assertions in this document which we believe are misleading or incorrect (figures in brackets refer to paragraph numbers in the document).

64) [1.1] *Dentists were drifting away from the NHS but PCTs did not have the local funding to replace them.*

65) It is true that dentists were drifting away from the NHS, however this was due to the increasing disparity in terms and conditions between the NHS and private sectors and not from lack of local funds.

66) [1.3] *If a dentist ceases to provide NHS services, the local NHS is now able to bring in new services as a replacement.*

67) Under GDS, funding followed the dentist, so when a new dentist moved into a PCT area the funding was automatically in place and the GDS budget was open-ended. Under the new system, funding is closed which prohibits any attempt at increasing access. Moreover if one dentist leaves, the PCT is left with the funding for one dentist, even if three are needed in the area. The new system is considerably worse than the old. PCTs would do well to concentrate on commissioning in areas of high need as that is all they are likely to be able to cover.

68) [1.4] *PCTs have commissioned more services than were delivered in the last year of the old contract.*

69) Services are now measured in Units of Dental Activity which are essentially empty courses of treatment. The commissioning of such units does not address the drop-off in treatment volume provided or the continuing access problems.

70) [1.5] *There has generally been little shortage of dentists offering to expand their services . . . and an upward trend in the number of dentists providing NHS services.*

71) The substitution of empty courses, for treatment items as a measure of productivity has (as intended) led to a temporary glut of UDAs. Initially dentists' appointment books were freed up as they found they could earn their points doing far fewer treatments. Rather than carrying out prevention they naturally used the extra time to create more UDAs towards their targets.

72) Once UDA targets were reached, it made good commercial sense to bid for more UDAs and this has led to a fall in the value of UDAs reflecting their lack of content. We consider that the value of a UDA will fall somewhat until it approaches the cost of production, at which time it will rise consistent with free market conditions of excess demand over supply.

73) [2.1] *the location and volume of services were previously decided by dentists, not by the NHS.*

74) Under the old system dentists took responsibility for establishing practices in areas that were dictated by the rules of the system in which they worked. These were mainly areas of high demand, since income depended on fees earned and we are still waiting for a satisfactory explanation of how to convert need into demand.

75) Dentists had a direct personal stake in the success of their practices and their large degree of autonomy meant that the relatively low business risk encouraged them to work within the NHS where they subsidised NHS practice in many cases from their private sector work.

76) It is not true to say that the "fee-per-item system created incentives for more invasive and complex treatment and increased costs—not consistent with reducing disease incidence[63]". Due to the surplus of demand over supply there was no incentive to create unnecessary treatment.

77) Under the new system, Primary Care Trusts dictate to dentists where they will work, which patients they will see and to whom they must sell their practice in case of ill-health or retirement.

78) The factors above have led to an increase in business risk which discourages most dentists from working wholly or mainly within the NHS.

[63] DoH evidence to 37th Report of DDRB

Possible Solutions

Voucher System

79) The Dental Practitioners Association (formerly the GDPA) has long been associated with a system of healthcare known variously as Grant in Aid or the Voucher System.

80) In this system the state makes a core contribution leaving dentists free to set their fees based on the service they wish to supply. As now, some dentists would work for core fees (for patients who are fully remitted or exempt or who want a basic NHS service) and other practices where patients would need to make a larger co-payment if (for example) they wanted a better quality material or prosthesis approaching private standards.

81) The patients' copayment would consist of their NHS charge plus any optional costs agreed with the dentist for better quality materials or laboratory work.

82) Before reading the following table it might be helpful to review para. 37 regarding the common fallacy about universal treatment standards.

Table 1

OBJECTIONS TO A VOUCHER SYSTEM WITH COUNTER ARGUMENTS

83) It is divisive—the NHS is predicated on the idea of a universal standard of health care. If it is good enough for me it is good enough for you.	84) This conspires against freedom of choice in health care and is a "levelling-down" argument.
85) Thanks to GDC standards, NHS care is as good as private care only cheaper.	86) See para. 37.
87) The wealthy and intelligent must be forced to use the NHS as they are the only ones who will insist that standards are kept high.	88) You cannot force anyone to use the NHS, and certainly not for the reason quoted.
89) If the NHS caters for only part of the population then economies of scale will be lost for those which remain.	90) As people leave the NHS more money is left to treat those who remain. The NHS is more than large enough to retain economies of scale.
91) NHS money is being used to subsidise the private sector.	92) All self-employed dentists work in the private sector and are subcontracted by the NHS.
93) Dentists would use the variable copayment to confuse and overcharge vulnerable patients.	94) This is a straightforward disciplinary issue.

Registration

95) The DPA would welcome the return of some form of registration of patients. Dentists do not like to see their patients on an ad-hoc basis and patients like to know who their dentist is and what rights they have. It is also consistent with the preventive cohort system (see para. 46)).

96) The contrived mechanism of recording the number of patients who attended within the last 24 months (and who have not seen another dentist) satisfies neither practices nor the patients.

Conscription

97) The DPA strongly recommends against extending the already unpopular "command and control" approach further, by requiring every dentist to complete a stint in the NHS. An objective analysis of most dentists' lifetime NHS commitment will show that dentists already voluntarily work for the NHS far more than could reasonably be required of them under any scheme of conscription.

98) A conscription scheme would be disastrous for morale and have to overcome serious obstacles in relation to the symmetrical treatment of other groups trained at public expense but not currently forced to work in the public sector during periods of shortage.

Oral Evidence

99) To sum up the problems of the current system and possible solutions in such a short document has been a considerable challenge and inevitably there are many important areas which have suffered.

100) Regulation 19 of the National Health Service (General Dental Services) Regulations 1992 imposes a requirement on the Secretary of State to consult with an organisation that is most representative of dentists working within the GDS. Note the use of the word "an". This has been used by DoH to exclude organisations such as the DPA from supporting and representing our members on terms and conditions, to the detriment of all concerned including our NHS patients.

101) The Health Select Committee has no constraints and, having given oral evidence in the past, the DPA respectfully asks that it is called to give oral evidence on this occasion as an organisation which is representative in the main area of this Inquiry.

ACKNOWLEDGEMENTS

102) The Dental Practitioners' Association welcomes the opportunity to discuss this document with any interested party.

103) The lead practitioner on this document is: Dr Derek Watson BDS LDS RCS DGDP, CEO, Dental Practitioners Association.

December 2007

Memorandum by The British Association for the Study of Community Dentistry [BASCD] (DS29)

DENTISTRY

SUMMARY

BASCD is an alliance of individuals with an interest in population oral health, working together to:

— Provide a set of principles for the improvement of oral health and the development of oral health care and promote their dissemination.

— Influence policy at international, national, regional and local level in support of oral health.

Members work in dental public health, primary and hospital dental care (particularly community and special care dentistry) and beyond. Our evidence relates to the following four main areas:

I. The role of Primary Care Trusts in commissioning dental services.

II. Patients' access to NHS dental care.

III. The quality of care provided to patients, which must involve prevention.

IV. The extent to which dentists are encouraged to provide preventive care and advice.

V. Workforce issues.

The Association has been involved directly or through its members in developing, and implementing, key guidance, in support of recent dental policy changes and the promotion of oral health particular, as outlined below.

THE ROLE OF PRIMARY CARE TRUSTS IN COMMISSIONING DENTAL SERVICES

1. Members of the Association play an important role within Primary Care Trusts [PCTs] and Strategic Health Authorities as advisors on commissioning of dental services. However, with recent management reorganisations there has been a significant reduction in service capacity. There are therefore serious pressures on the capacity of Dental Public Health specialists to deliver sufficient dental public health support to NHS organisations at a time when the expertise is clearly required to support the new commissioning powers of PCTs. The lack of Dental Public Health advice in some PCTS is a problem.

2. This reduction of capacity, in both the NHS and academia, has been recognised by the Department of Health. Within England there is currently a Review of Dental Public Health capacity and capability. This Association, welcomes this review and considers it vitally important that there should be sufficient specialist expertise at local and strategic levels to ensure that there is effective needs-led commissioning of dental care, both treatment and preventive.

3. In recognition that commissioning of dental care should relate to local need, members of this association have worked with Primary Care Contracting in developing a needs assessment toolkit to assist with assessing need at Primary Care Trust levels.[1] This is not a one-off process but requires work to inform commissioners on an ongoing basis on all aspects of oral and dental care. Members of BASCD have been involved in national events and workshops in shaping policy, commissioning and service redesign to support needs-led commissioning.

4. This Association through its Information Section has played, and continues to play, a major role in oral health surveillance through the coordination of local epidemiological surveys.[2] This includes quality assuring the programme. This information is important to inform needs-led commissioning as outlined above. In addition to local surveys, the comparative information on national trends from national surveys is vitally important. As an association we are concerned that the Adult Dental Health Survey for 2008 has

not yet been commissioned. This would have been the third UK survey and the fourth decennial survey for England. We urge that this national survey takes place as soon as possible as it provides national and regional information on adult oral health in the population.

Patients' Access to NHS Dental Care

5. Access to dental care is an important public health issue for all sections of society. NICE dental recall guidance suggests that adults should attend at least once every two years and children every year, with more frequent checkups based on their level of risk[3]. Current levels of uptake of dental care are in the region of 70.7% for children and 50.5% for adults in England[4]; and thus while a proportion of adults attend for private dental care, there is still a significant section of the population who is not accessing care regularly (within a 24 month period). Many of these groups will require care to be provided in modern delivery systems as outlined by Lord Darzi[5], which involves the development of primary care centres with extended opening hours and outreach facilities.

6. It is particularly important to ensure that in a market based health economy, that vulnerable groups in society do not miss out on receiving dental care and thus result in an increase in inequalities in health. This is particularly important when many vulnerable groups in society, such as older people, are not exempt from patient charges in England. Furthermore, people with high oral health needs are not supported in receiving care under the new system. Members of the association have been involved in the recent guidance on Valuing People's Oral Health[6], which highlights the importance of promoting oral health in people with learning disabilities.

7. For many BASCD members their area of clinical practice is in special care dentistry. They face daily the challenges and complexities of providing dental care for this client group. For many such patients the complexity of needs, even to enable the simplest dentistry to be performed, is considerable. BASCD members have worked with representatives of the BDA Central Committee for Community and Public Health Dentistry to develop a model which describes such complexities. This model, known as the "casemix toolkit" is now beginning to be used in many salaried dental services throughout the country. The model, which will be formally launched in January 2008, enables both providers and commissioners to better understand these needs and provide appropriate services to meet them.

8. Individuals from this Association are also leading and contributing to a review of Black and Minority Ethnic populations in relation to primary dental care for the Department of Health. Collection of ethnicity data as part of routine primary dental care information systems will be important to support this initiative.

The Quality of Care Provided to Patients

9. The quality of care accessed is important. One feature of quality which this association supports proactively is health promotion as outlined by the range of activities in which the Association, or members of BASCD as individuals, have led or been involved in a range of important initiatives in support of Standards for Better Health.

10. Information on the nature of care provided and how this relates to oral health needs and risk of disease should be collected in future at practice level to provide an indication of the "appropriateness" and therefore "quality" of care.

11. Members of the Association have supported dentists with a special interest in Prison Dentistry to develop support networks and quality initiatives in support of oral healthcare amongst this needy section of the population[7].

The Extent to which Dentists are Encouraged to Provide Preventive Care and Advice

12. Working with the Department of Health and other key stakeholders, members of this association have assisted with the development of a range of health promotion initiatives which include:

- Oral Health Promotion toolkit—Delivering Better Oral Health[8]
- Tobacco cessation—Smokefree and Smiling[9]

These are very important initiatives in supporting health promoting oral and dental care in line with contemporary evidence. The "toolkit" is currently being distributed to all dentists and requires a series of actions to support its implementation from education through to remuneration.

13. It is of great concern to this Association that there is nothing in the current dental contract to encourage dentists to provide preventive care and advice. A reorientation of dental services to promote oral health and prevent oral diseases in an evidence-based manner is the only way to play a major contribution to the public and patients in the long-term. In promoting this approach, the Association recognises the important work of Sir Derek Wanless[10,11], and the more recent work of Lord Darzi[5] which supports "staying healthy". This must be addressed in future dental policy. Members of BASCD are also working on a "Commissioning for Oral Health" self-assessment toolkit to support PCTs assess competence in this role and identify areas for improvement by describing and sharing excellence.

14. Prevention must not be limited to attendees of dental services but of necessity must focus on the whole population. Resources are therefore required to support public health programmes at population level.

Workforce Issues

15. In considering the size of the dental workforce, merely considering numbers of dentists, and dentist to population ratios is not sufficient unless the "whole time equivalent" is considered. Such data are currently not available.

16. To date, the new contract does not seem to provide a direct incentive for the use of skill-mix to extend the workforce. In future there should be greater emphasis on team-working and skill-mix maximisation, as many of the tasks in primary dental care could be undertaken by hygienists and therapists working with dentists. Individuals from this society have contributed to workforce planning projects and a national toolkit resource[12].

Dr Liana Zoitopoulos
Secretary of BASCD

December 2007

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Memorandum by Dr JE Gallagher and Professor NHF Wilson (DS 30)

DENTAL SERVICES

We have pleasure in submitting evidence to the Health Select Committee on Dentistry, based on our perspective as academics with a specific interest in the dental workforce as health services researchers, and educators, at the largest clinical academic centres in the United Kingdom.

1. As a result of policy changes in 2004, we are training an increased number of dentists and other dental healthcare professionals.

2. In order to promote oral health, dental services must provide graduates with the opportunity to practice quality dental care, including a strong emphasis on disease prevention and promotion of oral health. Research with graduates has confirmed this view.

3. Recent research, with final year dental students at Kings' College London Dental Institute [KCLDI] and Vocational Dental Practitioners in England and Wales, suggests that new entrants to the profession have been significantly attracted to dentistry by "features of the job" and hold a vision of a "contained professional life" [1-3].

4. New entrants to the profession also consider themselves to be "undervalued" by patients, government and the profession [2]. This impacts on their view of NHS dentistry[2].

5. Many dental graduates are entering the workplace with the pressure of significant student debt [1, 2]. Management of student debt impacts on the attitudes of new graduates in respect of developing a career in NHS dentistry.

6. Whilst a system should not be designed around the workforce, the dental system needs to be sufficiently attractive to the members of the workforce to retain their services. Whilst research suggests that the professional career expectations of the present generation of new graduates do not necessarily sit well with a highly managed system, they do however relate to government priorities of providing quality and preventive care. In support of workforce retention in the NHS and meeting the oral health needs of the population, an approach which supports quality and prevention, neither of which has been incentivised under the new dental contract, must, it is suggested, be implemented as a matter of urgency.

7. There are issues regarding the location of practice; however, in light of the changing demography of dental students [4], it is important to recognise that workforce movement is not always possible for social, family and cultural reasons.

8. Workforce planning should be an ongoing process in light of the pace and nature of change, with the anticipated developments in skill mix being managed in such a way as to capitalise on the strengths of the dental education system in the UK.

9. It is important that the system proactively harnesses the abilities and enthusiasm of new graduates. Students at KCL Dental Institute have, by way of example, identified that a range of factors may attract them to work within the NHS [unpublished]:

- Opportunity to gain experience.
- Reward of providing a public service.
- Option of salaried posts.

However, the students went on to make suggestions regarding changes that they considered would help to make NHS dentistry more attractive:

- Incentives to practice in deprived areas.
- Philosophy of care—re-orientating to prevention.
- The value of NHS dentistry—addressing the stigma.
- Permitting mixed economy—combining NHS and private practice.

Similar views were shared by Vocational Dental Practitioners [5].

Commissioners of dental care are one stage removed from employing new graduates, but should take account of the need to make the NHS an attractive option to new dental healthcare professionals.

10. Students need a degree of certainty about the future, in particular for the initial years following graduation when they are making the transition from dental school and endeavouring to address student debt. Systems should be put in place to address this need.

11. It is important that current reforms address career prospects for new graduates. There needs to be clear training paths for new graduates within the NHS, giving opportunity to experience and contribute to NHS care, with the prospect of being an integral element of healthcare provision in general.

12. Finally, there is a need to ensure the best use of the skill-mix of the dental team in future service developments. New graduates seek to have opportunity to lead dental teams in the provision of modern, patient-centred oral healthcare provision—a key factor in attracting new graduates to work within the NHS system.

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December 2007

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Memorandum by the NHS Confederation (DS31)

NHS DENTAL AND ORTHODONTIC SERVICES

The NHS Confederation represents more than 95% of the organisations that make up the NHS. We are the independent membership body for the full range of organisations that make up today's NHS across the UK. Our members include Primary Care Trusts, NHS Trusts, NHS Foundation Trusts and independent providers of NHS services.

The NHS Confederation welcomes the opportunity to give evidence to the Health Select Committee on NHS dental and orthodontic services. This evidence sets out our views, based on feedback from a cross section of our members, particularly those provided by members of our PCT Network. We are also providing case studies from two of our members, which are included as appendices.

Key Points

The NHS Confederation is of the view that the contract for NHS dental services has the potential to deliver change but:

- PCTs have lacked the capacity to realise the potential of the contract—both in management resource and access to dental public health expertise. PCTs will be aiming to address this shortfall as part of the World Class Commissioning programme, currently underway.
- There is an opportunity to consider the future direction of dental services within the Primary and Community Services Strategy, which is being produced as part of the Department of Health's Next Steps Review Commissioning.
- PCTs need to consider dental services alongside all their other local priorities. We estimate that it would cost £2.3 billion[64] to introduce full coverage of NHS dentistry across the country.
- Clinical engagement is crucial; where good relations are developed, good performance management arrangements are usually in place[65]. This is especially important to improve the quality of services.
- Incentives for prevention and health promotion should be strengthened.
- Funding needs to be reviewed due to the shortfall created as a result of less income from patient charges than expected and due to the consequences of allocations based on historical activity[66]. This is particularly significant in the run up to 2009 when PCT allocations for dentistry cease to be ring-fenced.

Background

The origin of the problems in accessing NHS dental services stems from the reforms in 1990 which changed the way dentists were paid, lining payments to the numbers of registered patients. Due to the large numbers of patients registered, (far more than planned for) fees were cut in 1992 and significantly reduced the earnings of dentists. The consequence of this was that dentists drastically reduced their NHS work, and many turned exclusively to private practice.

The Health and Social Care Act 2003 required that, "each Primary Care Trust and Local Health Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its powers so as to provide primary dental services within its area, or secure their provision within its area."

The protracted nature of the negotiations between the Department of Health and the British Dental Association meant that this only came into effect from April 2006.

However, these reforms probably represent the most radical reform of NHS dentistry since 1948. The devolution of funding to PCTs, alongside the statutory duty to commission services provides opportunities to tailor services to meet local health needs. This potentially enables PCTs to redress the uneven distribution of dental services in some areas which has arisen because previously dentists have been able to set up practice in areas of their choice rather than in areas of greatest need.

The reforms are intended to address three key issues:

1. Access to services—by putting PCTs in charge of commissioning.
2. Remuneration reform.
3. Simplify patient charges.

[64] See paragraph 2.4 for further detail.
[65] See sub-paragraph 1.1.5 for further detail.
[66] See paragraph 1.1 for further detail.

Patients now pay standard changes (3 bands) and dentists have a contract with the PCT to provide an agreed number of units of dental activity (UDAs) per year. This replaces the 400+ different patient charges in the previous contractual arrangements.

The financial allocations for the contracts were based on historic spend in 2003–04 and have been ring-fenced for dental services until 2009. No additional resources were made available to areas with higher needs. PCT budgets were also adjusted (downwards) in line with anticipated income from patient charges. This has caused additional financial pressure in some areas of the country.

From 2009 the resources will be part of the PCT general allocation.

1. *The role of Primary Care Trust's in Commissioning Dental Services*

1.1 There is no consistent national picture on the implementation of the reforms. This may be due to a range of factors, not least that the changes coincided with the reconfiguration of PCTs, but also the following:

1.1.1 A wide variation in the financial pressures that have resulted from the implementation of the new contract have been of major concern to some of our members and could potentially affect their future commissioning plans. The principle reason is the new arrangements for patient charges. PCTs had their resource allocation reduced based on the anticipated income from patient charges. This was predicted to be £634 million, however only £475 million was actually payable during 2006–07. The lack of revenue from patient charges appears to be due to dental practices seeing more "exempt" patients (including children) than predicted, who make no contribution to their treatment. This has led to a significant financial shortfall for PCTs, who are faced with uncertainty in relation to which patients will require NHS treatment. This has affected many areas with high levels of deprivation and, therefore, high levels of need. In a few cases PCTs are facing the possibility that they may have to reduce the current level of services.

1.1.2 The capacity of PCTs to use the new contract has been raised by our members as a key concern. In the light of the wide range of performance measures faced by PCTs there is a danger that dental services commissioning is not necessarily regarded as a mainstream issue.

1.1.3 Many PCTs have historically allocated limited resources to manage dental services. Dental contracts are often the responsibility of relatively junior managers, who have a contract management role and little involvement in strategic planning within their organisations. Their initial focus has been to ensure that contracts were in place. Where dentists have left NHS provision, new contracts have been let, but on the whole these have just re-provided the previous services. In some areas only two staff are responsible for managing 120 practices with 140 contracts. Should these staff leave, a lack of organisational memory could compromise the commissioning and performance management role of the PCT.

1.1.4 The limited access to dental public health advice is also of concern to some members. The number of Dental Public Health Consultants is decreasing at a time when their input is of increasing value as PCTs are required to make the shift from contracting to commissioning.

1.1.5 Some PCTs have extremely good relationships between the PCT, Local Dental Committees and/or dental contractors. Despite low levels of human resource, these areas have put good performance management arrangements in place. Other areas have extremely poor relationships and have limited arrangements.

1.2 Some members feel that the contract itself offers sufficient opportunities for local commissioning and that the utilisation of a balanced scorecard approach, which measures whether the activities of an organisation are meeting its objectives in terms of vision and strategy, alongside a clear commissioning strategy, provides the potential to develop services appropriate to local needs. However, other areas are not so positive, and the key appears to be long standing good relationships with their contractors.

1.3 The commissioning of dental services must be considered as part of the Department of Health's World Class Commissioning work programme or they will continue to be regarded as a separate responsibility outside of mainstream commissioning.

2. *Numbers of NHS dentists and the numbers of patients registered with them*

2.1 Our members report that they have few concerns about the number of NHS dentists, but are concerned about the lack of information about the availability of NHS dental services[67]. In areas where contractors have not signed contracts, or have since left the NHS they have had no difficulty in re-tendering the contracts. In many cases they have been able to commission extended services.

2.2 In London, where dentists did not take up new contracts for 3% of services, PCTs have already been able to replace all of these services by commissioning new or extended services from other dentists.

[67] See paragraph 5.2 onwards for our views on this issue

2.3 National and SHA level information on dental activity is provided by the Information Centre, who publish statistics quarterly. It should be noted that the information on the new contract is not directly comparable with the information collected under the old contract.

2.4 We have used a simplistic calculation to give an indication of the cost of covering the entire population (100%). 55.7% (51.5% of adults and 70.7% of children) of the population in England were seen by an NHS dentist in the two years to March 2007, which equates to 28.1 million people (20.3 million adults and 7.8 million children). Treating these patients amounted to a maximum total expenditure of £2,3978 million. Therefore, it would cost £4,656 million if 100% of the population were to be covered, which would require an increase of £2,258 million in funding. We readily acknowledge the simplicity of this argument. A large number of patients, perhaps as high as 20%, never access a dentist, although we would like to see this figure fall. Some will choose to go privately and the way in which the figures are reported is not necessarily indicative of need. However, we thought it might be of interest to the Committee to have a rough estimation of the cost of providing NHS dental treatment to all. Clearly, PCTs would need to consider this call on their resources alongside all their competing priorities.

4. *The work of allied professions*

4.1 Allied professions are an underused resource and, as Western Cheshire PCT note in their case study under Appendix B, it is necessary to have the benefits of a larger scale operation in order to take full advantage of the benefits of team working.

5. *Patients' access to NHS dental care*

5.1 Improved access to NHS dental services is one of the key aims of the new contractual arrangements. Responsibility for this has now been passed to PCTs from the dental profession. It is important to recognise that not all PCTs have problems with access. In fact, PCTs in London are addressing the issues raised by a shortage of people coming forward to seek dental care rather than a shortage of service provision.

5.2 An important part of the problem of patient access is the lack of easy access to information about the availability of NHS dental services, which is well documented in the Citizen's Advice Bureau report "Gaps to Fill". Many patients are unclear about how to find a dentist, despite some PCTs managing central waiting lists and national campaigns on NHS Direct and NHS Choices websites. Recent media reports with examples of a patient resorting to superglue for dental treatment actually occurred in an area where the PCT reports no difficulties with access to NHS services.

5.3 PCTs are finding innovative ways of addressing access problems. The benefits of operating a central waiting list are documented in Appendix A, which is a case study provided by Lincolnshire PCT, which has been able to offer 46,000 patients an NHS dentist. There are also many examples in London where PCTs have implemented specific schemes aimed at improving access. Tower Hamlets PCT has a dental access project which uses mobile dental surgeries staffed by the salaried service. People are dentally screened, and, if living in an area of low provision of dentistry receive NHS treatment. This pilot has proved to be very popular with the public.

5.4 In addition, all London PCTs directly provide or commission a Salaried Primary Care Dental Service which is able to deliver special care dentistry for vulnerable groups and people with special dental needs. These services are variable in their ability to respond to local needs, working to varying access criteria.

5.5 Tackling inequalities to access to dental care will require a range of initiatives to address the barriers towards dental care and may require additional resources over time to address uptake in areas of social deprivation and higher unmet need and amongst vulnerable groups.

6. *The quality of care provided to patients*

6.1 Ensuring the quality of care provided to patients is a key issue for PCTs. The first year of the contract has naturally focused on agreeing contract values with practitioners, and re-tendering contracts where dentists chose to leave the NHS. In order to address quality issues many PCTs require additional capacity. It is essential that PCTs engage with the profession and their current capacity does not always support this. Further improving the quality of care will be addressed as PCTs increase their capacity to use the contract imaginatively.

7. *The extent to which dentists are encouraged to provide preventative care and advice*

7.1 All PCTs have groups working on local oral health strategy and will be working with key stakeholders on implementation.

9. *The recruitment and retention of NHS dental practitioners*

9.1 PCTs have not encountered problems with the recruitment of NHS practitioners. Members report healthy levels of competition when re-commissioning services. They also report that contractors have been able to recruit to posts when they have become vacant.

NHS Confederation

December 2007

Annex A

LINCOLNSHIRE PCT

The Impact of the Dental Contract Reforms

1. *The role of PCTs in commissioning dental services—an improvement*

- The experience of Lincolnshire PCT, as a commissioner of dental services, has been a positive one in that the PCT has seized the opportunity to undertake procurement as a vehicle for addressing the challenge of access in the county.
- A procurement exercise in 2006–07 resulted in the award of ten new contracts across the county in areas of highest unmet need.
- The reforms allowed the PCT to decide on the type of service and the location of that service, the new arrangements allowed the PCT to focus on the more challenged localities, in terms of access to mandatory dental services, within the county.
- Recently there has been the opportunity to align localities were there has been significant demand to those of highest oral health need. Lincolnshire PCT has developed an Oral Health Strategy and an associated draft action plan. The PCT has identified access and health inequalities as two major target areas to address within the strategy. There are areas of significant deprivation within the PCT and while access is improving, the PCT recognises that more work needs to be done in these areas.
- The commissioning process is now needs based and the PCT has learned a great deal through each procurement exercise in terms of quality, value for money, and the move towards an outcome based commissioning approach. A second review of access was undertaken in early 2007 and it was agreed to commission an expansion of mandatory services through current providers and secure additional capacity through a further procurement tender exercise. This has been actioned through 2007–08 along side rapid reprovision where an existing provider has decided to leave the NHS.
- The new reforms have allowed the PCT to drive these changes forward to address access and health inequalities within the county. Local councillors have been involved in the review and consultation process and acknowledge that the reforms have brought about improvements in the commissioning of NHS dental services.
- Orthodontics and minor oral surgery are an access challenge for the PCT. The PCT is commissioning services to address this: expressions of interest have been requested for additional orthodontic capacity and a scoping exercise is underway for minor oral surgery services. Again, the reforms have allowed the PCT to determine where this additional capacity should be located rather than provider.

2. *Numbers of NHS dentists and the number of patients registered with them &*

5. *Patients' access to NHS dental care—an improvement*

- There are 85 NHS dental providers in the county and due to the action outlined above this has increased the numbers of dental performers since April 2006. The number of patients registered with an NHS dentist is no longer held by the PCT but the majority of dental practices retain a practice list in order to manage their contracted activity through the provision of courses of treatment.
- The PCT established a dental contact list in Autumn 2005 in readiness for the new capacity planned to be in place from April 2006. The PCT, through contract negotiations leading up to April 2006, offered existing providers the opportunity to increase their contracted activity and see new patients (for example, where a practice wished to retain a VT as a 1st year associate).
- However, since the implementation of the new contract, approximately 55,000 patients have been offered a place with an NHS practice. The majority of these have been placed with a new provider but some existing providers have also offered NHS places. The PCT has used the contact list to populate the new dental practices as they came on line and this was strictly managed to ensure

fairness and equity of provision. The contact is still used, particularly for areas where new capacity has been secured for areas of unmet need. In areas where there is a choice of NHS dental provider, patients now have direct access to these practices via practice contact details.

— This year there has been positive feedback from the Lincolnshire Health Scrutiny Committee on the progress made by the PCT in addressing access to NHS dentistry since April 2006.

8. *The quality of care provided to patients—under review*

— The PCT has experienced an increase in referrals to specialist and secondary care. This in part will be due to the improvement in access to mandatory services and new patients can be seen and their needs assessed. However, the Lincolnshire LDC has asked the PCT to investigate whether this increase could be due the clinical practice of overseas dentists with little experience of the NHS. In addition, secondary clinicians have asked the PCT to investigate whether clinical practice has changed due to the implementation of the new contractual arrangements. This debate often focuses on the more complex treatments in Band 2.

— One particular area is oral surgery and the PCT is undertaking a process mapping exercise in January 2008 as well as looking at the inappropriate referrals received by secondary care.

— The PCT has developed a service specification to try and incorporate quality elements into the new services commissioned, rather than solely activity and price based, and this is reviewed after each procurement exercise. The PCT is also developing KPIs and a balanced scorecard for NHS dental service providers. The PCT has faced a challenge with information available from the DPD and FP17s to effectively monitor prescribing profiles, value for money and quality standards.

— Many local practitioners still believe the new contract to be activity driven, hence we are working with the LDC to develop KPIs and a balanced scorecard (such a system has been developed for primary medical service providers).

— PALs and the PCT complaints department receive a number of complaints about the treatment charges, which are followed up with the dental practice. Patients like the simplicity of the new charge bands but are still confused about what is available on the NHS.

— However, patients are reluctant to complain or pursue complaints because they are concerned that their practitioner will not continue to see them. Patient perception still exists that it is difficult to access an NHS dentist.

9. *Dentists' workload and incomes*

10. *The retention and recruitment of NHS dental practitioners—under review*

— Some local dentists have decided to leave the NHS since April 2006 and the reason given is the workload associated with the new contract (ie the UDA rate in Lincolnshire is low when compared to other PCTs in the SHA area). Their view is that their clinical behaviour has not changed since the implementation of the new contract and they continue to undertake complex treatments under Band 2 rather than focus purely on UDAs. Their view is that the contract is activity driven and just a different treadmill. Such a case was reported in the local press last week.

— The PCT has been able to re-provide this activity. However, we wish to develop an approach which balances workload with the quality agenda as we move towards 2009.

— The PCT is working with the Post Graduate Deanery to extend the current network of training practices. There is a possibility of three new applicants this year, two of which are from new practices to the county.

— In addition, some of the existing VT training practices have raised an issue about retaining their VT as a 1st year associate. The PCT has taken the approach not to commit growth in a locality where there is not an unmet need; hence VT training practices in these localities will not be able to retain their own VT. Local training practices affected by this approach, believe that this is a negative factor arising from the new commissioning arrangements.

— However, the PCT is working with the deanery to look at the role of an enhanced training practice and how the PCT may wish to remunerate such practices.

— Some practices have advised the PCT that retention of dentists is more difficult because of the low UDA rate. One practice has undertaken a recruitment drive for overseas dentists and has experienced significant turnover: they believe that the dentist gains experience of the NHS with their practice and then looks for another practice with a higher UDA rate to which to relocate.

Annex B

WESTERN CHESHIRE PRIMARY CARE TRUST

1. *The role of Primary Care Trusts in Commissioning Dental Services*

— Western Cheshire Primary Care Trust had worked closely with its Dental Contractors in the years leading up to the new contract. Most of the major service providers had been working under Personal Dental Service Contracts following the principles established in the Ellesmere Port Pilot in 1999. There was therefore an established team with a clear understanding with regard to how dental services worked. The contractors had been working with the Primary Care Trust for two years to achieve the objectives which would meet patient needs around access and quality of service.

2. *Numbers of NHS dentists and numbers of patients registered with them*

— As detailed above the work carried out prior to the new contract identified any areas where dental services were at risk including those from practices intending to "privatise" rather than accept the new contract. The PCT was therefore able to anticipate any problem and investigate situations prior to them occurring. The result was that any withdrawals from the NHS were rapidly met by practitioners who had already identified their willingness to expand. The Primary Care Trust therefore was able to contract for more service than the previous year contracting with an increased number of whole time equivalent dentists. Dental Practice Board statistics identified that 84% of children and 65% of adults living within Primary Care Trust boundaries were treated during the year 06/07 confirming services had been maintained.

3. *The number of private sector dentists and the number of patients registered with them*

— The private sector has remained much as it was prior to the new contract. The majority who treat adults privately but requested children only contracts have been accommodated but with contracts restricted to 12 months. These contracts will be expected to reduce annually as an increasing number of patients take advantage of the access available in our practices.

— The Primary Care Trust's aim is to ensure that patients are not forced to accept private treatment due to a lack of NHS provision. It is confident that all its residents can be found an NHS dentist when they need treatment.

4. *The work of allied professions*

— In order to take full advantage of the benefits of team working it is necessary to have the benefits of a larger scale operation. The Primary Care Trust has encouraged practices to expand to ensure that they will be of a size to take advantage of Professions Complimentary to Dentistry. Several projects are being promoted using capital grants to assist practices to achieve the required growth and become training practices of the future.

5. *Patients access to NHS dental care*

— The UDA rate is crucial to the successful commissioning of dental services. The Primary Care Trust entered into negotiations with practitioners on the basis that the UDA payment rates agreed would be at a level fair to the practice and to the Primary Care Trust's responsibility to provide access. The result has been guaranteed access for any resident of the Primary Care Trust.

— Access for fee paying adults has an additional affect on patient charges. Low access means low Patient Charges, good access means high Patient Charges. Access and Patient Charges are therefore closely linked and a high UDA rate results in less activity and therefore less access it will be the fee paying adults who miss out and the Primary Care Trust left with Patient Charge shortfall.

6. *The quality of care provided to patients*

— The Primary Care Trust took part in the pilot scheme of Dental Reference Officer visits which confirmed the high standards being met by practices. This is partly as a consequence of the established Peer Review Groups led by the Primary Care Trust dental adviser over several years. The patients' survey carried out at the end of the 1st year confirms the patient's positive view of the services being provided.

7. *The extent to which dentists are encouraged to provide preventative care and advice*

— The Primary Care Trust has now established a new Oral Health Plan, and will be working with contractors through the Peer Review Groups to implement Primary Care Trust policy. Only one contractor has a GDS contract and the rest work under a PDS contract which will ensure they work with the Primary Care Trust to implement the Oral Health Plan.

8. *Dentists' workloads and incomes*

— The Primary Care Trust does not have information on these areas but there is little evidence that they have either received any additional bonus in either increased income or a reduced workload.

— This is implicit in good contracting to ensure the same levels of activity are maintained and that benefits are only achieved by working differently.

9. *The recruitment and retention of NHS dental practitioners*

— The Primary Care Trust has not noticed any real change in the movement of dental personnel. Despite the challenging UDA rates the contractors have been able to recruit to posts when they have become vacant.

In Conclusion

Western Cheshire Primary Care Trust has found the last three years to be very challenging with regard to implementing the new contract. It has benefited from keeping together an experienced dental team who have been able to commission services in a robust but fair manner. This has benefited the Primary Care Trust, the practitioners and most importantly the patients.

It is now moving forward with its contractors to develop dental services to meet the requirements of its population and to ensure that access for dental care is available for all.

Memorandum by Hillingdon PCT (DS 32)

DENTAL SERVICES

Executive Summary

1. The introduction of the new general dental contract in Hillingdon has been relatively trouble free. It was backed up by an oral health needs assessment which has proven useful in directing where any freed up resources were most needed. A history of good collaboration between the commissioner and general dental practitioners meant that the problems which were widely anticipated were not realised locally. *Teething Problems: A review of NHS Dental Care in London* published in November 2007[68] partly explains the Hillingdon experience in terms of access and take up of dental services.

Hillingdon, its PCT and Dental Provision

2. Hillingdon has a population of around 250,000 and is situated in outer North West London. It has a mixed population, with greater affluence towards the north of the Borough, with increasing diversity and deprivation towards Heathrow and the South of the Borough.

3. In recent years, Hillingdon PCT has been notable for the size of its financial problems, and it has pro rata one of the biggest accumulated deficits in the country. This has put pressures on its management, with frozen posts and considerable turnover in the executive team. The new dental contract could hardly have been introduced at a more challenging time for the PCT.

4. For years, there has been reasonable NHS general dental provision in the more affluent parts of Hillingdon, but less so in the more deprived areas. However, complaints about the inability to access an NHS dentist have been few, even though data suggests poor oral health is widespread in the south of the borough and there are wards with no NHS dental surgery.

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[68] London Assembly (2007), *Teething Problems: A review of NHS dental care in London, London*, Health and Public Services Committee

5. The PCT was encouraged to write to the committee with its experiences, to help balance the "submission bias" from areas where the introduction of the new contract proved more problematic. The reasons for the ease of introduction locally are assumed to lie in (a) good long term liaison between the lead commissioner, public health and the dental fraternity and (b) the earmarking of dental funds so these changes were insulated from the more general financial pressures. What has not yet happened, however, is any substantial shift in provision towards the more needy areas nor towards prevention.

The Role of the PCT in Commissioning Dental Services

6. There have been several changes taking place which have affected the PCT's involvement with dental services, of which the new contract for general dental practitioners has been only part but perhaps the most significant. The PCT also has nearly £2 million of spend on hospital dentistry, which now comes under tariff and in theory under the increasing influence of practice based commissioners.

7. There are also dental services provided by the Community Dental Service (CDS) for patients with special needs and a limited range of specialist services. Some oral health promotion activities also take place within this team.

8. An oral health needs assessment was undertaken in 2005–06 and will be extended in 2008. It was promulgated to dentists, was featured in the Annual Public Health Report 2005 and made available on the PCT's website (www.hillingdon.nhs.uk). It also formed the basis of a presentation to the UK Public Health Association (UKPHA) in April 2006, and an update has appeared in the latest Hillingdon Annual Public Health Report (also on website).

9. The oral health needs assessment provides the background for decisions about distribution of any freed up UDA. It proves very helpful in dealing with challenges from dentists who want to set up practice in an area that is already well served by dentists. As an example, appendix 1 presents the arguments used at the time, in a case that went to appeal. Appendix 1 also gives a flavour of the financial pressures on the PCT at the time the new GDS contract was introduced.

10. In spite of good intentions and some exceptions, in practice the PCT has had little influence on general dental provision due to the income guarantee extended to those GDPs who decided to take up the new contract in April 2006. However, the main tasks to ensure a smooth hand over from the old contract to the new and manage the primary care dental spend within its envelope were achieved successfully. This has been facilitated by the close working between dental professionals themselves and commissioners at the PCT.

11. Although the PCT has hosted a Dental Advisory and Liaison Group for over 10 years, in 2005 a Steering Group was also established with the task of introducing the new contract. Although this group has now served its purpose and only meets on a quarterly basis, it has forged ongoing links with the dental profession and has been recognised by the Local Dental Committee (LDC) as an excellent example of joint working.

12. Through this joint working, the PCT has over the last 18 months organised a series of clinical governance events aimed at supporting dental professionals achieve the standards set out in *Standards for Better Health* (2004).[69] Using the national Clinical Governance Framework,[70] these events have covered a range of topics and have attracted large audiences. Evaluation has been positive and the PCT expected to continue these events into 2008.

13. The PCT also commissions unscheduled care slots from local dentists. This service is designed for people who need to see a dentist urgently during normal surgery hours but either cannot get an appointment with their usual dentist or they do not routinely go to the dentist.

14. In terms of Out of Hours care, the PCT has been fortunate in joining with the other seven PCTs in North West London to provide its out of hours service. The dental nurse triage service operates between 6pm and 10pm weekdays and 9am to 10pm weekends and bank holidays. The triage provider works with NHS Direct and the PCT's GP provider of out of hours services, Harmoni. All patients are filtered through triage before accessing the dental service. The joint working between the sector PCTs has afforded greater economies of scale and provided a service that Hillingdon alone could not afford to commission.

Numbers of NHS Dentists and Access to NHS Dental Care

15. The PCT has 39 contracts for general dental services and four contracts for orthodontic services. In addition there is one contractor who only provides domiciliary services. One NHS GDP opted not to take a new contract in April 2006 which represented 0.4% dental activity in the whole of Hillingdon. Since April 2006, no GDP has terminated his NHS contract for reasons other than sale of premises.

[69] Department of Health (2007), *NHS Dental Reforms: One Year On*, London, Department of Health
[70] Primary Care Contracting (2006), *Primary Care Dental Services: Clinical Governance Framework*

16. A recent review of NHS dental care in London (London Assembly, 2007) illustrates the percentage of residents accessing NHS dental care pre and post the introduction of the new contract. In Hillingdon's case, 51.6% of residents accessed care in the two years to March 2006 compared with 53.2% in the two years to March 2007.

17. Although the PCT has not conducted a user survey to find out what patients think of NHS services provided, we do monitor calls into our PALS department and/or complaints.

	Apr–Jun 07	*Jul–Sept 07*
Total number of people who contacted PALS with queries or issues regarding general dental services broken down into:	44	36
Access to Treatment	15	11
Appointments	0	2
Attitude/Communication	2	1
Charges	8	7
Complaints process	1	0
Diagnosis/treatment	11	7
Request for Dental List	7	8
Number of people who contacted PALS and made a complaint regarding general dental services	4	0

Quality of Care Provided to Patients

18. Although the quality of care provided has not been compromised by the introduction of the new contract, the banding system seems to have affected the types of treatments offered. Similar to that reported in *NHS Dental Reforms: One Year On*,[71] the PCT has noticed a marked reduction in Band 3 treatments. Some might argue that this reduction in complex activity is clinically appropriate, the more cynical might suggest that fewer dentists are prepared to do the complex work for little return. The PCT will be monitoring this situation carefully and will consider building in stipulations to its commissioning intentions once the transitional period is over.

19. The new contract was funded to free up a dentist's time by 5% to allow them to offer more preventative advice. Anecdotal views given by Hillingdon commissioners suggest it is too soon to see whether the 5% incentive provided has been enough to encourage dentists to do more preventative work. Informed thinking is that dentists are unlikely to provide an enhanced service without additional funding and that a drop in activity has already occurred.

Patient Charge Income

20. In 2006–07 the PCT commissioned 353,142 UDA from contractors and 338,827 were delivered. This represents 96% achievement against target. The small shortfall will either be made up by the contractor concerned or funding will be clawed back. In terms of funding, the total ring-fenced allocation for commissioning primary care dentistry in 2006–07 was £6,912k and actual spend was £7,476k. Although when the services were commissioned at the beginning of 2006–07 the PCT remained within its ring-fenced allocation, shortfall on recovery of patient charges has meant the PCT sustained a cost pressure of £564k.

21. Similar to other PCTs, Hillingdon does not expect to see a marked improvement in the collection of these charges as the formula used by the DH to make the calculation seems to have been flawed. In acknowledgement of this, the DH has increased funding allocations slightly for 2007–08. However, the PCT will have to take measures to ensure this shortfall is covered and it is likely that when ring-fenced budgets end in 2009, the dental budget will be top-sliced to pay for the shortfall thus reducing the PCT's ability to commission services according to need.

Summary

22. Despite the uncertainties regarding funding, the PCT is confident that similar levels of NHS funded dental care could continue to be provided beyond 2009.

23. Patterns regarding how this activity will be provided will change with a greater focus on commissioning services according to need.

24. The PCT sees itself at the fulcrum of delivering NHS care and the new contract offers greater opportunity to delivery care in innovative ways.

[71] Department of Health (2004), *Standards for Better*, London, Department of Health

25. The PCT will continue to support its local dentists to achieve high standards of clinical governance through its development programme which would not have been possible without the joint working established as part of implementing the new contract.

Professor Yi Mien Koh
Chief Executive

Helen DeLaitre
Acting head of primary care

Professor Hilary Pickles
Director of Public Health

December 2007

APPENDIX 1

Decision-making about resources for DENTISTRY May 2006 (as prepared for a challenge about allocations to a dentist under the new dental contract)

This note explains how Hillingdon PCT makes decisions about the allocation of resources, with special reference to general dental services.

The overall approach to resource allocation is governed by the standing policies of the PCT based on its statutory responsibilities and mission statement. The PCT is charged with ensuring the provision of health-related services for its population, and has to balance the many calls on its limited budget in order to get the best deal overall for those for whom it has responsibility. The full "Difficult Choices" policy explains how the PCT deals with the broad issues and various specific areas, and is described in chapter 7 (pp56–62) of the annual public health report 2004[72]. This document needs further revision to reflect fully the latest nuances of the latest contracting/commissioning regime, and the recovery position in which the PCT is in at present, but the basic philosophy still stands. Important themes are the reduction in health inequalities and that greater health needs, like those affecting mortality, take priority over lesser ones.

Historically, the choices available in practice to the PCT for shifting its spend were limited. The expectation has been that the previous year's spend influences the next, with only marginal readjustments in the light of particular national and local priorities and specific growth pressures. With the size of the deficit being reported for 2005–06, a more radical approach is required, since the previous spend was unaffordable. At the time of writing the PCT is still preparing the details of its budget and recovery plan, looking to cut expenditure by March 2007 to a level that would give savings of £25 million (FYE). This needs to be done whilst still delivering the core priorities of the local, regional and national NHS.

There are various new priorities on the PCT, some of which like the health promotion priority of "Choosing Health" have indicative funding allocations within the allocation to the PCT. However, in view of the funding position of the PCT and the North West London sector as a whole, some of the expected year on year "growth" is being top-sliced before receipt by the PCT to help to address the collective deficit. Although the remaining growth may be adequate for the unavoidable inflationary uplifts, eg for salaries, it is expected there will be no additional resource for new priorities. Hence were it essential to fund new areas, this would require even bigger cut-backs in existing services than required just to reverse the previous overspending. This makes it especially important that any growth areas of spend present exceptional value for money.

Within this overall background it was decided that there were no grounds for increasing the expenditure on general dentistry. Almost uniquely among the services provided by the PCT, there were no cut backs being proposed for these services, although commissioned dental services including the Community Dental Service were expected to contribute to "savings". In the overall context of the reshaping of the PCT's spend back to an affordable level, this then represents a relative increase for general dental services. This is explained more by the constraints of the new dental contract than an explicit decision to increase the relative priority of general dentistry. According to the general philosophy as described in the "Difficult Choices" policy, and in the absence of a specific national target relating to investment in dental services, it appears dentistry starts 2006–07 more generously treated than might be expected. There certainly appear to be no grounds for increasing the size of the dental spend.

The allocation of the general dental budget identified for Hillingdon for 2006–07 between practices was made through an explicit process, as agreed with the LDC and consistent with the national guidance (see separate documents).

It is unlikely that dentistry would emerge as a local priority for increased investment, and especially were this to require additional disinvestment in other services such as those for children, mental health, cancer and so on. One of the documents which is expected to help set the priority agenda for the PCT is the annual report from the DPH (the APHR). In 2003 it was stressed the importance of dealing with inequalities, a government priority. The 2004 report was themed around money, stressing the "Wanless" approach of investing in healthy lifestyles.

[72] All APHRs are available on the PCT website (www.hillingdon.nhs.uk) under public health

In the 2005 report there is a chapter on oral health (pp43–45). It demonstrated that a higher proportion of Hillingdon's population who lived in deprived areas were likely not to be registered with a dentist. The attached graph presents the same data with each ward ranked according to its deprivation, using the same type of presentation as in the 2003 APHR. The distribution of NHS dentists was inversely related to deprivation, ie there were more dentists in the least deprived areas, which are just those areas where oral health was already good. In the more affluent areas of Hillingdon, like Northwood Hills, it is expected that a higher proportion of those unregistered with a NHS dentist use a private dentist, whereas in more deprived areas the expectation of the unregistered may be that they manage without a dentist.

The latest data on mean, decayed, missing and filled teeth (dmft) in five year olds was included when these data were presented to the UK Public Health Association conference in April 2006[73]. Northwood Hills was in the lowest dmft category in Hillingdon and there is a particular concentration of dental practices in Northwood Hills. However, several wards in the south of Hillingdon have no NHS dental practices at all, and higher rates of dental need as demonstrated by dmft rates. It was recommended that the new dental contract be used to target resources to even up access to dental services. The Health and Social Care Act 2003 asks for the PCT to commission appropriate services to tackle long standing oral health inequalities.

The conclusions from the above are:

— The PCT needs to trim its existing spend in order to meet its statutory responsibility of balancing its books.

— General dental services have already been generously treated overall compared to other areas of existing PCT spend.

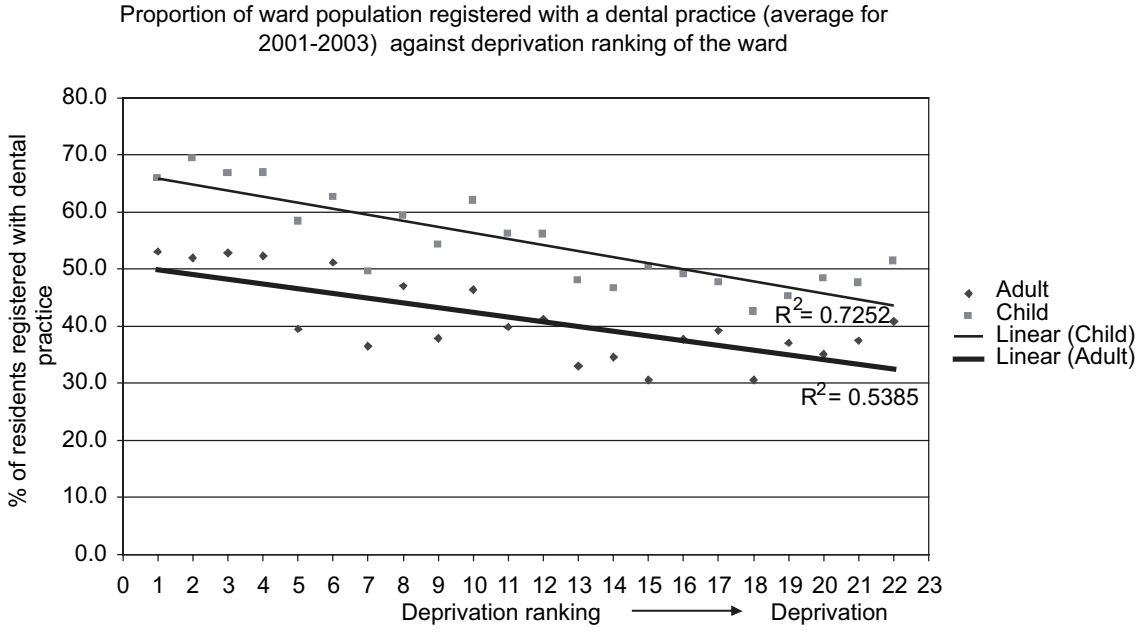
— Oral health is not a local priority for increased spend.

— Within the oral health field, general oral health promotion is a higher priority than dental services.

— Were there to be increased investment in dental services, one of the least appropriate locations for this within Hillingdon would be Northwood Hills—an area already well served by dentists and with low rates of dental need—since this would serve to increase the local inequalities in access to a NHS dentist.

— Increasing investment in general dental services in an affluent area of Hillingdon would appear perverse whilst other services for the people of Hillingdon are being restrained or cut back.

Dr Hilary Pickles, MA PhD MB BChir FRCP FFPH,
Director of Public Health



Ward 10 = Northwood Hills

Ward 22 = Townfield, a site of a Surestart programme which promoted access to dental services

For the identification of the other wards, and other examples of the use of this methodology, see APHR 2003

[73] Caroline Bowles and Heema Shukla. Using the new general dental services (GDS) contract to reduce health inequalities. Poster at UK PHA Forum 2006

Memorandum by Which? (DS 33)

DENTAL SERVICES

About Which? and our research on dentistry

1. Which? is an independent, not-for-profit consumer organisation with over 680,000 members. This makes us the largest consumer organisation in Europe. Entirely independent of government and industry, we actively campaign on behalf of consumers and are funded through our membership and the sale of our consumer magazines and books. 2007 marks our 50th anniversary.

2. Which? has undertaken extensive research into consumers' access to NHS dentistry and how the private market works for consumers, which has established us as the leading patient and consumer voice on dental services. We were members of the Department of Health Advisory Group on the reform of patient charges for NHS dentistry. In 2001, we submitted a supercomplaint to the Office of Fair Trading about the private dentistry market leading to a market investigation and a range of reforms including establishment of an independent complaints scheme for private dentistry.

3. Which?'s over-riding objective is that everyone should be able to get good quality oral healthcare when and where they need it, irrespective of their ability to pay. For many this will be access to NHS care, but for some it will be private care. If people choose private dental care, we believe they should have clear, transparent information about what treatment is proposed and its likely cost before any treatment commences.

4. This submission draws on our work over the past year to assess impact of the new NHS dental contract on consumers' access to care. This includes:

- "Mystery shopping" investigations into access to NHS care for routine and emergency care (repeating research undertaken in 2001 and 2005).
- Survey research on consumers' experiences of seeking dental care.
- Information from 130 of the 152 Primary Care Trusts (PCT) about what they have done to identify and meet the dental health needs in their local area[74].
- Letters and emails received from consumers in 2007 about their experiences of dental care.

Summary

5. Significant new investment in NHS dentistry and the introduction of a new NHS dental contract in 2006, together with PCT commissioning of services, have yielded slight improvements in consumers' access to NHS dental care. However, difficulties in access persist for many, particularly in certain areas of the country. These inequalities are exacerbated by a system for allocating funds to PCTs based on historic levels of NHS dental provision.

6. To address continuing access difficulties, Which? would like to see the allocation of PCT funds for dentistry based on community needs. Measures are also needed to ensure that anyone who cannot obtain NHS care is not left without any dental care because they cannot afford private treatment.

Consumers' experiences of current dental services

7. Which? research consistently shows that while most people try to get dental care every year, a significant proportion do not. Most recently, our 2007 research shows that almost two out of three people (64%) tried to get a dental appointment in the past 12 months,[75] consistent with our 2005 research. While most had gone for a routine check-up or non-emergency appointment, one in ten had sought an emergency appointment.

8. Reasons for not going to the dentist in the past year include difficulties in finding an NHS dentist in their area and the cost of treatment, as well as many feeling it was unnecessary because they had no problems with their teeth or they no longer had any natural teeth. The fact that not everyone wants to go regularly to the dentist highlights the need for a range of models of provision for dental care.

[74] At the end of 2006 we wrote to all PCTs requesting information about what they had done to assess local dental needs; what they had done to commission services to meet those needs; what arrangements are in place to assist people obtaining NHS dental care in your area; and what arrangements exist to assist people to find urgent NHS dental attention. This was followed up by a Freedom of Information request in late November 2006.

[75] Which? Omnibus research (2007): A representative sample of 2110 people were interviewed across the UK through the BMRB telephone omnibus survey in March 2007.

9. Over the past year, many consumers have told Which? of the difficulties they face difficulties getting dental care. For a few, this means difficulties accessing any sort of care, private or NHS. As one consumer told us:

> "Instead I found, after much difficulty, a private practice 60 miles away that would take me on. I have paid them four thousand pounds in just over two years, for very caring and painless treatment but I cannot afford this much longer. I have been on the waiting list for a local NHS dentist all this time." (Email from consumer, February 2007)

10. Surprisingly, a significant proportion of those who tried to get dental care (38%) did not even try to get NHS care. We do not know why some people do not automatically seek NHS dental care. It may be because their usual dentist no longer provides NHS care or they feel private treatment provides a better option. Or it may be they believe trying to find NHS dental care will be just too difficult.

Most can get NHS care easily

11. The good news from our 2007 research is that most people trying to get NHS dental care found it easy (68%) and the majority of people who sought NHS care (87%) did ultimately get an NHS appointment. However, there were marked regional variations, ranging from 95% in the North and 90% in London to just 75% in the South-West. Individual consumers have also told us about their positive experiences of finding NHS dental care, often to their surprise.

Difficulties with access to NHS care persist

12. However, difficulties getting NHS dental care still persist for many, particularly in certain parts of the country. Our 2007 research shows just over one in four people (26%) seeking NHS dental care said they found it difficult, with 16% saying they found it very difficult. Those seeking emergency treatment are more likely to say it was difficult: 38% compared with 25% for non-emergency treatment. Consumers have told us of their particular difficulties when moving to a new area or having to look for a new dentist when their current dentist retires or gives up NHS practice.

13. Results from our situation research in late 2006,[76] bear out this picture of difficulties finding NHS dental care. Just over one in three practices (36%) were taking on all NHS patients, with a further one in ten practices (11%) were taking only certain NHS patients, primarily children, those on benefits or exempt from charges.

14. Just over half (51%) of all dental practices contacted in England were not taking any new NHS patients. While this is a slight improvement on the 2005 level (58%), it is still not as good as the 2001 position when only 41% of practices were not accepting any NHS patients.

15. The main reasons given in our 2007 research for difficulty in finding NHS treatment were:

- Fully-booked/ not taking on new patients: 38%
- Gone/ are private: 25%
- None in the area: 24%
- Long waiting list: 6%.

We continue to hear of dentists giving up NHS practice, leaving people feeling forced into private dental plans or schemes or faced with the choice of having to find a new dentist.

16. Getting NHS care can often mean long journeys, with mentions of trips as long as 60 miles or a round trip of 100 miles (although an improvement on the previous journey of 175 miles). Having to travel long distances for care can result in significant additional costs, particularly for families or those facing a long course of treatment, which are not reimbursable for those on low incomes under the HC11 scheme. It also acts as a disincentive to seek regular care.

Significant regional variations in the availability of NHS dental care

17. Underlying these results is a picture of significant regional variations in access to NHS dental care. People in London were least likely to have tried to find a dentist (48%), whereas those in Yorks and Humberside were more likely to have sought care (66%). With the exception of London, people were least likely to have sought NHS dental care in areas where access was difficult: only 57% in the South-East and 58% in South-West had tried to get NHS care compared with 71% in East Anglia. Access to NHS care was easiest in London and East Anglia, with 76% and 80% respectively saying it was easy compared with just 56% in South-West.

[76] Between 6 and 10 November 2006, 466 calls were made to a random selection of dental practices from the 10 Strategic Health Authorities in England to find out whether they could be taken on at the practice as a new NHS patient. For each SHA, we randomly selected two to four PCTs aiming to achieve 40 calls in each area (80 within London).

18. Results from our "mystery shopping" in 2006 support the picture of wide regional variations in access to routine and emergency NHS care, with the situation appearing best in London:

- The number of practices not taking on any NHS patients ranged from 80% in Yorks and Humberside and 75% North West to 28% in the West Midlands and London.
- The number of practices taking on all NHS patients ranged from 63% in the West Midlands and 59% London, to just 13% in the North-West, 15% in Yorks and Humberside and 16% in South Central, which was worse than average.
- Over one in five practices in the South-West (22%) and South Central (23%) said they were only taking certain NHS patients compared with 11% for England as a whole.
- 88% of practices in London could offer an appointment within two weeks compared with 65% for England as a whole.
- For access to emergency care:
  - Only 5% of practices in the South-West and North-West could offer an appointment within 24 hours compared with 27% in the North-East and 29% in London.
  - Practices not offering any appointment at all ranged from 80% in the North-West to just 18% in London.

19. Difficulties in accessing NHS dental care also appear to be worse in rural/ "mixed" areas than in urban areas, resulting in consumers often having to travel significant distances to get NHS care. We found that:

- 59% of practices in rural/ "mixed" areas were not taking all NHS patients compared with 49% in urban areas.
- 16% of practices in rural/ "mixed" areas were taking all NHS patients compared with 39% in urban areas.
- 23% of practices in rural/ "mixed" areas were only taking on certain patients compared with 9% in urban areas.

Consumers are unable to get certain treatment on the NHS

20. Consumers have told us that they have been refused certain treatments under the NHS or can only get NHS appointments at certain times of the day or week. Treatments refused include some of the more complex treatments such as crowns, dentures and bridges, and a refusal to undertake scale and polish under Band 1 treatments. People have also said that they have been asked to pay extra to get better "quality" materials than those available on the NHS.

21. Particular concerns exist about the availability of orthodontics care, with consumers confused by apparent inconsistencies in assessing whether individual children qualify for NHS care or not. But even if children are assessed as qualifying for NHS orthodontic care, they cannot always obtain it. In these cases, the high cost of private orthodontics care puts this treatment beyond the reach of many families.

Failure to get NHS care can mean having to go private or going without

22. Our 2007 research shows that if people cannot get NHS care, they are faced with either going private (7%) or going without (4%). Again there are marked regional variations with just 2% in the North going private compared with 13% in East Anglia. More people (9%) in the South-West said that they went without treatment.

23. For some, private treatment seems the only option, but this is often expensive and beyond the pocket of some consumers, particularly those on low or fixed incomes, or those exempt from charges for any NHS treatment. Signing up to a private dental scheme will incur monthly charges, which can be particularly high for people with poor dental health as premiums are usually related to dental health status. We have been told of consumers having to pay premiums such as £35 per month for a retired person and £50 per month for a retired couple. Alternatively, people may self-pay and face significant costs ranging from about £70 for a single filling to several hundred pounds for a crown or root canal treatment or even over a thousand pounds for a replacement bridge. Consumers who have to pay for private care often feel considerably aggrieved at what they see as having to pay twice (through taxes and private dental charges) for NHS care to which they feel entitled.

24. If people decide to put off having dental treatment because of difficulties getting care, their actions are likely to result in worsening dental health, which can mean relatively small problems become more serious. This often results in a reliance on emergency care to deal with problems when they can no longer be ignored, but even getting emergency NHS care can be difficult. Our research[77] shows that only 15% of practices could offer NHS treatment within 24 hours. A further 9% of practices could offer an NHS

[77] Between 13 and 17 November 2006, 455 calls were made to a random selection of dental practices from the 10 Strategic Health Authorities in England to find out whether or not they would offer an emergency NHS appointment. For each SHA, we randomly selected two to four PCTs aiming to achieve 40 calls in each area (80 within London).

appointment but not within 24 hours, but 23% of practices could offer only a private appointment. We have received disturbing reports from consumers that deferring dental treatment because of difficulties in getting NHS care has resulted in having to have extractions, even in quite young adults.

The role of PCTs in commissioning dental services

25. Which? believes that PCT commissioning of NHS dental services provides the opportunity for a more systematic approach, allowing local NHS dental provision to be related to the local community's needs. However, the current system for allocating PCTs funds for dentistry is based primarily on historic levels of NHS provision in that area, and perpetuates existing inequalities of provision. In a patient-centred NHS funds for dental care should be related to community needs, both in terms of population size and the extent of dental health needs. Until there is a fairer allocation of funds between areas, major inequalities in provision will persist.

26. Our review of what PCTs have done to commission dentistry since introduction of the new contract has highlighted a very mixed bag of performance. Some PCTs have made major efforts to undertake dental health needs assessment, monitor complaints of unmet needs, calls to dental access centres and the PCT, and undertake patient satisfaction surveys. Some have used the resources released by dentists not taking up the new NHS dental contact to commission new services to meet unmet needs, or to focus on areas of particularly high dental health need or groups with special needs.

27. In terms of meeting needs of people without a regular dentist, some have established helplines, used significant resources to publicise services, or teamed up with the local Patient Advice and Liaison Service. Some have specifically commissioned open access slots at practices for people without a regular dentist, or have established dental access centres. Similarly, in order to meet urgent dental care needs, some have commissioned services to meet urgent unscheduled care needs as well as using dental access centres and out-of-hours triage systems. Many rely on NHS Direct to direct patients seeking dental care to appropriate local services both in-hours and out of normal surgery hours.

28. As the capacity of PCTs develops, so they should be better able to commission dental services to meet local needs. However, we are concerned that PCTs do not have sufficient expertise or capacity to take on a proactive role commissioning local NHS dental services, and are concerned about the impact of removing ring-fencing for dentistry in 2009. For many years dentistry has been afforded a low priority within the NHS, so we are concerned that when it is competing directly with other types of healthcare, it will not fare well.

Consumers need better information about dental services

29. Which?'s recommendation to anyone facing difficulty getting NHS dental care is to contact the PCT or NHS Direct. Our 2006 research shows that where people could not get an NHS appointment, two-thirds were given advice about how to find NHS treatment. Most commonly this was to contact NHS Direct (29%), but other suggestions included contacting another dental practice (19%) or the PCT (17%). Where people needed emergency care they were most often referred to a dental access centre or to NHS Direct. Accessible information about how to access NHS dental care will significantly benefit consumers, particularly those who feel there is no point in trying to get NHS care because it is just too difficult.

30. Consumers also need clear information about what dental care might cost. One benefit of the new system of NHS charges is to provide greater clarity about the cost of NHS treatment and current NHS charges should be displayed in every practice. But considerable confusion still exists about what dental treatment the NHS will cover and what it will cost.

31. A key part of our 2001 supercomplaint on private dentistry was the lack of transparent information, particularly about treatment costs. Despite requirements that practices should display indicative prices and provide written treatment plans and cost estimates prior to treatment beginning, this does not happen consistently. Enforcing this at a national level is impossible, but local Trading Standards may a role in ensuring that consumers receive clear information about dental treatments and its likely cost.

Key concerns about current dental policy

32. Our biggest concern about current dental provision is that access to NHS care is very much a postcode lottery, with many people not even trying to get NHS care. If dentistry is to remain an integral part of the NHS, this must be tackled urgently.

33. We are concerned that the current remuneration scheme for dentists clearly acts as a disincentive to provide more complex or extensive treatments under the different banding levels. This causes particular hardship to those who cannot afford private care or to supplement NHS care for these treatments.

34. We question whether greater focus should be placed on those with the greatest dental health needs. Poor dental health is closely related to socio-economic status and there is a danger of creating an underclass of people who cannot access any dental care because they cannot find or travel to get NHS care and cannot afford private care. As well as PCT commissioning, Which? suggests consideration should be given to spot-commissioning of services where the likelihood is that an individual will go without treatment.

35. Finally, we believe that much greater clarity is needed about what treatments are covered by the NHS and how to access them. An open and honest debate about the extent of NHS dental care is clearly needed.

December 2007

Memorandum by British Dental Health Foundation (DS 34)

DENTAL SERVICES

Executive Summary

1. The new dental contract introduced in April 2006 was the most fundamental change to the system of delivery of NHS Dentistry since the inception of the NHS. It followed a long term review and far sighted reports such as "Options for Change" which had promised a radical move away from the perceived treadmill of NHS dentistry and a "drill and bill" model towards an approach which was patient centred with an emphasis on prevention. Personal Dental Service pilots were supposed to trial the proposed changes but in the event much of the funds allocated for these trials were hijacked to the provision of Dental Access Centres to try (with no possible chance of success) to fulfil the Prime Minister's pledge of NHS Dentistry availability for all.

2. The new contract when it was finalised failed to implement many of the proposals contained in "Options for change" and has implemented a new simplified "drill and bill" structure.

3. Following such a major change it would have been expected that some parts of the new contract would work well and others would need further development and adjustment. The unwillingness of the Department of Health to consider any significant and meaningful changes to the system imposed in April 2006, assuming that they got it all right first time round is to be deplored.

4. In practice whilst lip service is given to greater emphasis on prevention this has not been recognised within the payment system and an opportunity has been lost.

5. The charging system for patients has been simplified but in the process when combined with the UDA system the effect is that patients are in general paying more for similar treatment than they were doing prior to institution of the new contract.

6. The simple three band UDA system has introduced perverse drivers into the system with radical reductions in the levels of complex treatment provided under band 3, little or no molar endodontics and an increased incidence of extractions and provision of partial dentures.

7. Local commissioning whilst admirable in principle has in many cases led to insecurity for practitioners, uncertain career pathways for the newly qualified dentist and has failed to address differences in the cost base of practice across the country.

8. The removal of ring fencing for dental funding to PCTs in 2009 combined with a perceived downward pressure on UDA values is perceived as presenting a real threat to those dentists continuing to work within the health service and to the availability in the future of a quality NHS Dental Service for patients.

9. Lack of provision of NHS orthodontics remains a major concern and the new contract has made an already appalling situation of undersupply far worse. The problem here is, however, a chronic one and can only be solved in the long term by the provision of more training places for orthodontists.

Introduction

1. The British Dental Health Foundation is the UK's leading charity dedicated to the promotion of good oral health by the population. It was formed in 1971. The charity receives no government funding. It runs a national dental helpline answering over 40,000 patient enquiries a year, distributes over a million patient education leaflets a year and runs two major annual awareness campaigns, National Smile Month, established 31 years ago and Mouth Cancer Awareness Week. The author of this evidence, the Chief Executive Dr Nigel Carter was a practising dentist for over 20 years and is a member of the New Dental Contract Implementation Group by invitation of the then Minister of State Rosie Winterton MP (now Key Stakeholder Group).

2. *The Role of PCTs in Commissioning Dental Services*

2.1 In principle devolution of commissioning of dental services to a local level is to be welcomed, but in practice the effectiveness of this measure has been very mixed across the country. Some PCTs have embraced their new role and appear to be using the funds available effectively to provide high quality services within their area whilst others do not appear to have adapted so well to their now role and are showing little in the way of innovation and good practice.

2.2 A real opportunity was missed in development of the new contract to redistribute funds or allocate new funds to ensure equality of provision across the country. If a PCT had low levels of provision of NHS Dental Services prior to the Institution of the new contract the funding they received did not allow them to address this imbalance.

2.3 Where contract values come up for re-allocation the ability of the PCT to determine where they wish to provision new services is to be welcomed since this can address areas of previous lack of provision within the community and to shape the service to meet need. This is being implemented with various degrees of effectiveness.

2.4 Some PCTs are concerned about their levels of patient charge revenue (PCR) and as a result have not been reallocating units of dental activity to provide improved access but instead have kept the funding to mitigate any PCR shortfall. This is to be deplored since it prevents extension of provision to those wishing to find an NHS dentist.

2.5 It is a matter of concern that where units of dental activity (UDAs) are returned to the PCT there seems in many cases to be a wish to retender for this provision on a lowest cost base. Whilst this may appear to potentially allow for additional provision, in practice if pursued this course will lead to provision of a poorer level of service by the contractors and a tendency to exclude those patients not currently accessing the service who may have the greatest need for treatment and be uneconomical for the practitioner at low UDA levels.

2.6 The reorganisation of PCTs which took place in the first few months of the contract was counterproductive to efficient delivery since staffing changes in many cases meant that developing knowledge and skills in the dental arena were lost.

2.7 The number of Consultants in Dental Public Health has been severely reduced since the introduction of PCTs. Many consultants are split over several PCTs on a part time basis and with a lack of consistency of direction are hampered in delivering effective advice.

2.8 Some Strategic Dental Health Authorities do not even have an identified dental priority or lead which is an appalling state of affairs.

2.9 The ability of PCTs to adequately monitor dental practices is of some concern especially when it comes to items such as infection control procedures.

2.10 PCTs have responsibility for provision of out of hours service. In some cases this is difficult to access and inadequate. More robust systems need to be in place.

3. *Numbers of NHS Dentists and the number of patients registered with them*

3.1 Following the initial fall out of dentists who did not accept the new contracts offered to them the numbers of dentists appear to having remained substantially stable. It is discouraging, however, to now see an increasing number of dentists either leaving or planning to leave NHS Dentistry. This trend appears to be greatest amongst the most experienced practitioners who see the potential for selling their practices within the NHS (traditionally part of their retirement planning) to be diminished by PCT control over whether a contract would be offered to their successor and at what level.

3.2 2009 when the dental budget for PCTs loses its ring fencing is seen by many as a great threat. At this stage the PCTs will be able to renegotiate contract values with the practitioner and many feel that this will lead to a general reduction in value per UDA and thus their income for similar levels of activity.

3.3 Traditionally practices grew based on the perceived demand for that practice's services and new dentists were then taken on as appropriate. This ability for dynamic expansion has been removed from practitioners under the new system as their income is effectively capped. The only alternative left to a practitioner in many cases to expand their practice is by increased private provision.

3.4 Many vocational dental practitioners were taken on as associates by their training dental practice at the end of their period of training. This allowed for further development of the skills of newly qualified dentists within a supportive environment. In the vast majority of cases this further employment cannot now take place as there are not additional funds available for the expansion of practices in this way.

3.5 Patients are of course no longer registered with a dentist but attend for only one course of treatment at which time their relationship with the practice may be terminated. This move away from the concept of continuing care implied by registration under the old contract is to be deplored since it does not encourage regular attendance and a preventive approach.

3.6 The initial period of the new contract saw some practitioners leaving the NHS and refusing to take up the new contract. This amount to about 4% of provision. Whilst not large this could be seen to equate to over one million patients disenfranchised at this point.

3.7 Whilst recommissioning of the lost UDAs may have been successfully achieved was in many cases slow to take place and even slower to come on stream. As a result the total number of UDAs delivered at the end of year one did not meet targets and patient's access must have worsened as a result.

4. *Numbers of Private Sector Dentists and the number of patients registered with them*

4.1 As seen in 3.6 a number of NHS dentists totally left the NHS system at the beginning of the contract.

4.2 Since the early months of the contract the perception is that the number of dentists leaving the system has reduced, although there are still conversions to private practice taking place.

4.3 Current estimates are that six to eight million attend for dental people privately, some 21% of the total number of regular attenders.

4.4 Two main threats appear to exist to ongoing commitment of dentists to the NHS going forward. The first of these is the perception that their level of income will be potentially reduced in 2009 when PCTs are free to negotiate revised UDA amounts. The second of these is the perceived threat to goodwill value by these changes in 2009. Both of these factors may be considered likely to influence some dentists to leave the NHS.

4.5 The current patient charge system may be seen in a number of cases to encourage private dentistry since the fee payable by the patient privately may be less than that on the NHS.

5. *The work of allied professions*

5.1 It is too early to determine the impact of the wider registration of dental professionals on the skill mix and delivery of NHS Dentistry.

5.2 Some early indications with effective "capping" of NHS income was that dentists were choosing to make less use of dental care professionals with associated salary cost to deliver their targets. This would potentially have an adverse effect of both the DCPs, in this case largely hygienists and therapists, and the level of preventive care provided to patients.

5.3 The reduction of quantity of Band 3, complex treatments involving laboratory work, has led to many dental laboratories going out of business or having to drastically downsize.

5.4 The lack of commitment to dental technician training over the last 20 years, combined with an increasing tendency to have technical work carried out abroad in the new EU accession countries or the Far East on a lower cost base could lead to almost annihilation of the dental laboratory industry in the UK.

5.5 Extended duties for the newly registered dental nurses could help to improve productivity of the scarce dental workforce but this is unlikely to be embraced by the profession unless additional funding is also provided.

6. *Patient's Access to NHS Dental Care*

6.1 Over one million patients were disenfranchised by the failure of dentist to take up NHS new contract offers. Whilst this work has been recommissioned it is not always in the same areas and in many cases has been slow to come on-stream.

6.2 Figures at April 2007 the first anniversary of the contract showed 50 000 patients less being seen. More worryingly the latest Department of Health figures show 250 000 less patients being seen in the two years to September 2007 than in the period prior to the contract. It is worrying to consider that if this increase is extrapolated by the end of two full years of the contract as many as half a million patients may have lost access to care.

6.3 Much work has been carried out by the Department of Health and PCTs in areas with little or no provision to commission new contracts and restore NHS Dentistry to areas where it had become scarce or non-existent.

6.4 Threats of dentists leaving the NHS in the run up to 2009 are detailed in paragraphs 4.4, 9.3 and 9.4. Whilst the principle is now well established of recommissioning lost activity there is a considerable time lag until this recommissioned volume comes on-line and in the meantime patient access is disadvantaged.

6.5 The announcement of an additional 11% funding for NHS Dentistry in 2008–09 is to be welcomed and it is hoped that a substantial proportion of this additional income will go towards addressing improved access.

6.6 There is evidence that the most disadvantaged in society, those irregular attenders with high oral health needs are having greater difficulty in accessing dental treatment since they have large amounts of work to be carried out for the same fee and are not perceived by the dentist to be economical. A greater

understanding of the economic drivers is needed by both the profession and PCTs to ensure no patients are disadvantaged in this way. It is particularly important therefore that PCTs are aware that new contracts awarded in areas where there has not been previous previous may need to reflect higher UDA values than those where the majority of patients are regular attenders. This recognition clearly only exists in a handful of cases at present.

6.7 Patient charges are now simpler for the patient to understand but in many cases patients are paying more for similar items of treatment than prior to the new contract and this is a disincentive to change.

6.8 Operation of the current charging system for emergency treatment and continuation of treatment is open to abuse (in a number of cases encouraged by the PCTs to maximise charge revenue) and should be reviewed.

7. *The quality of care provided to patients*

7.1 NHS Dentists in general continue to provide a high level of care for their patients but drivers have been introduced by the UDA system in the new contract which have tended to reduce this quality of care.

7.2 Molar endodontic treatment, taking at least an hour of chairside time, but attracting only the same number of UDAs as a simple filling taking 10 minutes has almost become a thing of the past. Our helpline has multiple calls on a daily basis from patients who are being denied this conservative treatment.

7.3 Levels of extractions are increasing, almost doubled from the Department's own figures and as a result we may expect to see an overall decline in the nation's oral health over a period of time. The dental trade have witnessed significant increases in the sale of dental forceps supporting this perception.

7.4 Cost neutral models to address this slant in prescribing have been proposed but are rejected out of hand by the Department.

7.5 The number of crowns and volume of advanced restorative treatment being provided within band three has decreased greatly. Whilst it may be true that the previous system tended to encourage overt treatment it seems increasingly clear that the current system is encouraging under treatment. In these days of evidence based health it is simply not adequate to suggest that the previous system encouraged over provision and the current system has things right. The Department has a duty to commission research to determine the appropriate volumes of treatment to be provided.

7.6 Some cases exist where excessive UDA targets have led to delivery of a poor quality of service and little attention to diagnosis and such items as smoking cessation.

8. *The extent to which dentists are encouraged to provide preventative care and advice*

8.1 Options for change contained promises for a new focus on prevention to produce long term improvements in dental health.

8.2 The last minute introduction of volume measures for treatment in the form of Units of Dental Activity (UDAs) in an attempt to retain control over dentist's treatment output meant that this opportunity for prevention was lost since prevention per se did not attract a payment for UDAs.

8.3 Overall allocation of UDAs was at a level to commit the dentist to lower levels of activity than in the previous year. It was the stated intention that this shortfall of activity be allocated toward preventive treatment. With the major adaptations required by dentists to work within the new system, an untried volume measure in UDAs and a requirement to meet UDA targets by the year end, few if any practitioners have focused on prevention.

8.4 The development of an Evidence Based "Toolkit for Prevention" in Primary Dental Care with the production of which the author of this evidence was involved is to be welcomed. Extensive distribution of the toolkit to PCT Commissioners and general dental practitioners should give a basis for high quality delivery of a preventive approach.

8.5 In the absence of specific funding for this preventive approach which is resource intensive for the practitioner it is difficult to see that the impact of this document will be to deliver increased levels of prevention.

8.6 As the co-ordinator of Mouth Cancer Awareness Week the Foundation has a particular interest in the role of practitioners in carrying out regular screening of patients for mouth cancer, particularly at risk groups. Mouth cancer is one of the fastest increasing of all cancers and unlike most other cancers survival rates have not increased over the past thirty years. This is largely as a result of late detection. It had been hoped that a new preventive approach would encourage greater and more detailed screening but pressure to achieve UDA targets has meant that this has not been seen.

9. *Dentist's workloads and incomes*

9.1 It is not within the remit of the Foundation to comment on this item specifically.

9.2 The new system was designed to be workload neutral, indeed to free up time for prevention. In the event some practitioners have been challenged to achieve their targets, others have achieved them early and not been able to provide treatment at the end of the contract year. This inequitable situation disadvantages patients and flexibility needs to be introduced into the system to ensure maximum access by patients.

9.3 Dentists are clearly worried by reallocation of unused contract funds at lower levels than they are currently being paid and what the impact of this will be when fee levels are renegotiated in 2009.

9.4 Control of assignment of contract when a practice is sold now being vested in the PCT leads to uncertainty for the practitioner leading up to sale, often at retirement and this could impact adversely both on the practitioners overall financial management and provision for retirement and their long term commitment to the NHS.

9.5 There is an acute lack of NHS orthodontists both in primary and secondary care and the effect of the new contract appears to have been to exacerbate what was already an acute problem as many general dental practitioners who carried out limited orthodontic treatment no longer do so. It is essential if waiting lists are to be shortened that further training places for orthodontists are provided as a matter of urgency. Mechanisms should also be sought to re-engage general dental practitioners happy to carry out orthodontics with appropriate payment mechanisms.

10. *Recruitment and retention of NHS Dental Practitioners*

10.1 Whilst many practitioners remain disillusioned about the new system and their future within NHS Dentistry it is difficult to envisage that it will be an attractive career option and for the reasons already discussed more dentists are likely to look to leave the NHS in future years.

11 *Recommendations for Action*

11.1 Greater dissemination of good practice to PCTs and further training in the delivery of quality commissioning leading to quality delivery of care.

11.2 Imposed focus on Strategic Health Authorities with regard to their role in provision of good quality dental care for their population.

11.3 Review of distribution function and workload for Consultants in Dental Public Health.

11.4 Review of current UDA system to encourage a more preventive approach and to ensure that the system encourages delivery of quality dental care.

11.5 Research into the appropriate level of band 3 complex treatments.

11.6 Provision of a specific incentive for prevention.

11.7 Institution of a requirement to screen for mouth cancer.

11.8 Review of the current application of the patient charge system for treatment continuations and emergency treatment to reduce patient disadvantage inherent in the current operation of the charging system.

11.9 Review of the patient charge system to make this more equitable, this could align with a review of UDAs.

11.10 Provide practitioner security and reassurance to stop a drift away to private practice.

11.11 Further training places for orthodontists should be provided as a matter of urgency.

11.12 Mechanisms to re-engage general dental practitioners able to provide some orthodontic services should be introduced.

11.13 More robust systems for out of hours service need to be introduced in some areas.

Dr Nigel L Carter BDS LDS(RCS)
Chief Executive

December 2007

Memorandum by Dr Amolak Singh (DS 35)

NHS DENTAL SERVICES

1. Introduction

The Dental NHS began life in 1948. The system was based on a fee for each item of treatment. There were over 400 items of treatment. It was free at the point of delivery. Dental disease was rampant after the war years and the system served the population well. Very soon patient charges were introduced. These charges commenced at £1, increasing over the years to a little under £400 just before the current new contract (2006). At the same time there followed successive fee cuts. This resulted in a treadmill system. The system was no longer fit for the 21st century. Morale was at an all-time low early this century. A new system had to be found. Consultations began for "Options for Change". No change was no longer an option.

2. Economic Duress

The consultation process was on "Options for Change". All sorts of options were discussed. None of the discussed options formed the basis of the current contract which is based on "Units of Dental Activity" (UDAs). The UDA contract was imposed without any meaningful consultation or pilots. Dentists were given just days, less than a week, in many cases. We were told "take it or leave it". Livelihoods were at stake. Dentists signed under duress and over two thousand signed with the words "under dispute". In law, to be valid, a contract must be entered into without force, pressure or deceit.

3. Atypical Years

The contract value for a practitioner was based on the gross earnings of the practitioner for the period 1 October 2004 to 30 September 2005. This is called the reference year. Provisions were made in the contract for those general dental practitioners (GDPs) who had an atypical reference year to make representations to their Primary Care Trust (PCT) to have their contract value amended where justified. Most PCTs refused to make any amendments regardless of the evidence submitted on the grounds that they had no funds. The PCTs willfully negated the very provisions in the contract for those with an atypical year. They could, at their will, thwart the intentions of the legislators. Complaints of ultra vires action by the PCTS went unheeded. The Department of Health was not interested, nor was the Secretary of State.

4. The NHS Litigation Authority

PCTs simply referred dentists to the NHS Litigation Authority (LA). This body is an arm of the Department of Health and cannot be seen to be an independent authority. There is a conflict of interest. Hence it is not surprising that almost 99% of the appeals were rejected. In my case, when I asked for reasons, I was given a sharp rebuff and told in no uncertain terms that I must not communicate with the LA and if unhappy with their decision I could go for a judicial review (JR). I simply decided not to fight the system but to increase my private work. The LA forgot that the whole process was one of "dispute resolution". In law, not giving reasons for a decision is tantamount to not having any reasons to give—as if the decision is arbitrary!

5. Ring Fenced Money

For the past few years PCTs have been receiving additional money from the Department for two specific purposes. The first sum is for Access, Quality and Choice (QCA). For 05/06 such a fund had a label attached to it, to specify how the sum should be used. For 06/07 and for 07/08 it was ring fenced. In spite of this PCTs have used this money to reduce their overspend. When a complaint was made to the Department and to the Secretary of State, no one appeared interested. A copy of the complaint was also sent to the then Prime Minister. I specifically asked the Secretary of State if her intention for the QCA funds was for PCTs to reduce their overspend. She did not answer this question. Her reply was non committal, ambiguous, incongruous and unintelligent. The PCTs action was ultra vires. It was abuse of power. There was no respect for the rule of law. Even the Health Ombudsman appeared uninterested as if this did not constitute maladministration.

The second fund was called "Capital Funding". Most PCTs paid this fund to GDPs, though not all PCTs did so. Those who did not pass on this sum to GDPs have again abused their power.

6. Goodwill

Goodwill is an asset. Practice owners paid for their goodwill when purchasing their practices. The law of the land (Human Rights Act 1998) and the Convention on Human Rights of which we are signatories since 1951, makes it clear that no one should be deprived of his/her property without due compensation. Yet clause 12 of the new contract says "the contractor shall not give, sell or assign, or otherwise dispose . . .." Worse still, GDPs who deleted this clause in the contract are told they cannot do so. I ask, "are clauses deleted in the contract, being forced on us?" Is this a contract of our free will?

7. Access—Prevention—Quality

The Secretary of State said that the new contract would increase access, prevention and quality of treatment. The reality is that the new contract is the biggest hindrance to access. Those with very low contract values will not accept any patient, new or existing, once they have achieved their contracted UDAs. If they did, they will be passing on to their PCT the patient charge revenue collected, and this will be deducted from their contract value. In short such GDPs will have to fund patients themselves. It is no different than the Government telling GDPs that they should not take on more NHS work, even if they wished to do so. This contract has stifled growth, obstructing access. The system is seriously flawed and needs urgent review if access is to be increased. Prevention cannot be achieved without UDAs being allocated for prevention. Nor will quality improve as the old treadmill has been substituted for a UDA treadmill.

8. Banding of Treatments and Patient Charges

From over 400 items of treatment, each with its own price and patient charge, Harry Cayton and his team have so over simplified treatment bands and patient charges, that the present system is unfair to both patients and dentists. Professor Wade, the father of English Administrative Law, says that, "administrative convenience and fairness can never be good friends". For some patients the charges are now almost three times higher. This itself is a deterrent to access.

9. Unilateral Contract Changes

PCTs are adding or amending contractual clauses. Goalposts are changing. Greater regulation, greater burdens and more monitoring has become the order of the day. Dentists have always been asked do more and more for less and less. Some PCTs are beginning to lower the UDA values of dentists, which means that dentists have to again work on a conveyor belt system. Such a state of affairs cannot continue. Such action is unacceptable, unlawful and will never raise standards.

10. Dentists Leaving the NHS

Dentists in the NHS feel frustrated. They feel they are unable to provide standards of care that they were taught and that which patients deserve. Some just cave under such pressure and decide to go private, often for reasons that under a private system they can provide higher standards and treat patients more ethically, even if they earn less!

11. Failed Appointments

GDPs are self-employed. Before the new contract they could charge patients for a failed appointment. The new rules prohibit them from charging patients for failed appointments. The Department goes on to broadcast this to patients in their patient information booklets. The result is that patients now can blatantly miss their appointments without fear of being charged. This is irresponsible action from the Department. There are no UDAs for failed appointments. I ask are GDPs self-employed or are they employees of the Department or PCTs !

12. GDPs Cannot Refuse NHS Acceptance Due to Oral Health of Patients

The contract forbids a dentist to refuse to accept a patient on the NHS due to the status of the oral health of the patient. This means that if a patient presents with loads and loads of treatment needs, (several fillings, root fillings, extractions, periodontal disease, crowns, and partial dentures) the dentist is obliged to accept the patient. The dentist must carry out all the treatment for a fixed maximum value (12UDAs), even if it takes 10 visits, spans over a six-month period, or his laboratory costs exceed what he is paid. I see this as onerous since during the reference year a GDP could refuse to accept such patients on the NHS.

13. Clawbacks

PCTs can make clawbacks in cases where dentists have not done the contracted amount of work. However, such clawbacks have to be made by following certain set procedures. PCTs do not follow such the procedures.

14. Discretion

PCTs simply do not understand how discretion must be exercised. They think discretion means they can do what they like or as they deem fit. They do not take relevant facts into account. They act in an arbitrary manner. Such behavior is unlawful.

15. London Weighting

London is one of the most expensive cities to work and live in. Almost everyone working in London receives a London Weighting Allowance. The Review Body for Doctors and Dentists Remuneration has expressed surprise that GDPs do not receive London Weighting. The Department, in its response said that the contract would be one based on local commissioning and such matters would be addressed in the 2006 contract. Sadly, GDPs have once again being misled.

Summary

The new contract is riddled with unreasonable and inequitable clauses. It is an obstacle to access quality and prevention. It needs urgent changes.

Amolak Singh MBE

15 December 2007

Memorandum by the Patients Association (DS 36)

DENTAL SERVICES INQUIRY

Role of PCTs in Commissioning

PCTs are now able to devise sound commissioning proposals for dentistry. Their dental services are now incorporated into general NHS planning.

No. of Dentists and Patients Registered

In respect of private sector dentists, and the number of patients registering with them, the view of the Patients Association is that we have seen a significant number of NHS and private dentists who are now offering private care.

The reasons for this are not only increased fees available privately, but the uncertainty over the renewal of the contract in 2009. In turn this is because of problems in achieving UDA's and whether or not a new contract will be forthcoming in 2009. Dentists are increasing their percentage of private work to ensure the viability of their practice. The contract with the PCT cannot be re-negotiated or alternatively if they are negotiated it will be on terms that affect the viability of their practice.

Patients have been grossly misled as to the availability of NHS dentistry. Media coverage of lack of dentists, confusion over the new contract terms, and the usual lack of information to patients about changes have led to a generalized view that there is no point in trying to access an NHS dentist.

This has not been helped by the fact that dentists are allowed to do far more private treatment alongside the NHS treatment than they used to do. A number of treatments available under the NHS can now be offered privately without there being a conflict with NHS care, and therefore patients are being offered private treatment (and accepting it) whereas under the old rules, the mixing of private and NHS treatment was far more difficult. This former point of principle may have ramifications for other NHS funding.

This acceptance of patients having private treatment makes the conversion of an NHS patient to a private patient much easier, and puts the NHS patient in a mindset where they feel that part of the treatment is not available under the NHS scheme. They feel they are being converted to private patients by a back door approach.

The Work of Allied Professions

In respect of the work of allied professions patients need assurance of the competence of technicians, providing dentures, traditionally the preserve of dentists, as they move to offering more complex forms of treatment. Patients will need the assurance that conditions which the technicians work under are of the same standard as dental surgeries ie problems with sterility, and appropriate clinical vetting.

Patients Access

In respect of patients access to NHS dental care, the Patients Association has had a number of calls to their helpline relating to the difficulty of obtaining NHS dental treatment in three specific areas:

1. Postcode lottery
2. Specific treatments—orthodontics, root canal. The contract has excluded care by stealth.
3. Uncertainty over charges leading to a patient withdrawing from dental care all together.

Preventative Care and Advice

If the contract does not allow for time for preventative care and advice there is a real danger of higher cost to patients, clinically and financially in the longer term. The dentist remains the main point of advice on oral health.

Dentists Workload and Incomes and the Recruitment and Retention of NHS Dental Practitioners

Unless dentistry is a financially attractive proposition it follows that there will be a shortage of NHS dentists from Britain or overseas. Without ring fenced funding PCTs will be unable to deliver the dental service required.

The public health responsibility of PCTs is made more difficult because of the variations in fluoridation levels of the water supply. This means in effect that the demands on PCT budgets varies according to the level of dental caries in their populations which directly relates to the level of fluoride in their local water supply. The Water Act 2003 gave the right to decide on water fluoridations in local communities. This variation in dental health is another example of the postcode lottery for health generally.

Patients Association

19 December 2007

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