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Committee of Public Accounts

Department of Health: reforming NHS dentistry

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Session 2004–05**

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The Committee of Public Accounts

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Contents

Report	<i>Page</i>
Summary	3
Conclusions and recommendations	5
1 Supply and demand for NHS dentistry services	9
An increasing number of adults are unable to access routine dentistry services on the NHS	11
Encouraging existing NHS dentists to increase or maintain their NHS commitment	12
Recruiting additional dentists	14
2 Risks associated with the proposed new contracting arrangements	16
New ways of working and paying dentists	16
Differences between the Department and dentists on the new contracting arrangements	18
The new system of patient charges	18
Primary Care Trusts' capacity to manage contracts with dentists' practices	19
3 Variations in oral health across England	20
A standard measure for oral health	21
Formal minutes	23
Witnesses	24
List of written evidence	24
List of Reports from the Committee of Public Accounts Session 2004–05	25

Summary

Dentistry has been available through the NHS since the creation of the Service in 1948, and during that time oral health has improved dramatically. Most of the 23,000 dentists in England provide both NHS and private dentistry services. In 2003–04 total expenditure on dentistry in England was some £3.8 billion of which £2.3 billion was accounted for by the NHS and an estimated £1.5 billion by private dentistry. The NHS recovered £0.5 billion of this expenditure from patient charges.

Traditionally dentists are independent contractors who choose where to locate their premises, and how much if any NHS dentistry to provide. Over the last ten years there has been an increase in the number of patients experiencing difficulties in accessing NHS dentistry, as many dentists reduced their commitment to the NHS and developed their private work. Over the same time period there has been pressure for reform of the dental remuneration system, in which dentists are paid per item of treatment provided, mainly because it has tended to encourage intervention, rather than prevention as favoured by modern dentistry.

In 1998 the Department of Health established Personal Dental Services (PDS) contracts to pilot new systems for paying dentists and new ways of working. In 2003 major changes were announced in which Primary Care Trusts are to be given responsibility for commissioning NHS dental services in response to local needs, including having more influence over where dental practices are located. The Department set an April 2005 target date for implementation of new contracts for all NHS dentistry, subsequently deferred until October 2005.

On the basis of a Report by the Comptroller and Auditor General¹ the Committee examined the progress made by the Department in implementing its challenging programme for reforming NHS dentistry. In particular we examined whether the significant risks identified in the report were being managed, including the mismatch between supply and demand for NHS services, primary care trusts' ability to commission services, and variations in oral health.

We found that in areas with high levels of social deprivation there are relatively few dentists, while in more affluent areas many adult patients experience difficulties in registering for NHS treatment. The Department's 2003 workforce planning exercise indicated a need for 1,000 new dentists and it has introduced various initiatives, including recruitment from abroad and increasing the number of dental training places, to tackle these access problems. The new contracting arrangements together with new guidance on dental recall periods, which recommends that recall periods should be based on clinical need (of between 3 and 18 months) rather than the standard recall period of six months, are also expected to increase dentists' commitment and ability to provide additional NHS services.

1 C&AG's Report, *Reforming NHS Dentistry: Ensuring effective management of risks* (HC 25, Session 2004–05)

Indicators of oral health show that twelve year old children in England have lower levels of decay than their European neighbours, and an increasing percentage of five year old children have no dental decay. There are wide variations in oral health levels across the country however, with children in some parts of northern England having, on average, twice the level of decay of children in other parts of the country. Likewise adults in northern England are twice as likely to have no natural teeth as those in the south.

Dentists remain concerned that the proposed commissioning arrangements will still not release dentists from the “treadmill” of being paid for treatment provided rather than focussing on prevention. The delay in publishing the details of the revised patient charges regime, and the lack of experience in primary care trusts of commissioning dental services, add to concern about the NHS’s ability to implement the reforms effectively. Following the Committee of Public Accounts’ hearing, the Secretary of State for Health announced that the timetable for implementation would be delayed until April 2006 to enable public consultation on key aspects of the new proposals, and to allow Primary Care Trusts to prepare for their new roles.

Conclusions and recommendations

- 1. The Department has set itself an ambitious programme for reforming NHS dentistry. Some key milestones have been missed, and the planned introduction of the new base contract was deferred by six months, to October 2005.** The Comptroller and Auditor General's report drew particular attention to concerns that Primary Care Trusts lacked the necessary skills and resources to undertake their new commissioning responsibilities effectively. The Committee are extremely concerned that in this vital area of services to the public the Department required Primary Care Trusts to take over the management of the new contracting arrangements without ensuring that they had the necessary expertise and resources. The Department acknowledged that they needed even more time to implement the new contracting arrangements, and have now delayed their introduction for a further six months. They have also established a support team to provide advice and guidance on commissioning dental services. Primary Care Trusts will need to give high priority to developing sufficient expertise in dentistry if the Department is to meet its new target of April 2006.
- 2. The Department is proposing to move from patient charges for 400 different items of treatment, to a small number of price bands. This radical upheaval to the historical system of charging may have unintended consequences both for dentists' willingness to provide treatment and for patients' willingness to pay.** The details of the new patient charges, which were submitted to Ministers in April 2004, are now to be the subject of public consultation in the summer 2005, followed by affirmative resolution. The Department will need to play close attention to the results of their consultation on dental charging if they are to emerge with a system which commands the assent of all parties. The charging system will also need to avoid creating incentives to offer private treatment to registered NHS patients at a lower cost than the NHS charge, leading to a fall in the costs recovered by the NHS from patient charges. The Committee is concerned that the time needed for the consultation and ministerial debate will leave little time for convincing dentists to agree to the new charges by April 2006. The Department will need to manage the risks inherent in this to prevent an exodus from the NHS at the eleventh hour.
- 3. Dentists will no longer have a financial incentive to try and collect debts from patients who fail to pay the correct NHS charges for the treatments they receive because, under the new system, dentists' income is guaranteed for three years and is not dependent on the level of charge income.** Primary Care Trusts will need to monitor outstanding debt to see whether dental practices are as rigorous in collecting payments under the new system as they were under the old system, and take appropriate action to ensure that similar levels of fee income per dentist are maintained.
- 4. The move away from a system where dentists are paid per item of treatment will mean that the Dental Practice Board will no longer be able to monitor dentists' performance by collating information on treatments carried out.** The Department has acknowledged the need to introduce alternative monitoring arrangements, and has revised the role of the Dental Reference Service accordingly. The new

arrangements being introduced by the Dental Reference Service will need to provide effective accountability arrangements, including clinical audit and evidence based quality assurance arrangements which monitor levels and quality of treatment.

5. **Indicators of oral health, which have tended to focus on children, show that children in England average lower levels of decay than their European neighbours, but with strong regional variations in the extent of dental decay in adults and children.** Children in some parts of northern England have on average twice the level of dental decay of children in some other parts of the country. Adults in northern England are twice as likely to have no natural teeth as those in the south.
6. **Poor oral health tends to be associated with social deprivation, and some deprived areas have relatively few dentists as it can be difficult to attract them to set up practices in these areas.** People in areas of social deprivation are likely to have greatest need for dental services but be least able to access them. The Department should consider whether initiatives such as using access centres and mobile dental units to target areas of need have been given a sufficiently high priority under the new system. Primary Care Trusts will need to use their new commissioning responsibilities for dentistry to influence dentists to provide NHS dental services in areas of greatest oral health need.
7. **The Department has not attempted to assess demand for NHS dentistry, although it estimates that currently there are about two million people who would like to register with an NHS dentist but are unable to do so.** Even in more affluent areas patients may experience difficulties registering for NHS treatments as dentists have reduced their commitment to NHS dentistry. If they are to commission dental services effectively, Strategic Health Authorities and Primary Care Trusts need to improve their understanding of both need and demand for local NHS dental services through modelling the requirements of their local health economies.
8. **Matching demand and supply of NHS dentists over the long term is dependent on the Department and Primary Care Trusts developing a clear understanding of dentists' reasons for switching to PDS contracts in advance of the new contracting arrangements.** The Department should undertake a survey of dentists who have moved to the PDS contracts to understand more fully their reasons and determine whether the expected increase in commitment is being realised.
9. **England has one of the highest ratios of people to dentists of all the European Union and G7 countries, and in 2002 the Department estimated that in 2003 there would be a shortage of 1,850 dentists.** The shortfall in dentists is being met in the short term by international recruitment initiatives. In the long term the Department is increasing the number of dental training places by 25% and is quadrupling the number of dental therapist places. The Department needs to explore options for incentivising these additional dentists to commit to the NHS.
10. **The Prime Minister's pledge that everyone should be able to see a NHS dentist by phoning NHS Direct requires up to date information on dentists' capacity, but the data provided to NHS Direct by Primary Care Trusts is often out of date.** Moreover NHS Direct do not follow up to determine whether callers were successful in locating a suitable dentist. Primary Care Trusts need to work with their local NHS

Direct to develop a more accurate system of providing the necessary data. NHS Direct should introduce a feedback system so that it can track the accuracy and effectiveness of its advice.

11. **The National Institute of Clinical Excellence's 2004 advice on changing the dental recall period, from the 6 months used by most dentists to between 3–18 months depending on clinical need, should also help free up capacity.** There is however a risk that the existing incentive for dentists to see their patients too often will be replaced by an incentive to reduce patient visits to below the optimum frequency for oral health. The Department should provide posters and leaflets to be displayed in dentists' surgeries which explain the rationale for the change, so that patients understand any proposed variation in their recall period.
12. **There is a lack of consensus on suitable measures of oral health.** The new contract provides remuneration to dentists for meeting their patients' oral health needs, so a common approach to monitoring oral health will be needed. The National Audit Office used an Oral Health Index devised by the University of Birmingham in preparing its report. The Department should consider adopting this index, or agree on a more suitable oral health measure.

1 Supply and demand for NHS dentistry services

1. Most dentists are not employed by the NHS. They are independent contractors running their practices as small businesses. Primary Care Trusts have no powers to compel dentists to take on NHS patients as they have for general medical practitioners. Traditionally NHS dentistry in England has been provided largely through the General Dental Service, the dental practices located throughout the country. They chose where to locate their premises and how much, if any, NHS treatment to provide. Since 1998, the Department of Health (Department) has been piloting Personal Dental Service contracts aimed at giving the NHS more influence over location of dentists and extent of NHS treatment.²

2. In 2002, the Department published its Options for Change report proposing a radical reform of NHS dental service in England which builds on the Personal Dental Services pilots. The “Options” paper suggested that any new system should be voluntary and would operate alongside the existing piece work system. In 2003, the Health and Social Care (Community Health and Standards) Act paved the way for major changes to dentistry. Each Primary Care Trust will be responsible for commissioning dental services “to the extent that it considers necessary to meet all reasonable requirements”. Dentists will be paid for delivering local contracts where they provide NHS dentistry to meet patients' oral health needs, rather than for each item of treatment. The Department initially set an April 2005 target date for implementation but, in response to consultation, announced in July 2004 that the changes would be implemented from October 2005. Subsequently the Secretary of State for Health announced that full implementation would be deferred until April 2006 but that in the meantime dentists will be encouraged to move over to a Personal Dental Services contract.³

3. As at September 2004 there were some 20,800 dentists working under the GDS and 3,500 under the PDS. In addition the NHS funds other dental services, and in 2003–04 two million patients were treated in hospital and community dental services (**Figure 1**). The net cost to the NHS of providing these dental services was some £1.8 billion, with £0.5 billion funded through patient charges.⁴

2 C&AG's Report, HC 25, Session 2004–05, paras 2, 1.5

3 *ibid*, paras 3, 5–7; Ev 23–24

4 C&AGs Report, HC 25, Session 2004–05 paras 3, 1.18; Ev 25–28

Figure 1: The numbers of different types of NHS dentists

Type of NHS dentistry	Number of dentists as at September 2004
General Dental Service (GDS)	20,800
Personal Dental Service (PDS)	3,500
Hospital Dental Service	2,245
Community Dental Service	1,940
Salaried Dental Service	200

Note: 700 Personal Dental Service dentists also worked in the General Dental Service and some Community Dental Service dentists also worked in the Personal Dental Service

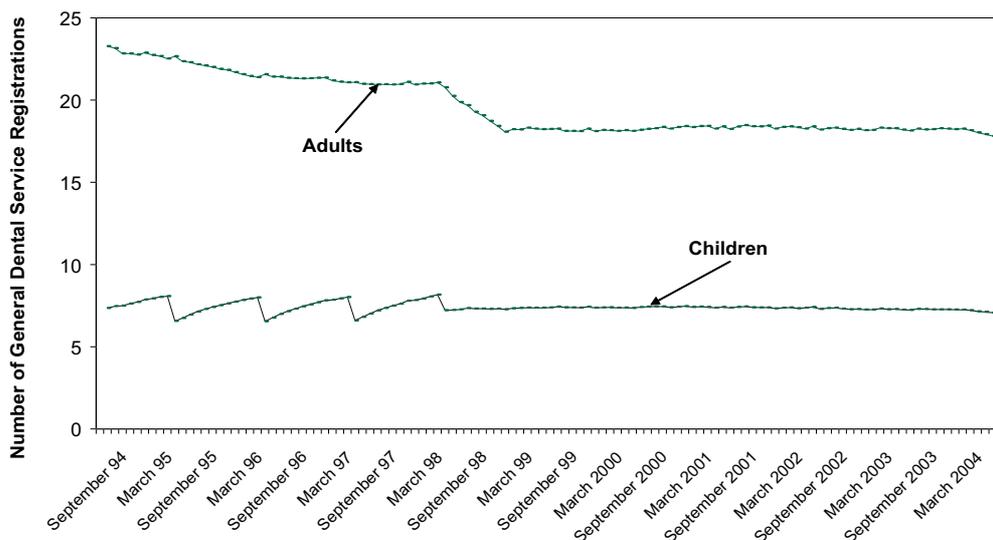
4. **Figure 2** details some of the key facts about the current and proposed systems.

Figure 2: Key facts about NHS Dentistry

- There are around 21,000 dentists in primary care, more than in previous years, but many spend a lower proportion of their time on NHS work which has left some people unable to get the routine treatment they want on the NHS, unless they are prepared to travel.
- Some 17 million adults (45%) and 7 million children (62%) are registered with an NHS dentist. Between 1994 and 1998, adult registrations fell by 5 million but for the last few years have decreased only marginally.
- Everyone is entitled to see an NHS dentist for emergency or urgent treatment, whether registered or not.
- NHS dentists currently operating under the General Dental Services contract receive a capitation fee for each registered patient and a fee per each item of treatment.
- All treatment necessary to maintain oral health is available on the NHS, although some are only provided through the hospital dental service. Overall there are some 400 items of treatment.
- Patients liable for dental charges currently pay 80% of the dentist's fee, ranging from £3.50 for one X-ray to £297.70 for a fixed brace. The maximum charge is £378 for one course of treatment. Full exemptions from fees apply to all patients under 18 years of age and expectant and nursing mothers; full remission of fees applies to adults in receipt of tax credits, job seekers allowance and income support. Additionally, some patients on low incomes are entitled to partial remission of fees.
- NHS treatment does not include purely cosmetic procedures such as tooth whitening. Complex tooth-coloured fillings on back teeth are generally not permitted, primarily because they are generally less reliable than silver amalgam.
- Some treatments are provided free to all patients. These include denture repairs, arrest of haemorrhage, removal of sutures, home visits and attendance to open the surgery in an emergency.
- From 2005–06 spending on NHS dentistry is set to increase with Primary Care Trusts set to receive an increased allocation of £250 million a year (a 19.3% increase over the equivalent spend in 2003–04).
- The NHS Workforce is set to increase by the equivalent of 1,000 dentists by October 2005. Some 3,500 dentist have already moved over to the Personal Dental Services contract and by April 2006 dentists will no longer be paid per item of treatment but will be paid an annual contract to provide treatment to patients on the basis of clinical need.

5. In 2003–04 17 million adults and 7 million children were registered with an NHS dentist, representing 45% of the adult population and 62% of children. Over the ten years to March 2004 the number of adults registered with the General Dental Service fell by 5.5 million (**Figure 3**). In areas with high levels of social deprivation there are relatively few dentists and consequently high levels of registration per dentist. In more affluent areas patients may experience difficulties registering for NHS treatment as dentists have reduced their commitment to the NHS.⁵

Figure 3: Fall in the number of adults registered with the General Dental Service of 5.5 million between April 1994 and March 2004



An increasing number of adults are unable to access routine dentistry services on the NHS

6. In order to access routine treatment such as check ups on the NHS a patient must be registered with an NHS dentist. The Department acknowledged that in some parts of the country it was difficult to get registered with an NHS dentist and that it was not delivering guaranteed routine treatment to people across the country.⁶ The Department estimated that there were around two million people who needed to register with a NHS dentist but were currently unable to do so. Its intention was that all these people would be able to register by October 2005.⁷

7. In 1999 the Prime Minister pledged that by September 2001 anyone would be able to see a dentist just by phoning NHS Direct.⁸ The Department explained this pledge as meaning that anyone phoning NHS Direct could get urgent or emergency dental treatment, not that they could register with an NHS dentist.⁹ The Department told us that around 19,000 people ring NHS Direct each month to try and access emergency and urgent dental treatment, and that around 94% are referred to a dentist within a short distance from their

5 C&AG's Report, para 1.14

6 Q 58

7 Qq 152, 155

8 C&AG's Report, Executive Summary, para 12

9 Q 56

home.¹⁰ Primary Care Trusts have developed local distance standards between the location of a caller to a helpline and the location of the dentist recommended to them. For example, the local distance standards for Durham and Chester-le-Street are shown in **Figure 4**.¹¹ The Department does not subsequently monitor whether the dentists to which these patients are referred provide treatment and therefore cannot say whether the Prime Minister's pledge is being met.

Figure 4: Local distance standards for Durham and Chester-le-Street Primary Care Trust

Urban areas		Rural areas	
Routine care	5 miles	Routine care	25 miles
Urgent care	15 miles	Urgent care	35 miles
Emergency care	15 miles	Emergency care	35 miles

Encouraging existing NHS dentists to increase or maintain their NHS commitment

8. In the early 1990s, following cuts in fees, many dentists reduced their provision of NHS services and developed their private work. Since then the General Dental Services (GDS) per capita spending has increased by only 9% compared with a 75% increase in overall NHS funding per capita. Currently, around 66% of dentists do 70% or more of their work for the NHS. However, there is a wide variation in total gross fee that dentists earn from the NHS which reflects the amount of GDS work performed; a significant number of dentists now do relatively small amounts of GDS work. The percentage of dentists earning less than £50,000 in gross fee earnings from GDS work increased by two percentage points between 2002–03 and 2003–04 (**Figure 5**).¹²

10 Qq 114–117

11 Ev 25

12 C&AGs Report, para 29; Qq 61, 67–70, 112, 136–138

Figure 5: The distribution of gross NHS fee earnings for Principal Dentists in £50,000 bands in 2002–03 and 2003–04¹³

Gross NHS Earnings	2002–03		2003–04	
	Total	Percentage distribution	Total	Percentage distribution
Under £50,000	4,688	32	4,959	34
£50,000 – £99,999	3,572	25	3,307	23
£100,000 – £149,999	3,484	24	3,524	24
£150,000 – £199,999	1,564	11	1,678	12
£200,000 – £249,999	576	4	561	4
£250,000 – £299,999	230	2	216	1
Over £300,000	335	2	228	2
Total	14,449	100	14,473	100

Notes:

Principal dentists are those who are contracted to provide general dental services and have worked for a full year.

The table excludes those dentists who worked for a body corporate, assistants and dentists on Vocational Training.

9. Dentists can earn more working in private practice than providing treatment for the NHS. For example, a dentist with a reasonable commitment to the GDS would have earned around £63,000 in 2002–03 after expenses whilst a dentist undertaking solely private work would have earned over £90,000.¹⁴ Both the Department and the British Dental Association told us that most dentists undertake private work because it allows them to move off a treadmill system of working and spend more time performing preventive work, rather than because of the additional money then can earn.¹⁵ The British Dental Association warned that unless those dentists currently offering NHS services in England could be persuaded to continue then there was a strong possibility of the almost total demise of the provision of dentistry on the NHS.¹⁶

10. In July 2004 the Government announced that from 2005–06, there would be additional funding of £250 million a year for NHS dentistry, an increase of 19.3% compared with 2003–04 spending.¹⁷ The British Dental Association was concerned that the majority of this money would be used to fund the recruitment of additional dentists from overseas and the

13 Ev 25–28; C&AG's Report, Figure 5

14 Ev 28

15 Qq 10, 67

16 Q 58

17 C&AG's Report, Executive Summary, para 18

dentists' annual pay review. Of the additional £250 million it estimated that only £60 million would be used for the expansion and growth of the existing service.¹⁸

11. England has a ratio of 1 dentist to 2,276 people, which is one of the highest ratios of population to dentists of all the European Union and G7 countries. The Department considered that it was misleading to consider only the ratio of dentists to members of the population without considering other members of the dental team. The Department's approach to workforce planning differs from some other countries, and in England a higher proportion of dental hygienists and dental nurses are employed as part of the dental team. There are however also shortages of dental hygienists, therapists and nurses in England which result in qualified dentists performing basic work which could be done by other dental professionals.¹⁹

Recruiting additional dentists

12. The Department had undertaken some limited attempts at manpower planning in the 1980s which led to the closure of 80 dental training places. In July 2004 the Department published a workforce review based on analyses undertaken in 2001–02. The review concluded that in 2003 there was a shortage of 1,850 whole time equivalent dentists and that, without additional resources, by 2011 the shortfall would increase to between 3,640 and 5,100 dentists. There were also shortages of dental hygienists, therapists and nurses. If the dental schools had not been closed in the 1980s then an additional 960 dentists would have been trained to date.²⁰

13. The Department announced in July 2004 that it needed 1,000 additional whole time equivalent dentists to meet England's short term dentistry needs. It has launched a return to NHS dentistry campaign and expects to recruit additional dentists from overseas, aiming to increase by the equivalent of 1,000 the numbers of dentists providing NHS treatments by October 2005.²¹ A first group of dentists from Poland have now arrived in England and started work in January 2005. Further tranches of Polish dentists will be starting work before October 2005, and the Department has also commenced recruitment in other countries including Spain, and Germany and India.²²

14. The additional dentists will be commissioned to provide NHS dentistry services in the areas of most need, though the Department recognised the risk that at the end of their contracts these dentists would transfer from providing NHS dentistry to more lucrative private practice. It intended to respond by making NHS dentistry more attractive.²³

15. To increase the supply of NHS dental services in the longer term, the Department is increasing the number of dental training places by 170 (a 25% increase) and quadrupling the number of dental therapist places. If the increase in the provision of NHS dentistry services accounted for by the additional training places and the dentists recruited from

18 Q 44

19 C&AG's Report, para 1.41 and Figure 25; Q 160

20 C&AG's Report, para 1.41; Q 159

21 C&AG's Report, para 1.41; Qq 152–156

22 HC Deb 10 January 2005, cc 7–8 WS

23 Q 60

overseas is to be sustained, the Department needs to be able to demonstrate to dentists and other dental professionals that the NHS is an attractive place for them to work.²⁴

24 C&AG's Report, para 1.43

2 Risks associated with the proposed new contracting arrangements

16. Historically high street dentists who provide NHS treatments under the General Dental Service contract receive two main forms of payment: payment for each item of treatment they carry out on a piecework basis and, since 1990, a fee for each registered NHS patient. The piecework element of the funding comprises three quarters of General Dental Service funding.²⁵ Many reports have argued for change, including reports from a previous Committee of Public Accounts (1984),²⁶ the Health Select Committee (2001)²⁷ and the Audit Commission (2002).²⁸ Likewise, the Department and the profession were in agreement that the General Dental Service contract was outdated because it was entirely focused on treating patients, and placed dentists on a “treadmill” which encouraged them to carry out potentially unnecessary treatment to earn their fees. As the oral health of England’s population had improved, it had become necessary to move to a contract which gave a greater priority to the prevention of dental decay and gum disease.²⁹

New ways of working and paying dentists

17. In 1998, fifteen Personal Dental Service pilots were established based on locally negotiated contracts between the then local health authority and one or more providers of dental services. Personal Dental Services are staffed by dentists who are paid salaries or funded through capitation arrangements rather than the piecework payment system. All of the pilots shared an objective to improve access to NHS dental and oral health services. The pilots showed that by paying dentists in different ways it was possible to maintain and increase their NHS commitment.³⁰

18. In 2002, the Department published its Options for Change report which proposed a radical reform of NHS dental services in England, building on the Personal Dental Services pilots. Part of the motivation for introducing Options for Change was to explore different methods of remunerating dentists, although the original intention was that there was to be no sudden change in method. Models for remunerating dentists were to be made available in demonstration sites and, if successful, rolled out across the country. There was unlikely to be one method to fit all circumstances.³¹

19. However, with the publication of the Health and Social Care (Community Health and Standards) Act 2003 the Department moved to rolling out a single method for paying dentists which was to be introduced in April 2005. In July 2004 the Department stated that the new working arrangements would be deferred until October 2005 and in a written

25 C&AG’s Report, para 1.15

26 17th Report from the Committee of Public Accounts, *National Health Service: General Dental Service* (HC 111, Session 1984–85)

27 1st Report from the Select Committee on Health, *Access to NHS Dentistry* (HC 247, Session 2000–01)

28 Audit Commission Report, *Primary Dental Care Services in England and Wales*, September 2002

29 C&AG’s Report, paras 4, 1.48; Q 1; *Options for Change*, Department of Health, 6 August 2002

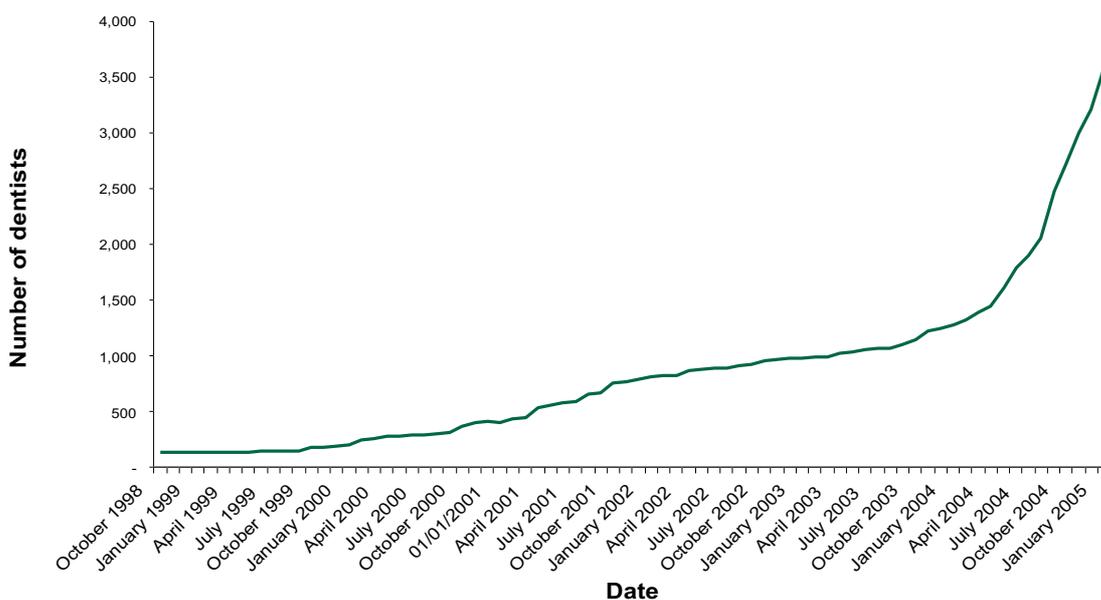
30 C&AG’s Report, para 1.63

31 *ibid*, para 6; Q 1

Ministerial Statement issued on the 10 January 2005 it was announced that the introduction would be further delayed until April 2006. Under the new approach all dentists working on a General Dental Service contract are now to move to a new base contract from April 2006. Dentists operating under the Personal Dental Service contracts will be able to continue to operate under these contracts for a three year period subject to any amendments needed to reflect expected changes in patient charges and monitoring arrangements. The Department has guaranteed that any practice that wishes to will be supported to move to a Personal Dental Service contract in advance of the introduction of the new April 2006 date.³²

20. Since April 2004, partly due to uncertainty over the new base contract, an increasing number of dentists have moved over to Personal Dental Service schemes (**Figure 6**).³³ In July 2004 over 1,500 dentists in more than 750 practices were working under Personal Dental Service contracts.³⁴ By January 2005 this had increased to 3,500 dentists in 1,300 dental practices, and a further 500 practices had applications in the pipeline. Once those applications are approved around 20% of practices will be working under Personal Dental Service contracts.³⁵ The Department has set a target of 25% of practices working under Personal Dental Service contracts by April 2005.³⁶

Figure 6: Increase in dentists with Personal Dental Service contracts between October 1988 and January 2005



Source: NAO and Dental Practice Board

32 C&AG's Report, paras 7, 2.6–2.10 and Figure 18; HC Deb 10 January 2005, cc 7–8 WS

33 C&AG's Report, para 1.63

34 *NHS Dentistry: Delivering change*, Report by the Chief Dental Officer (England) July 2004

35 HC Deb 10 January 2005, cc 7–8 WS

36 Letter from the Chief Dental Officer (England), 21 February 2005, Gateway reference 4449

Differences between the Department and dentists on the new contracting arrangements

21. The new contracting arrangements require Primary Care Trusts to commission local dental services in response to local needs. Dentists will be paid for delivering local contracts rather than for each item of treatment. After entering into discussions with the Department about the nature of the new contract, the British Dental Association became concerned that dentists would have to meet targets for courses of treatment and, in October 2004, pulled out of discussions. Subsequent to the hearing the Department told us that they did not expect this setback to lead to any delay in the timetable for implementing the new arrangements as local negotiations were the key to progress.³⁷

22. The Department intends that the introduction of the new base contract and changes in working practices will free up capacity within dental practices. For example, the National Institute for Clinical Excellence has recommended that the traditional six month recall period be replaced with the most appropriate recall period for individual patients, which could be up to two years in some cases.³⁸ The Department wants dentists to use the spare capacity this could create to take on additional patients, thus increasing access to NHS dentistry. The British Dental Association told us that freed up capacity was an illusion. Dentists would be performing fewer items of treatment, such as fillings, but would spend more time with their existing patients explaining preventive methods which would help them to improve their oral health.³⁹

The new system of patient charges

23. The NHS Dentistry Patient Charges Working Group made recommendations to Ministers about the simplified patient charges regime which will accompany the introduction of the new base contract in April 2004. The Department has not yet published details of the new charges. Dentists' practices are essentially small businesses and the uncertainty surrounding the details of the new charging system is creating uncertainty and anxiety.⁴⁰ At the hearing the Department said it was still considering the new charges and would ensure that details of the charges and the contract would be published in advance of October 2005. Since the hearing the Secretary of State for Health has announced his intention to delay the introduction of the new contract and patient charges regime until April 2006 and, in the summer of 2005, to publish for consultation the new regulations for commissioning of primary dental services and dental charging.⁴¹

24. Where dentists are no longer remunerated on a piecework basis activity levels typically fall by some 10%. Under the current system this would lead to a drop in income from patient charges. Furthermore, dentists no longer have a direct financial incentive to collect patient charges because, under the new system, their income is guaranteed for three years and there is a risk of dentists not providing the resources to undertake this work, of under

37 C&AG's Report, para 2.6; Qq 1-3, 48-50

38 C&AG's Report, para 2.16

39 Qq 5, 37-40

40 C&AG's Report, para 2.17; Q 9

41 Q 54; HC Deb 10 January 2005, cc 7-8 WS

recording activity or offering NHS patients private treatment at reduced rates at a cost to the NHS. The Department guaranteed that that where patient charge revenue fell because of new ways of working, practices would not lose out financially. However it said that practices would continue to be financially liable for bad debts, and that those patients with outstanding bad debts who approached NHS Direct or their Primary Care Trust for assistance in finding NHS dental care would not necessarily be identified.⁴²

25. Where income levels from patient charges fall the Department and the Primary Care Trusts will be responsible for making up the shortfall. The Patient Charges Working Group considered within its proposal how to devise a system that could raise the same proportion of service cost as the current system of patient charges. The Department believed it would be possible to introduce a far simpler system of patient charges which would be less onerous and bureaucratic for dentists to administer.⁴³

Primary Care Trusts' capacity to manage contracts with dentists' practices

26. From October 2006 the NHS dentistry budget will be allocated to all Primary Care Trusts which will monitor the oral health of their populations and commission dentistry services based on local need. There will be a member of staff in each trust whose responsibility it will be to manage contracts with dentists.⁴⁴ Although trusts have had previous experience of negotiating GP's contracts, there is a significant risk that a lack of resources and experience of monitoring oral health and commissioning dental services within trusts will lead them to conduct ineffective negotiations with dental practices.⁴⁵ Unless funds for dentistry are ring-fenced within trusts then there is a further risk that these funds will be diverted towards other priorities. The Department has established a support team to provide advice and guidance on commissioning to the trusts.⁴⁶

27. With the introduction of the new contracting arrangements and the cessation of items of service claims for payment the monitoring presently used by the Dental Reference Service will be difficult to sustain. The Dental Practice Board has identified that in light of the reduction in the range of information that will be available; the balance of potential risks to public funds under the new arrangements is likely to be significantly different from that under the current arrangements. New approaches such as patient audit questionnaires, patient record checks and an expansion of checks on patient payment status are being developed in order to continue to provide the necessary assurance.⁴⁷

42 C&AG's Report, paras 1.62, 2.8, 2.35; Qq 1, 74

43 C&AG's Report, para 2.34; Qq 3, 100

44 Q 80

45 Q 142

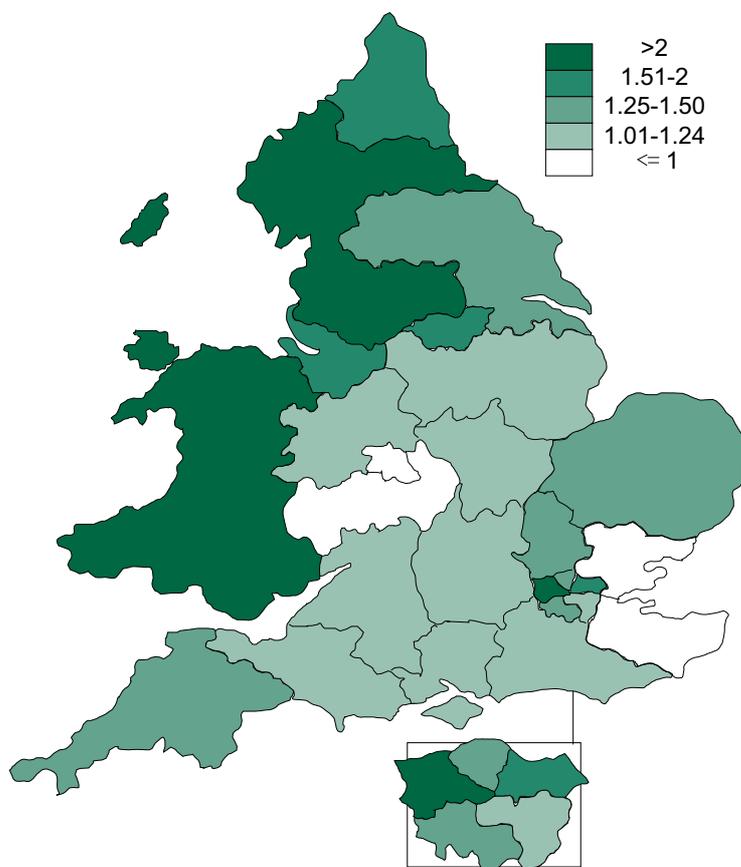
46 Q 146

47 C&AG's Report, paras 2.26–2.27, 2.37–2.38

3 Variations in oral health across England

28. Oral health measures, which tend to focus on children, show that England has comparatively good oral health when compared with the rest of Europe. 12 year olds have the best oral health in Europe whilst five year olds have the seventh best. Government dental health targets in England are set for five year olds, focusing on the number of decayed, missing or filled teeth and the proportion of children having no dental caries. The Government has made progress towards targets but has not yet achieved them. In 2003 outcomes of 59% of five year olds starting school with no tooth decay and five year olds having an average of 1.5 decayed, missing or filled teeth did not meet targets of 70% and one tooth respectively. Adult oral health has improved over the last 30 years and the percentage of adults with no teeth has fallen from 37% in 1968 to 12% in 1998. Despite the relatively good performance on oral health there are wide variations across the country. Children in some parts of Northern England have on average twice the level of dental decay of children in other parts of the country (**Figure 7**) and adults in Northern England are twice as likely to have no natural teeth as those in the south.⁴⁸

Figure 7: The average number of dental caries experienced by five year old children in England and Wales



Source: Dental Practice Board

A standard measure for oral health

29. England has a relatively high ratio of people to dentists compared with the rest of Europe and yet has the best oral health figures for 12 year olds.⁴⁹ Oral health is known to be affected by many factors including smoking, diet, availability of fluoride through toothpaste and water fluoridation, dental care and oral health education.⁵⁰ There is lack of knowledge about the direct effect of each factor, however, and further research is required as to why England has a comparatively good oral health record despite its relative shortage of dentists. Research is also required on how to alleviate social and regional variations in performance.

30. Whilst there is agreement between the Department and the profession that NHS dental services should be more focused towards preventive care than has been the case in the past, there is disagreement amongst the dental profession about what a suitable measure of oral health would be. If the remuneration system for dentists is to reward dentists for improving the oral health of their population then a consistent method for assessing oral

49 Q 160; C&AG's Report, para 1.24 and Figure 27

50 Q 41; C&AG's Report, para 1.23

health needs to be identified and applied. In their Report, *Reforming NHS Dentistry: Ensuring Effective Management of Risks*, the National Audit Office used an oral health index devised by Birmingham University.

31. The Department needs data to support detailed research on oral health. Under the current system the Dental Practice Board provides extensive dental health information to the public and professionals. It also approves payment applications and calculates and transfers payments to dentists who undertake NHS treatments. As a result of the introduction of the new contract and the cessation of payment per item of treatment, the Board will no longer be able to collect the same type of data. As a result the Dental Practice Board has work in progress to develop new methods of monitoring, based on examining clinical effectiveness of treatment provided and the clinical performance of dentists.⁵¹

51 C&AG's Report, para 2.38

Formal minutes

Wednesday 6 April 2005

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Allan

Mr Ian Davidson

Mrs Angela Browning

Mr Alan Williams

The Committee deliberated.

Draft Report (Department of Health: Reforming NHS dentistry), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 31 read and agreed to.

Conclusions and recommendations read, amended and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Thirtieth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

[Adjourned.]

Witnesses

Tuesday 14 December 2004

Page

Dr Lester Ellman , Chairman, General Dental Practice Committee	Ev 1
Sir Nigel Crisp KCB , National Health Service, Professor Raman Bedi , Chief Dental Officer for England, and Professor Aidan Halligan , Deputy Chief Medical Officer for England	Ev 7

List of written evidence

National Audit Office	Ev 20
Dr Paul Batchelor, Senior Lecturer and Consultant in Dental Public Health, UCLH	Ev 21
Department of Health	Ev 23
Department of Health	Ev 24

List of Reports from the Committee of Public Accounts Session 2004–05

First Report	The management of sickness absence in the Prison Service	HC 146 (<i>Cm 6496</i>)
Second Report	Tackling cancer in England: saving more lives	HC 166 (<i>Cm 6496</i>)
Third Report	The BBC's investment in Freeview	HC 237
Fourth Report	Improving the speed and quality of asylum decisions	HC 238 (<i>Cm 6496</i>)
Fifth Report	Excess Votes 2003–04	HC 310 (<i>N/A</i>)
Sixth Report	Excess Votes (Northern Ireland) 2003–04	HC 311 (<i>N/A</i>)
Seventh Report	Foreign and Commonwealth Office: Visa entry to the United Kingdom: the entry clearance operation	HC 312
Eighth Report	Ministry of Defence: Battlefield Helicopters	HC 386
Ninth Report	The Drug Treatment and Testing Order: early lessons	HC 403
Tenth Report	Welfare to work: tackling the barriers to the employment of older people	HC 439
Eleventh Report	Improving public transport in England through light rail	HC 440
Twelfth Report	Helping farm businesses in England	HC 441
Thirteenth Report	Ofgem: The Social Action Plan and the Energy Efficiency Commitment	HC 442
Fourteenth Report	Department for International Development: responding to HIV/AIDS	HC 443
Fifteenth Report	Managing risks to improve public services	HC 444
Sixteenth Report	Department of Health: improving emergency care in England	HC 445
Seventeenth Report	London Underground Public Private Partnerships	HC 446
Eighteenth Report	Financial management of the European Union	HC 498
Nineteenth Report	The accounts of the Duchies of Cornwall and Lancaster	HC 313
Twentieth Report	PFI: The STEPS deal	HC 553
Twenty-first Report	The United Kingdom's civil space activities	HC 47
Twenty-second Report	Facing justice: tackling defendants' non-attendance at court	HC 103
Twenty-third Report	Reducing crime: the Home Office working with Crime and Disorder Reduction Partnerships	HC 147
Twenty-fourth Report	Improving patient care by reducing the risk of hospital acquired infection: a progress report	HC 554
Twenty-fifth Report	Tackling congestion by making better use of England's motorways and trunk roads	HC 134
Twenty-sixth Report	Ministry of Defence: the rapid procurement of capability to support operations	HC 70
Twenty-seventh Report	The impact of the Office of Government Commerce's initiatives on the delivery of major IT-enabled projects	HC 555
Twenty-eighth Report	Network Rail: making a fresh start	HC 556
Twenty-ninth Report	Inheritance Tax	HC 174

Oral evidence

Taken before the Committee of Public Accounts

on Tuesday 14 December 2004

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Mr Frank Field
Mr Brian Jenkins
Jim Sheridan

Mr Gerry Steinberg
Jon Trickett
Mr Alan Williams

Mr Tim Burr, Deputy Comptroller and Auditor General, and Mrs Karen Taylor, National Audit Office, further examined.

Ms Paula Diggle, Second Treasury Officer of Accounts, HM Treasury, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL:

Department of Health—Reforming NHS Dentistry: Ensuring effective management of risks (HC 25)

Witness: Dr Lester Ellman, Chairman of the General Dental Practice Committee, examined.

Q1 Chairman: Good afternoon. Welcome to the Committee of Public Accounts. I am sorry for the late start due to there being two divisions in the House, and there may be further divisions later on this afternoon. We are looking this afternoon at the Department of Health—Reforming NHS Dentistry: Ensuring effective management of risks. Effectively we will be looking at the new contract that the government is trying to negotiate with dentists. We noticed in the Press last week that the British Dental Association has broken off negotiations with the government for the time being on this new contract, and we read comments by Dr Lester Ellman, who is the Chairman of the General Dental Practice Committee of the British Dental Association, and we thought it was only right and fair to give him the chance to come along this afternoon to tell us why the BDA has broken off discussions with the government. Dr Ellman?

Dr Ellman: Thank you very much. Can I just take you back a fraction to where we started this process? The original process started as a result of the *Options for Change* document that was published in 2002, which the BDA and the government endorsed, and said that this was a process that ought to be undertaken. The concept was that the existing scheme of things, in the way that general dental services are supplied and provided to patients, was probably, to some extent at any rate, outmoded because it is essentially the same concept that was began in 1948 with the inception of the Health Service. There have been some tweaks to it and some changes in the contract, notably in 1990, but essentially it is still the same contract. The basis of that contract is entirely treatment focused. In other words, you do some treatment and you get paid for doing the treatment. That is how dentists operate normally in the High Street. It was thought that because of improving dental health and oral health

generally that there ought to be a movement towards a more prevention and patient-orientated treatment modality. That is from where we started. The concept of *Options for Change* was to explore the possibilities of how this may be done, accepting the fact that in different areas of the country there are different problems. Some areas have many patients with high needs, some have a lot less because that is the way things are and that is the way it goes. So it was accepted that there needed to be some experimentation in changing what happened and how things worked, and that there would not necessarily be a one-size fits all sort of pattern. With that in mind *Options for Change* was launched as an idea to explore these possibilities, and the concept was to try them out in different areas and to evaluate and to define them and then to roll out what was found to be most suitable for any one particular set of circumstances at different points around the country. The action disappeared, in reality, with the activation of the Health and Social Care Act, November last year, when in fact the plan then was to move it all forward at quite a pace. So the BDA then entered talks with the Department with the concept of finding a way forward that would be acceptable to dentists. In the interim the fairly acute shortage of dentists on high streets became much more apparent. It has been apparent for a little while but it has become more apparent and the difficulties with which you are familiar, of finding access for patients to get NHS dental care, became more acute and more publicised by various different things that went on in the media. So this brought the focus into a slightly different position. Nevertheless, when we started the talks with the Department of Health the concepts were still ones of a high trust atmosphere, getting the dentists off the treadmill of *Item of Service*, which is the piecemeal system I described earlier, and is called *Item of Service*, and that no

Dr Lester Ellman

dentists would be disadvantaged by the changes. Eventually a three-year pay warranty was promised by the government, that any dentists who move into the new sphere and way of working would be guaranteed that their gross earnings, that is—

Q2 Chairman: I should say, Dr Ellman, that we do have the report in front of us, we know all this. We are very grateful for you to be here but time is pressing. Why have you broken off negotiations with the government?

Dr Ellman: Because we really do not find the promises that I was talking about are going to be enacted, shall I say, in what we think is going to be the new proposed contract. So we do not think that the contract that has been proposed to us moves away from a treatment-focused, product-focused system into one that gives a lot more time for patients and a lot more choice for patients.

Q3 Chairman: So why is that? Is it because as negotiations went through it became clear to you that you were going to carry on being paid just for individual treatment? Is that what it is for? You explained that your total income is going to be guaranteed so it is not a question of your total income, it is a question of you wanting to get off the treadmill of having to treat all these patients and being paid purely for each individual treatment, and as negotiations went through it was clear to you that that was going to remain the same, was it?

Dr Ellman: It is clear that that is basically going to remain the same. There are slight differences. Instead of getting paid per individual item of treatment the proposal seems to be that there will be targets for treatment that you have to do related to “courses of treatment” as opposed to individual items. Essentially there is not that much difference between the two systems, and our dentists, when we told them about it on 1 October, pointed out that as far as they were concerned it was essentially another treadmill.

Q4 Chairman: Do you think that more dentists are going to go private as a result; that there will be less NHS dentistry?

Dr Ellman: I am afraid that that may well happen because what we do know is from our surveys of dentists who do move to private, to a greater or lesser extent, then what they do it for is not money, it is in order to spend more time with their patients and to be able to improve the quality of their care.

Q5 Chairman: Do you think there is going to be an impact on patient charges, assuming this new contract goes ahead?

Dr Ellman: Patient charges is something I cannot comment on in a direct sense because although I was part of the working party that submitted the report to the Ministers from Harry Cayton’s Group we have no idea really what is going to come out at the other end. So we have no announcement about patient charges and that makes it awfully difficult to evaluate proposals for the contract anyway because they are actually tied to possible patient charges.

Q6 Mr Steinberg: How much does a dentist in the NHS earn?

Dr Ellman: Take home pay or gross?

Q7 Mr Steinberg: Tell us both.

Dr Ellman: About £60,000 take home pay.

Q8 Mr Steinberg: Very hard up. How much do they earn in the private sector?

Dr Ellman: Not very much more, in general about the same sort of money.

Q9 Mr Steinberg: Long before discussions regarding the contracts had broken down huge numbers of dentists had left the NHS. So the idea that because the contracts had broken down means that there are more dentists leaving the NHS does not seem to hold water to me. You cannot get a dentist for love nor money; what is the reason for that?

Dr Ellman: Two reasons really. One is that there is a tremendous shortage of dentists, and the accelerated move away from NHS to some extent is more the reverse, that the NHS has moved away from them in so far as the uncertainty is causing great problems for them. They are all small businessmen; they all run a business.

Q10 Mr Steinberg: Dr Ellman, I would put it to you that it has nothing to do with some of the arguments you have been putting forward. I was talking to a dentist recently and he confirmed what you said about an NHS dentist, confirmed between £50,000 and £60,000 a year. What he did not confirm was what you said to me, but he said he can earn between £100,000 and £150,000 a year when he goes private. So this frankly is rubbish that they earn the same and is misleading the Committee, in my view. The reason why they are leaving the NHS and leaving patients in despair is because they are going private and taking private patients, and they do not give a monkey’s about their patients—they just take them off their lists and leave them, and if they cannot afford dentistry they do not get it. What we should be doing is saying that if you are trained by the NHS you work in the NHS and if you want to train to work in the private sector then train yourself and pay for yourself.

Dr Ellman: That is a viewpoint and I cannot argue with what you think you have been told. We have done our surveys and our surveys do not show that dentists earn that much more by going private. Most of them go private, when they do, in order to be able to spend more time with their patients and to make prevention much more of their life.

Mr Steinberg: Dr Ellman, I do not want more time with my dentist, I want less time with my dentist—I would rather do anything than go to the dentist. All I know is that when I want to go to the dentist and I have toothache I want it putting right, and if I have a bad tooth I want it taken out. I do not want more time with my dentist, sitting chatting in the seat and giving me a service like that. What I want is treatment done on my teeth and out, and frankly I think it is hypocritical what you are saying, to be quite honest, in terms of putting all the emphasis on

Dr Lester Ellman

the government. I have no time for both of these last two governments who have clearly destroyed the NHS dentistry service, and it is an absolute disgrace the way we are today. That is not just this government, the last government as well—they have both destroyed it. But do not come and tell us that the dentists are all altruistic—they are not altruistic at all; what they are doing is looking for the biggest amount of money that they can make and that is why they are going into private practice. Thank you, Chair.

Chairman: Mr Trickett.

Q11 Jon Trickett: I want to follow on, really. Is it not possible to argue that it might well be in your interests to ensure that there is a breakdown in the negotiations since you yourself personally represent large numbers of dentists who have migrated away from the NHS into private practice? Is it not arguable—and some people would argue—that it is in your commercial interests to ensure that there is a breakdown in negotiations?

Dr Ellman: No, it is not. Let us be absolutely clear. I represent a lot of dentists, 20,000 dentists, most of whom work for some or part of their time or all of their time for the NHS, most of whom will be much happier working with the NHS for a large proportion of their time. They do not particularly want to move away from the NHS, what they want to achieve is a service that befits the 21st century and which allows them to spend the time with their patients and to get off this treadmill of running around when you have the average dentist seeing something like 50 patients per day, every day—that is a heck of a load to carry. Despite what your colleague said, many, many of our patients do want to have the time, they do not want to be treated as a “mouth on legs”, if I may phrase it that way; they want that personal touch.

Q12 Jon Trickett: You are the manager, I daresay, of a number of staff, and if more money was given to you to pay your staff you would not want that money necessarily to go simply in wage rises and the same number of dental treatments being made as were done previously and the money was simply going in the wage inflation. You would want to see more episodes, more balances for your book. Is it not reasonable for the government, which is putting billions of pounds into the NHS and hundreds of millions of pounds into dentistry, to say to you, “If we are going to inject large amounts of money we have to have management systems in place and possibly incentive systems too, which secure more payment treatments and more people being treated through the NHS, rather than simply more money going to the dentists for them to treat less people.” You are arguing to give more time to each person, but from the government’s point of view the objective must be to increase the number of patient episodes with the money, rather than it simply to go into that. So looking at the argument of your own practice and any other persons who are the same, is it not right that they want to introduce a contract

which actually secures output? Because you are clearly arguing against an output orientated budgetary system, are you not?

Dr Ellman: I am, purely because in the long-term if you change the focus of practice in towards prevention you encourage patients to help themselves to improve their oral health.

Q13 Jon Trickett: How does that help?

Dr Ellman: That in reality will produce long-term gains because you need less treatment if you can get somebody to actually do the things that they are supposed to do, which we believe are right, that are proven to be right. For instance, if we spent some time teaching you how to make a toothbrush work effectively—and this is not me knocking patients for not brushing, it is how you get the best out of that—then you reduce the amount of gum disease, you reduce the amount of dental decay and you reduce the amount of treatment, therefore, that is required. So on a longer-term basis that produces a much better value for money return, especially as we know that the introduction of fluoride possibly coming along further will help immensely. We now have young people—particularly young people—whose dental health is very, very much better than, say, my age group were at comparable age, and that needs to be maintained.

Jon Trickett: You have not convinced me that you counter proposing a system which would give the accountability, which must come with additional money, which will improve upon what the government has proposed, which I do not think is particularly attractive either, but I will hand it over.

Chairman: Mr Sheridan.

Q14 Jim Sheridan: Dr Ellman, I notice that you qualified in Glasgow in 1964.

Dr Ellman: I did.

Q15 Jim Sheridan: An area of high level of deprivation and high dependency on the NHS during those years, and I noticed in response to the Chair you said that there are variations in various parts of the country in terms of dental care and lack of dental care, and I think you then just dismissed that as we are where we are, so to speak. Can I say to you, Dr Ellman, that I have anecdotal evidence of a Member of Parliament in this House who raised the exact same question that Mr Steinberg has already raised, and she was told, in an anonymous letter—an *anonymous letter*—that if she continued with her argument about funding for NHS, people trained in the NHS on the back of the NHS, that this dentist would withdraw all services to NHS patients. Is that responsible?

Dr Ellman: I think that is very rare. Let me just illustrate a little more? Most of the dentists that I know will always treat children and the socially deprived, if I might say that, on the NHS, certainly in the areas I deal with. Mr Steinberg is shaking his head, and I cannot tell you what is happening in his locality, but by and large that is what happens and by and large dentists do have quite a strong social

Dr Lester Ellman

conscience and feel that they ought to be able to particularly look after those who are unable to look after themselves in that way.

Q16 Jim Sheridan: So if someone who is deprived, or a child or the elderly, goes along to a dentist and says, "I cannot afford to pay you but can you give me treatment?" you are telling me that the dentist will say, "I am a kind soul and I will do it for nothing?"

Dr Ellman: No, they do not; they do it on the National Health Service as National Health Service patients and in fact in most of the practices that I deal with in Manchester, where I am based, as far as I am aware they all treat children and exempt adults on the National Health Service.

Q17 Jim Sheridan: You have not answered my question. If people like us ask legitimate questions about dentists, about how they are funded, how they train and how they operate, and they then come back with an anonymous letter saying, "If you keep up this kind of argument I personally am going to withdraw NHS services from your constituents," they do not even have the bottle to put their name to letters, that is the kind of people I am talking about, not the altruistic dentist who says, "Come in, I want to spend some time talking to you," but "Come in, I want to get your money," that is what they are saying.

Dr Ellman: I think that is a very rare occurrence. I am sorry that somebody has done that because I think that is rather sad and not something I would like to see. But to deal with the capacity issue—and this is a tremendous issue—there is not that much spare capacity in the service at all because we are very short of dentists.

Chairman: Mr Williams.

Q18 Mr Williams: You referred to children's teeth and we have this table 23, which shows that England has the best record of all 18 European countries in relation to children aged 12. You do not disagree with that?

Dr Ellman: No, it is a matter of record.

Q19 Mr Williams: Why then do we set our targets at age five if it is doing so well? Why do we pick that age as opposed to the 12, and how do you explain this magic reversal between the figures that are claimed at five and the achievement that this falling dentistry service in the UK is able to achieve by the age of 12?

Dr Ellman: You are not comparing like with like. The teeth of a five-year-old are deciduous, that is they are lost when the child is around eight or nine. The teeth of a 12-year-old are relatively new and we would not expect, therefore, to see an advanced level of decay.

Mr Williams: You referred to fluoride. I would warn you that I am no enthusiast of fluoride. We had it quoted when there was a debate on fluoride in the House of Commons that 67% of the British public support fluoride and that is also used in an official publication on behalf of dentists and Health people

we have in the room. That means that 33%—20 million people—who do not want it have to be forced it. Do you think that is justified?

Dr Ellman: I think it is not an argument that I really want to enter into because I am not an expert on that either.

Q20 Mr Williams: I do because you are pushing fluoride.

Dr Ellman: I did not push it actually, forgive me, I merely mentioned it.

Q21 Mr Williams: You are stoking it down people's throats.

Dr Ellman: It isn't being pushed and not by me, and that is a different argument again.

Q22 Mr Williams: Why is it not being pushed by you?

Dr Ellman: Because I am not sure that I know enough about it really and I am not a scientist on fluoridation. One thing we do know is that when you compare fluoridated areas with non-fluoridated areas the general decay levels in fluoridated areas are considerably lower than in non-fluoridated areas and from that viewpoint, if no other, that is beneficial.

Chairman: This is a very interesting conversation but we do not want to spend too long on it because we have a long afternoon thinking about this contract.

Mr Williams: I know when I am being told off!

Chairman: Mr Jenkins.

Q23 Mr Jenkins: Dr Ellman, I do not want to talk about the present situation and how much dentists earn and how much they do not earn and how many days they work, I think that is not relevant to what we are talking about and discussing now. What is relevant is the way forward and I thought the answer you gave about output is quite good because what we want to move from is a movement of output in so far as how many fillings and how the piecemeal system works to an output of oral health. So if we have that as a starting point, would you say that if we developed a system where the number of patients—and roughly saying that a dentist has to look after 3,000 patients on his books, like a doctor—and his or her job was to ensure the oral health of the 3,000, plus they have to leave some time aside for emergency work, people walking in off the streets and so on, then we should be looking at a reduction in that 3,000 over time of fillings, scales, examination, *et cetera*, and therefore the extra is likely to build up to a greater number of individuals they are looking after. So if that is the purpose and the outcome that we desire what is the problem? If you are there to monitor and safeguard the health of people—and we have one of the best records in Europe, so we have been doing a good job in the main—where is the difficulty since we all seem to have a common objective? So it is in the detail and the detail must be hammered out in negotiations. So where did you feel the Department has moved away

 Dr Lester Ellman

from it to a level where we are not moving down the same track but they are on a tangent to you? What was their point?

Dr Ellman: Can I say that I agree entirely with what you said, in that the reduction in the number of fillings and the like should occur if we get the prevention orientation correct, and that was one of the points I was trying to make. That was where we thought we started from just about a year ago because a year ago, in our discussions with the Department, the concept was one of caring for, in exactly the way you mentioned, a tranche of patients, as we have done before, and looking after them in, for want of a better phrase, “an holistic manner” to try to do this. It is that concept that the Department have latterly decided to move away from by moving towards a treatment-focused sort of concept again.

Q24 Mr Jenkins: Would you accept that if we are putting in public money it has to be accountable to some degree? So if we were to pay a person, like any dentist, X, Y or Z and say, “We have 3,000 patients, you look after those 3,000 patients”, and if at the end of a two-year period we found that he or she had done no work on those 3,000 patients you would be totally flabbergasted, would you not? You would think that this is appalling, that the health of those patients had suffered. So there must be a monitoring process. So if the Department’s monitoring process were historically based on the number of courses of work that is not acceptable. What would be your alternative as to what would be acceptable, because the difficulty I have is that the PCTs are going to monitor this and they have no track record of monitoring this. If the Board is taken away how do we monitor the health and the progress in dentistry in this country? Have you got an alternative?

Dr Ellman: First of all, let me agree with you that monitoring is an essential aspect. This is public money, I am well aware of the fact. Therefore, it is not unreasonable that we are accountable for what we do with it. I have no objection in direct terms to monitoring courses of treatment, but I do have objections when you have to say to somebody, “You have to do X number of courses of treatment in order to get your money,” because that is not the concept; the concept is to change treatment modality so that we orientate away from invasive treatment and toward prevention.

Chairman: Can you make this the last one because we have Sir Nigel Crisp waiting to come in?

Q25 Mr Jenkins: If the dentist can say to the NHS, “Look, I have 3,000 patients, I treat those 3,000 patients, I have increased their oral health. If you are not satisfied come and take a sample of those patients and see what I am doing wrong because they do not need the course of work that you are going to pay for, they need oral health.” That is the breakdown, is it not, at the moment?

Dr Ellman: Yes, that is where it is broken, and I would agree with you that they need oral health, and it is oral health gain that we are talking about

because inevitably oral health gain should lead to a reduction in treatments and a better value for money for the Health Service in the slightly longer-term.

Chairman: Mr Bacon.

Q26 Mr Bacon: Dr Ellman, this shortage of dentists, you mentioned that you represented 23,000?

Dr Ellman: 20,000.

Q27 Mr Bacon: Is that pretty much all the dentists in the UK?

Dr Ellman: It is the BDA’s members across the UK.

Q28 Mr Bacon: How many dentists do we have altogether and how many do we need?

Dr Ellman: In England and Wales we have about 19,000 who work part-time or full time—it varies—with the NHS. The University of Bath did a study not long ago which said they reckoned we would need another 5,200. They have revised it recently and said it was slightly more, but let us stick with that sort of figure at the moment.

Q29 Mr Bacon: Only in NHS or in total?

Dr Ellman: In total because dentists usually work between the two things.

Q30 Mr Bacon: Would you agree that the fact there is such a shortage of dentists is *prima facie* evidence that they are not being paid a huge amount in the way that Mr Steinberg suggested? Presumably if everyone could do so much better at it there would be more people coming into dentistry than there are?

Dr Ellman: First of all, you have to go back a little way to the late 1980s. Somebody did some manpower planning that was subsequently proved to be inaccurate so a couple of dental schools were closed in early 90s.

Q31 Mr Williams: 1987.

Dr Ellman: The mistake that we made, I suppose, that was made by the profession and the government, was that we did not revisit to see whether we had got that one right or not until very recently; it is only recently that the manpower report was published, in about July.

Q32 Mr Bacon: Is it true that there are some dentists earning six figure salaries, in the way that Mr Steinberg suggested and, if so, how many of them?

Dr Ellman: I suppose there must be because there are some who spend their whole lives doing lots and lots of cosmetic work and the like. That will inevitably attract a different sort of fees structure. That is not what we are talking about really.

Q33 Mr Bacon: You think that those sort of income levels are a minority?

Dr Ellman: Very much a minority.

Q34 Mr Bacon: In your letter of 7 December to Martin Sturges, you referred to the principles, which we discussed with you, and you say that the base contract which the Department wishes to offer “contains many elements which diametrically

Dr Lester Ellman

oppose the advice we have offered to you and is at complete variance with the ‘principles’ which we discussed with you . . .”. Are these principles the same as these five drivers for change?

Dr Ellman: Not dissimilar.

Q35 Mr Bacon: What are the principles referred to in this letter?

Dr Ellman: I cannot remember. There was a whole list and I do not have that with me. Basically they are about the concept of getting off the treadmill and changing the treatment focus to one of prevention orientation and things of similar nature.

Q36 Mr Bacon: In the National Audit Office Report it warns, in paragraph 2.29, “While freed up capacity could be used to help meet access problems, dentists may choose to spend more time with existing patients, rather than take on new patients.” Basically, you are saying that that is what you would like to do, is it not?

Dr Ellman: That is what the government said they would like us to do.

Q37 Mr Bacon: I am asking you if you think that dentists should spend more time with existing patients.

Dr Ellman: Yes.

Q38 Mr Bacon: Rather than take on new patients. Let me read the quote again. The warning from the National Audit Office is, “While freed up capacity could be used to help meet access problems, dentists may choose to spend more time with existing patients, rather than take on new patients.” I am asking you, you are basically saying that dentists should spend more time with existing patients rather than take on new patients, are you not? That is what you are saying.

Dr Ellman: Can I just answer it slightly differently and say, the first thing—

Q39 Mr Bacon: I would rather you answered it in my way.

Dr Ellman: Freed up capacity, can we just deal with that one and I will come back to the rest of it, I promise? Freed up capacity is an illusion because if you are changing treatment modalities, what you are doing is saying that in terms of numbers of fillings that you are doing it falls compared to the existing system. But you are not really comparing like with like because what actually happens is that if I spend more time teaching you how to clean your teeth I am still occupying my time but hopefully not having to perform quite as many fillings as I did under the pre-existing system that is still excellent for people in general dental services. So, yes, I do want dentists to be able, where they feel it is necessary, to spend more time with patients in order to improve their oral health and reduce their incidence of gum disease and decay and helping them to help themselves.

Chairman: Thank you, you have made that very clear. Mr Field.

Q40 Mr Field: I asked my dentist to brief me for today’s meeting and he gave me the figures on dentists’ income. He gave me that 44% of dentists earn between £100,000 and £149,000 and 19% earned over £150,000 a year, and it would be possible to check from the Tax Returns how much of that would be private work and how much of that would be NHS.

Dr Ellman: Can I pick something up on that because I think the figures that you have are probably accurate but they are actually turnover figures, they are not take home pay figures. From those figures you normally have to deduct the money that you paid for rent and staff and materials and laboratory costs, and so on, which notionally comes to 56.1%. So in other words you can reckon that the balance of that, which is 43.9%, of those figures would be their take home pay on average.

Mr Field: But we have 1,000 new dentists from Eastern Europe and the advert shows that they are being offered jobs at £30,000 a year, which for them at the moment is beyond the dreams of avarice, and you are advocating that dentists should then sit down and chat to us about oral health, are you not—this making a difference? If we look at the causes about whether we have, in this area, good health or bad health, is not the first determinant hereditary? The second is smoking; thirdly is about stresses; fourthly about oral hygiene. If we are really trying to make a real difference in the state of people’s dental health three of the big factors are outside what the new contract is geared to get doctors to do, which is to chat to us about cleaning our teeth. They are important matters but they are not the really big ones, are they, to change the state of dental health in this country?

Q41 Chairman: Keep your answer to focus on the contract, please. How are we going to change things?

Dr Ellman: There is a strong movement by the dentists to combat smoking and they do advise patients not to smoke in order to reduce their gum disease levels because there is a tie between the two. They do advise patients on diet control, which is also part of their job, as well as tooth brushing and the like. So the whole thing goes as a composite, as you rightly said. It is not just one item, you cannot pick it out. This is in a way where I was coming from before, talking about the quality of care that we want to offer. I think that British dentists do a jolly good job in the broadest terms, but that does not mean we have to be complacent and we cannot move forward.

Q42 Mr Williams: Just a factual question, and you may not know the answer and you may be the wrong person to ask. You referred to the closure of the Edinburgh and London dental schools and there were losses of other places around the country at the same time. Do you happen to know or does NAO happen to know how many dental training places were lost as a result of that process?

Dr Ellman: I am sorry, I do not know.

Mrs Taylor: The figure is available but I do not have it here, but the Department can supply it.

Dr Lester Ellman

Mr Williams: That would be very helpful.

Q43 Chairman: Thank you for coming in, Dr Ellman; you have been generous to come in. Is there anything that you are dying to say to us before you leave? Anything in the 35 minutes that you have been here that you think you have missed out?

Dr Ellman: The government has put in some £250 million into frontline dentistry and it sounds a very exciting figure, until you analyse it, and that figure means that if you have 1,000 new dentists who will earn roughly £140,000 to £150,000 gross—and that is the figure I was talking to you about—then that would take about £140 million to £150 million out of that £250 million, leaving about £100 million, just for round figures, from which this year's Doctors and Dentists' Review Body pay award needs to be removed, which, if it is about 3%, which is possible—2% to 3%—will take out another £40 million. That

will leave comparatively little for expansion and growth of the existing service, and one of the things that we desperately need to do is to encourage the dentists who are in the service to remain in the service and those who were thinking of moving out of the service not to move out of the service because otherwise—and I have been pleading this for ages—the whole service will collapse effectively to a greater extent than it is now. Personally I would—and I know the British Dental Association would and most of our dentists would—be devastated to see the almost total demise of the National Health Service and I really make a strong plea in that direction.

Q44 Chairman: Which you think is a possibility?

Dr Ellman: I think it is a very strong possibility, unfortunately, and I am very sad about that.

Chairman: Thank you very much for coming to see us. We will now invite Sir Nigel to join us.

Witnesses: **Sir Nigel Crisp KCB**, Permanent Secretary for the Department of Health and Chief Executive of the National Health Service, **Professor Raman Bedi**, Chief Dental Officer for England and **Professor Aidan Halligan**, Deputy Chief Medical Officer for England, examined.

Q45 Chairman: We are now joined by our witnesses from the Department of Health, Sir Nigel Crisp, who is the Permanent Secretary and NHS Chief Executive, and we are sorry that you were ill last week.

Sir Nigel Crisp: Thank you for the courtesy of holding off the Committee. I had lost my voice so I would have been an even worse witness than normal!

Q46 Chairman: Professor Raman Bedi, who is Chief Dental Officer for England and Professor Aidan Halligan, who is Deputy Chief Medical Officer for England. We are very grateful to you. I do not know if you heard the evidence of Dr Ellman because you were outside?

Sir Nigel Crisp: Two of us did not, no.

Q47 Chairman: Would one of you answer this question? What Dr Ellman has told us is that he has now broken off negotiations, and the timetable for reforming NHS dentistry is on page 39 of the Comptroller and Auditor General's Report, at figure 19. Clearly this timetable is not now going to be met. We would like to know what has gone wrong. What Dr Ellman has said, to paraphrase it, is that it was the hope—and I think it was the hope of you, Sir Nigel, as well—that dentists would get off the treadmill, as they call it, and they would have a more holistic nature to their job and they could look at the general oral health of their patients, and that it became clear to them as this contract was going through that that was not going to be the case, and that is why they have broken off negotiations, and effectively they would still be on this treadmill. So what has gone wrong?

Sir Nigel Crisp: Let me pick up on that point. Firstly, obviously, we were surprised and disappointed that they decided not to attend the talks this week. I think there are three relevant points here, which means

that this is not absolutely crucial for us implementing the timetable. The first one is that they made it clear right from the start that they were not involved in negotiations; that they were happy to talk to us about the framework contract but that there were no circumstances, as I imagine he made clear, in which he would recommend the outcome of that to his members or take it to a ballot. It was not negotiations, it was a talk. With all the other negotiations we have had with people—obviously whether it was the pharmacists or the BMA or other people—we have always ended up in a position of having an agreement and them taking it to their members for ballot. The BDA made it clear to us that that was not their role. So these were useful discussions, essentially, but not negotiations. The second point is that, as I understand the difference between the two sides—

Q48 Chairman: If I may interrupt you there, because I think this is quite an important point.

Sir Nigel Crisp: It is.

Q49 Chairman: Useful discussions but not negotiations, but this is a fairly crucial organisation, which we were just told represents most, if not all, of NHS dentists in England and Wales. They just walked out of these friendly discussions. Is there any chance that this timetable is going to be met?

Sir Nigel Crisp: Yes. Shall I carry on?

Q50 Chairman: Yes.

Sir Nigel Crisp: The point therefore means that the negotiations actually need to be done at a local level. So that is the point, that we cannot negotiate at national level—although we can talk about it and get a framework we cannot negotiate to a national

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

level, and we will therefore negotiate locally. The two other very important points, if I may, are firstly—¹

Q51 Chairman: Can I just stop you there? You think that you may have more success locally than you do nationally?

Sir Nigel Crisp: I think the evidence, as again this report makes clear, is that now we are getting up to about 20% of dentists who are taking up or applying to take up what is called the Personal Dental Services, which is essentially the same framework as the new contract. So we actually have a number of areas—and it is Mr Field's area, for example—where most of the dentists are already on the Personal Dental Service and are very happy to negotiate. So those negotiations are taking place with that 20% moving in that direction, and we expect that to increase.

Mr Field: Only 60% of those in Wirral actually have NHS treatment. So although you say we are a pioneering place, here in the pioneering area 40% have not got NHS treatment and part of the Wirral is very rich. I could not get the figures from the PCT in my area, which is relatively poor.

Q52 Chairman: Let Sir Nigel Crisp carry on.

Sir Nigel Crisp: The third point I would want to make is that, as I understand it, the basic difference is that with the new contract what we are doing is moving to a more appropriate way of treating people, which is more preventative orientated, which will see less intervention. That will release a dividend in terms of dentists' time. What we have said throughout the process is that the first 11 days of that we would leave with the dentists for their professional development, for ensuring that we have got quality, clinical governance and so on, but over and above that we would expect to use the rest of that dividend, as we have done with the Personal Dental Service pilots, to treat more patients and have more access. I think what Dr Ellman is suggesting is that we want the whole of that area for treating more patients. We do not. We want to make sure that there is good quality treatment, professional time, 11 days we think is pretty generous, and in addition to that we want, as the NAO says in its Report, to make sure that in this change we get some benefit for patients in terms of additional patients having access as a result of this process, which is what we are getting through the PDS pilots. I am disappointed that the BDA have decided not to continue talking to us but, as it was not a negotiation, we can carry on and we will have negotiations with people locally and we would not expect the timetable to slip.

Q53 Chairman: Can I ask you about patient charging as referred to in paragraph 2.17 of the Report on page 32? Would you explain why you delayed announcing the details of these new charges?

Sir Nigel Crisp: We are still considering the new charges and we will be making sure that before October 2005, which was the deadline that you referred to earlier, we have the new patient charges out and the framework contract that we want PCTs to negotiate within.²

Q54 Chairman: Would it be a fair criticism of you that you have effectively removed yourself from providing NHS treatment to new patients in some deprived areas of this country, that it is no longer possible for the NHS to guarantee treatment for new patients coming to the NHS in some deprived areas of the country? There is a reference to this in paragraph 1.33 which you can find on page 19.

Sir Nigel Crisp: No, I do not think that is right.³

Q55 Chairman: You are telling us that it is possible in all areas of the country for new patients who wish to access NHS dental treatment to achieve it, because I am sure you are not claiming that?

Sir Nigel Crisp: Let me make the distinction, which is that if a patient rings up NHS Direct they will be told of where they can get urgent or emergency dental treatment. That is not the same as registering with an NHS dentist.

Q56 Chairman: Emergency treatment, not routine dental treatment?

Sir Nigel Crisp: Emergency or urgent treatment.

Q57 Chairman: But not routine treatment? We have given up in this country now guaranteeing NHS routine treatment to people in many areas of this country? That is right, is it not?

Sir Nigel Crisp: No. We are failing to deliver that, which is a slightly different point. Urgent and emergency treatment is accessible through NHS Direct but I do know that in parts of this country it is difficult to get registered with an NHS dentist and that is precisely why we are changing the contract and employing more dentists.

Professor Bedi: You are right that access is difficult in certain areas of this country and it will increasingly get difficult and the NAO Report will say that the reforms we are doing are to address that very issue. The risks are much greater if we do nothing. We are doing three things. We are increasing the investment that we announced back in July. We are increasing the workforce tremendously and also the system of reforms we are putting into place will address the very issues which you raise.

Q58 Chairman: Are you finding 1,000 new dentists here?

Professor Bedi: The short term measure is 1,000 equivalent dentists to address the immediate term. We have a long term strategy of increasing the number of students in our undergraduate dental schools.

¹ Ev 23

² Ev 23

³ Ev 23

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

Q59 Chairman: How can you guarantee that these 1,000 new dentists will not simply transfer from areas of greatest deprivation in the NHS into more lucrative private practice, like many of the others?

Sir Nigel Crisp: Because the process we are going through is to sign them up onto the contracts and target on the areas that need them so that we will sign them up as dentists to deliver that service. The supplementary question is, in the long term could they then shift to do more private work? Part of what we are trying to do is make sure that NHS dentistry is attractive to people. As I said, we are approaching now 20% of dentists that have signed up or are wanting to sign up to the PDS do indicate that there are a lot of people who are finding it attractive, but we have to make it attractive.

Q60 Jon Trickett: On that point, there was a debate earlier with the previous witness about the differentials in income to the dentists rather than to the practice because we understand there is a difference between the NHS dentistry and private practice. Can you tell us what you believe the ratios between the two are?

Sir Nigel Crisp: The headline figure is that 70% of dentists do 70% of their work in the NHS but that hides quite a lot of variation.

Q61 Jon Trickett: I am thinking about the income. We were told, for example, that an NHS dentist might anticipate earning £50,000–£60,000 and then there was a debate about how much somebody in private practice might earn and some member said it might be a multiple of that. Can you give us an idea of the ratios of income to the dentist as an individual rather than to the practice?

Professor Halligan: A well accepted practice is that 70% of dentists get their income from the NHS.

Q62 Jon Trickett: No: how much do they earn? This is the third time I have tried.

Professor Bedi: In the Inland Revenue figures 2002–03 dentists average, for working full time in the NHS, about £63,000.

Q63 Jon Trickett: Gross pay, would you say that was?

Professor Bedi: No, that was the net figure, take-home pay.

Q64 Jon Trickett: That is rather more than we were being told.

Professor Bedi: In 2003–04 the Inland Revenue figure we anticipate is £66,000. We have postulated that with inflation for 2004–05, and the NAO Report has the figures there, it is £69,000. On top of that we estimate what an average dentist may earn within private practice and it seems to be rounding at the present time to about £90,000. That is £69,000 from the NHS plus the additional.

Q65 Jon Trickett: If somebody was wholly in private practice do you have an idea what they might be earning, because it does seem to me that if it was a

significant gradient between wholly or largely NHS and largely private people are going to migrate across?

Professor Bedi: It depends to a large degree on the nature of the private practice. There are some private practices that specialise in certain things such as orthodontics, the more complex restorative treatment, and it depends on location. Those in London and certain other areas will earn far more. Most dentists have a mixed economy in that 70% of dentists earn 70% of their income from the NHS. They supplement that with certain items and it depends very much on the items that they offer. A lot of dentists do the cosmetic side or the much more complex side and do it privately or through a different system.

Q66 Jon Trickett: I just want to try to focus on the fact that the previous witness was an example of a dentist who was formerly wholly NHS and he is now doing 90% private practice. It seems to me therefore that for the 70% who are NHS, if it is more favourable to do private work, eventually they will be tilting the balance, will they not, in decreasing the amount of work they do for the NHS and increasing the amount of work they do in the private sector? What I am trying to understand is the gradient between public sector work, if you like, and private sector work because that seems to be one of the key issues for dentists if you speak to them, as many of us have done. A lot of us have spoken to our own dentists in the last few days when this was coming up. Are you able to help us there?

Professor Bedi: To some degree because, like you, I speak to an awful lot of dentists, it is often not how much they earn; it is how they have to earn it. That is the fundamental issue here and that is what we call the treadmill. The types of figures you see are very similar for private dentists in many parts of the country.

Q67 Jon Trickett: So there is no substantive differential in income per procedure between NHS work and private work?

Professor Bedi: I think it varies significantly in different parts of the country. Private fees are unregulated. We know exactly how much dentists charge for NHS work. The key thing that we have learned for almost 20% of practices now in the new system is that they enjoy working under the new reformed NHS dentistry and we also recognise that there are certain areas, the cosmetic side such as whitening, etc, where they do—

Q68 Jon Trickett: Sir Nigel, do you think there is a degree of resentment within the profession? First of all, it seems to me that supply and demand mean that it is a seller's market in a sense, that they are in very powerful position because we have made some critical errors in the past about the number of people coming into the profession. There seems to be a degree of resentment in the profession about decisions made in the past to do with fee cuts and the 24 months' registration down to 15 months, both of which (and probably other issues as well) affected

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

dentists' income. Whilst I am not totally convinced that there is no gradient between private and public dental work, is that not the problem, that there is now a degree of distrust in the profession about historic decisions?

Sir Nigel Crisp: Yes, is the short answer. I also suspect that that might be why the BDA has not been involved in the negotiation.

Q69 Jon Trickett: Do you accept that there were effective reductions in dentists' income as a result of decisions which were made public for the right reasons at the time?

Sir Nigel Crisp: There was a reduction in fees. I am not absolutely certain whether that meant individuals' incomes went down or if they just did not go up as much as people expected them to.

Professor Bedi: There was a reduction in fees and dentists did feel very much that they were asked to make a commitment and that penalised them financially. That was the scenario that happened 14 years ago in the early nineties. It still has scars.

Sir Nigel Crisp: It still rankles.

Q70 Jon Trickett: I was interested in the previous witness with the debate about how we can increase the amount of money spent on dentists. Surely a little bit of tender loving care to dentists who feel bruised would also secure an increased number of outputs? It seems to me that is something we have to achieve and possibly an increased income to the dentists but not to the extent that the money goes on increasing pay rather than increased outputs. Is there no possibility of a meeting of minds to achieve what does not seem to be too difficult, a virtuous circle on these matters?

Sir Nigel Crisp: That is exactly where we were, Mr Trickett, and it is exactly the debate that all our PCTs are now having on the PDS project with their individual practices: what is the balance here? Let us move away from an interventionist system to a more appropriate system and in doing that free up some time. How much should go to the dentist and how much should go to the patient—

Q71 Jon Trickett: One final point but an interesting one: bad debts by patients. Are the dentists going to be expected to collect bad debts?

Professor Halligan: Where patients are charged that will no longer be borne by the practice. It will be borne by the PCT. That is very clear in the new contract. That is a major source of concern for dentists. You said earlier that there were rankles from 1992. There most certainly are. There is a big selling exercise needed here because there is a low grade anxiety that, for all sorts of unintended reasons, there may not be engagement. That is why we are guaranteeing gross earnings for three years and that is why we are making sure that those earnings are not based on interventional treatment but on appropriate treatment and we are moving the risk to practices on patient charging to the PCTs.

Q72 Jon Trickett: If I understand this issue of bad debts, my dentist feels that he may be required to take a hit on bad debts whilst the NHS then finds the patient who owes the dentist money another dentist should they require further treatment. Can you totally rule that out, that that will not impact at all on the individual dentist?

Professor Halligan: It is a very reasonable concern. We have factored that in and as long as they make real efforts to deal with those debts and are not cavalier about them that risk will be taken by the PCT, not by the practice.

Q73 Jon Trickett: Is it true that the NHS would find that person, who perhaps owed significant money to a dentist or to the NHS, another dentist without first of all securing the money that they owe?

Sir Nigel Crisp: I do not know the answer to that question. We will come back to you.⁴

Q74 Jim Sheridan: I apologise if I am repeating questions that have already been asked previously. Professor Bedi, if I were to say to you that I have anecdotal evidence of a Member of Parliament asking a question about dentists and NHS funding and particularly the training that was given and paid for by taxpayers, and that Member of Parliament then receiving an anonymous letter saying that if they continued with this line of argument then he would withdraw all NHS services in their constituency?

Professor Bedi: Sorry, that they would withdraw because of—?

Q75 Jim Sheridan: Because of the line of argument that the taxpayer has already paid for NHS dentists to train and now they are being asked to pay again by the dentists going private. This Member of Parliament received an anonymous letter from a dentist in their constituency saying that if they continued with this line of argument then he would withdraw those NHS services. Is that fair?

Professor Bedi: Yes, we spend a considerable amount of taxpayers' money to train dentists but there are no plans to tie them into any type of activity over commitment into the NHS that I am aware of.

Q76 Jim Sheridan: Would you support a Member of Parliament being blackmailed into diluting that argument because this dentist is threatening to withdraw NHS services?

Professor Bedi: As a fundamental principle, irrespective of the issue, I think blackmailing anyone is not acceptable.

Q77 Jim Sheridan: So if an individual dentist abdicated all responsibility for NHS treatment would someone somewhere ask the reason why?

Professor Halligan: Yes, they would. The current risk in the current system is over-treatment. 20% to 30% is what is postulated within this report. In the new contract there is a real risk of under-treatment. The only way this will work is by monitoring it

⁴ Ev 24

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

closely. If someone is not treating, our dental reference officers on the patch will identify those outliers and they will be asked to account for what they have not done.

Q78 Jim Sheridan: So if constituents receive a letter from a dentist saying, "I no longer provide NHS treatment", someone somewhere in the profession is asking that particular dentist why?

Professor Halligan: Absolutely.

Sir Nigel Crisp: Locally.

Q79 Jim Sheridan: Who locally?

Sir Nigel Crisp: There is a member of staff in the Primary Care Trust whose responsibility it is to manage contracts with dentists. That is where we are going to be. We will certainly want to know why.

Professor Bedi: An example of that for me was a dentist who said they were leaving and when asked by their Primary Care Trust about that they said, "The premises are not right. I cannot expand", and the Primary Care Trust came along and provided new premises, new facilities and engaged in a new contract. This new system, the reforms that we want to do, allow for that to address some of the frustrations dentists have about the present system.

Q80 Jim Sheridan: I know this report is restricted to England and Wales. Have you any idea how that situation operates in Scotland?

Sir Nigel Crisp: They do not have Primary Care Trusts. I am afraid I do not know the exact arrangements.

Professor Bedi: In preparation for this, as I always do, I spoke to my counterpart, the CDO in Scotland, and they are going through a major consultation, as we did in 2002. They are looking at a new way of systems and that consultation has just finished and they are just going through the responses of how the different sectors, the patient groups, voluntary organisations and the dental professionals, want to change NHS dentistry in Scotland.

Q81 Jim Sheridan: Again I will focus on anecdotal evidence that I have of speaking to people who have been to the dentist. Where this report is related to England and Wales people who want NHS treatment depend on dentists providing that treatment. I have been told that some dentists use substandard treatment and equipment when treating NHS patients on benefit. Is that off the mark or is that accurate?

Sir Nigel Crisp: I cannot comment on your individual anecdote but as a matter of principle that must be wrong. They should work to the standards which we have.

Q82 Jim Sheridan: So in terms of caps or crowns or fillings, whether you are on benefits or whether you are paying for the treatment, everyone in your opinion gets the same treatment?

Sir Nigel Crisp: Sorry; if you are talking about people receiving NHS treatment, yes. If they are receiving private treatment they may get different materials.

Q83 Jim Sheridan: If they are in for a filling or a cap—

Sir Nigel Crisp: If they are having NHS treatment there should not be any discrimination between people whether they are on benefits or not. In private practice they may do different things.

Q84 Jim Sheridan: So if somebody goes to a private dentist for a filling they will get different treatment from somebody on NHS dental treatment?

Sir Nigel Crisp: They may do.

Q85 Jim Sheridan: So there is substandard treatment?

Sir Nigel Crisp: No, that does not mean to say it is substandard.

Professor Bedi: There is one type of care. A professional acts professionally and provides one standard of care. There are certain groups—children, pregnant women and nursing mothers and those on low income—whose contribution to the cost of treatment is met by the state. They are exempt from patient charges but the standard that they receive should be universally of the same quality as any other NHS patient.

Professor Halligan: I think your point is very fair and I never ignore anecdote. I suggest to you that in general terms most dentists are caring and ethical. However, there is always a concern that people will behave less than acceptably. The new contract is measured in two ways: in the complexity of treatment given and the actual course of treatment. Beyond that there are 11 days a year for dentists to understand their duties of accountable care as professionals. One of them would not be to differentiate between private and public patients. That is anathema to everything that we stand for in the NHS and that is something that we need to emphasise more and more. If we invested more and more in developing quality professionals understanding what best practice is, which is what this is all about; this new contract is evidence based, we would not have the sort of anecdote that you have just described.

Q86 Jim Sheridan: I am extremely glad to hear that. Going back to the question about salaries, the previous witness suggested that the figures quoted of £140,000 or £150,000 did in fact take into account staff costs, accommodation, that kind of thing. Is there a maximum in the way that Members of Parliament have a maximum amount of allowances that they can claim for staff and accommodation?

Sir Nigel Crisp: Are you talking about if they are working in the private sector?

Q87 Jim Sheridan: Yes.

Professor Bedi: Dentists earn a gross fee and there is an agreement with the Inland Revenue that there is a percentage of that gross fee that they should address for expenses. It is part of an annual discussion we have when we look at the pay of dentists and it usually works, if I am right, at 55% of the gross fees, so when I say that in 2005–06 it is £69,000 for someone working reasonably within the

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

NHS, the gross fees may be in the region of £140,000 but the difference between those figures is to meet practice costs, nurses and other expenses.

Q88 Mr Field: Sir Nigel, can I ask the basis of this Report? I know after this afternoon's proceedings in the House, when none of us knows what we are voting on, that the pot should not be calling the kettle black, but you are saying that they were not negotiations; they were discussions and that discussions have now been called off, like negotiations used to be in the old days. This document, however, talks about a new contract, does it not?

Sir Nigel Crisp: Yes indeed. That will be between the PCTs and individual practices. It is exactly the same as with GPs where the NHS Confederation negotiated a contract with the BMA around primary care and then the BMA organised a vote of their members as to whether or not they would accept it, but the actual negotiation had to be done by the PCT.

Q89 Mr Field: So when will this come into operation?

Sir Nigel Crisp: October.

Q90 Mr Field: But if you look at paragraph 2.30 of the Report, it says, "Primary Care Trusts will therefore need to establish effective arrangements for monitoring access, oral health and patient satisfaction", but it is all going to come in in October?

Sir Nigel Crisp: We are bringing in the new contract in October.⁵

Q91 Mr Field: Of next year?

Sir Nigel Crisp: Of next year.⁶

Q92 Mr Field: So they have almost a year to run?

Sir Nigel Crisp: Yes. Part of the reason for having a delay was listening to the profession about how much work they believed needed to be done in order to do that because the original date was April, so we have put it back to October.

Q93 Mr Field: But you talk in the document, Sir Nigel, about guaranteeing the fee income and that somehow dentists should not be on this treadmill. We are on a treadmill, you are on a treadmill, my constituents are on a treadmill. Why should dentists not be on a treadmill? We want them to deliver some outputs, do we not, tangible ones which we can measure?

Sir Nigel Crisp: We do indeed, and that is why we are going for a framework contract which basically says that by moving to this new arrangement which is more preventative and more appropriate so that you do not have to have a check-up every six months; you can stop having unnecessary check-ups and that is the treadmill bit, that will release the benefit of a certain amount of time. We are saying that part of

that time we want dentists to use for their professional development in quality and part of that time we want to secure more access for patients.

Q94 Mr Field: If we go back to one of the Chairman's first questions, it was about whether we do not now provide an NHS dentist service throughout the country and you rather skilfully said that the aim is still to do that although we will not deliver that. Do you not think it is more difficult to deliver that if, for example, my constituents cannot get onto the books of a local NHS dentist if you are bringing in a contract which is telling dentists that they should spend quite a lot of their time doing things other than what my constituents most need, and that is not just in cases of emergency when we are beside ourselves with pain but that we have a general service like we do with the doctor?

Sir Nigel Crisp: If I may literally take your constituency as an example, as it happens your constituency went live on 1 January with a pilot for this, a field site. Forty-four practices joined. They went onto this new system and as a result at the end of October 4,600 new NHS patients have been able to get onto the lists.

Q95 Mr Field: You say "my constituency". It is four constituencies, is it not?

Sir Nigel Crisp: This is The Wirral field sites.

Q96 Mr Field: The Wirral has some very different areas in it. I pushed the PCT to give me the breakdown for the four constituencies because I guessed there might be differences where these new patients were picked up but they could not provide that. Might you push them for the figures?

Sir Nigel Crisp: I will absolutely push them because part of what we are trying to do is to deal with inequalities.⁷

Q97 Mr Field: Although we cannot break down the figure we have still only got 60% of residents in Wirral who feel they have got the service that the Chairman was asking about and that is that they know who their dentist is. Because of this special effort we have managed to get over half. It is an achievement. I am really pleased that they have done it, but it shows the mountain to climb, does it not?

Sir Nigel Crisp: I think it does but you also deal with another point here which is that because we are changing the nature of the service some people will still be saying, "Do we not need to have six-month check-ups and is this not just the government saving money by not doing that?", whereas my colleagues argue that you need check-ups when you need check-ups.

Q98 Mr Field: I am happy with that. I have two other points. Under this new robust system we are going to get do you think bad debts will rise or fall? They will rise, will they not?

⁵ Ev 23

⁶ Ev 23

⁷ Ev 24

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

Sir Nigel Crisp: I do not know. It is not something I have considered but I will now consider and I do not know whether colleagues know that, whether the PCTs will be better debt collectors than individual dentists.

Professor Bedi: With this new system we have looked at some of our field sites and pilots where there is bad debt and how charges are being collected and we are getting mixed results with regard to that, but it is new both for the patient and for the dentist. We are learning through the field sites about bad debts and about patient charges. One thing for certain is that we need to make patient charges simpler.

Q99 Mr Field: Is not collecting bad debts part of the treadmill you are trying to get dentists off? It is part of the job they do not want to do. Doctors do not want to sign sick notes. Everybody wants somebody else to do the nasty side of their job and they just want to pick up the nice side of the job. Can I just leave that with you?

Sir Nigel Crisp: Please, and I can come back to you, because I do not know the answer.⁸

Q100 Mr Field: You say how new the contract is and the approach. All that is welcome but earlier you talked about two groups who are exempt from charges and that was nursing mothers and young children. Since Mr Attlee brought in the idea that we should be very concerned about those two groups Britain has changed significantly. Did you look at whether these were the two most deserving groups if we were going to exempt groups en bloc from charges? Was this questioned or does this attitude come down from Mount Sinai set in stone, not to be questioned? Are there no more deserving groups like diabetics or others who perhaps ought to be given free treatment?

Sir Nigel Crisp: May I come back to you on that as well, which I do think is important?

Q101 Mr Jenkins: It is very interesting having a witness before you, Sir Nigel, and when I talked to the previous witness and went through this outline programme I failed to understand where the difficulty was and why these talks broke down. As far as I understand it you have both got the same outcome in mind, and that was not to have an output of fillings but an output of oral health. The number of patients a dentist had to look after could be containable plus an element of time for emergencies in the week, and the reduction of fillings, scale and polish, examinations, etc, would allow us to increase the number of patients looked after, if not in the first year, maybe over a three, four or five year period as the work on his original patient load was falling. I just do not understand it because to me it is the right approach; we are moving forward here, rather than talking about how much dentists earn or not earn, to look, as we have done, at an agreed formula to make sure they do not fall out of practice and do not fall out of the NHS. The figures you quoted to us on the NHS I just find unbelievable, that 75% of dentists'

income and 69% of their work comes from the NHS. It does not bear any relationship to the real world. About a year ago the Dental Board wrote to me and said, "Your dentist has now decided that he is a private-only practice", 100% private, no NHS at all, because they recognise that they could make more money. The difficulty to me now is, having trained them and supported them, having a common accord, we have now got this divergence. Is that the real reason why there has been this breakdown in talks?

Sir Nigel Crisp: We did not initiate a breakdown. As you say, there is a lot of commonality. We are surprised and disappointed but we will move on. On your wider point what is interesting here is that the NAO has made very clear that the heading of this report is something like *The Risks To Be Managed*, and there are risks and you have just highlighted one. We have done quite a lot of piloting of this now in that the first areas started in 1998. We have got quite a lot of evidence in quite a lot of the country of dentists wanting to move into this new system, as I say, getting up to 20%. We do need to make it worthwhile and good for dentists but also we need to be tough about making sure we secure the benefits for patients.

Q102 Mr Jenkins: One of the things that surprises me is the amount of work that dentists have. I know it is difficult to quantify but I was sitting here thinking that if there are 220 days in a year, taking away 33 days' holiday and seven days off sick, and there are 23,000 dentists, that is over 5,060,000 days a year. If there are 50 million people in the country that means that if a dentist saw ten people in a day it would cover every person in the country. There must be some rationale. It takes about 15 minutes to have an examination and there must be a bolt-on for treatment, so why are we getting so many treatments when we should be looking at 50 million people? If we have a programme of oral health in place would that mean that the amount of work on those 50 million would tumble?

Sir Nigel Crisp: Maybe Professor Bedi will say this in a bit more detail, but in these pilots we have actually seen numbers of treatments come down because the concentration has been precisely on oral health. There is another thing which to a non-dentist is fascinating, that 30 years ago 40% of the population did not have teeth. We are now down to something like 10% who do not have teeth, so the needs of the population for dentistry have changed enormously and there is much more conservation work now.

Q103 Mr Jenkins: Now I will tell you another little story which ties in with this. When I went to the dentist a few years ago, I had a nice dentist, he chatted to me a lot and did some work on my mouth, and I was grateful to him. When I went back this year he had left so I had to go to another dentist. He examined me and he said, "Who has done this?", and I said, "This practice". He said, "Oh, my word. It has all got to be redone. It is a mess", because the dentist who had done the work originally was interested in

⁸ Ev 25

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

maximising earnings and not in maximising my oral health whereas the new dentist starts off saying, "Come in and this will be put right", but rather than reporting him to the Dental Board and tracking him down they said, "They will do it and the practice will pick the bill up". I am beginning to think maybe the amount of work they do, fillings and all the rest of it, is sometimes linked to the amount of income the dentist makes rather than the oral health of the patient..

Sir Nigel Crisp: Our position is very clear. We believe that the vast majority of dentists are concerned about the needs of their patients but there is some scope for abuse within the system. The new system, which is not based on treatments but on oral health, will get rid of that perverse incentive if it is there.

Q104 Mr Jenkins: The answer to that question is that you still have to monitor and it is this monitoring that is going to be done with the PCTs?
Sir Nigel Crisp: Yes.

Q105 Mr Jenkins: Do you believe that the PCT is in a position to monitor the work undertaken by these dentists to ensure not that we get value for money but that the patient gets the best oral treatment?

Professor Bedi: We are introducing a system which is not new. In 1998 we were piloting this and the NAO commissioned a report from the University of Birmingham to look at the difference between those working in the new way as opposed to the present system. They did not find any major differences. The fears that we had were not realised in that study. The NAO recognises this is a risk. We have put into place a reference system, checking, peer group support. There are fewer risks in the new system with the reforms than there were in the old system.

Q106 Mr Jenkins: In the Report the Barnsley field study looks like an excellent scheme. Since we have got this are we going to reinvent the wheel or are we going to send this out as the pattern to be replicated up and down the country?

Sir Nigel Crisp: This is the point of the framework contract, that we want to introduce a few contract and best practice examples. Raman has got a dental support team—I cannot remember how many—whose aim is to help PCTs to do just that, learn the lessons.

Q107 Mr Jenkins: How much does it cost to train a dentist?

Professor Bedi: The present figures vary but at the moment if we include the five years that they train, plus the one year vocational training it is about a quarter of a million.

Q108 Mr Jenkins: It costs the NHS a quarter of a million pounds to train a person who can walk away and set up in private practice the next day?

Professor Bedi: During that period they are working in NHS facilities providing patient care in their training.

Q109 Mr Field: Even worse.

Professor Bedi: In their vocational training they are working within NHS practices.

Professor Halligan: So you get some service out of them.

Chairman: While they are students.

Mr Williams: They are practising on their patients and not going on the books.

Q110 Mr Jenkins: They have an opportunity to develop that skill and practise within the NHS. If we did not have an NHS training regime, if they had to go away and pay to train in a private training college, bringing people into practice, it would cost them individually at least a quarter of a million pounds?

Professor Bedi: 70% of the income of dentists comes from doing NHS treatment.

Mr Jenkins: You keep saying that like a mantra. It is wrong, it is out of place, please do not believe it. There are NHS dentists out there doing 100% of their work on the NHS and others have walked away from the NHS on day one. They are making up to £150,000 a year and pocketing it on the misery of people and they have been trained and financed by the NHS, the taxpayers of this country. That is the only point I was making.

Q111 Chairman: National Audit Office, do 70% of dentists do 70% of their work on the NHS?

Mrs Taylor: I cannot answer that from the information that I have at the moment here. I can find out for you.

Chairman: That would be very useful.

Q112 Mr Field: Chairman, is it 70% of all dentists or 70% of those dentists who undertake some NHS work, because the point that has just been made is that you could have a group who train and practise on us and then set up in private practice who would not be part of the base 100% from which that 70% is calculated.

Mrs Taylor: I will check with my colleague but my understanding from the information that we got to do the analysis we have is that because dentists can come in and out of NHS treatment it is not a static position at all, and because they can change the proportion of NHS treatment to private that they give at any one time, coming up with a figure is very difficult. I am interested in seeing the source of the figure and we will work that out as far as we are able to.⁹

Q113 Mr Steinberg: This meeting is totally surreal. I cannot believe what I have been listening to because the story that you are giving me is totally different from the story that I get in my constituency, from the rest of the country, from people I have talked to. I have never known such complacency in all my life. The fact of the matter is that dentistry in this country is in meltdown, absolute meltdown. You cannot get

⁹ Ev 20

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

an NHS dentist. It is all right for the Prime Minister to say, "Ring NHS Direct and you will get a dentist". How many people have rung NHS Direct?

Sir Nigel Crisp: 19,000 a month.

Mr Steinberg: Do they all get dentists?

Q114 Chairman: Emergency.

Sir Nigel Crisp: Emergency and urgent.

Q115 Mr Steinberg: Did they get a dentist?

Sir Nigel Crisp: For emergency and urgent. The figures we have got are something of the order of 94% get it within a short distance. I cannot remember the distance but they are able to access emergency or urgent treatment—

Q116 Mr Steinberg: What is "a short distance", Sir Nigel?

Sir Nigel Crisp: I need to come back to you on that.

Q117 Mr Steinberg: You had better because I was talking to a Member of Parliament this afternoon and he told me that in his constituency they have to travel 70 miles to get an NHS dentist. Is that a short distance?

Sir Nigel Crisp: No, that is not. The point that I made earlier, which was not remotely complacent, in response to your Chairman was that we are not doing as well as we want to.¹⁰

Q118 Mr Steinberg: That is complacent, you are not doing it as well as you want. I had three people last week who could not get a dentist.

Sir Nigel Crisp: Did they try NHS Direct?

Q119 Mr Steinberg: They came to me and I told them to go to NHS Direct. I also mentioned it to the PCT. We have not got one dentist in my constituency who is taking new NHS patients, not one. My dentist told me a fortnight ago that he is no longer going to take NHS patients, so for you to come along and say that everything seems to be okay and this damn new contract is going to solve everything, that is not right. People cannot get a dentist.

Sir Nigel Crisp: I am not remotely saying that everything is okay today. I said earlier that people are not getting a dentist, which is why we are recruiting a thousand—

Q120 Mr Steinberg: It is easier to win the National Lottery than to get a dentist.

Sir Nigel Crisp: It is 14 million to one on the National Lottery. It would be a good quotation on *Today*.

Q121 Mr Steinberg: Exactly.

Sir Nigel Crisp: It is not 14 million to 1 to get an NHS dentist.

Q122 Mr Steinberg: You ask my constituents who cannot get one whether it is easier to win the National Lottery or not and they will say there is no difference.

Sir Nigel Crisp: Can I be clear what I have been saying, which is that if you use NHS Direct you can get access to emergency and urgent care.

Q123 Mr Steinberg: But that is not good enough. I want to be able to ring up a dentist, as I have done for 55 years, at least, my parents did it for me and then me since, and for my own kids to be able to ring up a dentist and say, "I have got toothache. Can I come and see you?", and they say, "When can you come?". Now you have got to ring up NHS Direct, who many people have never even heard of for a start, and then they have to travel 70 miles to get treatment. Also, we were told by the previous witness that no dentist would turn away kids. He is living in cloud cuckoo land because kids are being turned away in my constituency. I had a woman phone me up and say that she could not get a dentist for a small child of about five or six and NHS Direct eventually found her one. That is not what NHS dentistry is all about. It is about people having access to a dentist.

Sir Nigel Crisp: I absolutely agree with you, which is why—

Q124 Mr Steinberg: Then why do you not do something about it?

Sir Nigel Crisp: We are.

Q125 Mr Steinberg: You are not, though. Nothing is being done at all.

Sir Nigel Crisp: Your colleague to your right made the point that we do not want to over-treat people. We want to introduce a contract which ensures that people have got good dental health. The other thing in this Report is that we have got very much improving oral health, the best figures for children in Europe.

Q126 Mr Steinberg: That is fine. If you look at paragraph 2.30, it says, "... the British Dental Association surveyed 25,000 dentists and reported that 60% of the 7,500 dentists who responded would either reduce their provision of NHS services or opt out of the NHS altogether". We are talking about 60% of dentists who are thinking of leaving the NHS or reducing capacity.

Sir Nigel Crisp: You are thinking of 60% of 30% if you read those figures. A third of the dentists responded and 60% of those who responded—

Q127 Mr Steinberg: We can assume that the two-thirds who did not respond are probably in the same boat.

Sir Nigel Crisp: I do not know about that. We have got 2,500 dentists and getting up to 20% who are opting for the new arrangements.

Mr Steinberg: It is a bit like the government saying if 50% do not vote that that is a vote for them. That does not follow.

¹⁰ Ev 25

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

The Committee suspended from 5.31 pm to 5.40 pm for a division in the House

Q128 Chairman: Sir Nigel, can you complete your answer please?

Sir Nigel Crisp: I have forgotten the question. I beg your pardon: what I wanted to say was that we said something earlier about bad debts which we do not think is right. Can I send you a note on that?

Chairman: Of course you can.

Q129 Mr Steinberg: I brought up paragraph 2.30 on page 36 and we were having an argument about whether or not it is two-thirds or a third. It is irrelevant really, is it not? Regardless of what the statistics are, the fact of the matter is that if that number of dentists are going to drop out of the system you are going to be woefully short of dentists. As I said before, we are almost in a meltdown situation and that seems to substantiate it. You are hoping to recruit a thousand dentists if I remember correctly, but a thousand is not even going to make a difference to the ones who have dropped out, let alone add further dentists to the system.

Sir Nigel Crisp: Can I draw your attention to page 45 of the Report, which is the other side of this argument, if I may put it like that, where you see a very interesting curve on that graph. This is the number of dentists who have not filled in a form on the questionnaire to their association. This is the number of dentists who have voted with their feet and signed up contracts. You can see the angle of that increase there, and these figures are September 2004, and they are people who have signed up. The figures I mentioned earlier were the people who have expressed an interest in signing up. There is a considerable body of opinion out there who are wanting to sign up to the new arrangements.

Q130 Mr Steinberg: That is fine.

Sir Nigel Crisp: It is.

Q131 Mr Steinberg: But at the end of the day the number who are wanting to sign up and the number who will sign up are still going to be woefully short of the number of dentists that you need. That is obvious.

Sir Nigel Crisp: No, I do not think it is because the first one was a vote and that you can take your view as to how likely you think the people in that survey will follow that through with action. This is what dentists are doing in practice. In addition to that I am happy to get in at some point the description of how we are going to secure the thousand more dentists we believe we need, because we believe we need a thousand more.

Q132 Mr Steinberg: Somebody else can answer that question because I want to move on. I think the whole thing is summed up on page 13 in figure 3. You are making great play on that thing that you have just shown me to take it as proof of what is going to happen. I look at figure 3 and think to myself, "No wonder national dentistry is in the state that it is in today" because if you have a look at the

spending that has gone on since 1991, not just by this government but the previous government, we are spending, according to this, less now than we were in 1992, 12 years ago.

Sir Nigel Crisp: Yes.

Q133 Mr Steinberg: So how on earth can the system manage and how can all the problems that most of us have outlined that have taken place recently be solved when frankly it is quite clear that it is just a matter of resources?

Sir Nigel Crisp: Two things. First, as it says here somewhere, that figure from 2003 to 2005 goes up very sharply by 19%. The next figure on the curve goes up 19%. What you will know from the last 100 of these Committee hearings on health is that there are a number of areas where we have put in much more than the average: cancer, for example, and coronary heart disease. There is a whole series of areas where we have put in much more expenditure. Dentistry has stayed flat, I absolutely agree with you, and that is a significant part of the problem, but we are now coming to the point where we are going to invest a lot more money in dentistry and in the next two years, again as this report says, it goes up by 19% which is higher than the increase in spending during that period.

Q134 Mr Steinberg: Sir Nigel, that is all well and good, but really—

Sir Nigel Crisp: And true.

Q135 Mr Steinberg: It could well be true and the *Today* programme will probably say that as well, but the fact of the matter is that it has taken you and Professor Bedi and Professor Halligan—I do not know how long you have been in your jobs but if I had had this graph when I started my job I would have looked at it and said, "It is quite obvious why we have got no National Health dentistry because there is no money going in". In fact, in 1996 it almost disappeared off the graph. I am surprised we have any dentists at all.

Sir Nigel Crisp: I am sorry. You are absolutely right that we have not increased the expenditure in dentistry at the same pace as we have increased it in areas that we have given higher priority to and that is why it is below the average increase in spending, but we need to rectify that. There are a number of other features that have happened over that 14-year period, including the discussion that was raised earlier about—

Mr Steinberg: How much have a Permanent Secretary's wages gone up in that time?

Chairman: I do not think that is a fair question.

Q136 Mr Steinberg: I was being a little bit facetious. **Professor Bedi:** Can I make a comment, Nigel? This graph is exactly why we are doing the reforms, because the low level is because the dentists determine how much NHS dentistry and how much activities they draw from the open-ended public expenditure, so the commentary there is that we need these people because of the present system and the way it works.

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

Q137 Mr Steinberg: Why has it taken 10 years, Professor, to work out that you need these reforms? If you look at 1993–94, the expenditure had gone down considerably and it has never really increased since, so it has taken 10 years for somebody to come up with this magnificent view that something needs to be done. In the meantime people cannot get a dentist.

Sir Nigel Crisp: Dentists are very important and the ability to get dentists is fantastically important. What has happened over this period is that in that first ten years there was lack of clarity about what needed to be done because oral health was improving very fast and it was not clear how many dentists were needed. A lot of work has happened since 1998. The other point worth making is that we have spent the increased money in the NHS on things which have been seen as a higher priority at the time, like cancer and coronary heart disease. I do notice, for example, that this Committee has not examined dentistry in its last 100 sittings. We have given it the same—

Chairman: That is a bit of a mean shot.

Mr Steinberg: You just decided your fate there.

The Committee suspended from 5.48 pm to 5.54 pm for a division in the House

Q138 Mr Bacon: Can I ask you to send the Committee a detailed note which summarises the position for dentists in the UK as to income and numbers? The note I would like you to send would contain information on all the dentists in the UK, let us know how many there are, how many of them work purely in public practices, in the NHS, how many of them work purely in private practice, that is, purely for themselves privately, and how many operate what you call a mixed economy, and what the income levels are for these different types of dentists, showing also regional variations, so a public/private mix, showing also the difference between income for the practice and the actual income for a dentist. Can you do that?

Professor Bedi: I can certainly go to the Dental Practice Board who have detailed information about NHS commitments for people who undertake NHS activity. There are some estimates from Inland Revenue figures, which we have, that are two years old.

Q139 Mr Bacon: If the note comes from a variety of sources I do not mind, but can you send us a note?

Professor Bedi: We will try to get in all that information.¹¹

Q140 Mr Bacon: I would be grateful. Sir Nigel, you said that your discussions having failed you were now going to leave it to local negotiation. I take it that you mean by the PCTS?

Sir Nigel Crisp: I did indeed, yes.

Q141 Mr Bacon: Given the huge pressure PCTS are under at the moment with the agenda for change, I was talking to the financial director of a PCT

yesterday who said that they still do not know what it is going to cost, the GP contract, which is supposedly fully funded but plainly is not; there are clear pockets of under-funding or in some senses unfunded commitments, the consultant contract, and other things like the National Programme for IT which Professor Halligan knows all about. Given all those pressures, do you seriously think you are going to get a better deal for NHS dental patients out of these PCTS who already have the huge pressure of negotiating locally in terms of retaining the required number of dentists?

Sir Nigel Crisp: Yes, for two reasons. This will be the first time that PCTS can determine what dentistry is provided within their area, so they can go out—and you have got a rural constituency and I know that there are issues of access in rural areas—and actually take decisions about where they want the dentists to be. That is really important; local issues are fantastically important. The second thing is that you will be aware that with the primary care contract which came in this year it was the PCTS who ended up negotiating within a national framework with 30,000 GPs very smoothly and there is a lot of overlap between what negotiation they had to do for the primary care contract, and at this point I will ask Professor Halligan to describe that, and what they will have to do with this.

Professor Halligan: I guess a lot of learning has happened in three areas. First, negotiating locally with professionals is a real art form and that is about selling the new GMS contract. Secondly, change management has been building up, evolving maturing PCTS. Thirdly, for the first time ever there has been a shift to quality and outcome focus. Those particular perspectives are now internalised in the developing PCTS.

Q142 Mr Bacon: You are saying you think the PCTS—and, Sir Nigel, please comment as well—have got the skills that are required to do the negotiation? There has been a lot of criticism of the professionalism of PCTS. Only one in four, I was reading yesterday, have an IT director. Two-thirds of them have part-time finance directors. You are seriously suggesting that the required negotiation skills are there in the PCTS to negotiate this depth of contract locally?

Sir Nigel Crisp: Let me come back with two points. The first one is that they have just done it on primary care.

Q143 Mr Bacon: GPs?

Sir Nigel Crisp: Yes.

Q144 Mr Bacon: As a result of which emergency admissions have gone through the roof from 3.5 million to 4.6 million because the GPs got the better of the deal.

Sir Nigel Crisp: No. At the last PAC hearing we went through emergency admissions and that is not the evidence that we have, that emergency admissions are going up as a result of that.

¹¹ Ev 25

Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

Q145 Mr Bacon: They are going up but not because of that, is that what you just said?

Sir Nigel Crisp: They went up but actually they are tending to stabilise now. They have got some good GP contracts working now around the country. The second point I would make is that of course it is patchy with 300 organisations, which is precisely why Professor Bedi has an NHS support team to support PCTs in doing that. This is the right level to do it in terms of getting the right local deals for people in—

Q146 Mr Bacon: Assuming PCTs have got the money, but they are already telling us they are hugely overstretched with all these other initiatives and change, all of which are costing more than the government thought they would.

Sir Nigel Crisp: In terms of financial issues, of course there are financial pressures in the system. There always have been and I am afraid to say there always will be because the NHS is very ambitious and is trying to do more and more with the money which has been voted for to do it. Those need to be managed but in this particular case we have identified some specific money that is going into the system and we have safeguards in place to help them to manage these negotiations.

Q147 Mr Bacon: You are talking about the extra £250 million?

Sir Nigel Crisp: The £250 million, yes.

Q148 Mr Bacon: Can I ask you about that? That was my next question. Dr Ellman said that £140 million to £150 million of that would go on the thousand extra dentists. Assuming roughly a 2%–3% pay rise a further £40 million will go on that, which takes you up to £190 million or so and leaves you only about £60 million. Do you broadly agree with those figures?

Sir Nigel Crisp: I do not know whether I do or not because I have not seen that breakdown. The point that I would make is that the thousand extra dentists are part of the solution and that money will be going through the PCTs, will it not?

Q149 Mr Bacon: Professor Halligan, I know that Sir Nigel said that you may have mis-spoken on the question of debt recovery but you did say that as long as they made real efforts then the risk would be borne by the NHS. That set me wondering what constitutes “real efforts”, how you measure whether there are real efforts, and are you proposing to set up an NHS dental recovery performance management agency, run by Capita perhaps? You are not?

Professor Halligan: If you like I will send you a note clarifying the issues around that.

The Committee suspended from 6.01 pm to 6.09 pm for a division in the House

Q150 Mr Jenkins: Sir Nigel, in response to Mr Steinberg you said, “We are not short of dentists”. I know you were referring to the new programme, but obviously we are short of dentists.

Sir Nigel Crisp: We are short of dentists today, yes.

Q151 Mr Jenkins: How many dentists have your department estimated we need today in Britain, bearing in mind the rising demand, bearing in mind the inability to provide dentists in socially deprived areas? I suggest that if we compare ourselves internationally that is 33,000, but since we have dental nurses and hygienists it might be a lower figure, it might be down as far as 30,000 or 29,000. What is your estimate for the number we need and what are you doing to secure that number in my lifetime, shall we say?

Sir Nigel Crisp: Professor Bedi published this document in July, which has the workforce estimates in it. We say increasing the NHS workforce capacity by the equivalent of a thousand dentists, and I recognise that some of them are part-time, so it is the equivalent of a thousand whole time dentists, by October next year will allow an extra two million people to register with an NHS dentist. That is a thousand equivalent who we intend to secure by October next year and we have got an advance programme on that. Would you like me to ask Professor Halligan to—

Q152 Mr Jenkins: I would like you to answer the question: how many dentists? What is the figure we need?

Sir Nigel Crisp: A thousand.

Q153 Mr Jenkins: You are telling me that if we have 23,000 now 24,000 will meet the needs of the country?

Sir Nigel Crisp: This was a pretty exhaustive piece of work looking at the workforce needs and this is the figure—

Q154 Mr Jenkins: Who is going to stake their reputation that with these thousand extra dentists—I could have Mr Steinberg or any other member coming here and saying, “I have no NHS dentists in my constituency”, because that is what you are telling me. I have given it out here: how many dentists do we need to do the same as the European countries with 33,000? I am not interested in the income of dentists. I am interested in the treatment of people. You tell me why we need less and what is the figure?

Sir Nigel Crisp: I understand that, which is why Professor Bedi led a working party to try and address precisely that question.

Professor Bedi: Yes, we did, and it is not just the number of dentists we need; it is the twin needs: the investment which we have announced and the reforms, which are very important because there is no point pouring dentists into a system when there is a haemorrhage at the other end. We have said that we estimate that there are approximately two million people that we need to address.

Q155 Mr Jenkins: So the total number is 24,000?

Sir Nigel Crisp: We need to increase it by 1,000.

Mr Jenkins: I would not put my reputation on it.

 Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

Q156 Mr Williams: While you are waiting for us to come back from this division will you get your statisticians to work out how many extra dentists we would have had now if we had not closed down the places in 1987?

Sir Nigel Crisp: Is that the dental student places?

Q157 Mr Williams: Yes.

Sir Nigel Crisp: If we had not closed the dental student places in 1989. Okay.

The Committee suspended from 6.12 pm to 6.20 pm for a division in the House

Q158 Mr Williams: Did you work it out for me?

Sir Nigel Crisp: Our best estimate is 550 in England and 550 who would have graduated in Scotland.

Jim Sheridan: Oh, a thousand.

Q159 Mr Williams: Can I for a moment turn to page 54, tables 23, 24 and 25? It is rather puzzling that England with such a high population for dentists emerges from table 23 as having the best figures of all the countries in that list for 12-year olds. How do you explain that?

Professor Bedi: We have significant improvements, which is a credit to a lot of groups—dental professionals, health educationalists, but also to the general nutrition that is happening. We have for our 12-year olds undoubtedly the best oral health among our European colleagues, but when we have a look at the number of dentists per population ratio that can only be understood when you look on the other page at the members of the dental team to population. I think it is archaic to look at the number of dentists per population. We should look at the members of the dental team to population. We have more dental hygienists and therapists than most of our European colleagues and we are increasing that and that I feel is good news and the way we should be providing dental care.

Q160 Mr Williams: That is quite interesting because it is contrary to the impression we have been getting about the situation. In fact, we are the second highest spender in terms of public expenditure on dentistry, are we not?

Professor Bedi: Yes.

Q161 Mr Williams: Strangely enough, we are virtually the worst spender privately on dentistry. Why do you think there is this cultural difference? We are putting the money into the public sector although that is not the impression you get, and yet we do not seem to be as responsive as individuals in the same way as other countries. Is there any explanation for it?

Sir Nigel Crisp: I suppose the only explanation is that we have had the policy of having NHS dentistry provided in the way that we have talked about, whereas elsewhere in this document it talks about other areas having completely different policies.

Q162 Mr Williams: You see, again, when we listen to all the pressure for fluoridation and so on from dentists, they always concentrate on the five-year

olds. I have never seen figures for 12-year olds before. Why is it we have got control figures for 12-year olds here but when dentists want to talk about fluoridation they always talk about five-year olds, and if it is so bad at five how can it be so good at 12?

Professor Bedi: There are a number of issues there. The improvement for five-year olds has also been significant but is beginning to plateau. Fluoridation is an issue not just for children but for adults as well. Fluoridation is a discussion about inequalities and addressing them for those sections of our community that have not seen the benefits. What we are seeing here is mean figures but they do hide the fact that there are vast discrepancies and inequalities in our country.

Q163 Mr Williams: How do we redeem it by the age of 12 if it is so bad at five because they have not got fluoridation? It does not seem to make any sense.

Professor Bedi: What we are seeing here is mean figures and they hide the fact that there are disparities. There is good news. The majority of our children leaving school are totally decay-free but there are sections in our community that would benefit from community based water fluoridation.

Q164 Mr Williams: And yet it is only a very small proportion of the country that has fluoridation.

Professor Bedi: Approximately 10% of our population are benefiting from fluoridation.

Q165 Mr Williams: If there is only 10% that cannot explain these figures that you are saying are very good. Fluoridation is irrelevant. They have been achieved without that.

Professor Bedi: The approach to fluoridation is that populations will decide whether it is suitable for them.

Q166 Mr Williams: Which populations will decide?

Professor Bedi: In the regulations on the Water Act that had Royal Assent in 2003 the direction of travel is clearly to say that local populations should decide whether they wish to have water fluoridation and we are working out mechanisms to assess that. I am sure that there will be certain areas of our country that will simply say it is not appropriate.

Q167 Mr Williams: This is shades of votes for the foundation hospitals and things like that, where you get about 60 people casting votes. How are you going to have an electoral system for all the populations in relation to something like fluoridation and have any credibility? I have got the figures here. The Pro-Fluoridation Campaign argues that 67% of the public are in favour of fluoridation. That means that 33% are not. That means 20 million people, if you have your way, would be forced-fed fluoride whether they want it or not. They do not have any democratic right to say no to it.

Professor Bedi: The debate was in both Houses of Parliament and it was given Royal Assent.

Department of Health, Chief Dental Officer for England, Deputy Chief Medical Officer for England

Q168 Mr Williams: I was there; I know what was said and I heard a lot of rubbish as well.

Professor Bedi: The regulations have gone out for consultation. We have had quite a wide-range of consultations and they will come back to Parliament when there is consultation and the regulations are laid.

Mr Williams: You mean we will have a one and a half hour debate with no chance of amendment and that will be the way we decide how it is to be imposed. Is that what you are saying?

Chairman: That is a bit of an unfair question.

Q169 Mr Williams: I just want to see what he is willing to impose on other people. Why should your neighbours have fluoride stuffed down their children's throats because you want them to have it?

Professor Bedi: It is for local populations to decide.

Q170 Mr Williams: That is a joke.

Professor Bedi: All I can say is that I have provided specialist and consultant care in a fluoridated area for 10 years and I have done likewise for 10 years in a non-fluoridated area. Having provided consultant care for young children and older children, I can say that for me it is fairly self-evident, but the regulations are—

Q171 Mr Williams: But what about the people who do not want it?

Professor Bedi: The regulations are for local populations to decide.

Q172 Mr Williams: So what do the people who do not want fluoride do? Where are they getting their water from?

Professor Bedi: The regulations will be quite clear. They will be laid down and it is for local populations to decide.

Q173 Mr Williams: That is a farce and you know it. We will leave it for now. Sir Nigel, back to your figures on the extra dentists we would have had. My calculation on the basis of the figures you have given me is that if dentists worked 200 days a year, allowing weekends off and 60 other days, and if they only did 30 instead of the 50 treatments a day, and 50 is what we were told is the NHS level at the

moment, that would provide us at the moment with an extra 3.5 million dental treatments a year. It was a disastrous decision, was it not?

Sir Nigel Crisp: The decision as I understand it was taken because oral health was improving and the view was taken, not just in this country but in other countries as well, that we did not need so many dentists in the future and with hindsight that was wrong.

Q174 Mr Williams: Who got it wrong?

Sir Nigel Crisp: The policy-makers at the time.

Mr Williams: Who would have been Minister in 1987? Do you remember? Does anyone know who was the Minister for Health in 1987?

Chairman: Let us say it was Tony Newton or something and blame it on him.

Jim Sheridan: He was a Tory anyway.

Chairman: He was a Tory anyway. I think Mr Trickett wants to ask for a note.

Q175 Jon Trickett: Can you let us have a note about the money going to the PCTs, whether it is going to be ring-fenced to stop the PCTs stealing dentists' money for other things?¹²

Professor Bedi: Yes.

Q176 Chairman: I would like to have a note please on paragraph 2.8, where the National Audit Office notes that "it is still not clear what services dentists will be contracted to provide, what services patients can expect or what charges patients will pay". I would like to have a note on when you intend to provide dentists and the public with this information. I would also like a note please on paragraph 1.43. How confident are you that the proposed expansion in training places is sufficient to meet the longer term projected future need for dentists? I would also like to have a note please from you, Sir Nigel, on the fact that patients will be moving from a system of paying for each item of treatment to paying for improved oral health. What is the expected impact on income from charges? I am letting you off. It has been a hard afternoon, so we are doing it by notes now, not questions. Thank you very much, gentlemen. I am sorry for all the interruptions but it is a very important subject and we will return to it in our report.

¹² Ev 28

Supplementary memorandum submitted by the National Audit Office

Q112 Chairman: National Audit Office, do 70% of dentists do 70% of their work on the NHS?

Mrs Taylor: I cannot answer that from the information that I have at the moment here. I can find out for you.

This figure is taken from the Review Body on Doctors' and Dentists' Remuneration: Supplement to the Thirtieth Report 2001 (Cm 4999) which showed that, in 2000, 71% of dentists did at least 70% of their work within the NHS. This information was obtained from a survey of General Dental Practitioners' workload conducted by BMRB Social Research on behalf of the Review Body on Doctors' and Dentists' Remuneration. BMRB asked 4,000 dentists to keep a workload diary for a week and complete a background questionnaire. The results from the respondents on the proportion of their time spent working for the General Dental Service are given in Figure 1.

Figure 1: Ratio of General Dental Service Work: Private Work¹

<i>Number of respondent: 1,762</i>	<i>Percentage of General Dental Service dentists</i>
100%GDS: 0% Private	25
90% GDS: 10% Private	33
80% GDS: 20% Private	8
70% GDS: 30% Private	5
60% GDS: 40% Private	2
50% GDS: 50% Private	3
40% GDS: 60% Private	3
30% GDS: 70% Private	5
20% GDS: 80% Private	7
10% GDS: 90% Private	6
0% GDS: 100% Private	1

Note: The table does not sum to 100% due to rounding

This research did not cover the small number of dentists who do no NHS work at all. The Office of Fair Trading Report, “*The Private Dentistry Market in the UK*”, published in March 2003, stated that only around 200 dental practices are solely private out of 11,000 dental practices in total.² The impact of these practices on the results will therefore be negligible.

This is the latest data available on the proportion of time General Dental Practitioners spend on NHS funded treatment. Since 2000 the Department estimates that dentists’ average General Dental Service commitment has fallen by about 1–2% a year. If it is assumed that all dentists who worked between 70 and 80% of their time in the General Dental Service in 2000 now spend less than 70% of their time in the General Dental Service, then the figure for the number of dentists working 70% or more of their time in the General Dental Service will have fallen from 71% to around 66%.

Memorandum submitted by Dr Paul Batchelor, Senior Lecturer and Consultant in Dental Public Health, UCLH

1. INTRODUCTION

The publication of the National Audit Office (NAO) Report examining the proposed reforms of the NHS primary dental care system is to be welcomed. The Report provides an overview of some of the key issues that remain outstanding regarding the reforms of the oral health care system in England. The Report also identifies many of the potential problems that require answers if the proposals are to address the reported shortcomings. However, as described in the NAO Report, the Department of Health (DoH) has to date failed to provide sufficient detail that will allow any critical analysis of the proposals. The meeting of the Public Accounts Committee provides an opportunity to help address this shortcoming.

2. OVERVIEW

This paper is split into two further sections; the first provides the basis for the key questions that appear in the second section. As mentioned in the introduction, while the NAO have identified many of the potential areas where risks exist, their relative importance and the actions of the DoH to date raise considerable uncertainties, not least on the sustainability of the Department’s policy decisions. The risk management of the proposals can be examined by exploring each of the functions from the perspective of the three major parties involved namely the public, the Primary Care Trusts (PCTs), and the profession.

The Department has stated that the major problems facing the care system are in accessing NHS care and in the variation in levels of oral health. From the public’s view the reforms need to be able to confirm that both these issues will be addressed; that both the increase in workforce will not simply provide care through non-NHS arrangements and that the policies adopted will help improve the oral health of those currently with the worst levels to a greater extent than under the present system. A further issue is the need to ensure that any resources allocated by Parliament for the provision of dental care do so. For PCTs any policy needs to provide them with the opportunity to manage the system overall better than is currently the case, and in particular that the resources to do so exist. Finally, for the professional any policy needs to provide a

¹ Review Body on Doctors’ and Dentists’ Remuneration, Supplement to the Thirtieth Report (Cm 4999), Appendix E (Survey of General Dental Practitioners’ Workload), Table 5f.

² The Office of Fair Trading, *The Private Dentistry Market in the UK* (OFT 630), Summary and Conclusions, paragraph 1.4.

sustainable base from which the financial risks of providing care under NHS arrangements can occur and are in part commensurate with the rewards under non-NHS arrangement as failure to do so will not address the current movement by care providers away from the NHS.

The difficulty facing any organisation trying to assess the impact of the reforms are three fold. First, there are a lack of reliable data to provide an overview of the current performance of the care system in total. While data exist for all three components of the NHS oral health care system, the information arrangements prevent any meaningful comparisons on performance. The General Dental Services (GDS) uses an independent contractual agreement and is the major sector through which care is provided. It relies upon a fee-per-item arrangement that provides data on the precise activities on both an individual patient and provider allowing the monitoring of care provision, in particular a cost-effective quality assurance mechanism. Any reduction in the level of detail captured will increase the risks of a decline in the quality of care. The Community Dental Services (CDS), a salaried arrangement with a role defined in previous published Health Circulars HC89(4), including information on children through the epidemiological programmes and special needs groups. However a different information arrangement to gather data exists that prevents comparison to the GDS exists. Finally, the Hospital Dental Services combines specialist and training roles, again salaried but using yet another data information arrangement. Each of the three delivery systems plays a role that is to an extent unique and, crucially, will alter with changes to any one of the three systems. It is this overall synergy between the systems that must be considered: it is not whether the primary care sector alone improves but whether the system in total functions.

A further major stumbling block in assessing any meaningful analysis of oral health care policy lies in the shortfalls in the lack of knowledge regarding the nature of the non-NHS sector. All studies examining the non-NHS sector to date are remarkably weak and lacking in scientific rigour. This failure to be able to provide an overview hinders any ability to assess the extent to which the current proposals will make progress towards addressing the perceived shortcomings in oral health care arrangements and managing risk.

The second issue centres on the definition of oral health by the public. Dentistry is an elective process: all treatments after the relief of pain are of subjective value. This value will vary within society and hence so will the need and demand for care. As all treatment carry a cost, there is likely to be further variation within the population on the value of any intervention. This issue will account for some of the variation in reported oral health that relies upon clinical measures alone.

Thirdly, and most importantly, has been the abject failure to define the purpose of the NHS oral health care system. Without a definition of what NHS dentistry actually means one cannot answer any questions on whether the system is value for money. Should the system provide all treatments to all individuals?

3. QUESTIONS

The questions below arise from the material in the NAO Report and the issues raised above in the previous section of this paper. They are:

3(a) *Access*

What evidence can the Department provide that the reforms to the present system will increase access to NHS care?

Research has identified that the major barrier to accessing dental care in the UK is cost. Could the Department provide the Committee with the detailed proposed modifications to the arrangements for patient charges and explain how the modifications will reduce the barrier formed by cost of dental care that currently exists?

What percentage of individuals who have tried to access an NHS dentist have done so with a clinical need as opposed to simply trying to register due to the current registration arrangements? What proposals does the Department have regarding the registration of patients? Has the Department considered adopting the registration arrangements that currently operate in the medical sector, and if not, why not?

Could the Department provide an estimate of the impact of the recent NICE guidelines on dental recall intervals on capacity within the care system? What is the basis for this figure?

3(b) *Access and workforce*

In light of the proposed reforms to the care system how valid is the methodology used to estimate the number of dentists required over the next 10 years? Precisely how have the results of the performance of the Personal Dental Service field site programmes been used in the workforce estimates?

What progress has been made to achieving the target of an additional 1,000 whole time equivalent dentists and from which countries are overseas graduates being recruited? Could the Department explain how Poland that has higher disease levels but a similar number of dentists per head of the population has an excess workforce when compared to England and Wales where there is a claimed shortfall?

Given that the overall volume of NHS care has remained almost constant over the past year or so yet the number of dentists who have a contract has increased, the volume of care being provided by each dentist must be diminishing. Could the Department provide an explanation as to why this is happening?

The Department has been active in recruiting from abroad to address the current workforce problems. Could they provide precise details of the total expenditure to date on this programme and the estimated expenditure over the next 10 years?

Of those dentists who have qualified by passing IQE what steps are being taken to ensure that they contribute to improving oral health care by working in the National Health Service as opposed to practising in the non-NHS sector? How many of the dentists who have passed the International Qualifying Examination are now working whole time in the NHS? How many of the dentists who have recently passed the International Qualifying Examination are now studying for specialist qualifications?

To what extent have dentists reduced their reliance on the NHS for incomes over the last 12 months?

3(c) *Service delivery*

Could the Department explain how the changes to the Dental Practice Board will lead to improvements in the quality assurance mechanisms that currently exist within the GDS? With the loss of a fee-per-item arrangement what data will be collected to monitor the performance of the system? The data collected under the existing GDS system provides the opportunity to target unusual practice. Such data has provided the basis for both the Dental Reference Service and the Dental Counter Fraud Squad to target unusual prescribing patterns. How will the proposed changes to the data collection improve on the existing arrangements?

Could the Department explain why the percentage of claims submitted with no active intervention has increased steadily in line with improvements in oral health if dentists are providing unnecessary treatment?

Given the discrepancy in patient charges between the sectors to what extent might these affect referrals? What proposals do the Department have to ensure that referrals to the secondary care sector are appropriate?

With the changes in the patient charging arrangements and the reduction in incentives for the dentist to collect the monies what estimates have the Department made regarding the decline in patient revenues?

The move from the GDS to the Personal Dental Services (PDS) accelerated in March 2004. Could the Department provide an explanation for this? Were any of the schemes offered more favourable financial contractual agreements when compared to those when working under the GDS?

3(d) *Oral health inequalities*

Could the Department provide the definition of oral health that they will be using to assess the impact of the reforms and explain how the proposed reforms will address the existing inequalities?

Does the Department feel that any areas of England and Wales are oversubscribed with dentists? Given the announcement that all dentists will receive the same funding as under the present GDS system for the next three years how will the misdistribution issue be addressed?

What is the volume and level of expertise that exists within PCTs to handle the provision of dental care and what are the total additional costs that the Department estimate will arise following the transfer of the management of dental services to these organisations?

2 December 2004

Supplementary memorandum submitted by the Department of Health

You may be aware of the Written Ministerial Statement (WMS) made by the Secretary of State today, regarding NHS Dentistry Reforms, which announces that full implementation of the reforms has been deferred but will take place by April 2006.

You will recall my answers to questions raised at the Committee of Public Accounts hearing held on 14 December 2004, specifically questions 50, 53, 54, 90 and 91.

Question 50 specifically asked whether the British Dental Association's decision to withdraw from the discussions with Department of Health would mean that the timetable of implementation of the new contractual arrangements for primary care dentistry in England would no longer be met. My reply stated that this event would not result in a delay. As you know, the discussions were not absolutely crucial to the implementation of the timetable.

The reasons for later implementation are outlined in the WMS attached. These include the desire to continue implementing some of the changes currently underway, for example, dentists who want to move to Personal Dental Service status being able to do so as quickly as possible and the National Audit Office's concern that Primary Care Trusts should have sufficient time to acquire the necessary skills and resources before the full commissioning of NHS dentistry.

The WMS also highlights the need for implementation of the recently announced NICE guidance on dental recall intervals, modifications to existing information systems and public consultations about the change to patient charges.

In my reply to question 91, I indicated that Primary Care Trusts would be ready to introduce the new contract in October 2005. I believe they would have been. However, the decision to allow more time for PDS conversion before full implementation does give them even more time to prepare.

The decision to delay was taken in the light of these factors subsequent to the PAC hearing and are unrelated to the British Dental Association's decision to suspend discussions with the Department. However, I thought that it was important to send you this letter and to make the position clear.

Sir Nigel Crisp KCB

Chief Executive

Department of Health and NHS

10 January 2005

Further supplementary memorandum submitted by the Department of Health

I attach the notes promised at the hearing. In addition, Sir Nigel would like to amend the estimated figure of 1,100 he gave to question 159 at the hearing to 960. A total of 80 training places in the UK were lost with the closure of the Edinburgh and University College London dental schools. The schools were run down to complete closure by 1992. In the 12 years from 1993 to 2004, therefore, some 960 additional dentists would have trained but for the closures.

Question 73 (Jon Trickett): Will the NHS find a person, who perhaps owed significant money to a dentist or to the NHS, another dentist without first of all securing the money that they owe?

Under the present patient charge arrangements, dentists are responsible for bad debts if patients fail to pay the correct NHS charges for treatments they receive. Generally, dentists are well practised at minimising the risk of bad debts, for example by requiring patients to pay as they go if their treatment extends over more than one visit. If a dentist is unwilling to treat a particular individual, they also have the ultimate right to refuse to treat that patient.

Whilst the incidence of bad debts can undoubtedly be a nuisance and irritant, the profession have not brought forward evidence to suggest that the scale of loss is a serious financial burden, or that it is large enough to justify maintaining a centralised system to track patients with a record of bad debts. Therefore, a patient who approaches their primary care trust (PCT) or NHS Direct for assistance in finding NHS dental care would not necessarily be identified if they had an outstanding bad debt arising from a previous NHS treatment.

We have given guarantees that where patient charge revenue falls because of the new ways of working (ie not where patients have just simply not paid), practices will not lose out financially. We will expect dental practices to be as rigorous in the new world as they are now in collecting patient charges.

Question 96 (Mr Field): Could you give the breakdown for the four constituencies on the Wirral, because I guessed there might be differences where these new patients were picked up?

Patient registrations (or on practice lists) with general dental service or personal dental service, dentists on 30 September 2004 in the four constituencies within Wirral are as follows:

	<i>Adult registrations/listed</i>	<i>Children's registrations/listed</i>
Birkenhead	36,431	11,368
Wallasey	44,149	15,520
Wirral West	33,121	10,364
Wirral South	35,628	10,427
Total	149,329	47,679

The registrations/listings are with the dentists in these areas. The figures will include some patients who are resident in other areas. Similarly, some patients from these areas will get dental treatment in other areas. Therefore, the figures for small areas should be treated with caution.

The registration period in the general dental service is 15 months. Patients who have not seen a dentist in the past 15 months eg some occasional attenders will not be counted in these figures. In the personal dental service, the registration/listing periods can be different; a longer period increases the numbers because occasional attenders are counted for longer after their last attendance.

The registration/listing rates for the area covered by the four constituencies are 68.8% for children and 61.1% for adults. Separate rates cannot be calculated for the individual constituencies because population figures are not available. However, for adults, using the electoral roll numbers in individual constituencies to estimate adult populations for the individual constituencies gives the following registration/listing rates:

<i>Adult registration/listing rates 30 Sept 2004</i>	
Birkenhead	62.8%
Wallasey	68.3%
Wirral West	53.3%
Wirral South	59.6%

These rates are affected by the particular locations of dentists.

Question 99 (Mr Field): Is not collecting bad debts part of the treadmill you are trying to get dentists off?

The “treadmill” in NHS dentistry usually refers to the Item of Service approach to remuneration, whereby a dentist is paid more for providing more operative dental treatments where these are permitted in the Statement of Dental Remuneration.

Dentists will still be expected to be the initial collection point for NHS charges, because that is the most convenient arrangement for patients. However, by moving away from the “treadmill” of an item of service approach to remuneration for dentists, which in turn has given rise to the nearly 400 different treatment charge rates, it should be possible to introduce a far simpler system of patient charges which will be less onerous and bureaucratic for dentists to administer.

Question 100 (Mr Field): Did you look at whether nursing mothers and young children were the two most deserving groups if we were going to exempt groups en bloc from charges? Are there no more deserving groups like diabetics or others who perhaps ought to be given free treatment?

The issue of NHS patient charge exemption categories is wider than the modernising dentistry programme. Current exemptions from dental charges are based in primary legislation, and were only recently reconfirmed in the Health and Social Care (Community Health and Standards) Act 2003. In his Written Ministerial Statement on NHS dentistry reforms on 10 January 2005, the Secretary of State confirmed that new regulations for dental charging will be published for consultation in the summer of 2005.

Promoting dental health care towards nursing and expectant mothers may still have benefits as preventable oral diseases can, and do start, in children as young as 0–5 years of age.

Question 117 (Mr Steinberg): What is “a short distance” (ie distance between caller and dentist recommended)?

Primary care trusts have developed local distances standards between the location of a caller to a helpline (either local or NHS Direct) and the location of the dentist recommended to them.

For example, the local distance standards for Durham and Chester-le-Street (Mr Steinberg’s PCT) are as follows:

In urban areas, routine care five miles, urgent care 15 miles and emergency care 15 miles. In the case of rural areas, agreed distances are generally greater: routine care 25 miles, urgent care 35 miles and emergency care 35 miles.

Question 139 (Mr Bacon): Can you summarise the position for dentists in the UK as to income and numbers, including information on all the dentists in the UK, let us know how many there are, how many of them work purely in public practices, in the NHS, how many of them work purely in private practice, that is, purely for themselves privately, and how many operate what you call a mixed economy, and what the income levels are for these different types of dentists, showing also regional variations, so a public/private mix, showing also the difference between income for the practice and the actual income for a dentist?

Number of Dentists

The number of NHS dentists in Great Britain can be broken down by dental service as follows:

	<i>Number of dentists (headcount)</i>
General Dental Service (GDS)	20,800 at Sept 2004
Personal Dental Service (PDS)	3,500 of whom 700 also work in the GDS
Community Dental Service (CDS)	1,940 some of whom also work in the PDS
Salaried Dental Service (SDS)	200
Hospital Dental Service(HDS)	2,245

Very few practising dentists do no NHS work at all. The Office for Fair Trading Report reported that only 210 practices out of 11,000 in the UK are wholly private.

Dentists' Income

Self-employed dentists

Dentists working in the General Dental Service (GDS) are largely principal dentists who are qualified to work unsupervised. These dentists are self-employed. They are free to vary the amount of NHS work they do. These dentists receive both capitation payments—monthly payments for each registered patient—and payments for treatment carried out. The fees are a national set of fees and are set out in a Statement of Dental Remuneration. The payments are gross and are intended to cover a dentist's practice expenses as well as their personal income. Dentists in PDS who are self-employed will also be paid using various combinations of capitation, treatment or fixed rate service payments.

Gross fee income of GDS dentists

Average gross GDS fee income of a GDS dentist for GDS work in 2003–04 was £101,000 in England. Gross fee income of a NHS dentist includes both their personal remuneration as well as business expenses such as staff salaries, laboratory charges and dental consumables. The average net GDS income after expenses would be about £45,000.

The income distribution is very wide reflecting the large differences in the amount of GDS work done by individual dentists. Principal GDS dentists do not have a standard working week. They are self-employed and choose the amount of GDS work they do. Most dentists have other income either from private dentistry or from other NHS work.

Gross fee income of dentists with a reasonable commitment to the GDS

Average gross GDS fee income for dentists with a reasonable GDS commitment was about £143,000 in 2003–04. The average excludes dentists with gross fee income of less than £57,300 which excludes dentists doing two days or less each week. Taking into account estimated expenses, average net fee income of a GDS dentist with a reasonable GDS commitment was around £66,700 in 2003–04. This is equivalent to about £69,000 this year, 2004–05.

Earnings split

In 2003–04, dentists' fee income accounted for about 92% of total earnings as follows:

- Child capitation payments—13%;
- Child item of service—13%;
- Adult continuing care payments—7%;
- Adult item of service—59%.

Dentists' other payments make up a further 8%. This includes Continuing Professional Development, commitment payments, seniority payments, training grants, business rates etc.

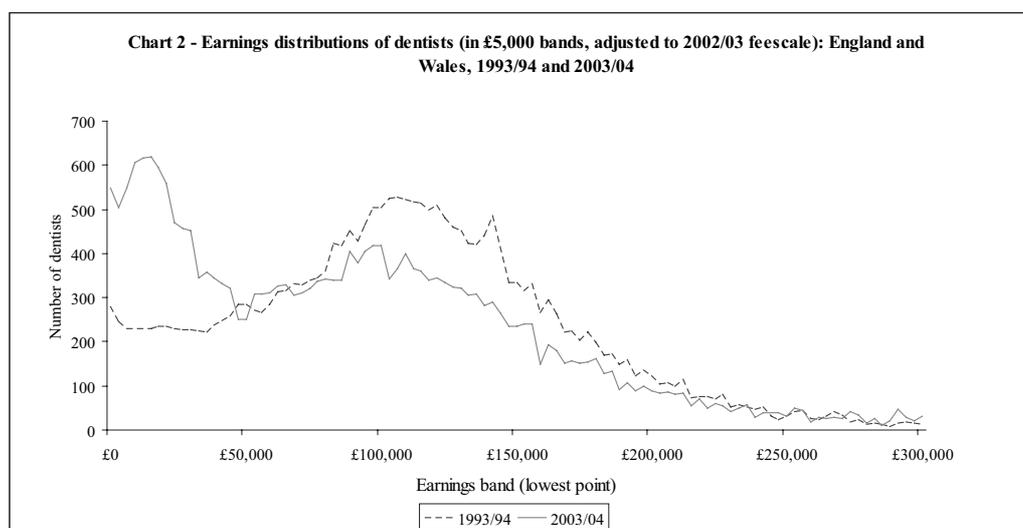
Distribution of gross fee earnings

There is a wide distribution of gross fee earnings, which reflects many variations in the amount of GDS work done. A significant number of dentists now do relatively small amounts of GDS work.

Table 1 below shows the distribution of gross fee earnings in £50,000 bands, 2003–04, this is also illustrated graphically below (figure 1)—

<i>Gross earnings</i>	<i>Men</i>	<i>Women</i>	<i>Total</i>	<i>% of total</i>
Under £50,000	3,255	1,704	4,959	34%
£50,000—£99,999	2,024	1,283	3,307	23%
£100,000—£149,999	2,574	950	3,524	24%
£150,000—£199,999	1,438	240	1,678	12%
£200,000—£249,999	496	65	561	4%
£250,000—£299,999	190	26	216	1%
Over £300,000	208	20	228	2%
Total	10,185	4,288	14,473	100%

Figure 1—Earnings distributions of dentists (in £5,000 bands, adjusted to 2003–04 feescale): England and Wales, 1993–94 and 2003–04



GDS earnings by region

Average gross GDS fee earnings are highest in the Yorkshire region. Figures by region are shown below. The higher figure in Yorkshire will be due to dentists in that region doing more GDS work.

Table 2 below shows the distribution of gross fee earnings by region, 2003–04—

<i>Region:</i>	<i>Number of Principals</i>	<i>Gross Earnings</i>	<i>Average Gross Earnings</i>
Yorkshire	1,206	146,349,525	121,351
South West Thames (excluding London)	1,753	200,668,969	114,472
Northern	1,692	189,156,837	111,795
Wessex	1,422	156,696,885	110,195
South East Thames (excluding London)	1,350	148,111,319	109,712
Wales	806	86,736,573	107,614
Oxford	2,244	219,754,839	97,930
South Western	2,542	217,267,166	85,471
West Midlands	1,458	119,640,692	82,058
Total	14,473	1,484,382,806	102,562

Private and GDS earnings

Information is available from the Inland Revenue for reported schedule D earnings covering both NHS and private work. The information is for average gross income, expenses and net income after expenses. For the tax year 2002–03, the results are available for 3,000 single-handed dentists. Average gross income for these dentists from both NHS and private work was £167,300 for the tax year 2002–03. On average 56.6%

of their income was allowable as expenses. This left £72,550 for average net earnings. The averages cover all dentists whether or not they are working full-time or part-time. An analysis by sex and age group is Table 3 with separate figures for the Thames regions and elsewhere.

Average gross income of £167,300 covering both NHS and private work can be compared to the GDS gross income for these dentists in the financial year 2002–03 of about £97,500. This indicates that GDS income accounts for almost 60% of total income on average.

The average of £72,550 for net income after expenses for both NHS and private work covers all dentists whether they work full-time or part-time. For full-time dentists the average would be higher.

Average net income of £72,550 covering both NHS and private work compares with the assessment of £63,000 for the average GDS income in 2002–03 of a dentist with a reasonable commitment to GDS. Since GDS income is almost 60% of total income on average, this implies that a full-time private dentist will earn an average of over £90,000 a year in order for the overall average for NHS and private work to be £72,550.

Table 3: Gross income, expenses ratio and net income from NHS and private dental work for the tax year 2002–03: Great Britain

			<i>Number in Survey</i>	<i>Gross Pop_n</i>	<i>Average Gross Earnings</i>	<i>Expenses Ratio (%)</i>	<i>Average Net Earnings</i>
<i>Men</i>							
Single-handed	Aged under 35	Thames regions	42	78	£167,765	60.67	£65,990
		Elsewhere	126	237	£175,634	58.66	£72,606
	Aged 35-44	Thames regions	169	276	£207,628	58.20	£86,791
		Elsewhere	559	847	£185,966	56.08	£81,675
	Aged 45-54	Thames regions	208	324	£192,589	60.18	£76,697
		Elsewhere	767	1,041	£167,234	55.56	£74,327
	Aged 55 and over	Thames regions	134	212	£162,605	55.95	£71,625
		Elsewhere	343	464	£145,694	54.48	£66,326
In partnership	All ages	Thames regions	13	28	£189,805	56.43	£82,702
		Elsewhere	158	245	£158,017	52.12	£75,663
All men			2,519	3,752	£173,806	56.37	£75,833
<i>Women</i>							
Single-handed	Aged under 35	Thames regions	14	40	£130,868	64.71	£46,181
		Elsewhere	54	102	£153,834	62.70	£57,377
	Aged 35-44	Thames regions	42	82	£137,818	55.93	£60,742
		Elsewhere	156	258	£156,089	59.79	£62,758
	Aged 45-54	Thames regions	38	64	£137,642	58.65	£56,910
		Elsewhere	104	178	£130,935	55.55	£58,203
	Aged 55 and over	Thames regions	15	24	£117,078	50.05	£58,479
		Elsewhere	37	49	£100,111	55.19	£44,860
In partnership	All ages	Thames regions	8	16	£141,684	51.97	£68,052
		Elsewhere	52	74	£125,997	51.96	£60,535
All women			520	887	£139,706	58.00	£58,675
All dentists			3,039	4,639	£167,286	56.63	£72,552

Salaried dentists

Dentists working in the CDS, SDS and HDS and some dentists in PDS are salaried dentists and are paid on salary scales recommended by the Review Body (Doctor's and Dentist's Review Body DDRB). The Community Dental Officer salary scale payable from the 1 April 2004 ranged from £30,313 to £48,016. The Senior Dental Officer scales ranged from £43,721 to £59,422.

Question 176: The money going to PCTs, will this be ring-fenced to stop the PCTs stealing dentists' money for other things?

Primary care trusts' additional dental allocations will be "floor funded" for the initial three-year transitional period, requiring them to spend at least that amount on primary dental services. Primary care trusts will be free to supplement these allocations with additional funds for dentistry from their devolved resources if they consider this necessary in the light of local needs and priorities.

Question 176 (Chairman): I would like to have a note please on paragraph 2.8, where the National Audit Office notes that "it is still not clear what services dentists will be contracted to provide, what services patients can expect or what charges patients will pay and on when you intend to provide dentists and the public with this information?"

It is proposed to carry forward broadly the same definition of "treatment" as used in the NHS (General Dental Services) Regulations, Regulation 2, except for orthodontic treatment and sedation, which will be subject to separate agreements with the primary care trust. The GDS definition would, therefore, read:

"treatment" means all proper and necessary dental treatment, which a dentist usually undertakes for a patient and which the patient is willing to undergo, including examination, diagnosis, preventive treatment, periodontal treatment, conservative treatment, surgical treatment, the supply and repair of dental appliances, the taking of radiographs, the supply of listed drugs and the issue of prescriptions.

Under a general dental services contract in the new arrangements, practices will have to provide dental treatment that is clinically necessary.

There will be a contractual requirement to submit data to the Dental Practice Board or its successor body for verification of patient charges due and activity carried out under the contract. The Dental Reference Service will also have functions in relation to quality assurance of the new system. Information for contract monitoring by the primary care trust will be reported on a monthly basis.

Ministers are considering Harry Cayton's report. What is clear is that any new system will be simpler to understand and administer and more transparent, and we have given a guarantee that practices will not bear any financial risk from any possible fluctuations in charge revenue.

We can also confirm our intention to publish for consultation the new regulations for local commissioning of primary dental services and dental charging in the summer of 2005.

How confident are you that the proposed expansion in training places is sufficient to meet the longer term projected future need for dentists (ref para 1.43 of the NAO Report)?

We provided additional funding for 170 extra training places for dental undergraduates—a 25% increase which, by 2010, will result in some 850 additional dental students under training. But, because the course takes five years, the first cohort of new dentists will not qualify until summer 2010. As an interim measure, we are recruiting the equivalent of 1,000 more dentists by:

- encouraging dentists taking career breaks to return to work;
- providing incentives for dentists with mixed private and NHS practices to increase their NHS commitment; and
- recruiting overseas dentists.

We are confident the new contract will revitalise NHS dentistry and reverse the drift of dentists into private practice, but later this year we will check the assumptions upon which our expansion of the dental workforce are based.

As patients will be moving from a system of paying for each item of treatment to paying for improved oral health, what is the expected impact on income from charges?

The remit of the patient charge working group was to devise a system that could raise the same proportion of service cost as the current system of patient charges. It is intended to publish the new regulations for local commissioning of primary dental services and dental charging, for consultation, in the summer of 2005.