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Dental Services

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Report, together with formal minutes

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The Health Committee

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, and these can be found in HC 289–III. Written evidence is cited by reference in the form 'Ev' followed by the page number; Ev x for evidence published in HC 289–II, Session 2007–08, on 4 February 2008, and DS x for evidence to be published in HC 289–III.

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Summary

Introduction

The nation's oral health has improved significantly since the establishment of the NHS General Dental Service (GDS) in 1948. As recently as the 1968 the proportion of the adult population in England and Wales who were edentate (toothless) was 37%. The latest figure is estimated to be 6%.

Nevertheless, by the 1990s there was a powerful case for reform of the GDS contract. It was widely agreed that, while in some areas of the country provision of NHS dentistry was good, overall it was patchy. Moreover, the payment system lacked sufficient incentives for the provision of preventive care and advice. In addition, the Department argued that there were too many incentives to provide complex treatment.

In April 2006 the Department reformed the GDS making a number of far-reaching changes: Primary Care Trusts (PCTs) were given the power to commission dental services; the patient charging system was simplified; and under the terms of a new dental contract, dentists were remunerated according to the number of Units of Dental Activity (UDA) completed. The Department issued a number of criteria for success: patient experience; clinical quality; NHS commissioning and improving dentists' working lives. We looked at whether they had been met.

The patients' experience

The Department's original goal that patient access to dental services would improve from April 2006 has not been realised. The Chief Dental Officer admitted this, but claimed that the situation had stabilised and that improvements would soon be realised as a result of new facilities being established. However, the various measures of access all indicate that the situation is deteriorating. The total numbers of dentists working for the NHS and the activity (number of courses of treatment) they have provided for the NHS has fallen, albeit slightly. In addition the total number of patients seen by an NHS dentist between December 2005 and December 2007 has fallen by 900,000 compared with the two years up to March 2006. Although in some places access to dentistry has improved since 2006, it remains uneven across the country. In some areas severe problems remain.

The introduction of the new charging system has simplified the system for patients. However, there are problems. Some courses of treatment such as those involving a single filling have become more expensive. In addition, different patients are charged the same amount for very different treatments which fall within the same charging band. We heard concerns that some low-income patients store up dental problems and delay visiting their dentist, at some cost to their long-term dental health.

Clinical quality

While the Department argued that the new contract would improve preventive care, this was disputed by dentists who claimed that the new contract failed to provide the time and the financial incentive to do so. We recommend the Department undertake research to determine the extent to which preventive advice is being given and its cost-effectiveness.

Some PCTs and the Department have made efforts to provide dental care for those people who visit a dentist infrequently. However, we received no evidence about how many PCTs conduct similar initiatives or about how cost-effective they are. The Department should monitor the impact of outreach initiatives with particular attention to their cost-effectiveness.

The number of complex treatments involving laboratory work fell by 50% during the first year of the contract. The number of root canal treatments has fallen by 45% since 2004. At the same time the number of tooth extractions has increased. The reason for the decline in the number of complex treatments since 2006 has not been explained satisfactorily and we are very concerned that some patients do not receive the quality of care they need within the NHS. There is no evidence for the Department's claim that the decline is to be explained by more appropriate simpler treatments. The Department must publish an explanation for this trend and commission research into the effect of this decline within the NHS system and its impact on oral health.

The Department has acknowledged that changes in 2006 to the way treatments were recorded led to a decline in the quality assurance mechanisms for dentistry. Although the Department responded in April 2008 by introducing an "enhanced data set", it is too early to determine at this stage whether this will prove sufficient to improve both clinical and financial accountability.

PCTs

The Minister admitted that PCT commissioning of dental services has been poor. Many PCTs possess weak in-house commissioning skills and fail to make full use of Specialists and Consultants in Dental Public Health when assessing local dental needs and commissioning services. SHAs, which have responsibility for managing the performance of PCTs, have failed to do this adequately. PCTs with low numbers of dentists committed to the GDS have suffered from the Department's decision to allocate funds to PCTs on an historic basis.

Dentists' working lives

The new remuneration system based on UDAs has proved extremely unpopular with dentists. To make matters worse too many PCTs seem to have set unrealistic activity targets and have applied UDAs too rigidly. It is extraordinary that the Department did not pilot or test the UDA payment system before it was introduced in 2006.

Looking ahead, there are fears that many established dentists will leave the GDS following the end of their income guarantee in 2009, but the Department argues that no such exodus of dentists will occur. We lack the evidence on which to judge the more likely outcome, and recommend that the Department monitor closely the career plans of NHS dentists.

There are also concerns that some overseas dentists are insufficiently familiar with the dental equipment and treatment provided within the NHS. PCTs must ensure that all dentists, irrespective of where they were trained initially, are of the standard necessary to provide high quality dental care.

Improvements to the system

We make a number of recommendations for improving dental services. PCTs should improve their commissioning by drawing on advice from dental public health specialists and SHAs must improve their performance management of PCTs. In addition, The Department must base future PCT dental funding on a local needs assessment, not on an historic basis.

We recommend that patient registration be reinstated because dental care is most effective when delivered over time and as part of a trusting dentist-patient relationship.

In the short term the Department should consider increasing the number of UDA bands so that dentists are rewarded for providing appropriate treatment. In the longer term we recommend that the Department review the UDA system and consider whether it is the best mechanism for delivering oral health care. In addition, the Department should consider the introduction of a QOF-style reward system for dentists who improve the dental health of their patients. It is vital that any changes to the system should be piloted and tested rigorously.

Finally, we welcome the Department's decision to analyse how dental services might develop over the next five years. The analysis should identify the Department's response to the changing nature of dentistry. In particular, it should clarify the level of service which should be provided by the NHS and it will need to address the extent to which NHS dentistry should offer the growing number of treatments which do not address clinical ill-health but are concerned with improving the quality of life.

1 Introduction

1. The way in which NHS dental services are provided and commissioned has recently undergone significant change. Although there have been great improvements in oral health over the last fifty years, the provision of dental services has attracted negative public and media attention for over a decade. The 1990s were marked by increasingly difficult relations between the Department of Health and dentists. Later, reports of long queues of patients hoping to register with a newly established NHS dentist added a vivid, if in many places misleading, image of a system that was under intolerable strain. In 1999, faced with increasing disquiet at the state of NHS dental services, the then Prime Minister, Rt Hon Tony Blair MP, committed the Government to ensuring that, within two years, access to an NHS dentist would be available to any one who wanted it.

2. In July 2000 the Department restated the Government's commitment to improving access to dentistry in the *NHS Plan: A Plan for Investment, A Plan for Reform*.¹ The same year the Department published its strategy to meet this commitment in *Modernising NHS Dentistry: Implementing the NHS Plan*.² In 2002 it published *NHS Dentistry: Options for Change* which contained recommendations for radical changes to the NHS dental service.³ In 2004 some of the proposed changes were piloted by dentists working in Personal Dental Service (PDS) pilots across the country. In April 2006 a new General Dental Service (GDS) contract was introduced. At the same time a new contract for orthodontic services was implemented.

3. The new contracts changed the way in which dental and orthodontic services were commissioned by the NHS and the way they were provided by dental practitioners. The Department faced the challenge of adapting the dentistry system to ensure that patients who required dental treatment from the NHS could obtain it more easily while at the same time retaining a dental profession committed to providing treatment within the NHS. The new arrangements were also intended to take into account a fundamental shift in public dental health needs over recent years from a focus on ensuring that teeth were healthy and pain-free to an increased emphasis on their cosmetic appearance.⁴ In addition, the Department expected that changes to the remuneration system would encourage dentists to switch their treatment patterns from active treatment to a greater emphasis on prevention.⁵

4. The contract introduced in April 2006 made significant changes, notably:

- Primary Care Trusts (PCTs) were given powers to commission services to meet local needs (previously commissioning had been done centrally by the NHS).
- The charging system for patients was simplified.

1 Department of Health, *The NHS Plan: A Plan for Investment, A Plan for Reform*, Cm 4818, July 2000

2 Department of Health, *Modernising NHS Dentistry: Implementing the NHS Plan*, September 2000

3 Department of Health, *NHS Dentistry: Options for Change*, August 2002

4 Ev 1

5 Ev 2

- The system by which dentists were remunerated changed from a fee-per-item of treatment provided to payment in return for an agreed annual level of service provision.

5. The new arrangements, which had been postponed from their original implementation date of October 2005, were received without enthusiasm by the dental profession. Many dentists felt particularly concerned by the terms of the new remuneration arrangements. Concern was also expressed by dentists and patient groups about the ability of PCTs to commission dental services effectively and whether the new arrangements would improve preventive care or access to NHS dental services in areas where they were in short supply.

6. In 2006 we looked briefly at the issue of dental charges as part of our Report, *NHS Charges*. We decided that it was too early, at that stage, to assess the impact the changes to dental charges had had on dental services and we resolved to explore the matter further once the new contract had bedded down.⁶ We recommended that after one year the Department should institute a review to report on the effects of the new contract and we listed parameters to be covered.⁷

7. In August 2007 the Department published an initial evaluation of the new arrangements for dentistry, *NHS Dental Reforms: One year on*.⁸ The report concluded that “This first year of the dental reforms has helped lay much more secure foundations for the future”.

8. In October 2007 we announced an inquiry into dental services. Its terms of reference were:

- The role of PCTs in commissioning dental services;
- Numbers of NHS dentists and the numbers of patients registered with them;
- Numbers of private sector dentists and the numbers of patients registered with them;
- The work of allied professions;
- Patients’ access to NHS dental care;
- The quality of care provided to patients;
- The extent to which dentists are encouraged to provide preventive care and advice;
- Dentists’ workloads and incomes; and
- The recruitment and retention of NHS dental practitioners.⁹

9. Our inquiry follows this Committee’s previous inquiries into NHS dentistry in 1993 and 2001. In 1993 the Committee produced a report, *Dental Services*, which looked at the

6 Health Committee, Third Report of Session 2005–06, *NHS Charges*, HC 815-I

7 Ibid.

8 Department of Health, *NHS Dental Reforms: One year on*, August 2007

9 www.parliament.uk/parliamentary_committees/health_committee/hcpn151007.cfm

funding of NHS dentistry.¹⁰ In 2001 our predecessors' report, *Access to NHS Dentistry*,¹¹ examined the issues affecting patient access and expressed concern that the Department's plans for improving access, as outlined in *Modernising NHS Dentistry: Implementing the NHS Plan*, might not be effective.¹²

10. We received 50 written submissions from consumer groups, patient organisations, practising dentists and orthodontists working in both the NHS and the private sector, dentists' representative organisations, and associated trade bodies. We held four oral evidence sessions during February and March 2008 with, amongst others, a dentists' campaigning group, PCT commissioners of dental services, public dental health experts, the Chair of the British Dental Association (BDA) Executive Board, the Chief Executive Officers of the Dental Practitioners' Association (DPA) and the British Orthodontic Society (BOS), Citizens Advice, the Patients Association and practising dentists. We also held evidence sessions with Mrs Ann Keen MP, Parliamentary Under Secretary of State for Health Services, and the Chief Dental Officer for England, Dr Barry Cockcroft.

11. Our report first examines the system which was in place for delivering dental services from the establishment of the NHS in 1948 to the introduction of the new contract in 2006. In the following chapter we look at how well the new system has operated over the last two years. We examine the four main "success criteria" by which the Department claimed its policies should be judged. We then consider the issues dental services might face in the near future before concluding with recommendations for improvement.

12. We would like to thank all those who submitted written evidence to this inquiry. We are grateful to our specialist advisers, Professor Kenneth Eaton and Dr Paul Batchelor, who provided us with expert advice throughout the inquiry.

10 Health Committee, Fourth Report of Session 1992–93, *Dental Services*, HC 264–I

11 Health Committee, First Report of Session 2000–01, *Access to NHS Dentistry*, HC 247

12 Department of Health, *Modernising NHS Dentistry: Implementing the NHS Plan*, September 2000

2 General Dental Services 1948–2006

The pre-2006 system

13. NHS dentistry was founded in 1948 with the establishment of the General Dental Service (GDS). The GDS provided patients with “dental care via general dental practitioners (GDPs) who mainly worked as independent contractors from high street and local surgeries”.¹³

14. In 1993 our predecessors described the history of the management of the GDS since 1948 as one of “supervised neglect”.¹⁴ In effect the way that services were delivered through the GDS had remained largely unaltered for nearly sixty years.¹⁵ Until 2006 those dentists and orthodontists who chose to work within the GDS did so as independent practitioners and were able to choose where they established their practice and which services they provided to patients.¹⁶ Many dentists operated in what the British Dental Association (BDA) described as “a mixed economy” providing both NHS dentistry and private treatment according to the level of demand in their locality. Secondary dental care, usually for particularly complex cases, was provided in hospitals by dental specialists.

15. Another important element of NHS dentistry was the Community Dental Service (CDS). The CDS comprised approximately 1,000 dentists who were employed by local health authorities and received an annual salary. CDS dentists provided a service for particular categories of patient: for example, those with an extreme phobia of dentists and those with special needs.¹⁷

16. The Dental Practice Board (DPB) provided probity and quality assurance to the system.¹⁸ One of its roles was to detect poor or unnecessary treatment given to patients. Dentists recorded the treatment given to patients and the DPB examined a sample of patients to ensure that the work claimed for by dentists had in fact been carried out.¹⁹

17. In 2005–06 the NHS spent £1.78 billion on NHS dental services.²⁰ In 2005–06, a dental practice owner on average received an annual income, net of costs, of £114,000.²¹ Dentists who used the facilities within another dentist’s practice received an average annual income

13 Department of Health, Departmental Report 2007, Cm 7093, May 2007

14 HC (1992–93) 264

15 Ev 2

16 Orthodontics is the branch of dentistry concerned with growth of the face, development of the teeth and bite, also of the prevention and correction of problems with the teeth and bite.

17 DS 45

18 In 2006 the DPB was dissolved and its functions merged into the Business Services Authority.

19 DS 37

20 NHS Information Centre for Health and Social Care, NHS Expenditure for General Dental Services and Personal Dental Services England, 1997/98 to 2005/06. The figure given is net of patient charges.

21 Most dentists worked in both the GDS and private sectors. Therefore the proportion of income earned through the GDS differed in each case.

of £61,000.²² According to the BDA, in 2005–06 an “average dentist” earned 41.9% of their income from the GDS with the remainder from private practice.²³

Changes to the system, 1948–2006

18. Since the establishment of an NHS dental service in 1948 there have been three major developments:

- the introduction of patient charges in 1951;
- a revised dental contract between the Department of Health and dentists in 1990; and
- the new GDS contract between dentists and Primary Care Trusts in 2006.

19. NHS dental charges were introduced in 1951 for adult patients, with exemptions for those in receipt of income support or who were pregnant or nursing mothers. Charges were made according to an itemised list of treatments which, by 2006, had mushroomed to over 400 items ranging from a simple check-up to more complex root canal treatment and crown work.²⁴

20. The next significant change occurred in 1990 when the Department introduced registration for adult patients. Capitation payments for treating children up to the age of 16 were also introduced. The declared intention of the new arrangements was to place greater emphasis on continuing dental care. However, following the changes, in 1991–92 the Department had overspent its dental budget by £190 million.²⁵

21. In 1992–93, in an attempt to bring the expenditure on dental services under control, the Department reduced the amount paid for each item of treatment by 7%.²⁶ This action resulted in great discontent amongst the dental profession and in 2001 our predecessors concluded that since the 1992–93 dispute there had been “a defined haemorrhage of dentists away from the NHS”.²⁷

Oral health of the nation

22. During our inquiry it was universally accepted by our witnesses that there had been a radical improvement in the overall state of the nation’s dental health since 1948. In the immediate post-war period large numbers of the adult population were literally toothless (edentate), as a result of a wide range of factors. In 1968 37% of the adult population of England and Wales had no natural teeth.²⁸ By 1998 the figure had fallen further to 13%.²⁹

22 Review Body on Doctors’ and Dentists’ Remuneration, Cm 7327, April 2008

23 Ev 55

24 Ev 2

25 Our predecessors concluded in their 2001 report that “Dentists feared the net effect of the reforms would be to depress their incomes. To protect their incomes they worked harder (by a factor of 8.5%) increasing the payments due to them and leading to an overspend in 1991–92 of £190 million”. HC (2000–01) 247-I

26 HC (2000–01) 247-I

27 Ibid.

28 http://www.statistics.gov.uk/downloads/theme_health/AdltDentHlth98_v3.pdf

The Department estimates that today 6% of the population are edentate.³⁰ The improvements in oral health are due to a combination of developments, including fluoridation (of toothpaste and, in some areas, the water supply).

23. Within this overall positive picture, there are generational differences in oral health. Dental practitioners sometimes refer to ‘the heavy metal generation’, that is people aged over 45 who did not benefit from fluoridated toothpaste or water supplies when they were children. This cohort has, unlike previous generations, maintained their teeth but frequently has had large fillings (which from time to time require replacements involving more complex treatment). In comparison, people aged under 45 generally have better dental health. The implication for dental services of this generational difference is discussed in more detail in chapter 3 of this report.

24. For children, the figures for oral health have shown similar improvement since 1948. During our inquiry, citing statistics on comparative oral disease collated by the World Health Organisation (WHO), Dr Barry Cockcroft, Chief Dental Officer (CDO), told us that the oral health of English children was comparable with the best in the world.³¹ Although this was disputed, there has undoubtedly been a significant improvement.³² Decay rates have fallen in all social groups albeit significant disparities remain between socio-economic groups and between regions of the country (between for example, Birmingham which has relatively good oral health and Manchester where oral health is worse).³³

25. While oral health has generally improved, demand for dental services has not diminished. The Department explained that there had been a change in demand as “patients’ focus has moved from simply ensuring their teeth are healthy and pain-free to an ever-stronger desire that they should also be cosmetically pleasing”.³⁴

26. Moreover, problems of gaining access to GDS dentistry grew during the 1990s in some parts of the country and discontent increased about how dentists were remunerated for the treatment they provided under the GDS. Faced with these problems the Department began to consider how best to improve the system.

The case for change

27. During the 1990s the Department argued that the GDS no longer met the oral health needs of the population and required substantial reform. A series of publications beginning with *Modernising NHS Dentistry* in September 2000 made the case that the most pressing concerns facing the GDS were to improve:

- access to NHS dentistry;

29 Ev 1

30 Ev 1

31 Q 137

32 Q 61

33 Ev 33

34 Ev 1

- the quality of dental care; and
- the information that dentists give patients about the cost of treatment.³⁵

28. In 2001 the Health Committee examined the Department's analysis of the problems facing dentistry and its proposals for addressing them. In *Access to NHS dentistry*, published March of that year, our predecessors described patient access to NHS dental services as inequitable and noted that the situation was deteriorating further as dentists left the NHS and developed their business in the private sector. Our predecessors also argued that the Department's proposals contained in *Modernising NHS Dentistry* lacked sufficient weight to deal with the changed situation facing dental services.³⁶

29. In 2002, a further report by the Department, *NHS Dentistry: Options for Change*, provided more analysis of the problems faced by NHS dentistry.³⁷ The key problems it identified were:

- As before, access to services: significant problems of patient access to NHS dentistry existed in areas of England as a result of “dentists drifting away from the NHS”.
- Remuneration for dentists: dentists were paid on a fee per item basis. The Department argued that this payment system created incentives for invasive and complex treatments and little scope for preventive work. In addition it contributed to a “drill and fill” treadmill which was dispiriting for dentists. This resulted in a situation where, according to the Department, “the more treatment delivered and the more complex that treatment was, the more the dentist earned”.³⁸
- Patient charges: there were over 400 patient charges for different treatments and this caused confusion for patients. The Department also argued that some patients were uncertain about whether certain types of cosmetic treatment were available through the GDS.

30. In addition, the CDO told us that the payment system provided incentives for some dentists to “over treat” patients, in other words to provide unnecessary treatment. Although he accepted that the vast majority of dentists only treated patients according to clinical need, he argued that,

Anything that incentivises intervention where it may not be necessary, where you can treat these things with a fluoride varnish or something like that, is a better way to go. The old system did create an incentive.³⁹

31. Many of our witnesses, including the British Dental Association (BDA) and the Dental Practitioners' Association (DPA), and others who were highly critical of the new contract, accepted that the dental system had needed reform. Mr John Renshaw of Challenge told us,

35 Department of Health, *Modernising NHS Dentistry*, September 2000

36 HC (2000–01) 247-1

37 Department of Health, *NHS Dentistry: Options for Change*, August 2002

38 Ev 1

39 Q 230

“I do not think anybody would ever claim that the old system was perfect”.⁴⁰ Ms Susie Sanderson, Chair of the Executive Board, BDA, told us

The BDA worked with the Department of Health and signed up very enthusiastically to the aims of Options for Change which looked at the local needs for dental care, explored different ways of remunerating dentists to deliver the provision of care and also made sure that the quality of care was robust...We thought they were very fine aims.⁴¹

Conclusions

32. Since the establishment of the General Dental Service in 1948, there have been many improvements. The nation’s oral health has improved significantly: in the 1940s a large proportion of the population were edentate; by 1968, 37% of the population had no natural teeth; the estimated figure in 2007 was only 6%. Increasingly the focus of dentistry has switched from pain relief to the provision of preventive care and cosmetic treatment.

33. Nevertheless, by the 1990s there was a powerful case for reform of the General Dental Service contract. It was widely agreed that, while in some areas of the country provision of NHS dentistry was good, overall it was patchy. Moreover, the payment system lacked sufficient incentives for the provision of preventive care and advice. In addition, the Department argued that there were too many incentives to provide complex treatment.

40 Q 3

41 Q 367

3 The new dental contract and other arrangements: are they working?

The key aspects of the new system

34. The new arrangements made three key changes to the dental system. From April 2006:

- PCTs were given the power to commission dental services to meet local needs.
- The patient charging system was simplified from more than 400 possible charges into three charging bands.
- Dentists were remunerated according to Units of Dental Activity (UDA) completed.⁴²

Commissioning by PCTs

35. In essence, the changes involved a switch from the General Dental Services (GDS) contract, under which dentists were paid by the NHS for the work they had done, to a system whereby Primary Care Trusts commissioned dental practitioners to provide an agreed level of activity. This brought dentistry in line with other NHS services. The Department argued that PCTs were best placed to tailor dental services according to local needs.⁴³

Charging system

36. In place of the more than 400 possible charges, the Department introduced a three-tier payment structure covering treatments ranging from check-ups and fillings to more extensive and complex work such as crowns and dentures. The Department argued that that reform of the fee per item charging system would benefit patients by removing confusion about what they could expect to pay for their treatment.⁴⁴ It was also argued that reform would bring greater clarity for patients regarding which treatment was available under the NHS and which treatment was provided under private arrangements.

Remuneration of dentists

37. The new contract replaced the old fee per item payment system with a remuneration system which provided dentists with an annual income in return for an agreed amount of dental treatment measured in Units of Dental Activity (UDAs).⁴⁵ The Department argued

42 Department of Health, NHS Dental Reforms: One year on, August 2007

43 Ibid

44 Ev 2

45 Ibid

that the UDA system gave dentists an incentive to switch the focus of their treatment from active treatment of patients to prevention.⁴⁶

Success criteria

38. In March 2006, the Department announced the establishment of an Implementation Review Group, “comprising representatives of patients, dentists, NHS organisations and dental laboratories, to review the impact of the reforms”.⁴⁷ The Group identified four success criteria for the new system.⁴⁸ The new contract should deliver improvements to:

- patient experience;
- clinical quality;
- NHS commissioning capacity and capability; and
- improving the working lives of dentists.⁴⁹

These criteria provide the basis for our assessment of the effectiveness of the new contract later in this chapter. First, however, we look at how the contract was implemented.

Implementation

39. Mr John Renshaw representing Challenge told us,

Nobody would argue that the old system was not creaking but the danger was in going for a completely new system that was untried and untested and that is our problem. It is not that the new system was introduced but that it was introduced without bothering to find out whether or not it was going to work.⁵⁰

40. The Department began testing various proposals for inclusion in a new dental contract in 1998 through the establishment of Personal Dental Service (PDS) pilots. In 2003 the Department’s NHS Modernisation Agency established “a programme of Options for Change ‘field sites’, which built on the PDS pilots, testing new remuneration systems and new ways of working to improve the quality of care received by patients”.⁵¹

41. By September 2004 approximately 2,500 dentists in 1,000 locations were working in this way.⁵² Many of the PDS pilots tested salaried or capitation remuneration systems as an alternative to the old fee-per-item system. While the National Audit Office concluded that the PDS pilots produced some benefits, the Department was concerned about cost

46 Ev 2

47 Department of Health, *NHS Dental Reforms: One year on*, August 2007

48 In October 2007, the review group reformed as the Key Stakeholder Group (KSG). According to the Department “The KSG meets quarterly and provides a forum for stakeholders to identify and discuss and advise on key issues arising from the provision of NHS primary care dental services from the patient, commissioner and provider perspective.”

49 Department of Health, *NHS Dental Reforms: One year on*, August 2007

50 Q 108

51 National Audit Office, *Reforming NHS Dentistry: Ensuring Effective Management Of Risks*, HC 25, November 2004

52 Ibid

control.⁵³ In particular, it concluded that schemes which guaranteed dentists an income without requiring them to provide a set level of treatment in return would not provide value for money. Mr David Lye, Head of Dentistry and Eye Care Services, Department of Health, told us,

One of the things we learnt from PDS is that, if you have a system whereby you guarantee the amount of money up front but the Primary Care Trust then does not agree a suitable monitoring mechanism, there is a danger that you do not get good value for money.⁵⁴

42. The Chief Dental Officer told us that the PDS pilots had proved the need for “a clear, identifiable currency” to measure treatment.⁵⁵ He added that after some consideration,

We came up with weighted courses of treatment over about six months of discussions with the BDA in 2004. We had a little working group—which I was not on—with three people from the Department and three people from the BDA so the monitoring currency was based on weighted courses of treatment. There was never any grief expressed around that at the time.⁵⁶

43. The BDA confirmed that it had taken part in the working group referred to by the CDO, but argued that it had not formally endorsed the concept of weighted courses of treatment.⁵⁷ In late 2004 the BDA suspended negotiations with the Department for nine months. In August 2005 the Department announced that UDAs would be the identifiable unit of currency for the new contract; the BDA claimed that it had not been “involved in, or consulted on, that development”.⁵⁸

44. It is unclear what consultations took place about UDAs before the Department’s announcement. They were certainly not tested in a PDS pilot.⁵⁹ According to Challenge, UDAs were introduced without prior consultation with dentists or explanation of how they had been derived.⁶⁰ Mrs Margaret Naylor, an NHS dental practice owner in Rotherham and Sheffield, who had been involved in PDS pilots, told us that she was unclear about how UDAs had been derived.⁶¹ Mr Derek Watson, Chief Executive of the DPA, told us about the confusion felt among the dental profession at the introduction of UDAs:

53 The NAO concluded in its 2004 report that “Where piece work remuneration systems are replaced, activity levels fall with no impact on oral health”.

54 Q 198

55 Q 755

56 Q 755

57 DS 19A

58 Ibid

59 Ibid

60 Q 8

61 Q 551

People felt very strongly that the system which was eventually introduced was not one of the pilots. It may have been based on some wisdom which was gleaned collectively from the pilots but the system actually was not piloted.⁶²

45. The original intention had been to introduce the new arrangements in October 2005 but the Department decided to delay implementation for six months to give Primary Care Trusts more time to negotiate contracts with dentists, a significant number of whom were reluctant to sign-up to the terms on offer.⁶³ By April 2006 11% of dentists had rejected the contract they had been offered by their PCT (equating to 4% of GDS dental provision) and 35% of dentists had signed their contracts while in dispute with their PCT.⁶⁴ By June 2007, 13% of contracts signed in dispute a year earlier had still not been finalised.⁶⁵

Are the new arrangements working?

46. Two years since the introduction of the new arrangements, opinion is divided on whether they are working. On the one hand, aspects of the new contract have continued to be widely and strongly criticised by dentists and patient groups alike. For example, Challenge, a campaign group representing dentists who oppose the contract, acknowledged that the reform of NHS dental services had been needed, but added that the reforms had been introduced in a “seriously flawed” manner and that one imperfect system had been replaced with another very imperfect system.⁶⁶ The British Dental Association stated that the reforms had “failed to meet the Government's own success criteria”.⁶⁷ The Dental Practitioners’ Association described the contract as characterised by “inefficiency, inflexibility and unfairness”.⁶⁸

47. On the other hand, some aspects of the new contract, particularly the emphasis on local commissioning of dental services and the simplification of patient charges, were welcomed by several witnesses.⁶⁹ In addition, the Department told us that “Many challenges remain but the first eighteen months have demonstrated beyond doubt that the new system is workable and working”.⁷⁰

48. We now examine the impact of the new arrangements according to the Department’s own criteria for success.⁷¹ We begin by looking at how patients’ experience has been affected since April 2006.

62 Q 568

63 <http://news.bbc.co.uk/1/hi/health/4648507.stm>

64 Review Body on Doctors’ and Dentists’ Remuneration, Thirty Seventh Report 2008, Cm 7327, April 2008

65 Ibid

66 Q 109

67 Ev 50

68 Ev 75

69 For example, Ev 21, Ev 85,

70 Ev 2

71 See para 38

The patient experience

Is patient access improving?

49. The Department described access as “the single most difficult and high-profile issue for NHS dental services for the last 15 years”.⁷² Throughout the 1990s and the early 2000s various measures showed that patients were experiencing increasing difficulty in accessing NHS dental treatment.⁷³ A particularly striking representation of access problems appeared in 2004 when television images showed patients queuing in Scarborough in the hope of gaining access to a newly opened NHS dental practice.⁷⁴

50. The Department initially stated that the key test of its reforms would “be their ability to support improved patient access”.⁷⁵ Many witnesses claimed that access problems remained severe. Basing its findings on a survey of 2,000 people, one year after the new arrangements were implemented, Citizens Advice estimated that there were up to 7.4 million people who had wanted to be treated by an NHS dentist but had been unable to do so because they could not find one.⁷⁶ Of this figure, Citizens Advice claimed that 2.7 million people had gone without treatment altogether (the remaining 4.7 million had received private treatment).⁷⁷

51. In October 2007 there were lurid accounts of patients claiming they had been forced to take the drastic action of self-treatment, because of a lack of an available NHS dentist.⁷⁸ A survey of PCTs by the Patients Association in March 2008 reported continued problems of access to dentistry and orthodontic services and a high volume “of calls to its helpline from patients unable to find a dentist”.⁷⁹

52. During our inquiry the Department’s emphasis changed. Rather than improving access, the CDO claimed that the reforms introduced in April 2006 had not made things worse, “Access has been broadly stable across the transitional period at national level”.⁸⁰ The CDO argued however that “we are not going to change access in one month, we are going to improve it gradually over a period of a year or two or three”.⁸¹ He added that it would take time for PCTs to commission new services but argued that he was opening new dental services every month.⁸²

72 NHS Dental Reforms: One year on, Department of Health, August 2007

73 Ibid

74 www.guardian.co.uk/society/2004/feb/18/health.medicineandhealth

75 NHS Dental Reforms: One year on, Department of Health, August 2007

76 Q 668

77 Q 668

78 <http://news.bbc.co.uk/1/hi/health/7045143.stm>

79 The Patients Association, *The New Dental Contract-full of holes and causing pain?* March 2008

80 Ev 2

81 Q 149

82 Q 711

53. Before we can consider what has happened to access since 2006, we must decide what is meant by the term. Ms Susie Sanderson, Chair, BDA Executive Board, described to us the problem of arriving at an agreed definition of patient access:

Is it the number of times somebody goes to the dentist? Is it the amount of care the patient needs to make sure his or her oral health is corrected?...there is no definition of access and measuring that on an ongoing basis is flawed.⁸³

54. The argument that access should be considered as “the amount of care the patient needs to make sure his or her oral health is corrected” is appealing. Unfortunately, it is not measured. Instead, we need to look at what is measured to get some idea, however unsatisfactorily, of whether access is improving. The measures we do have are: the numbers of dentists and the activity they provide under the GDS; the numbers of patients seen by them; and, less systematically, accounts of difficulties in accessing dentists; a few PCTs keep waiting lists.

Numbers of dentists and orthodontists and activity levels

55. Table One shows the number of dentists providing NHS services between 1996 and 2007 and the scale of their commitment, as measured by the number of treatments they provided under the GDS.⁸⁴

Table One

	1996–97	2002–03	2003–04	2004–05	2005–06	2006–07
Number of general dental practitioners ⁸⁵	16,470	18,801	19,026	19,797	21,111	21,041
Adult courses of treatment (thousands) ⁸⁶	24,580	26,726	27,031	26,488	25,844	25,121 ⁸⁷

Source: Department of Health Departmental Report 2008

The table shows that there was a steady rise in the number of dentists providing dental care between 1996–97 and 2005–06, but a small fall in 2006–07, the year the contract was introduced.⁸⁸

56. However, both the Department and the BDA recognise that the number of dentists providing dental services is a less valuable indicator than the amount of treatment they

83 Q 374

84 Department of Health, Departmental Report 2008, Cm 7393

85 Total includes dentists working within Personal Dental Service (PDS) pilot schemes.

86 Data on courses of treatment until 2005–06 represent completed treatment claims processed by the Dental Practice Board within the relevant year. For 2006–07, the figures are for courses of treatment conducted within the year.

87 Because of the changes in measuring activity and reporting introduced in 2006 it is no longer possible to determine what constitutes a ‘course of treatment’.

88 Department of Health, Departmental Report 2008, May 2008, Cm 7393

provide patients through the NHS.⁸⁹ Following a steady rise in the number of courses of treatment delivered between 1996–97 and 2004–05, the number of treatments began to fall from 2004–05. In 2006–07, the first year of the contract, the number of treatments declined by a further 700,000 courses of treatment compared with the previous year.

57. Many of our witnesses, including Challenge, the BDA and the Dental Practitioners' Association, were concerned by the decline since 2006 in both numbers of dentists and the courses of treatment they provided for the GDS. These organisations considered the data as evidence that the dental contact was failing to improve patient access.⁹⁰

58. In contrast, the Department argued that the fall in the number of dentists in 2006 was due to the 11% of dentists who had decided not to sign-up to the new contract. It provided two lines of argument to explain the decline in activity. First it noted that the activity the dentists who had not signed up provided represented only 4% of total NHS dental activity and that this had been replaced within six months of the implementation of the contract.⁹¹ Secondly, it argued that the decline in the number of courses of treatment was “in line with aims of the reforms, which aspired to fewer interventions, freeing up more time for a preventive approach”.⁹²

Private dentistry

59. While the number of NHS dentists and their activity levels have fallen since 2005–06,⁹³ private sector dentistry appears to have grown. Although there is a lack of reliable data about the number of dentists working in the private sector and the amount of work they do, Denplan, the largest private provider of dental care with 1.9 million patients registered, estimated that the private dental market was worth up to £3 billion and that it contributed between 40% and 50% by volume and between 50% and 60% by value of the total dental market.⁹⁴ The BDA estimates that the value of the private dentistry market is now at least equal to that of NHS provision.⁹⁵

60. The BDA also argued that the number of patients seeking dental treatment under private arrangements had continued to expand in recent years.⁹⁶ The BDA told us that the number of patients Denplan treated had increased by more than one third in the last three years.⁹⁷ Denplan also argued that an increasing number of dentists are deciding to work wholly either in the NHS or private sector, rather than in the “mixed NHS and private model”.⁹⁸

89 Ev 5, Ev 76

90 Q 29, Ev 77

91 Ev 6

92 Ev 65

93 See Table 1 (although both measures show an increase compared with 1996–97)

94 Ev 66

95 Ev 66

96 Ev 50

97 According to the BDA, Denplan currently has 1.9 million registered patients, compared with 1.3 million patients three years ago.

98 Ev 66

Numbers of patients seen

61. Another measure of access is the number of patients seen. Between 1990 and 2006 dentistry differed significantly from general medical practice in that individuals who wished to ensure continued access to dental care had to be registered with an NHS dentist and, as a condition of registration, were obliged to attend for regular check-ups whether or not they had any clinical need to do so.⁹⁹

Patient Registrations

62. Table Two contains information for the period 1997–2006 when the registration requirement was ended.¹⁰⁰ It shows that between 1997 and 1999 there was a fall of 2.5 million adult patients registering with an NHS dentist. This was followed by a period of stability between 1999 and 2005 with a slight increase in 2006 to 17.7 million. During this time child registrations remained relatively at around 7 million.

Table Two

Year ending	Millions of patients registered		
	Adults	Children	All
1997	19.8	6.6	26.4
1998	18.8	6.9	25.6
1999	17.3	7.0	24.3
2000	17.3	7.0	24.3
2001	17.3	7.0	24.3
2002	17.3	7.0	24.3
2003	17.0	6.8	23.8
2004	17.4	7.0	24.4
2005	17.2	6.9	24.1
2006	17.7	7.0	24.8

Source: NHS Information Centre for Health and Social Care

Patients seen by an NHS dentist

63. Until 2006 the Department's chosen method of determining usage of dental services was the number of patients seen by a dentist in a 12 month period. Table Three shows the percentage of adult and child patients who attended an NHS dentist in England as a proportion of the population, in the previous year, between 1997–2006.¹⁰¹

99 HC (2000–01) 247-I

100 NHS Information Centre for Health and Social Care, NHS Dental Activity and Workforce Report—England: 31 March 2006

101 Ibid

Table Three

Year ending	Percentage		
	Adults who attended an NHS dentist over a 12 month period prior to 31 March of that year	Children who attended an NHS dentist over a 12 month period	All who attended an NHS dentist over a 12 month period
1997	52.9	59.0	54.3
1998	49.8	61.2	52.4
1999	45.6	62.4	49.5
2000	45.3	62.9	49.3
2001	45.1	62.8	49.1
2002	44.9	62.8	48.9
2003	44.0	61.7	47.9
2004	44.5	62.9	48.6
2005	44.2	62.3	48.2
2006	45.3	63.7	49.3

Source: NHS Information Centre for Health and Social Care

64. According to the CDO, the proportion of adult patients seen by an NHS dentist has never exceeded 60% of the adult population within any 12 month period.¹⁰² In 1997 only 53% of the adult population had seen a dentist working within the NHS at least once during the previous year. By 2000, the total had fallen to 45.3% of the population, the same percentage recorded in 2006. The percentage for children who visited a dentist was higher. In 2006, 63.7% of children were registered with a dentist an increase of 4.7% since 1997.¹⁰³

65. From 2006 the Department changed the period it used to record the number of patients who visited a dentist from 12 to 24 months. The Department justified the change on the basis that it brought it in line with guidance from the National Institute for Health and Clinical Excellence (NICE) which stated that 24 months was the longest period that a patient should go without seeing a dentist.¹⁰⁴ Table Four shows the number of adult and child patients seen in England in the previous 24 months by an NHS dentist since March 2006.¹⁰⁵

102 Q 805

103 Information Centre for Health and Social Care, NHS 2004 Dental Activity and Workforce Report—England, March 2006

104 Department of Health, *NHS Dental Reforms: One year on*, August 2007

105 Information Centre for Health and Social Care, NHS Dental Activity and Workforce Report—England, March 2008

Table Four

Table Four shows the number of adult and child patients seen in England in the previous 24 months.¹⁰⁶

24 months previous as at:	Millions seen in the previous 24 months		
	Adults	Children	All
March 2006	20.35	7.80	28.15
March 2007	20.29	7.81	28.10
June 2007	20.10	7.78	27.88
September 2007	19.90	7.80	27.70
December 2007	19.60	7.65	27.30

Source: NHS Information Centre for Health and Social Care¹⁰⁷

Table Five below shows the number of adult and child patients seen in England in the previous 24 months, as a percentage of the population.¹⁰⁸

Table Five

24 months previous as at:	per cent seen in the previous 24 months		
	Adults	Children	All
March 2006	51.6	70.7	55.8
March 2007	51.0	71.0	55.4
June 2007	50.5	70.7	54.9
September 2007	50.0	70.3	54.4
December 2007	49.3	69.6	53.7

Source: NHS Information Centre for Health and Social Care

66. The tables above, show that the number of patients seen by an NHS dentist fell by 2.3% or approximately 900,000 patients between the introduction of the new contract in April 2006 and December 2007. In total 27.3 million people saw an NHS dentist in the two years to December 2007. This compares with 28.1 million patients in the two years to April 2006. The figures probably under-estimate the decline in the numbers of patients seen since the contract was introduced because, as noted above, in 2006 the Department changed the time period in which data was recorded. Several witnesses, including the BDA, told us that the change from 12 to 24 months meant that some patients who had visited a dentist before the contract was introduced in April 2006 had been included in the data.¹⁰⁹

67. The Department argued that the data did not reflect the improvements which had been made since April 2006 and identified a number of actions PCTs had taken to improve

106 NHS Information Centre for Health and Social Care, *NHS Dental Statistics for England, Quarter 3, 31 December 2007*

107 Ibid

108 Ibid

109 Ev 53

access to dental services.¹¹⁰ These included the opening of new dental practices in PCTs, such as in Penzance, Cornwall, where a practice was opened “to accommodate 7,500 patients from the area”.¹¹¹ The Department also noted that some PCTs such as Bristol PCT, had commissioned greater out of hours dental provision and that domiciliary services for older people had been commissioned in West Sussex PCT and Ashton and Wigan PCT.

68. In June 2008, after we had finished taking evidence, data covering the third quarter of 2007–08 were published which showed a further fall of approximately 300,000 adult patients seen since September 2007. The CDO maintained that “The...figures do not reflect the new services that are opening all the time. Rather, the figures are retrospective and include the temporary decrease in access which occurred following the transition to the new system in 2006”.¹¹²

Dental deserts

69. Within the national picture, the ease with which a patient is able to see a dentist varies considerably across the country. Since the 1990s statistics provided by the Information Centre and surveys carried out by organisations including Citizens Advice have consistently revealed the existence of what the BDA described as “dental deserts” in particular areas of the country.¹¹³ In rural Devon less than 30% of the adult population visited a GDS dentist in a 12 month period.¹¹⁴ In areas of Surrey and West Kent, only 44% of the adult population visited a GDS dentist.¹¹⁵

70. Commissioners of dental services from Devon, Hillingdon and Sandwell PCTs informed us that it was too early to tell whether the 2006 reforms had improved access in their areas since 2006, but they insisted that the early indications were positive.¹¹⁶ Mr Andrew Harris told us that prior to 2006 in some areas of Devon PCT only 27% of the population used NHS dental services.¹¹⁷ Despite commissioning new services since 2006 and treating an additional 9,000 patients in the first year of the contract, Devon PCT still had a 7,000 strong waiting list for dental services.¹¹⁸ Ms Karen Elley, told us that Sandwell PCT had started from a position of a relatively high level of access with 72% of the population using NHS dental services and that she was confident that this percentage would increase further.¹¹⁹

110 DS 01B

111 DS 01B

112 <http://www.timesonline.co.uk/tol/news/uk/health/article4073515.ece>. The Department later confirmed that this was the CDO's view

113 Q 670

114 Ev 42

115 Ev 70

116 Q 309

117 Q 310

118 Q 312

119 Q 305

71. The CDO concluded that,

The current situation is positive, it is growing but it is probably not growing as fast as we would like it to do in some areas.¹²⁰

72. Others disagreed. Challenge informed us:

If you live in Bradford or Teesside you will probably find access fairly easy. If you live in Epsom or Winchester you will not be so fortunate...In some areas, like Birmingham, where access was never a problem under the old system, there have been signs of an access problem for the first time.¹²¹

73. Citizens Advice also found evidence of regional differences in access. Their survey, undertaken in 2007, found that in the South West, 53% of people who had not visited a NHS dentist since April 2006 gave the reason that they had been unable to locate an NHS dentist in their area.¹²² In the North West the figure was 39%. In contrast, only 19% of respondents in Greater London and 21% in the West Midlands reported experiencing difficulties in finding an NHS dentist.¹²³

74. The Department's original goal that patient access to dental services would improve from April 2006 has not been realised. The CDO claims that the situation has stabilised and that improvements will soon be seen as a result of new facilities which have been established. However, the various measures of access available all indicate that the situation is deteriorating. The total numbers of dentists working for the NHS and the activity (number of courses of treatment) they have provided for the NHS has fallen, albeit slightly. In addition the total number of patients seen by an NHS dentist between December 2005 and December 2007 has fallen by 900,000 compared with the two years up to March 2006. This figure possibly underestimates the decline because the data still include patients treated under the previous contract. Although in some places access to dentistry has improved since 2006, it remains uneven across the country. In many areas severe problems remain. The indications are that the new arrangements have failed so far to improve patient access overall.

Orthodontic capacity

75. There is as yet little sign of an increase in the number of orthodontists or in the number of treatments they provide. The British Orthodontic Society (BOS) told us that the UK ranks 15th out of 17 countries in Europe in terms of orthodontic provision. According to the BOS, the UK has one orthodontist per 73,000 people. In contrast, Germany and Austria have a ratio of one orthodontist per 30,000 people.¹²⁴ Even allowing for some difference in how orthodontists are defined in different countries, the CDO confirmed the lack of orthodontic provision in England and highlighted its uneven provision across the country:

120 Q 711

121 Ev 14

122 Ev 152

123 Ibid

124 Ev 23

“Someone once said to me that there were 21 specialist orthodontists within one mile of Guildford centre but there was not one within 21 miles of Middlesbrough town centre”.¹²⁵

76. The British Orthodontic Society advised that in April 2006, the Department introduced the Index of Orthodontic Treatment Need (IOTN) into NHS practice,¹²⁶ as a result of growing demand for orthodontic treatment. The IOTN provides a mechanism for classifying patients according to their dental health needs and for the NHS to ration resources available for orthodontics.¹²⁷ Those with the highest needs are given a score of 5 and those with the lowest a score of 1. This classification is qualified by an aesthetic “cosmetic” score of between one and ten. Patients classified as 3, according to their health needs, are accepted for treatment by the NHS if they have an aesthetic score of 6 higher. Thus the cut-off point for acceptance is therefore 3.6.

77. The BOS argued that the Department of Health’s assessment of the number of children requiring orthodontics was flawed. The Department’s Children’s Dental Health Survey undertaken in 2003 indicated that 34% of all children had an IOTN score of 3.6 or above and according to the Department’s own guidance, therefore had a need for some orthodontic treatment.¹²⁸

78. However, according to the BOS, the Department had estimated that around half of parents did not believe that their children with an IOTN score of 3.6 or above, actually required orthodontic treatment and that consequently PCTs were allocating only enough resources to ensure provision for around half of those children who might need orthodontic treatment.¹²⁹ As a consequence, the BOS believed that some children in need of treatment would go without it.¹³⁰

79. Steps have been taken to ameliorate the situation, particularly by the establishment of Local Orthodontic Clinical Networks (LOCNs).¹³¹ LOCNs provide a forum for general practitioners, alongside specialists and hospital consultants, to discuss orthodontic service provision. The BOS told us that in places such as Bristol orthodontic specialists had been working closely with other dental professionals for the first time and that this had helped them conduct local needs assessments and provide PCTs with a greater understanding of the orthodontic needs of the area.¹³²

80. We recommend that the Department clarify the evidence on which it bases its claim that many parents do not consider their children with an IOTN score of 3.6 or above, require orthodontic treatment. We are concerned that some children who require orthodontic treatment will not receive it because adequate funds have not been allocated by PCTs.

125 Q 729

126 Ev 20

127 Ev 21

128 Ev 22

129 Ibid

130 Ibid

131 Ibid

132 Q 404

81. We welcome the establishment of Local Orthodontic Clinical Networks as making a significant contribution to improving the process by which local orthodontic assessments are made.

Patient charges

82. Dental charges have long been viewed as a barrier to accessing dental care, even where it is readily available. Charges are paid by the majority of the population. There are exemptions for people under 18, or in receipt of income support or pregnant.¹³³ Help is also available from the NHS Low Income Scheme, which provides income-related assistance for those on a low income for meeting health charges.¹³⁴ Nevertheless for those who do not qualify for help, dental costs can be a burden.¹³⁵

83. The Department argued that the changes it had made to patient charges had brought benefit to those people not entitled to an exemption in two main ways. It had:

- Removed confusion by reducing the possible number of charges from 400 to 3; and
- Reduced the maximum payment from £389 under the old system to £198.¹³⁶

84. From 1 April 2008 charges were as follows:

- Band 1 covers a check-up and simple treatment such as examination, diagnosis, x-rays, advice on preventive measures and a scale and polish (£16.20).
- Band 2 covers up to six fillings and extractions and root canal work in addition to work covered under band 1 (£44.80).
- Band 3 covers complex treatments such as crowns, dentures, and bridges in addition to band 1 and Band 2 work (£198).¹³⁷

133 Ev 1

134 http://www.ppa.org.uk/ppa/low_income.htm

135 Q 682

136 As at 1 April 2008

137 Department of Health, *NHS Dentistry in England: information for patients*, April 2008

85. Table six shows the numbers and proportions of courses of treatment by payment band in England 2006–07 and the first 3 quarters of 2007–08.

Table Six

Year		Band 1	Band 2	Band 3	Urgent and other ¹³⁸	Total
2006–07	Number of treatments (000's)	19,013	10,688	1,529	3,821	31,230
	Proportion	54.2%	30.5%	4.4%	10.9%	100%
2007–08 (Q1, Q2 and Q3)	Number of treatments (000's)	14,396	8,097	1,236	3,000	26,729
	Proportion	53.9%	30.3%	4.6%	11.2%	100%

Source: NHS Information Centre: NHS Dental Statistics for England, Quarter 3, 2007–08

86. Some witnesses questioned the need for simplifying charges stating that there had been little call from patients to simplify the charging system. Mr John Mills, a retired dentist, described the new system as “simplistic” rather than simplified and argued that patients are well-used to dealing with a range of prices in their daily lives. For patients, Mr Mills argued, the previous charging structure “Was actually no more complicated than understanding the till receipt from the supermarket”.¹³⁹

87. Dr Anthony Halperin, of the Patients Association, questioned the logic of a charging system where in band 2 the cost to a patient of one filling would be the same as the cost of multiple fillings. According to Dr Halperin the new charging system “appears to be irrational not only to the dentist but probably to the patient as well”.¹⁴⁰ Although Citizens Advice generally welcomed the simplification of patient charges, particularly the reduction of the maximum charge for band three (more complex work), the organisation told us that some patients were concerned that for some treatments such as fillings, charges under the new system were significantly greater than they had been under the old system.¹⁴¹ This additional cost would, the organisation argued, particularly affect low-income patients who did not qualify for payment exemptions.¹⁴² It was claimed by other witnesses that these patients, who traditionally have a low-take-up of dental care, might choose to live with dental pain and delay further visiting a dentist for treatment.¹⁴³

¹³⁸ Urgent refers to treatment provided to a patient in severe pain by reason of their oral condition Care is provided to address severe pain. Other treatments include arrest of bleeding, bridge repairs, removal of sutures and prescription issues.

¹³⁹ Ev 19

¹⁴⁰ Q 682

¹⁴¹ Ev 71, Ev 153

¹⁴² Q 682

¹⁴³ Ev 52, Ev 69

88. Citizens Advice and the Patients Association argued that many of these problems might be avoided if there was a greater uptake by low income earners of the financial assistance available to them through the NHS Low Income scheme.¹⁴⁴ Ms Teresa Perchard told us that,

Literature that is available on the new dental charges really is quite understated about how you could get an exemption or help with charges.¹⁴⁵

89. **We welcome the simplification associated with the new charging system.**

90. **However, there are problems. Some courses of treatment such as those involving a single filling have become more expensive. In addition different patients are charged the same amount for very different treatments which fall within the same charging band.**

91. **There is a danger that some low-income patients will store up dental problems and delay visiting their dentist, at some cost to their long-term dental health. We recommend that the Department make further efforts to raise awareness among lower income earners of the assistance available for meeting dental charges.**

Clinical Quality

92. This section examines how the new contract has affected key elements of quality of care: the treatment given to patients, including the encouragement of preventive advice; and the clinical governance and quality assurance systems under which advice and treatment is provided.

Prevention

Providing preventive advice to patients

93. The Department argued that a major aim of its reforms was improving the provision of preventive dental treatment. It claimed that the new contract made it clear that preventive treatment and advice should be provided by dentists along with a check-up as part of band 1 treatment.¹⁴⁶ Previously there had been no such requirement, although dentists were rewarded financially for providing preventive treatment.

94. In addition to the changes to the contract, the Department recently published new guidance on preventive care for dentists, *Delivering Better Oral Health, an evidence-based toolkit for Prevention*, which provided “dental professionals with comprehensive advice on how to provide preventive care”.¹⁴⁷

144 Qq 681–682

145 Q 682

146 Ranging from simple scale and polishes to fluoride varnishes.

147 Department of Health, *Delivering Better oral health, an evidence-based toolkit for prevention*, September 2007

95. However, some dentists argued that the contract did not provide them with adequate financial incentives to provide preventive advice to patients.¹⁴⁸ Dr Paul Batchelor in a submission to our inquiry argued that the importance of preventive care and advice had not been sufficiently emphasised in the contract because it had been bundled together with other treatments under band 1.¹⁴⁹ Dr Batchelor argued that there were no financial benefits, in terms of UDAs, to the dental provider to actually provide the preventive element of band 1 because “they get paid the same whether they do or do not provide preventive advice” (we discuss UDAs further in paragraphs 163–183).

96. In addition, other dentists told us that owing to the pressure to meet UDA targets, they were too rushed to dispense preventive advice.¹⁵⁰ Mrs Diane Martin told us:

The pressure is immense. I can afford to give a patient just 15 minutes for a full examination, scale and give advice. Where is the time for prevention?¹⁵¹

97. We received no evidence from the Department that the amount of preventive advice given by dentists had increased since April 2006. However, a survey conducted in 2007 by the London Assembly found that only 69% of NHS dental patients had received preventive advice when they last visited their dentist. The corresponding figure for private dental patients was 86%.¹⁵²

Outreach initiatives

98. Probably as important as providing preventive advice to patients who visit a dentist regularly is providing it to those patients who visit infrequently, which has been a considerable challenge. Some PCTs have used their responsibilities under the new arrangements to launch outreach initiatives. Sandwell PCT runs an oral health promotion scheme targeted at schools where there are a high number of pupils with decayed, missing and filled teeth. Such promotions included healthy eating policies within schools.¹⁵³ Teachers also encouraged pupils to visit a dentist regularly and to take care of their teeth.¹⁵⁴ However we received no evidence in our inquiry to indicate how typical such outreach initiatives among PCTs are or any indication of their cost-effectiveness.

99. The Department has put in place a “Brushing for Life” initiative where the Department provides information booklets on dental care and fluoridated toothpaste to adults and children.¹⁵⁵ The booklets are then distributed by those PCTs which have chosen to take part in the scheme.¹⁵⁶ The Minister told us about another scheme, in collaboration with the

148 Ev 7, Q 449, Q 591

149 Ev 34

150 Ev 7

151 Ibid

152 London Assembly, *Teething problems*, A review of NHS dental care in London, December 2007

153 Q 328

154 Q 328

155 According to the Department, 11 PCTs in the North West, five in London, four in Northern and Yorkshire, and one in Trent take part in the “Brushing for life” scheme.

156 Q 797

supermarket ASDA, of holding mobile dental surgeries in supermarket car parks. The aim was “to get preventive treatment delivered in the non-dental surgery environment because a lot of the people who have the most needs would not go near the dental surgeries to save their lives”.¹⁵⁷

100. While the Department argues that the new contract should improve preventive care and advice, this is disputed by dentists who claimed that the new contract failed to provide the time and the financial incentive for them to do so. A survey in 2007 undertaken by the London Assembly showed that almost one third of NHS patients had not received preventive advice when they last visited their dentist. We recommend the Department undertake research to determine the extent to which the provision of preventive advice is being given and its cost-effectiveness.

101. We welcome the initiatives made by some PCTs and the Department to provide dental care for those people who do not currently receive it. However, we received no evidence about how many PCTs conduct similar initiatives or about how cost-effective they are. We recommend that the Department monitor the impact of outreach initiatives with particular attention to their cost-effectiveness.

The number of complex treatments

Reduction since 2006

102. There are concerns that since 2006, as a result of the contract, some patients who require complex dental treatment are not receiving it. The volume of more complex dental treatment administered by dentists within band three (requiring laboratory work such as crowns, bridges and dentures) has fallen sharply since 2006. According to the Dental Laboratories Association (DLA), there had been a significant fall in Band 3 treatments requiring laboratory work in England during the first year of the new contract. The organisation told us that since 2006 dental laboratories had experienced a decline of 57% in prescriptions for crowns and bridges and dentures, other than those replacing a single tooth.¹⁵⁸ Before 2006, 8% of all treatments were what are now termed band 3 treatments. Since 2006, the figure is 4%.¹⁵⁹ In contrast, during the same period the percentage of complex treatments provided in both Scotland and Northern Ireland (which have not introduced the new contract) had risen by more than 15%.¹⁶⁰ The British Endodontic Society (BES) told us that the number of root canal treatments had fallen by 45% since 2004 while at the same time the number of tooth extractions had risen.¹⁶¹ The Department did not collect data on the total number of extractions carried out since 2006 but has announced that full data for 2007–08 will be published in August 2008.¹⁶²

157 Q 787

158 Ev 73

159 Ibid

160 Ibid

161 Ev 11

162 In answer to a Parliamentary Question from Sandra Gidley MP [209200] the Department stated that the “Dental Treatment Band Analysis, England and Wales 2007–08” would provide information on the number of root-fillings, crowns, partial dentures, full dentures and extractions carried out in 2007–08.

103. Ms Helen Delaitre informed us that some patients in Hillingdon had complained to the PCT because they were having “difficulty accessing endodontic work”.¹⁶³ Commissioners from Devon PCT and Sandwell PCT acknowledged that band 3 treatments had declined in their area.¹⁶⁴

104. The Department considered the fall in band three treatment an indication that the new system has delivered greater clinical freedoms to dentists to provide simpler courses of treatment.¹⁶⁵ However, it provided no evidence that simpler treatments were being carried out because they were more clinically appropriate.

105. In contrast, Mr Andrew Harris of Devon PCT argued there was not sufficient incentive to provide more complex treatment: “a dentist may feel that the reward [UDAs] is not there to do as many band 3 treatments as he did in the past”.¹⁶⁶ The BES argued that the contract provided dentists with a financial incentive to persuade a patient to have a decayed tooth extracted rather than undergo the more complex procedure of restoring it. The BES argued that:

The UDA...system does not appear to recognise the placement of a root filling and that the introduction of single use instruments may result in teeth which could be reasonably saved being extracted. Extraction is a simpler procedure, takes less time and has the same recognition under the UDA monitoring system.¹⁶⁷

The BES argued that many tooth extractions were unnecessary and that patients benefited more from having a root filling and retaining their tooth, as opposed to having it extracted.¹⁶⁸

106. The number of complex treatments involving laboratory work fell by 50% during the first year of the contract. The number of root canal treatments has fallen by 45% since 2004. At the same time the number of tooth extractions has increased. The reason for the decline in the number of complex treatments since 2006 has not been explained satisfactorily and we are very concerned that as a result of the contract some patients do not receive the quality of care they need within the NHS. There is no evidence for the Department’s claim that the decline is to be explained by more appropriate simpler treatments. We recommend the Department publishes an explanation for this trend and commissions research into the effect of this decline within the NHS system and its impact on oral health.

The effect on salaried dentistry and secondary Dental care

107. We also received evidence that since the introduction of the new arrangements in April 2006 more patients who required complex treatment had been referred to dental hospitals and salaried dental services. Dr Andrew Sadler, a Consultant in Oral and

163 Q 344

164 Ibid

165 Ev 4

166 Q 344

167 Ev 11

168 Ev 11

Maxillofacial Surgery, told us that there had been a significant increase in referrals for dental extractions to the hospital service since 2006 from general dental practitioners who lacked the financial incentive to treat them.¹⁶⁹ He added that patients had been disadvantaged because they had been pushed unnecessarily into the hospital system, “causing them delay, sometimes in pain, for extractions which should be done by a Primary Care Dentist”.¹⁷⁰

108. Dr Sadler stressed the effect that the increase in referrals to secondary care had had on the workload of his team, making it extremely difficult to meet 18-week treatment time targets, since “It has also meant that clinical priority for those with more urgent need has been subordinated to patients who require routine dental extractions so that waiting time targets can be met”.¹⁷¹

109. Mrs Jane Davies-Slowik, a Clinical Director of Salaried Services, found that there had also been an increased number of referrals to Salaried Primary Dental Care Services (formerly the Community Dental Service) by GDPs of patients with high disease levels or those needing complex restorative care. She noted that a survey conducted by the BDA between May and September 2007 had found that 78% of Clinical Directors had reported an increase in referrals from general dentists.¹⁷² The effect of this had been “to increase the waiting times for the traditional group of...patients from priority groups particularly those who are less able to speak out for themselves”.¹⁷³

110. We are concerned about the increase in referrals of patients requiring complex treatment to dental hospitals and community dentists. This can be bad for those patients who would prefer to be treated by their general dental practitioner and can also have adverse affects on patients who are traditionally treated in these settings and who have had to wait longer for treatment.

Quality Assurance

111. It is vital that any clinical service operates within strong quality assurance guidelines backed up with adequate checks. Several of our witnesses claimed that the new arrangements had undermined quality assurance since 2006.¹⁷⁴

112. Under the previous arrangements the Dental Practice Board provided quality assurance through both monitoring and auditing the GDS system.¹⁷⁵ It had three primary functions:

- to give to or withhold approval from dentists’ claims for payment;

169 Ev 127

170 Ibid

171 Ibid

172 DS 45

173 Ibid

174 Ev 15, Ev 33

175 In 2006 the DPB was dissolved and its functions merged into the Business Services Authority but the DRS remains today.

- to make payment for approved claims, efficiently, effectively and economically; and
- to prevent and detect fraud and other forms of abuse.¹⁷⁶

113. Mr John Taylor, former Chief Executive of the DPB, told us that the key change since 2006 had been that dentists were no longer obliged to record individual treatments given to patients. He argued that the previous system had worked efficiently for nearly sixty years as the decline in oral decay rates among both adults and children illustrated. In particular, he emphasised that a great strength of the previous system had been that it required dentists to record the treatment they had given patients in order to receive payment. The Dental Reference Service could if necessary check the record to see whether the treatment had in fact been given and whether the treatment had been of the required quality.¹⁷⁷

114. Other witnesses conceded that in reality it was questionable whether the DRS had the capacity to check a meaningful number of recorded treatments, but insisted that the possibility that a DRS Officer might visit and audit records was a powerful discipline for dentists to ensure the treatment they provided was appropriate.¹⁷⁸

115. Mr Taylor argued that under the new arrangements only the band of treatment administered was reported, making it impossible for the DRS to check that individual items of treatment had been carried out, or had been carried out to the right standard.¹⁷⁹ It had also become impossible to check whether the treatment given had been necessary.¹⁸⁰

116. The Department acknowledged the weakness in the reporting system it introduced in 2006 and agreed that PCTs and dentists required more information about treatment patterns.¹⁸¹ The CDO told us that from April 2008 more data on the treatments given within each band would be collected from dentists by the DRS following the introduction of an “enhanced clinical data set”.¹⁸² The additional data would capture information “about what goes on within the individual courses of treatment” and would record for the first time “preventive activity on an official NHS form”.¹⁸³

117. The Department added that it also planned to enhance the role of the DRS. From April 2008, in addition to monitoring dental records, it would examine information gathered “through the claims received for payment...and carrying out a thousand surgery inspections per year”.¹⁸⁴

176 DS 37

177 Ibid

178 Q 494

179 Q 97

180 Qq 97–103

181 Q 783

182 Ibid

183 Ibid

184 Q 786

118. The Department has acknowledged that changes in 2006 to the way treatments were recorded led to a decline in the quality assurance mechanisms. In April 2008 it began to record an “enhanced data set”. It is too early to determine at this stage whether the enhanced data collected by the Department will prove sufficient to improve both clinical and financial accountability. We recommend that the Department carries out a review of the effectiveness of the “enhanced data set” after an appropriate time.

NHS commissioning capacity and capability

The role of PCTs

119. Under the new contract, the responsibility for commissioning dental and orthodontic services now rests with the 152 Primary Care Trusts (PCTs) in England.¹⁸⁵ As with other NHS services, PCTs were given a statutory duty to ensure the provision of primary dental services to meet local need. In 2006–07 the Department allocated PCTs £1.8 billion to commission dental services in addition to which PCTs were expected to raise £634 million revenue from patient charges.¹⁸⁶

120. As well as holding budgets for dental services, PCTs agree contracts with general dental practitioners or commercial organisations. The contracts, which typically last for three years, stipulate the UDAs to be provided by a dentist over a year in return for 12 monthly payments. We discuss UDAs in more detail later.¹⁸⁷ Should a dentist decide to end, or not renew, their contract with a PCT, the PCT has the power to purchase replacement services from other dentists or commercial providers.¹⁸⁸

121. Although the Department has placed great emphasis on the new commissioning powers of PCTs, so far PCTs have mainly contracted services from existing providers. New dental services have been commissioned to replace services lost when, for example, a dentist retires or leaves the NHS. When the new contract was introduced in April 2006, existing dentists were given strong protections during the period of transition—not least a guarantee that their pattern of service or remuneration would not be changed (unless they agreed) until April 2009.¹⁸⁹

122. PCTs took on their new role at a challenging time. In the summer of 2006 the Department halved the number of PCTs, in many cases resulting in a period of reorganisation of services and rationalisation of staff.¹⁹⁰ For example, the newly created Devon PCT, which had been formed from six existing PCTs, was faced with creating a

185 Department of Health, *Departmental Report 2007*, Cm 7093

186 According to figures published by the Department of Health, 23 August 2007, patient charge revenue only generated £475million instead of the expected £634 million, resulting in a shortfall of £159 million in the dental budget.

187 See para 163–183 for further discussion of UDAs

188 Ev 79

189 Ev 3

190 Cm 7093

unified structure and removing duplication of services while at the same time taking on the new responsibility for managing the new dental contract.¹⁹¹

123. During our inquiry scepticism was expressed at how well the PCT system would cope with commissioning dental services. The main areas of concern were: the funding available to PCTs to commission dental services; the commissioning skills of PCT staff; and the lack of data available to PCTs about local oral health needs. These issues are now considered. In addition, there was criticism of how PCTs had used UDA targets which is discussed later in paragraphs 168–174.

Allocation of funding

Historic funding

124. From the beginning of the new contract the Department decided to allocate the £1.75 billion dental budget to PCTs according to their historic patterns of GDS dental provision.¹⁹² During our inquiry we heard much criticism of this decision. The effect according to Which? has been that access problems have been “exacerbated” because PCTs with low numbers of NHS dentists and associated patient access problems had no additional money with which to commission new services.¹⁹³ A review of NHS dental services undertaken by the London Assembly found that historic funding allocations in London had “done little to tackle the uneven spread of provision, meaning that patients in areas of lower provision such as South-West London may struggle to find a dentist”.¹⁹⁴

125. The BOS argued that for orthodontics the effect of historic funding had been:

serious problems in terms of how we ensure there is a more even provision, because it has been frozen at one point in time. Good areas are fine; the poor areas are very badly off.

126. The Minister argued that historic funding allocations had been necessary because: “We had to start by honouring existing contracts and maintaining existing levels of service”.¹⁹⁵ Mr David Lye added that:

To have moved away from the historical funding would have destabilised places where there were NHS services in place.¹⁹⁶

127. In December 2007, the Department announced an increase of 11% in total funding for dental services from 2008–09.¹⁹⁷ This will increase the total net dental allocation for primary dental care services in England from £1.87 billion in 2007–08 to £2.08 billion in

191 Q 265

192 Department of Health, *Departmental Report 2008*, Cm 7393, May 2008

193 Ev 96

194 London Assembly, *Teething problems, A review of NHS dental care in London*, December 2007

195 Q 735

196 Q 737

197 www.dh.gov.uk/operatingframework

2008–09 (i.e. before taking account of income from dental charges).¹⁹⁸ Of this additional funding, 9% has been allocated to PCTs directly and the remaining 2% to Strategic Health Authorities.¹⁹⁹ According to the Department, in total the increase in the allocation for dental services was £209 million. However as we show below this figure is only £50 million more than the shortfall in patient charges recorded for 2006–07.

128. The additional £209 million for dental services was welcomed by our witnesses, but several of them expressed concern that the Department had not yet decided the formula by which future funding for dental services would be allocated to PCTs. Ms Teresa Perchard, of Citizens Advice, for example argued that funding should be made according to the dental needs of the population rather than in line with historic provision.²⁰⁰

129. When we asked the CDO how this additional resource would be allocated between PCTs he told us that:

Areas that have more dentists and a better service get slightly less and the areas ...that historically have low allocations, we are starting to address that now by making the funding available on a population basis. It will take some time to make progress, to get it completely based on a population basis but we are moving that way.²⁰¹

The Minister told us that local needs assessments would form the basis of future funding, but acknowledged that the funding formula had yet to be decided.²⁰² Work by the Department on the funding formula would begin immediately. The Minister added that:

Thank you for highlighting this to me today in the way you have. This will be very seriously looked at.

130. The decision to allocate funds to PCTs on an historic basis made it extremely difficult for PCTs to contract additional dental providers in areas with traditionally few GDS dentists.

131. We welcome the Department's provision of additional funding and the CDO's statement that there would be a shift towards allocating funding on a needs basis. We are disappointed, however, that the formula to be used for future funding allocations has yet to be determined.

Ring-fencing

132. Some witnesses also expressed concern that the funding provided by the Department for dental services would be ring-fenced only until 2009 after which it would be included in the consolidated PCT budget allocation.²⁰³ It was suggested that this would leave open the

198 DS 01E

199 Q 743

200 Q 669

201 Q 737

202 Q 747

203 Q 667

option for PCT commissioners to reallocate resources from dentistry to other health services. The Department acknowledged these concerns and the Minister announced that ring-fencing of dental budget allocations would continue until 2011.²⁰⁴

Revenue from patient charges

133. Approximately one quarter of the funding for general dentistry is derived from patient charges.²⁰⁵ However, in the first year of the contract PCTs did not collect as much revenue from patients as had been expected. In 2006–07 they had expected to collect £634 million but only collected £475 million, a shortfall of £159 million.²⁰⁶ The submission from Sandwell Local Dental Committee blamed the Department for the shortfall stating,

If you impose a completely untried system that has not been piloted or tested, as the Department has done... it cannot be a complete surprise to discover a major shortfall in patient charge income.²⁰⁷

134. The impact of the shortfall inevitably had had a direct impact on dental services. Commissioners from Devon, Hillingdon and Sandwell PCTs confirmed that as a result they would have less money to spend on dental services. In Hillingdon PCT the shortfall in patient charge income resulted in a deficit of £564,000 for 2006–07.²⁰⁸

135. The CDO acknowledged that the Department had miscalculated the expected patient charge income for 2006–07 and recognised that it had resulted in some PCTs diverting money from their general allocation towards dental services to make up the shortfall.²⁰⁹ He was confident, however, that future estimates would prove more robust, adding that

A change of this magnitude is going to cause some difficulties and certainly this was a difficulty in the first year. We have a much better handle on it now; we think this year's figures will be much better.²¹⁰

136. The Department's prediction of patient charge revenue in 2006–07 was overestimated by a sum of £159 million. As a consequence PCTs went without the revenue they had planned for and had to reduce spending on dentistry or divert resources from other areas of expenditure to dentistry. The overestimate is unsurprising given that the scheme was introduced without piloting. We recommend that the Department improve its financial forecasting in this area.

PCT commissioning capability

137. PCTs had to build-up commissioning skills for dentistry from scratch. Successful commissioning depends on the skills of PCT commissioners and administrators, including

204 Q 708

205 Ev 51

206 Ev 51

207 Ev 27

208 Ev 93

209 Q 815

210 Q 815

their ability to make use of dental specialists. We heard that they were of variable quality. Some, such as Sandwell PCT and Sheffield PCT, appear to have used dental public health specialists well when conducting local dental needs assessments and commissioning services.

138. Other PCTs appear not to have done well, leading the Patients Association to conclude that many PCTs displayed “a lack of creativity in commissioning”.²¹¹ Mrs Sarah Elworthy, a dentist practising in Kent, told us that

[PCT commissioners’] level of knowledge on dental practice appears to be limited to their own (limited) dental experiences. Factual knowledge on the dental needs for the area appears negligible, and they have no obvious strategies or objectives.²¹²

Mr John Renshaw claimed that in some PCTs only junior staff worked on dental commissioning and that the quality of service to dentists and orthodontists had suffered as a result.

Some are really quite good, but some of them are using the lowest level managers who really do not understand what they are doing and they are rambling around the country threatening people with legal action and all the rest of it.²¹³

139. We asked witnesses what could be done to improve commissioning but received few suggestions. The Minister acknowledged that there was “very, very strong evidence that some PCTs need much more support”.²¹⁴ Her aim was that PCT commissioning should become “world class” and she had put forward two main ways of achieving this: the Department’s guidance to PCTs contained in the “Commissioning Framework for Health and Well-being”²¹⁵ and the encouragement to PCTs to share best practice in order to improve commissioning skills.

140. In-house commissioning skills vary greatly between PCTs. As the Minister acknowledges, too many PCTs are not doing a good job, neither employing appropriately trained staff nor making full use of Specialists and Consultants in Dental Public Health when assessing local dental needs and commissioning services.

Data collection on dental health needs

National data

141. Commissioners need good quality data on the dental health of a population to make decisions about the level and type of dental services to commission. Fortunately a valuable set of data has been provided since 1968 by the ten yearly Adult Survey of Oral Health and the ten yearly Child Survey of Oral Health, first commissioned in 1973. Expert dental health witnesses including the CDO recognised the importance of these regular national

211 The Patients Association, *The New Dental Contract—full of holes and causing pain?* March 2008

212 Ev 49

213 Q 47

214 Q 705

215 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_072604

surveys. Mr Melvyn Smith told us that they provided an overview of the nation's oral health and were considered by many dental health specialists to be invaluable to planning dental need provision. An advantage of the national surveys was that they cover all of the population, not just those who had visited a dentist.²¹⁶ In that way,

We can look at the particular areas of the country we are in, compare it with London, or whatever region it might be, and see how we are doing against the trends that are occurring on this nationally collected data survey.²¹⁷

142. We were concerned to discover during the inquiry that there was some uncertainty about whether the NHS Information Centre, “a special health authority that provides facts and figures to help the NHS run effectively”,²¹⁸ would commission the next in the series of Adult Oral Health surveys, due later this year and also whether the Child Oral Health survey would be carried out as planned in 2013.²¹⁹

143. The CDO recognised that the adult survey was extremely useful to PCT commissioners and dentists alike, but he argued that it was up to the NHS Information Centre alone whether or not the next survey was commissioned. He later told the annual conference of the BDA in May 2008 that the adult survey would be carried out in 2009.²²⁰

Locally collected data

144. Mr Melvyn Smith argued that the data collected by the national survey should be supplemented with a greater amount of information collected locally. Such data, he argued, should be drawn from questioning patients about their experience of visiting a dentist, including questions about how easy it was to find a dentist to treat them and their opinion on the level of service they received. For example,

If they have a toothache, can they get the service when they want it? On a Sunday, do they have to travel a million miles to get it? Those kinds of measures we do not collect.²²¹

145. Mrs Jane Davies Slowik indicated how reliable information about local dental needs helped PCTs commission services for community dental services:

For example, if we have an aging population with their own teeth who might have Alzheimer's or be in nursing homes then it has a real impact on how we plan our services, what services we have to take to people and we have to transport them back into the surgery. It is really useful information.²²²

216 Q 499

217 Q 499

218 <http://www.ic.nhs.uk/>

219 Q 438

220 www.dentistry.co.uk/news/news_detail.php?id=1211

221 Q 487

222 Q 503

146. Mr John Green explained the importance of dental health specialists like himself in shaping dental service provision. His role was one of “gathering information through epidemiological surveys or feedback from patients, identifying need and acting as an advocate for particularly disadvantaged groups”.²²³ Mr Green, however, noted that although some PCTs did collect good quality data on oral health, the approach by PCTs to collecting local data was neither “concerted or consistent”.²²⁴

147. Up-to-date comprehensive data are vital to PCTs for commissioning dental services. We are therefore concerned at the uncertainty caused by the initial delay in the NHS Information Centre’s decision to commission the next decennial survey on Adult Oral Health.

148. However, we welcome the fact that the survey is now to be undertaken in 2009, albeit a year late. We recommend that the Department confirm its intention to conduct the next ten yearly child oral health survey due in 2013.

Children-only contracts

149. According to the Patients Association 76.5% of PCTs the organisation surveyed permitted “limited NHS contracts”, of which “Children-only” contracts were a common example.²²⁵ Children only contracts are a legacy of the old system where dentists only provided NHS treatment for young people under 18 and treated adult patients under private arrangements. As the Patients Association survey found, this arrangement was fairly common. For example, Mrs Sarah Elworthy told us that she treated children under NHS arrangements, but took on adults as private patients because of what she considered to be the financial restrictions associated with treating adults under the NHS.²²⁶

150. The CDO told us children only contracts had no place “in long term commissioning plans”.²²⁷ But some PCTs such as Devon had taken what they saw as a pragmatic decision to allow children only contracts to continue in the short term. If they had not, they feared that dentists might have decided to leave GDS practice altogether and so exacerbate access problems.²²⁸

151. The Department maintained that it could only encourage PCTs not to enter into such contracts, it could not direct them to. PCTs retained the flexibility to negotiate children-only contracts with dentists if they thought it necessary.²²⁹

152. Although we did not investigate the matter in great detail, we examined some witnesses about allegations that some dentists had told parents they would only provide treatment for their children under the NHS on condition that they registered with them

223 Q 446

224 Q 505

225 Patients Association, *The New Dental Contract—full of holes and causing pain?* March 2008

226 Q 514

227 Q 712

228 Devon PCT will not allow child only contracts from 2009

229 Qq 715–717

under private arrangements.²³⁰ All our witnesses agreed that the practice of coercing parents to register as private patients so their children could be treated through the NHS was unacceptable.

153. Children-only contracts have been continued by some PCTs so that access to NHS services is maintained in the short term. The Department argues that PCTs should be strongly discouraged from entering children-only contracts with dentists. The Department should make it a priority to remove children-only contracts from NHS dental service provision as soon as possible.

The role of Strategic Health Authorities

154. In view of PCTs' variable performance in commissioning dental services, the role of Strategic Health Authorities (SHAs) in managing their performance and providing support in their commissioning role is important.²³¹ However, the performance of SHAs with regard to dental services is mixed. In January 2008 the National Audit Office (NAO) conducted a survey of seven of the ten SHAs for the Committee. It found that:

- Only one SHA had developed a formal strategy for dentistry.
- Most SHAs did not collect data on dental need or access. Most acknowledged that they had “left the responsibility for understanding patient access to dentistry to PCTs”.
- Although most SHAs monitored the performance of PCT commissioning in general, the performance of commissioning of dental services was a low priority.
- The majority of SHAs acknowledged that “expertise and capacity on dental issues could be improved”.²³²

In summary the NAO survey found that SHA involvement in dental services was limited, with PCTs largely left to devise and implement policy.

The working lives of dentists and orthodontists

155. This section examines whether the changes to the GDS and orthodontics contract have improved the working lives of dentists and orthodontists as the Department intended.

Orthodontists

156. The new contract for orthodontists had a particular impact because of the average length of time it takes to complete a course of treatment. Like dentists, orthodontists' UDA targets were calculated according to their treatment activity between October 2004 and September 2005. However, unlike general dentistry, many courses of orthodontic treatment take two years to complete. As a result, the income received by an orthodontist

230 Qq 23–28, Qq 712–716

231 DS 50

232 Ibid

under the old contract reflected their work for up to two years previously and in many cases no longer truly reflected current workload.²³³

157. We were told that this had significant implications for newly established orthodontists. Dr Ashish Dhopatkar, an orthodontist practising in Birmingham, opened a new practice in early 2005. When the time came for the PCT to determine the value of his contract, it determined his contract value according to the amount of completed treatment he had given during the period up to September 2005 rather than extrapolating the figure over two years.²³⁴ Dr Dhopatkar's situation, according to Iain Hathorn, Chairman of the British Orthodontic Society, although an extreme example of a PCT acting without sensitivity, was by no means unique and caused considerable financial anguish for those orthodontists involved.²³⁵

Changing the system of dentists' remuneration: Units of Dental Activity

The new remuneration system

158. Under the 2006 reforms the Department implemented a remuneration system in which PCTs commissioned an annual total of treatment from dentists, measured in Units of Dental Activity (UDAs), in return for twelve monthly block payments.²³⁶ For dentists employed under the old GDS contract, the number of UDAs commissioned reflected the dentist's activity in 2004–05. However, new dentists were required to negotiate with PCTs a target number of UDAs they were expected to deliver in the coming year and the payment per UDA that the PCT would make in return.

159. Although NHS dentists who had been employed under the old GDS contract were set UDA targets by their PCT, they were also given a guarantee, lasting until April 2009, that their income would not drop below pre-April 2006 levels, whether or not they achieved their target. This income protection did not apply to dentists whose services had been commissioned by PCTs since April 2006. This latter group was subject to financial penalties known as 'claw back' if they failed to meet their agreed UDA target.²³⁷ Typically, we were told, PCTs 'clawback' money given to dentists if they did not achieve 96% of their UDA target.²³⁸

160. The CDO, argued that reforming the previous payment system had been a necessary step in attempts to change the focus of dentists' working culture from intervention to one focused on providing more preventive advice and simpler courses. It was, he argued, inevitable that dentists would protest against the changes because "culture change is one of the most difficult things to do".²³⁹

233 Ev 21

234 Ev 29

235 Qq 397–399

236 Ev 5

237 Ev 7

238 Ev 54

239 Q 209

Criticisms of the UDA system

161. The new system was heavily criticised by dentists, patients groups and public health specialists alike. Sandwell Local Dental Committee described UDAs as “an ill conceived and artificial construct”.²⁴⁰ The BDA argued the UDA system favoured productivity over prevention.²⁴¹ The DPA claimed that under the system “chasing UDA targets conflicts with decisions based on clinical need”.²⁴² Mr John Renshaw suggested that the previous payment system had been flawed but maintained that it had major advantages over the system that replaced it.²⁴³

162. The UDA system clearly remains a source of great resentment for many dentists. The most common criticisms were:

- the lack of piloting;
- UDA targets had been set at unrealistic levels;
- dentists’ workloads had increased;
- the financial consequences for new dentists who missed their UDA target;
- the treatment bands were too wide; and
- the system did not reward dentists who provide training.

Lack of Piloting

163. As we discussed earlier, there was widespread criticism that the UDAs system were introduced without prior testing in a PDS pilot.²⁴⁴

UDA targets are set at unrealistic levels

164. According to the BDA, in 2006–07, the first year of the contract, 47% of all dentists failed to meet their UDA target.²⁴⁵ Both the BDA and Challenge told us that the failure of nearly half of all dentists to meet their targets represented a failure by PCTs: either the data on which they set their UDA targets were unreliable or dentists had been set unachievable UDA targets. The Department was more positive, arguing that “even in the inevitably hard first year dentists delivered 95% of the activity contracted for” and that many dentists missed their target by only a small amount.²⁴⁶

240 Ev 26

241 Ev 55

242 Ev 79

243 Q 3

244 See paras 39–45

245 Ev 54

246 Ev 2

Impact on dentists' workloads

165. Despite the Department's claim that dentists' workloads would fall by 5% under the new contract,²⁴⁷ a number of witnesses including the Oxfordshire PCT and Public Patient Involvement Forum stated that the new system had failed to reduce workloads for many of its dentists.²⁴⁸ The organisation claimed that one third of dentists in Oxfordshire PCT had described their workload since 2006 as excessive and characterised by "endless waiting lists and huge pressures".²⁴⁹ The BDA told us that 82% of dentists they had surveyed in 2007 rejected the claim that the new contract had reduced their workload.²⁵⁰ Other witnesses argued that the target driven system had resulted in dentists spending less time with their patients and that it had become more difficult to find the time to provide preventive treatment.²⁵¹

Financial consequences for new dentists of missing UDA targets

166. As we have seen earlier, dentists who joined the GDS after 2006 were given no income guarantee. The BDA told us that PCTs varied in how they treated dentists who had failed to meet their UDA target. A survey of newly established dental practices by the BDA in August 2007 found that 40% had failed to meet their UDA target and faced having to repay money given to them by their PCT.²⁵² For some dentists who had failed to meet their UDA target the financial implications were severe: an NHS dentist in the Wirral felt forced to close his practice having been required by his PCT to pay back £20,000.²⁵³

167. Some PCTs took a more sympathetic approach.²⁵⁴ According to the BDA survey just over 35% of the new practices who had not met their target in 2006–07 had been allowed to make-up their UDA shortfall in 2007–08.²⁵⁵ Ms Karen Elley told us that Sandwell PCT had initially sought to recover payments from practices which had failed to meet their target by more than 4%, but later decided to relent if such practices could instead provide a credible business plan which demonstrated how they would make-up the UDA shortfall in the following year.²⁵⁶

247 Ev 4

248 Ev 37

249 Ev 39

250 Ev 7, Ev 39, Ev 55

251 Ev 55

252 Ev 54

253 Ibid

254 Q 301

255 Ev 54

256 Q 324

The treatment bands are too wide

168. Table Seven shows the UDA value for the dentist by treatment category.

Table Seven

Treatment category	Type of treatment	UDA value
Band 1	Examination, X-rays, advice on prevention	1
Band 2	Fillings (up to six), root canal work, extractions	3
Band 3	Full dentures and Crowns, Bridges	12
Urgent treatment		1.2
Arrest of bleeding		1.2
Bridge repair		1.2
Denture repair		1
Issue a prescription		0.75

Source: NHS Information Centre for health and Social Care

The implication of much of the evidence we received was that band 2 in particular was too wide and incorporated too wide a variety of treatment. This can bring about significant anomalies in the way that dentists are remunerated for the treatment they provide. The BDA told us that,

Dentists earn the same number of UDAs regardless of the number of items of treatment provided within a course of treatment. For example: a patient requiring one filling would fall into the Band 2 course of treatment, earning for the dentist three UDAs. A patient requiring four fillings and root canal therapy would fall into the same band, also generating for the dentist just three UDAs.²⁵⁷

169. Mr John Mills, who told us that he had “recently retired, which allows me to give an opinion which is not biased by motives of personal gain”,²⁵⁸ argued that under the previous system, both patient charges and payments to the dentist were directly related to the treatment carried out but that under the new system, that link had been broken. After listing useful examples of the anomalies of the new payment system, he concluded: “In some cases, the patient pays more than the cost of the treatment. In other cases, the dentist receives less than the basic cost of providing the treatment”.²⁵⁹

Vocational training

170. The UDA system also affects vocational dental training. Experienced dentists who act as vocational trainers by employing vocational trainees and overseas dentists in their

257 Ev 54

258 Ev 18

259 Ev 20

practice will spend a considerable amount of time guiding them to work effectively within the GDS system. However, dentists are not rewarded for providing training through the UDA system. Sandwell Local Dental Committee (LDC) told us that Sandwell PCT had initially informed practices that the UDAs generated by vocational dentists would count towards a practices' UDA total. However, according to the LDC, the Department later issued an instruction to PCTs that the work done by Vocational Dental Practitioners (VDPs) should not count towards a practice UDA total.²⁶⁰

171. The CDO maintained that the UDA system was not the appropriate way to reward vocational trainers because they were already rewarded financially in the terms of their Service Level Agreement with the PCT.²⁶¹

172. According to the BDA, providing vocational training has become increasingly less attractive as a career to experienced dentists since 2006. The BDA stated that “a cohort of highly experienced VT trainers had declared that this would be their last year as a VT trainer”.²⁶²

The Department's defence of the UDA system

173. In response to criticisms that the UDA system was too target-driven, the Department told us that UDAs were “a language for discussion of expected activity” rather than an inflexible requirement.²⁶³ The CDO implied that PCTs had failed to manage dental contracts with sufficient flexibility adding that PCTs should not rely solely on UDAs to manage dental contracts. PCTs were able, he said, to include non-treatment based measures in contracts with dentists. Such measures could include monetary rewards for values such as quality, access, working with the PCT, and clinical governance.²⁶⁴ The CDO summed up,

There was a very rigid transition which focussed completely on UDAs. Everybody needs to get away from that and start to use the flexibility that is in the contract to work in a more flexible way.²⁶⁵

174. While the CDO was critical of the inflexibility shown by some PCTs, he also argued that dentists should approach treatment bands with more flexibility. He told us that the UDA system provided financial “swings and roundabouts for dentists”.²⁶⁶ For some treatments, for example in band 3, he conceded that it might well cost dentists more to administer treatment than the payment they received for doing it. However, for other treatments such as providing a single filling, the opposite would be true. Over all, most dentists, he argued, would receive a very similar annual income to that which they had received prior to 2006.

260 Ev 26

261 Q 767

262 Review Body on Doctors' and Dentists' Remuneration, Cm 7327, April 2008, (VT trainer is the term used here by the BDA for vocational trainer)

263 Ev 2

264 Q 757

265 Q 240

266 Q 762

175. The introduction of UDAs as the measure of dental activity and the basis for remunerating dentists has proved extremely unpopular with dentists.

176. The Department acknowledged that it had learned valuable lessons from the PDS pilots it had conducted from 1998 onwards, but the new remuneration system, based on UDAs was not tested through a pilot. It is extraordinary that the Department did not pilot or test the new payment system before it was introduced in 2006.

177. Too many PCTs seem to have set unrealistic UDA targets. According to the BDA, nearly half of dentists failed to meet their UDA target in the first year of the contract, if only by relatively small margins. This had financial consequences for new dentists when they failed to meet them. The Chief Dental Officer told us that PCTs were applying UDAs too rigidly. We recommend that PCTs adopt a more flexible approach to UDAs, as he proposed.

178. The vocational training of newly qualified UK dentists and equivalent training for those dentists trained overseas is vital to the future viability of NHS dental services. Dentists should possess the full range of skills required to work in the NHS and vocational training provides a forum for these skills to be tested. However, we received evidence that vocational dental training has become a less attractive option. The Department should undertake research to determine whether a viable number of vocational dental trainers will be maintained in the future and take steps to ensure that this happens. The Department should also ensure that there are sufficient training places for all UK graduates to undertake vocational training and for all overseas graduates to demonstrate equivalent experience after they have passed either the International Qualifying Examination or Overseas Registration Examination.

Conclusion: is the new contract working?

179. The Department asked for the contract to be assessed according to its own criteria for success: patient experience; clinical quality; PCT commissioning; and dentists' working lives. We conclude that the contract is in fact so far failing to improve dental services measured by any of the criteria.

180. Nationally, fewer patients are visiting an NHS dentist than before April 2006 and access to dental care in many areas so far shows no sign of improvement. There is little evidence that the provision of preventive care has increased. There has been a decline in the number of complex treatments. The Department claims that this is because dentists are treating patients more appropriately, but there is some evidence that it is more likely that patients are not receiving the complex treatment they require within the NHS. It would help to clarify the picture if the Department provided evidence to back-up its claims.

181. The CDO appears to argue that if PCTs and dentists acted more flexibly and used common sense and good will the new arrangements would work. However, we see little evidence that this will happen.

4 Trouble ahead?

182. This section examines future problems. We look in particular at the effect of the contract on retention, recruitment and the transfer of financial risk from PCTs to dentists.

Retention

183. As we have seen, dentists working in the GDS before 2006 were given an income guarantee until April 2009 regardless of whether or not they met their UDA target.²⁶⁷ The DPA and Challenge feared that the end of the income guarantee in 2009 could lead to an exodus of dentists from the GDS. The British Dental Health Foundation stated that the end of the income guarantee was a “real threat” to dentists currently working within the GDS and considered it likely that some dentists would leave the NHS rather than face financial penalties should they not meet their UDA target.²⁶⁸ Mr Derek Watson told us that the DPA was “very worried about what might happen in April 2009”.²⁶⁹ Mr John Renshaw was even more pessimistic about the implications for ending the income guarantee. He told us that April 2009 would be a “watershed” for the GDS and that he feared significant numbers of dentists would leave the GDS to work in private practice.²⁷⁰

184. Mrs Sarah Elworthy, a dentist who provides NHS treatment for children in Cranbrook, Kent, had failed to meet her UDA target and was concerned about the financial penalties she would experience once the income guarantee ended in 2009. As a consequence she was considering no longer treating children under the GDS and might instead provide only private treatment.²⁷¹

185. The Chief Dental Officer, however, was optimistic that there would be no rush of dentists from the GDS in 2009 and argued that most of the concerns were misplaced,

We do not expect that. Obviously some people may decide to move...but if you go back to before April 2006 I think people were saying that 20%, 30% or 40% of dentists would leave, but in actual fact the dentists who left represented 3.6% of service.²⁷²

186. We note the fears that many dentists will leave the GDS in 2009. We also note the Department’s assurance that no such exodus of dentists will occur. We lack the evidence on which to judge the more likely outcome. We recommend that the Department monitor closely the career plans of NHS dentists.

267 See para 168

268 Ev 101

269 Q 566

270 Q 124

271 Ev 49

272 Q 819

Recruitment

UK-trained dentists

187. The number of dentists in training is increasing. In 2006–07 the NHS trained 849 students in dental schools around the country, an increase of 184 students compared with 2002–03. In addition there are plans to expand the number of students still further. The newly-opened dental schools in Lancashire, Devon and Cornwall will be supplemented by new centres in Yorkshire and the south of England.²⁷³

188. While there has been an increase in dental students and dental colleges, a number of witnesses were concerned that an increasing number of dental graduates would prefer to work in private practice rather than enter vocational dental practitioner (VDP) training within the GDS. The BDA argued that working conditions in the private sector were more favourable and it was possible to spend more time with patients.²⁷⁴ In March 2008, the BDA reported that its survey of younger dentists (aged up to 35 years) found that their commitment to the GDS had diminished significantly and that they now earned only 36% of their income from the GDS compared with 65% in 2000–01.²⁷⁵

189. The CDO acknowledged that increasing numbers of younger dentists were working in private practice, a trend he ascribed to their greater willingness to embrace cosmetic practice, which was largely available only in private practice. He added however that “There is no shortage of dentists bidding to provide local NHS dental services”.²⁷⁶

Dentists trained overseas

190. Over recent years PCTs have been recruiting dentists who have been trained overseas both within and outside the European Economic Area (EEA). A large number have been recruited. The BDA told us that in 2005, the NHS had recruited 1,240 new dentists from the EEA alone and that recruitment levels had been similar in 2007.²⁷⁷ Of this total 744 dentists were recruited “mainly from Europe and India” through the Department’s “Project 1,000”²⁷⁸ aimed at recruiting a total of 1,000 extra dentists in 2005.²⁷⁹ According to the Patients Association survey of PCTs, Poland is the most favoured place from which to recruit overseas dentists. Spain and India were also identified as popular sources of recruitment.²⁸⁰

273 Q 725

274 Ev 55

275 <http://news.bbc.co.uk/1/hi/health/7271232.stm> “Young dentists reject NHS”, 7 March 2008

276 Ibid

277 Q 383

278 Ev 136

279 In total 1,453 additional dentists were recruited: 513 were from the EEA, 230 were from other countries outside Europe, mostly India, 88 were home recruits eg dentists returning from career breaks; and 622 resulted from PCTs increasing local capacity eg dentists with mixed private and NHS practices who agreed to increase their NHS commitment

280 Patients’ Association, The New Dental Contract—full of holes and causing pain? March 2008

191. The General Dental Council (GDC) checks the qualifications and credentials of all dentists trained overseas before they are able to practise in England. Dentists from outside the EEA, wishing to practise in the GDS, are also required to undergo a test of their understanding of English.²⁸¹ They then have to meet the requirements of the General Dental Council's International Qualifying Examination or, since January 2008, the Overseas Registration Examination (ORE) which is designed to test their professional competencies.²⁸² Having met these requirements, non-EEA dentists then apply to join a "PCT practitioner list".

192. In contrast, dentists from within the EEA are exempt from having to sit the IQE or ORE and are admitted to the GDC's register without any formal test of their knowledge of English.²⁸³ However, PCTs are advised to "require all EEA dentists (except those trained in English) to produce evidence of their ability to communicate in English before including them in their dental performers lists; and advise and consider supporting EEA dentists...who do not have a language testing certificate but wish to undergo training".²⁸⁴

193. Despite this advice to PCTs, some witnesses were concerned that these dentists were not always fully equipped to practise safely and effectively in the GDS. Ms Susie Sanderson described the cultural challenges facing dentists trained overseas in adapting to the GDS:

The culture of UK dentistry is quite hard to grasp when you first arrive. I think that some PCTs and deaneries have made attempts at induction programmes, but it has been a bit of a culture shock.²⁸⁵

194. We received no statistical evidence as to whether or not patient oral health had suffered from treatment by dentists trained overseas. However, we were told that some overseas dentists lacked certain skills necessary for practising effectively in the GDS. Mr John Green argued that there were sometimes significant skills gaps between dentists trained in the UK and those trained overseas:

It is not a question of their competence in what they are skilled in, it is a question of whether they have the full range of skills. For instance, Polish dentists are not taught how to do radiography.²⁸⁶

195. Mrs Jane Davies-Slowik claimed that the quality of dentists trained within the EEA was of greatest concern since, unlike dentists trained outside the EEA, dentists trained within the EEA were not required to take the GDC's International Qualifying Examination to prove their competence. Neither were they required to demonstrate that they possessed similar experience to UK vocational training or to demonstrate equivalent experience.²⁸⁷

281 International English Language Testing System (IELTS)

282 The International Qualifying examination is being phased out and being replaced by the Overseas Registration Examination. In the meantime the two schemes will run in parallel.

283 Department of Health "Implementing local commissioning for Primary Care Dentistry, Language Testing for Dentists Applying for Inclusion in PCT Dental Performers Lists".

284 Ibid

285 Q 384

286 Q 455

287 Q 455

196. Most deaneries provide courses designed to familiarise newly qualified dentists, including dentists who qualified within the EEA, with the workings and culture of the NHS.²⁸⁸ Mr John Green agreed that such courses were worthwhile but noted the resource implications of training overseas recruits, telling us that deaneries did what they could but often they had to be funded by the individuals or by the practices which were intending to employ them. He added that there was no central funding available from the NHS for the courses and that payment was either made by the individual dentists or from “within the profession”.²⁸⁹

197. We note the BDA’s concerns that dental school graduates will choose not to practise in the GDS following graduation. The Department must ensure that GDS dentistry remains an attractive career option for dentists and dental care professionals.

198. The recruitment of overseas dentists has enabled PCTs to replace much of the lost NHS dental capacity which followed the introduction of the new dental contract. There is no clinical evidence that patients’ oral health has suffered as a result, but there are concerns that some overseas dentists are insufficiently familiar with the dental equipment and treatment provided within the NHS. The onus must be on PCTs to ensure that all dentists, irrespective of where they were trained initially, are of the standard necessary to provide high quality dental care.

Investment

199. Unlike general medical practitioners, who are directly reimbursed up to 70% of their capital and running costs, dentists have traditionally been expected to cover their capital and practice running costs from their total income.²⁹⁰ It was argued that dentists not only have to pay the costs associated with running their practice, but that the new arrangements have created new financial concerns. The DPA argued that the 2006 contract had resulted in a transfer of financial risk from the NHS to individual practices. Under the new arrangements, the traditional autonomy of dentists had been replaced by a system where PCTs “dictate to dentists where they will work, which patients they will see and to whom they must sell their practice in case of ill-health or retirement”.²⁹¹ In addition, the fixed-term nature of contracts between PCTs and dentists made the future more uncertain and has resulted in a reluctance by dentists to make long-term investments in their practice.²⁹²

200. The CDO recognised that “the NHS needs to invest more of NHS capital in improving the NHS dental estate”.²⁹³ He informed us that he had taken steps to encourage investment and in 2006–07 and 2007–08 the Department had made £100 million available for Strategic Health Authorities to invest in improving dental premises.²⁹⁴ The Review Body on Doctors’

288 Ev 65

289 Q 546

290 Q 773

291 Ev 79

292 The notice period required from PCTs for terminating a dentist’s contract is currently uncertain.

293 Q 769

294 Q 769

and Dentists' Remuneration reported "confusion about what this funding could be used for within dental surgeries".²⁹⁵

201. Witnesses also argued that the financial costs associated with running a practice have increased, pointing out the financial implications associated with ensuring compliance with legislation including cross-infection control.²⁹⁶ The London Regional Group of Local Dental Committees told us that "the latest infection control requirements necessitate the purchase of additional equipment, and longer times spent by staff that is not recognised by Units of Dental Activity".²⁹⁷ The BDA in its submission to the Review Body on Doctors' and Dentists' Remuneration argued that dentists should be given additional money to fund the additional costs for dentists associated with the new contract.²⁹⁸

202. In April 2008 the Review Body on Doctors' and Dentists' Remuneration considered the issue of practice costs in the light of the new dental contract. Despite the concerns expressed above, the Review Body estimated that the proportion of costs to income for non-associate dentists has remained stable since 2006 at around 58% of income (although it recognised that it was too early to assess the impact of the new contract on expenses).²⁹⁹

203. We note concerns that the new GDS contract has transferred financial risk from the NHS to dentists. The fixed-term contract may make dentists reluctant to make long term investments in their practice.

295 Cm 7327

296 Ev 17, Ev 100

297 Ev 17

298 Cm 7327

299 Ibid

5 Recommendations for improving dental services

204. The Department's aims for dental services are widely shared. Improving patient access to NHS dental services, promoting preventive care and allowing PCTs to decide and commission dental provision according to local need were all recommendations made by our predecessors in 2001.³⁰⁰ However, a wide range of witnesses argued that the realisation of these aims was uncertain.

205. Here we look at proposals for addressing three key areas where we have found serious concerns:

- Primary Care Trusts;
- Revisions to the contract; and
- the future of NHS dentistry.

While we received less evidence about how to improve the situation than we did about the current failings, there are number of proposals for improvement.

Primary Care Trusts

206. Since 2006 PCTs have had a major role in making the dental contract work. The Department acknowledged that PCTs had previously held little responsibility for delivering dental services. They had, in a short time, changed their role from “glorified payment agents to full-scale commissioners”.³⁰¹

207. However, as we saw in Chapter 3 of this Report, many witnesses described the performance of PCTs in implementing and managing the contract as, at best, patchy. The Minister agreed that there were serious weaknesses.

Commissioning

208. The commissioning skills of PCTs vary greatly. Moreover as the CDO noted, some PCTs are implementing the contract with insufficient flexibility. In addition the lack of local data collection has hindered the ability of PCTs to conduct oral needs assessments of their local population and has consequently affected their ability to make meaningful, evidence-based, decisions about which dental services should be

209. SHAs have the duty of performance managing PCTs. The NAO survey of SHAs undertaken on behalf of this committee, found that dentistry has a low priority for PCTs.

210. We have seen previously how the introduction of Local Clinical Networks, in places such as Bristol, have assisted commissioners of orthodontic services. We heard evidence

300 HC (2000–01) 247

301 Ev 3

that through working closely together, general practitioners specialists and hospital consultants have improved commissioning in some PCTs.³⁰² The BOS and the BDA argued that the establishment of local networks of to support the commissioners of dental services should be extended more widely.³⁰³

211. **Some PCTs do not:**

- **Conduct adequate local oral health needs assessments;**
- **Have adequately trained commissioning staff;**
- **Make use of specialists and consultants in dental public health; or**
- **Implement the contract with sufficient flexibility.**

212. **Without adequate data on the oral health of the population, PCTs are not able to make valid dental needs assessments. We recommend that PCTs take immediate steps to widen the scope of the data they collect on the oral health of their local population. We also recommend that PCTs:**

- **establish consultative committees comprising a mixture of experience and expertise including: patients, professionals and PCT personnel; and**
- **employ appropriately trained staff and make full use of dental public health specialists and consultants.**

In addition, the Department must clarify how it intends to improve the performance management of PCTs which are failing to implement the contract with sufficient flexibility. SHAs must place greater importance on their role of managing the performance of PCTs in respect to dentistry.

Funding allocations

213. As we have seen, Dentist organisations and patient groups argued that in future funding for GDS dental and orthodontic services should be allocated according to local needs assessments rather than historical funding as it has been since 2006.³⁰⁴

214. The Minister and her officials were unable to tell us the basis on which future allocation of funding for dentistry and orthodontics would be provided following the end of ring-fencing in 2011, but she added that she and her officials would begin work immediately on determining how the funding for PCTs would be determined in future.

215. The Department must base PCT dental funding on local needs assessments rather than historical provision. We recommend that the Department publishes the formula which it will use to determine future dental funding for PCTs as soon as practicable.

302 Q 399

303 Q 399

304 Ev 16

Revisions to the new contract

QOFs

216. The new contract does not seem to have resulted in increased provision of preventive care and advice despite the Department's stated aim that it should do so. We put it to the Minister that the provision of preventive care might be better encouraged through the introduction of a reward scheme for dentists similar to the Quality and Outcomes Framework (QOF) through which GPs are financially rewarded for meeting a range of quantitative and qualitative measures.³⁰⁵ Both the Minister and the Chief Dental Officer expressed support for the proposal. The Minister added, "I think a QOF-type system would be a very positive way forward".³⁰⁶ She thought that such a measure "might help bring dentistry into the mainstream of primary care".³⁰⁷

217. We recommend that the Department consider further how to provide incentives for dentists to offer preventive care and treatment. Consideration should be given to the introduction of a QOF-style reward system for those dentists who through the provision of preventive care improve the dental health of their patients. The Department should consult dentists' representatives about how such a QOF-style system for dentists might work in practice.

Registration

218. Long-term continuing dental care is a key component of good dental health. Mrs Elworthy claimed that "Building up a good long term relationship with the patient (and for children, with their parents too) is a major part of effective preventive dental care". Mr John Green argued that the open-ended registration arrangements, which exist in general medical practice, might enable dentists to improve their patients' oral health over time.³⁰⁸ Ms Susie Sanderson considered that if patients were registered with a dental practice they would receive regular prompts and encouragement to attend for check-ups. She added:

If I know the families I am treating I am aware which children I need to encourage to make sure that prevention is right; I know which parents have got it right and do not need to come quite so often and I can trust them to get on with it.³⁰⁹

A range of witnesses, including Challenge, the BDA and patient groups supported the reinstatement of the registration requirement as a means of encouraging long term continuing care.

305 According to the Department of Health, "QOF awards surgeries achievement points for: managing some of the most common chronic diseases e.g. asthma, diabetes; how well the practice is organised; how patients view their experience at the surgery; and the amount of extra services offered such as child health and maternity services".

306 Q 789

307 Q 789

308 Q 466

309 Q 372

219. **We agree with witnesses that dental care is most effective when delivered over time and as part of a trusting dentist-patient relationship. We recommend that the Department reinstate the requirement for patients to be registered with an NHS dentist.**

UDAs

220. The UDA banding system is too wide and acts to discourage treatment at the upper end of bands two and three.³¹⁰ The evidence we received from PCT commissioners and dentist organisations showed there had been a dramatic fall in the numbers of crown and bridge work in England since 2006.

221. They argued that the system should be reviewed.³¹¹ The DPA suggested that an additional two bands should be created comprising bands 2a and 2b and 3a and 3b. This, they argued, would allow sufficient reward to dentists for providing more complex treatments at the extreme ends of the scale. For example, a greater UDA value would be awarded for six fillings than for one filling.

222. Others recommended a more fundamental and “urgent re-consideration” of the entire UDA system³¹² and the BDA suggested scrapping the UDA system “as the sole indicator of performance”.³¹³

223. **We recommend that the Department commission research, as a matter of urgency, to find out why the volume of band three treatments has fallen so dramatically and the likely outcome of this fall on the oral health of patients.**

224. **We recommend that, as a short-term measure, the Department consider increasing the number of payment bands from three treatment bands to five or more. In this way, dentists would be rewarded with a greater UDA value for treatment given at the upper ends of bands 2 and band 3. While there should be no incentive to provide unnecessary complex treatment, neither should there be disincentives to provide it where it is clinically appropriate.**

225. **In the longer term we recommend that the Department review the UDA system and consider whether it is the best mechanism for delivering oral health care. Any changes to the system should be piloted and tested rigorously.**

The future of NHS dental services

226. In the future NHS dentistry faces two fundamental and linked questions that need to be answered: how NHS dentistry should be funded and the level of dental service which should reasonably be provided by the NHS and private sector respectively.

310 As we saw in para 170–171

311 Q 344

312 Ev 20

313 Ev 54

Funding

227. The DPA recommended a radical change to the financing of the GDS, namely replacing the present system with a voucher or co-payment system. The DPA argued that under a voucher system patients would receive core NHS work free but would pay any additional costs agreed with the dentist. Such additional costs might comprise, for example, better quality materials, teeth whitening or laboratory work.³¹⁴ The DPA claimed that a voucher system would find favour with many patients as they were often surprised that they could not pay for any additional treatment not available under NHS arrangements. Patients, he said, had often said to him,

I am entitled to National Health Service treatment, I want this done on the National Health Service but I would like nicer teeth on my denture or white filling material and I will just pay the difference.³¹⁵

228. However, the CDO told us that, “I have absolutely no interest in moving down that route at all”.³¹⁶ He argued that a voucher system would only serve to benefit the private sector because “they would be getting NHS money as well as their private money”.³¹⁷ He added that such a system would prove divisive as only a core service would remain in the NHS for patients whom were exempt from charges while other patients were effectively treated in the private sector. In addition a co-payment system would do little to encourage dentists to establish NHS practice in areas that are currently under-supplied by dentists.³¹⁸

Dental services which should be provided by the NHS

229. Linked to how NHS dentistry should be funded is the level of service that should be provided. We were told throughout the inquiry that the nature of dentistry had changed significantly since the establishment of NHS dental services in 1948. As the nation’s dental health has improved, the dental demands of patients has increasingly shifted from one of pain relief through disease control to what the CDO described as “a massive explosion in cosmetic dentistry”.³¹⁹ The changed nature of demand for dental services leads to consideration of the fundamental question of what dental services the NHS should be expected to provide in the future.

230. Both the BDA and Challenge argued that in future there should be a well-funded NHS dental service existing alongside a vibrant private sector so that patients would make a choice between being treated privately or within the NHS. Ms Susie Sanderson told us:

Disposable income buys choice in holidays, schools, cars and it also buys choice in dentistry at the moment. I would like to see that choice available right across the

314 Ev 80

315 Q 610

316 Q 821

317 Q 821

318 Q 821

319 Q 241

board, but it comes with a cost, and that applies also to services provided under the NHS.³²⁰

231. The CDO predicted a future where the NHS provided treatment to satisfy dental needs such as fillings and the private sector was focused on what may be termed life-style dental treatments of a cosmetic nature such as teeth whitening:

One of the things I see in the future is a more complementary relationship between private dentistry, which is providing that service need for patients that is not actually properly covered by the NHS... the fancy cosmetic stuff and stuff like that...but the NHS providing healthcare, and that is what I think the future will be.³²¹

He also acknowledged there was sometimes a thin line between treatment that was purely cosmetic and treatment that would help a patient overcome psychological difficulties or even to get a job:

If you wanted to get a job in a supermarket and you have got very ugly teeth, it is likely they would find some reason not to employ you other than the ugly teeth.³²²

232. The implication of the CDO's evidence was that the Department would have to decide which treatment should and should not be provided by the GDS. To help the Department consider these issues, the Minister told us that she had commissioned an analysis of how dental services should be configured in five years' time.³²³ The analysis, "NHS Dentistry-5 years on" would be completed by the end of 2009.

233. We welcome the Department's decision to analyse how dental services might develop over the next five years. We recommend that the analysis be published. It should clarify the level of service which should be provided by the NHS and hence how many dentists will be needed. It will need to address the extent to which NHS dentistry should offer the growing number of treatments which do not address clinical ill-health but are concerned with improving quality of life.

320 Q 440

321 Q 239

322 Q 243

323 Q 836

Conclusions and recommendations

1. Since the establishment of the General Dental Service in 1948, there have been many improvements. The nation's oral health has improved significantly: in the 1940s a large proportion of the population were edentate; by 1968, 37% of the population had no natural teeth; the estimated figure in 2007 was only 6%. Increasingly the focus of dentistry has switched from pain relief to the provision of preventive care and cosmetic treatment. (Paragraph 32)
2. Nevertheless, by the 1990s there was a powerful case for reform of the General Dental Service contract. It was widely agreed that, while in some areas of the country provision of NHS dentistry was good, overall it was patchy. Moreover, the payment system lacked sufficient incentives for the provision of preventive care and advice. In addition, the Department argued that there were too many incentives to provide complex treatment. (Paragraph 33)
3. The Department's original goal that patient access to dental services would improve from April 2006 has not been realised. The CDO claims that the situation has stabilised and that improvements will soon be seen as a result of new facilities which have been established. However, the various measures of access available all indicate that the situation is deteriorating. The total numbers of dentists working for the NHS and the activity (number of courses of treatment) they have provided for the NHS has fallen, albeit slightly. In addition the total number of patients seen by an NHS dentist between December 2005 and December 2007 has fallen by 900,000 compared with the two years up to March 2006. This figure possibly underestimates the decline because the data still include patients treated under the previous contract. Although in some places access to dentistry has improved since 2006, it remains uneven across the country. In many areas severe problems remain. The indications are that the new arrangements have failed so far to improve patient access overall. (Paragraph 76)
4. We recommend that the Department clarify the evidence on which it bases its claim that many parents do not consider their children with an IOTN score of 3.6 or above, require orthodontic treatment. We are concerned that some children who require orthodontic treatment will not receive it because adequate funds have not been allocated by PCTs. (Paragraph 82)
5. We welcome the establishment of Local Orthodontic Clinical Networks as making a significant contribution to improving the process by which local orthodontic assessments are made. (Paragraph 83)
6. We welcome the simplification associated with the new charging system. (Paragraph 89)
7. However, there are problems. Some courses of treatment such as those involving a single filling have become more expensive. In addition different patients are charged the same amount for very different treatments which fall within the same charging band. (Paragraph 90)

8. There is a danger that some low-income patients will store up dental problems and delay visiting their dentist, at some cost to their long-term dental health. We recommend that the Department make further efforts to raise awareness among lower income earners of the assistance available for meeting dental charges. (Paragraph 91)
9. While the Department argues that the new contract should improve preventive care and advice, this is disputed by dentists who claimed that the new contract failed to provide the time and the financial incentive for them to do so. A survey in 2007 undertaken by the London Assembly showed that almost one third of NHS patients had not received preventive advice when they last visited their dentist. We recommend the Department undertake research to determine the extent to which the provision of preventive advice is being given and its cost-effectiveness. (Paragraph 100)
10. We welcome the initiatives made by some PCTs and the Department to provide dental care for those people who do not currently receive it. However, we received no evidence about how many PCTs conduct similar initiatives or about how cost-effective they are. We recommend that the Department monitor the impact of outreach initiatives with particular attention to their cost-effectiveness. (Paragraph 101)
11. The number of complex treatments involving laboratory work fell by 50% during the first year of the contract. The number of root canal treatments has fallen by 45% since 2004. At the same time the number of tooth extractions has increased. The reason for the decline in the number of complex treatments since 2006 has not been explained satisfactorily and we are very concerned that as a result of the contract some patients do not receive the quality of care they need within the NHS. There is no evidence for the Department's claim that the decline is to be explained by more appropriate simpler treatments. We recommend the Department publishes an explanation for this trend and commissions research into the effect of this decline within the NHS system and its impact on oral health. (Paragraph 106)
12. We are concerned about the increase in referrals of patients requiring complex treatment to dental hospitals and community dentists. This can be bad for those patients who would prefer to be treated by their general dental practitioner and can also have adverse affects on patients who are traditionally treated in these settings and who have had to wait longer for treatment. (Paragraph 110)
13. The Department has acknowledged that changes in 2006 to the way treatments were recorded led to a decline in the quality assurance mechanisms. In April 2008 it began to record an "enhanced data set". It is too early to determine at this stage whether the enhanced data collected by the Department will prove sufficient to improve both clinical and financial accountability. We recommend that the Department carries out a review of the effectiveness of the "enhanced data set" after an appropriate time. (Paragraph 118)

14. The decision to allocate funds to PCTs on an historic basis made it extremely difficult for PCTs to contract additional dental providers in areas with traditionally few GDS dentists. (Paragraph 130)
15. We welcome the Department's provision of additional funding and the CDO's statement that there would be a shift towards allocating funding on a needs basis. We are disappointed, however, that the formula to be used for future funding allocations has yet to be determined. (Paragraph 131)
16. The Department's prediction of patient charge revenue in 2006–07 was overestimated by a sum of £159 million. As a consequence PCTs went without the revenue they had planned for and had to reduce spending on dentistry or divert resources from other areas of expenditure to dentistry. The overestimate is unsurprising given that the scheme was introduced without piloting. We recommend that the Department improve its financial forecasting in this area. (Paragraph 136)
17. In-house commissioning skills vary greatly between PCTs. As the Minister acknowledges, too many PCTs are not doing a good job, neither employing appropriately trained staff nor making full use of Specialists and Consultants in Dental Public Health when assessing local dental needs and commissioning services. (Paragraph 140)
18. Up-to-date comprehensive data are vital to PCTs for commissioning dental services. We are therefore concerned at the uncertainty caused by the initial delay in the NHS Information Centre's decision to commission the next decennial survey on Adult Oral Health. (Paragraph 147)
19. However, we welcome the fact that the survey is now to be undertaken in 2009, albeit a year late. We recommend that the Department confirm its intention to conduct the next ten yearly child oral health survey due in 2013. (Paragraph 148)
20. Children-only contracts have been continued by some PCTs so that access to NHS services is maintained in the short term. The Department argues that PCTs should be strongly discouraged from entering children-only contracts with dentists. The Department should make it a priority to remove children-only contracts from NHS dental service provision as soon as possible. (Paragraph 153)
21. In summary the NAO survey found that SHA involvement in dental services was limited, with PCTs largely left to devise and implement policy. (Paragraph 154)
22. The introduction of UDAs as the measure of dental activity and the basis for remunerating dentists has proved extremely unpopular with dentists. (Paragraph 175)
23. The Department acknowledged that it had learned valuable lessons from the PDS pilots it had conducted from 1998 onwards, but the new remuneration system, based on UDAs was not tested through a pilot. It is extraordinary that the Department did not pilot or test the new payment system before it was introduced in 2006. (Paragraph 176)

24. Too many PCTs seem to have set unrealistic UDA targets. According to the BDA, nearly half of dentists failed to meet their UDA target in the first year of the contract, if only by relatively small margins. This had financial consequences for new dentists when they failed to meet them. The Chief Dental Officer told us that PCTs were applying UDAs too rigidly. We recommend that PCTs adopt a more flexible approach to UDAs, as he proposed. (Paragraph 177)
25. The vocational training of newly qualified UK dentists and equivalent training for those dentists trained overseas is vital to the future viability of NHS dental services. Dentists should possess the full range of skills required to work in the NHS and vocational training provides a forum for these skills to be tested. However, we received evidence that vocational dental training has become a less attractive option. The Department should undertake research to determine whether a viable number of vocational dental trainers will be maintained in the future and take steps to ensure that this happens. The Department should also ensure that there are sufficient training places for all UK graduates to undertake vocational training and for all overseas graduates to demonstrate equivalent experience after they have passed either the International Qualifying Examination or Overseas Registration Examination. (Paragraph 178)
26. The Department asked for the contract to be assessed according to its own criteria for success: patient experience; clinical quality; PCT commissioning; and dentists' working lives. We conclude that the contract is in fact so far failing to improve dental services measured by any of the criteria. (Paragraph 179)
27. Nationally, fewer patients are visiting an NHS dentist than before April 2006 and access to dental care in many areas so far shows no sign of improvement. There is little evidence that the provision of preventive care has increased. There has been a decline in the number of complex treatments. The Department claims that this is because dentists are treating patients more appropriately, but there is some evidence that it is more likely that patients are not receiving the complex treatment they require within the NHS. It would help to clarify the picture if the Department provided evidence to back-up its claims. (Paragraph 180)
28. The CDO appears to argue that if PCTs and dentists acted more flexibly and used common sense and good will the new arrangements would work. However, we see little evidence that this will happen. (Paragraph 183)
29. We note the fears that many dentists will leave the GDS in 2009. We also note the Department's assurance that no such exodus of dentists will occur. We lack the evidence on which to judge the more likely outcome. We recommend that the Department monitor closely the career plans of NHS dentists. (Paragraph 186)
30. We note the BDA's concerns that dental school graduates will choose not to practise in the GDS following graduation. The Department must ensure that GDS dentistry remains an attractive career option for dentists and dental care professionals. (Paragraph 197)
31. The recruitment of overseas dentists has enabled PCTs to replace much of the lost NHS dental capacity which followed the introduction of the new dental contract.

There is no clinical evidence that patients' oral health has suffered as a result, but there are concerns that some overseas dentists are insufficiently familiar with the dental equipment and treatment provided within the NHS. The onus must be on PCTs to ensure that all dentists, irrespective of where they were trained initially, are of the standard necessary to provide high quality dental care. (Paragraph 198)

32. We note concerns that the new GDS contract has transferred financial risk from the NHS to dentists. The fixed-term contract may make dentists reluctant to make long term investments in their practice. (Paragraph 203)
33. Some PCTs do not:
 - Conduct adequate local oral health needs assessments;
 - Have adequately trained commissioning staff;
 - Make use of specialists and consultants in dental public health; or
 - Implement the contract with sufficient flexibility. (Paragraph 211)
34. Without adequate data on the oral health of the population, PCTs are not able to make valid dental needs assessments. We recommend that PCTs take immediate steps to widen the scope of the data they collect on the oral health of their local population. We also recommend that PCTs:
 - establish consultative committees comprising a mixture of experience and expertise including: patients, professionals and PCT personnel; and
 - employ appropriately trained staff and make full use of dental public health specialists and consultants.

In addition, the Department must clarify how it intends to improve the performance management of PCTs which are failing to implement the contract with sufficient flexibility. SHAs must place greater importance on their role of managing the performance of PCTs in respect to dentistry. (Paragraph 212)

35. The Department must base PCT dental funding on local needs assessments rather than historical provision. We recommend that the Department publishes the formula which it will use to determine future dental funding for PCTs as soon as practicable. (Paragraph 215)
36. We recommend that the Department consider further how to provide incentives for dentists to offer preventive care and treatment. Consideration should be given to the introduction of a QOF-style reward system for those dentists who through the provision of preventive care improve the dental health of their patients. The Department should consult dentists' representatives about how such a QOF-style system for dentists might work in practice. (Paragraph 217)
37. We agree with witnesses that dental care is most effective when delivered over time and as part of a trusting dentist-patient relationship. We recommend that the Department reinstate the requirement for patients to be registered with an NHS dentist. (Paragraph 219)

38. We recommend that the Department commission research, as a matter of urgency, to find out why the volume of band three treatments has fallen so dramatically and the likely outcome of this fall on the oral health of patients. (Paragraph 223)
39. We recommend that, as a short-term measure, the Department consider increasing the number of payment bands from three treatment bands to five or more. In this way, dentists would be rewarded with a greater UDA value for treatment given at the upper ends of bands 2 and band 3. While there should be no incentive to provide unnecessary complex treatment, neither should there be disincentives to provide it where it is clinically appropriate. (Paragraph 224)
40. In the longer term we recommend that the Department review the UDA system and consider whether it is the best mechanism for delivering oral health care. Any changes to the system should be piloted and tested rigorously. (Paragraph 225)
41. We welcome the Department's decision to analyse how dental services might develop over the next five years. We recommend that the analysis be published. It should clarify the level of service which should be provided by the NHS and hence how many dentists will be needed. It will need to address the extent to which NHS dentistry should offer the growing number of treatments which do not address clinical ill-health but are concerned with improving quality of life. (Paragraph 233)

Glossary

BDA	British Dental Association
BES	British Endodontic Society
BOS	British Orthodontic Society
CDO	Chief Dental Officer
CDS	Community Dental Service
DLA	Dental Laboratories Association
DPA	Dental Practitioners' Association
DPB	Dental Practice Board
DRS	Dental Reference Service
EEA	European Economic Area
GDC	General Dental Council
GDP	General Dental Practitioner
GDS	General Dental Service
IELTS	International English Language Testing System
IOTN	Index of Orthodontic Treatment Need
IQE	International Qualifying Examination
LOCN	Local Orthodontic Clinical Network
NAO	National Audit Office
ORE	Overseas Registration Examination
PCT	Primary Care Trust
PDS	Personal Dental Services
QOF	Quality Outcomes Framework
SHA	Strategic Health Authority
UDAs	Units of Dental Activity
VDP	Vocational Dental Practitioner
WHO	World Health Organisation

Formal Minutes

Monday 23 June 2008

Members present:

Mr Kevin Barron, in the Chair

Jim Dowd
Sandra Gidley
Stephen Hesford

Dr Doug Naysmith
Mr Lee Scott
Dr Richard Taylor

Draft Report (Dental Services), proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 88 read and agreed to.

Paragraph 89 read, amended and agreed to.

Paragraphs 90 to 233 read and agreed to.

Summary agreed to.

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

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

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report

[Adjourned till Thursday 26 June at 9.30 am

Witnesses

Thursday 7 February 2008

Mr Eddie Crouch and **Mr John Renshaw**, CHALLENGE, and **Mr John Taylor**, former Chief Executive, Dental Practice Board (1987–2006)

Dr Barry Cockcroft, Chief Dental Officer, **Mr Ben Dyson**, Director of Primary Care, and **Mr David Lye**, Head of Dentistry and Eye Care Services, Department of Health

Thursday 21 February 2008

Ms Helen Delaitre, Acting Head of Primary Care, Hillingdon PCT, and **Ms Karen Elley**, Consultant Dental Public Health, Sandwell PCT, and **Mr Andrew Harris**, Primary Care Manager, Devon PCT

Ms Susie Sanderson, Chair, Executive Board, British Dental Association, **Mr Iain Hathorn**, Chairman, British Orthodontic Society, and **Mr David Smith**, Dental Laboratories Association

Thursday 28 February 2008

Mr John Green, Director of Dental Public Health, Sheffield PCT, **Ms Jane Davies-Slowik**, Clinical Director, Salaried Services, and **Mr Melvyn Smith**, Senior Lecturer Dental Public Health, University of London

Ms Sarah Elworthy, a Dentist working in Cranbrook, Kent, **Ms Margaret Naylor**, a Dentist with practices in Rotherham and Sheffield, and **Mr Derek Watson**, Chief Executive, Dental Practitioners' Association

Thursday 6 March 2008

Dr Anthony Halperin, Chairman, Patients Association, and **Ms Teresa Perchard**, Policy Director, Citizens Advice Bureau

Ann Keen MP, Parliamentary Under Secretary of State for Health Services, **Dr Barry Cockcroft**, Chief Dental Officer, and **Mr David Lye**, Head of Dentistry and Eye Care Services, Department of Health

List of written evidence

The following memoranda were published as *Dental Services: Written evidence*, HC 289–II, Session 2007–08

DS

- 1 Department of Health
- 2 Dr Jillian Pritchard
- 3 Mrs H Diane Martin
- 4 David G Hillam
- 5 British Endodontic Society
- 6 CHALLENGE
- 7 The London Regional Group of Local Dental Committees
- 8 John Mills
- 9 British Orthodontic Society
- 10 Sandwell Local Dental Committee
- 11 Dr Ashish Dhopatkar
- 12 Stephen Day
- 13 British Fluoridation Society
- 14 Dr Paul Batchelor
- 15 Oxfordshire PCT Patient & Public Involvement Forum
- 16 Brian Bird
- 17 Coventry Local Dental Committee
- 18 Sarah Elworthy
- 19 British Dental Association
- 20 Castle College, Nottingham
- 21 Oral Health Task Group, Lancashire County Council's Adult Social Care and Health Overview and Scrutiny Committee
- 22 Socialist Health Association
- 23 NHS Workforce Review Team
- 24 Denplan
- 25 Citizens Advice
- 26 Dental Laboratories Association
- 27 Dental Technologists Association
- 28 Dental Practitioners' Association
- 29 The British Association for the Study of Community Dentistry
- 30 Dr J E Gallagher and Professor N H F Wilson
- 31 NHS Confederation
- 32 Hillingdon PCT
- 33 Which?
- 34 British Dental Health Foundation
- 35 Amolak Singh, General Dental Practitioner, Bexleyheath, Kent
- 36 Patients Association

List of further written evidence

The following written submissions were received after the publication of *Dental Services: Written evidence*, HC 289–II, Session 2007–08. They are reproduced with the Oral evidence in Volume III of this Report.

- 1 John Taylor (DS 37)
- 2 Sandwell Primary Care Trust (DS 38)
- 3 Melvyn Smith (DS 39)
- 4 Teethwhite (DS 40)
- 5 Greater London Branch of the Socialist Health Association (DS 41)
- 6 John Green (DS 42)
- 7 Margaret R Naylor (DS 43)
- 8 Faculty of General Dental Practice (UK), The Royal College of Surgeons of England (DS 44)
- 9 Ms Jane Davies-Slowik (DS 45)
- 10 Andrew Sadler (DS 46)
- 11 General Dental Council (DS 47)
- 12 Professor Martin Tickle (DS 48)
- 13 Robin Pope, Monkmoor Dental Practice, Shropshire (DS 49)
- 14 National Audit Office (DS 50)
- 15 Department of Health (DS 01A)
- 16 Department of Health (DS 01B)
- 17 Department of Health (DS 01C)
- 18 Department of Health (DS 01D)
- 19 Department of Health (DS 01E)
- 20 CHALLENGE (DS 06A)
- 21 Sandwell Local Dental Committee (DS 10A)
- 22 British Dental Association (DS 19A)
- 23 Citizens Advice (DS 25A)
- 24 Citizens Advice Bureau (DS 25B)
- 25 Dental Laboratories Association (DS 26A)
- 26 Dental Laboratories Association (DS 26B)

Reports from the Health Committee

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2007–08

First Report	National Institute for Health and Clinical Excellence	HC 27 (Cm 7331)
Second Report	Work of the Committee 2007	HC 337
Third Report	Modernising Medical Careers	HC 25
Fourth Report	Appointment of the Chair of the Care Quality Commission	HC 545

Session 2006–07

First Report	NHS Deficits	HC 73 (Cm 7028)
Second Report	Work of the Committee 2005–06	HC 297
Third Report	Patient and Public Involvement in the NHS	HC 278 (Cm 7128)
Fourth Report	Workforce Planning	HC 171 (Cm 7085)
Fifth Report	Audiology Services	HC 392 (Cm 7140)
Sixth Report	The Electronic Patient Record	HC 422 (Cm 7264)

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)

The following reports have been produced by the Committee in the 2001–05 Parliament.

Session 2004–05

First Report	The Work of the Health Committee	HC 284
Second Report	The Prevention of Thromboembolism in Hospitalised Patients	HC 99 (Cm 6635)
Third Report	HIV/AIDS and Sexual Health	HC 252 (Cm 6649)
Fourth Report	The Influence of the Pharmaceutical Industry	HC 42 (Cm 6655)
Fifth Report	The Use of New Medical Technologies within the NHS	HC 398 (Cm 6656)
Sixth Report	NHS Continuing Care	HC 399 (Cm 6650)

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23 (Cm 6438)
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696 (Cm 6433)

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)