By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 26 March 2010

Subject: Dentistry

Introduction

In 2006, a new system of dentistry was introduced. There were three main components:

- Three payment bands were brought in to replace a system of around 400 possible charges.
- Responsibility for commissioning services was devolved to local Primary Care Trusts (PCTs).
- A new General Dental Services (GDS) contract was introduced. The previous system had been based on dentists receiving fees for items of service. Under the new system, dentists would now be paid an annual sum in return for delivering an agreed number of courses of treatment (UDAs, or Units of Dental Activity).

The charges for the different bands of treatment from 1 April 2009 are:

- Band 1. £16.50. "This covers an examination, diagnosis (e.g. X-rays), advice on how to prevent future problems, a scale and polish if needed and application of fluoride varnish or fissure sealants. If you require urgent care, even if your urgent treatment needs more than one appointment to complete, you will only need to pay one Band 1 charge."
- Band 2. £45.60. "This covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or if your dentist needs to take out one or more of your teeth."
- Band 3. £198.00. "This covers everything listed in Bands 1 and 2 above, plus crowns, dentures or bridges."[1]

There are various groups that are exempted from dental charges (including those under 18), or who receive help with costs.[2]

Charges offset 29% of the cost of NHS dentistry[3]. In 1997/8, NHS dentistry accounted for 2.9% of NHS net expenditure. By 2007/08, this had reduced to 2.1%.[4]

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[1] All quotations in the section taken from Department of Health leaflet, "NHS dental services in England", http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096611.pdf

[2] Ibid, this leaflet contains details of exemptions.

[3] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Department of Health, June 2009, p.25,

Dental Commissioning

Primary Care Trusts commission most dental services through either a GDS (General Dental Service) or PDS (Personal Dental Service) contract.

PCTs can also commission services of a more specialist nature through the DwSIs (Dentist with Special interest scheme) – the scheme was launched with four initial key competencies, Orthodontics, Minor Oral Surgery, Endodontics, and Periodontics.[5]

Alongside the independent contractors there are a number of dentists who work as salaried dental primary care dentists. They often provide generalist and specialist dental care for vulnerable groups and are involved in public health work.[6]

Under the new GDS contract that was introduced in 2006, a provider is contracted to undertake a specified number of Units of Dental Activity (UDAs). There is no specified number of patients who must receive treatment. The number of UDAs can sometimes be provided before the end of the contract period. If a provider has not undertaken all the UDAs by the end of the contract period, money can be 'clawed back' by the PCTs.

A dentist is awarded 1 - 12 UDAs for each course of treatment, depending on its complexity:

- Band 1 treatment = 1 UDA
- Band 2 treatment = 3 UDAs
- Band 3 treatment = 12 UDAs
- Urgent treatment = 1.2 UDAs[7]

As a result of the way the transition from the old to the new contracts was regulated, there is no set value for 1 UDA. In other words, different dentists receive differing amounts of money for delivering a course of treatment. The average is £25, with a range of between £17 and £40.[8]

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http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

[4] Ibid, p.30.

[5] Details of the different contracts can be accessed through the Primary Care Commissioning website, http://www.pcc.nhs.uk/89.php. Information can also be found in the British Dental Association's Independent Local Commissioning Working Group Report, available here: http://www.bda.org/dentists/policy-research/bda-policies/local-commissioning/index.aspx

[6] Salaried Primary Dental Care Services (SPDCS) were formally known as Community Dental Services.

[7] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Department of Health, June 2009, p.68, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

[8] Ibid, p.28.

Dentists are allowed to provide both NHS and private dental services (for different patients and for the same patient). There is no prescribed list of what treatments should be offered on the NHS.

While there has never been a requirement for a patient to 'register' with an NHS dentist, between 1990 and 2006, a portion of a dentists' remuneration was linked to the number of patients registered. "Since 2006, this feature of the remuneration system has no longer applied, but this does not prevent patients from receiving continuity of care."[9]

The Impact of the New Contract

There has been a lot of discussion about the impact the new GDS contract, both prior and subsequent to its introduction on 1 April 2006.

On the introduction of the new contract, around 4% of NHS provision was lost with some dentists choosing to convert to private care[10].

One of the higher profile pieces of work to have been carried out on the impact of the new contract was a report by the House of Commons Health Select Committee published in June 2008[11].

The interim Government response was published in October 2008 with the final response published in January 2009[12]. In the interim report, the Government confirmed that it would carry out "a review of how dental services should develop over the next five years and what action is needed to ensure that, nationally and locally, dental commissioning evolves continuously to reflect public needs."[13]

In December 2008, The Secretary of State for Health (then Alan Johnson MP), asked Professor Jimmy Steele to undertake this independent Review of NHS Dental Services in England. This was published in June 2009. The

[9] Government Response to the Health Select Committee Report on Dental Services, October 2008, p.18, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_088997.pdf

[10] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Department of Health, June 2009, p.14, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

[11] House of Commons Health Select Committee, NHS Dentistry, July 2008, http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/28902.htm

[12] Both Government responses can be accessed here: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093318

[13] Government Response to the Health Select Committee Report on Dental Services, October 2008, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_088997.pdf

executive summary and key recommendations of this independent Review are appended to this Briefing Note.[14]

The Department of Health has subsequently established a 'Steele Implementation Programme' to pilot the key recommendations. PCTs have been asked for expressions of interest in running local pilots.[15] On 12 March 2010, it was announced that at least 30 NHS dental practices had been selected. [16]

Decontamination

On 1 December 2009, *Health Technical Memorandum 01-05: Decontamination in Primary Care Dental Practices*, was published "to reflect a reasonable and rational response to emerging evidence around the effectiveness of decontamination in primary care dental practices, and the possibility of prion transmission through protein decontamination of dental instruments."[17]

According to the covering letter from the Barry Cockcroft, the Chief Dental Officer, "the aim is that all practices will have met the HTM's essential quality requirements within 12 months of receiving this guidance."[18]

Staff Numbers

The workforce statistics which are collected by The Information Centre for Health and Social Care provide a breakdown of dentists by contract and dentist type, as well as by gender and age. A selection of this information is provided on the following page.

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[14] The full version of the report and associated material can be accessed here: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101137

[15] Department of Health, Steele Implementation Programme, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112295

[16] Department of Health Press Release, 12 March 2010, http://nds.coi.gov.uk/clientmicrosite/Content/Detail.aspx?ClientId=46&NewsAreaId=2&ReleaseID=412116&SubjectId=36

[17] Department of Health, *Health Technical Memorandum 01-05: Decontamination in Primary Care Dental Practices*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109363

[18] Department of Health, Chief Dental Officer Letter, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109366.pdf

Table 1: Population per dentist and dentists per 100,000 of population[19]

Area	*Population per dentist*		*Dentists per 100,000 of population*	
	2007/08	*2008/09*	*2007/08*	*2008/09*
England	2,455	2,394	41	42
South East Coast SHA	2,052	1,998	49	50
NHS Eastern and Coastal Kent	2,422	2,422	41	41
NHS West Kent	2,242	2,176	45	46
NHS Medway	920	934	109	107

Table 2: Total number of dentists with NHS activity[20]

Area	*Total number of dentists with NHS activity*		
	2007/08	*2008/09*	*% difference*
England	20,815	21,343	2.5
South East Coast SHA	2,087	2,144	2.7
NHS Eastern and Coastal Kent	300	300	0.0
NHS West Kent	298	307	3.0
NHS Medway	274	270	-1.5

Access to Dentistry

The data that the NHS collects centrally on how many people have accessed NHS dentistry is given as a total number and as a percentage of the population receiving treatment in a given PCT area that have been seen by an NHS dentist in the previous two years.

Table 3: Number of total patients seen in the previous 24 months ending at the specified dates (percentage of population in brackets)[21]

Area	*31 Mar 2006*	*31 Dec 2008*	*31 Dec 2009*
England	28,144,599 (55.8)	27,272,083 (53.4)	28,162,628 (54.7)
NHS Eastern and Coastal Kent	351,681 (49)	339,720 (46.8)	352,244 (48.1)
NHS West Kent	319,438 (48.7)	267,231 (40.0)	276,404 (41.0)
NHS Medway	135,083 (53.7)	161,886 (64.2)	166,768 (65.8)

[19] The Information Centre for Health and Social Care, NHS Dental Statistics for England 2008/09, http://www.ic.nhs.uk/webfiles/publications/Primary%20Care/Dentistry/dentalstats0809/NHS_Dental_Statistics_for_England_2008_09_Annex_2a_PCT_Factsheet.xls

[20] Ibid.

[21] The Information Centre for Health and Social Care, NHS Dental Statistics for England Q2 30 September 2009, http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/nhs-dental-statistics-for-england-quarter-2-30-september-2009

Table 4: Number of total child patients seen in the previous 24 months ending at the specified dates (percentage of population in brackets)[22]

Area	*31 Mar 2006*	*31 Dec 2008*	*31 Dec 2009*
England	7,796,750 (70.7)	7,612,302 (69.2)	7,685,509 (69.8)
NHS Eastern and Coastal Kent	107,656 (67.9)	102,013 (64.5)	102,062 (64.5)
NHS West Kent	112,146 (74)	94,514 (61.9)	95,412 (62.2)
NHS Medway	45,807 (75.4)	48,759 (82.1)	49,557 (83.8)

Care Quality Commission

As part of the Annual Health Check carried out by the Care Quality Commission for 2008/09, Primary Care Trusts were given an overall grade for 'quality of commissioning services'. This grade is either:

- Excellent (2.0%)
- Good (50.7%)
- Fair (44.7%)
- Weak (2.6%)

The numbers in brackets refer to the percentage of Primary Care Trusts that were awarded each grade.

It should be noted that the Annual Health Check 2008/09 covered performance for the year ending 31 March 2009.

This grade is aggregated from separate grades for 'meeting core standards', 'existing commitments', and 'national priorities' (which in turn have a number of component parts).

One of the 23 national priorities which PCTs were assessed about is 'Access to primary dental services'. The rationale for this, as expressed by the Care Quality Commission, is as follows:

> "According to guidelines issued by the National Institute for Clinical Excellence (NICE, 2004), the recommended longest period a patient over the age of 18 should go without an oral review is 2 years. However, many patients experience difficulty in accessing a NHS dentist, and recent figures show that during the 24 months leading up to 31 March 2008, only 53.3% of the total population of England were seen by an NHS dentist (NHS Dental Statistics England, 2007/2008, published by the Information Centre). Of the remaining population, some patients will opt to receive private treatment, a proportion of which, in itself, is likely to be a direct result of difficulty accessing an NHS dentist. A recent survey commissioned by the Citizens Advice Bureau estimated that approximately 7.4m people in England and Wales say they would like to access NHS dentistry, but cannot. Of these, 2.7m say they are not able

[22] Ibid.

to access a dentist at all. Consultations by two SHAs have shown that the public consider this to be a major problem for the NHS to resolve.

The Government has responded to this issue of access by increasing funding for NHS dentistry in England from April 2008, by 11 per cent, as part of the comprehensive spending review. The NHS 'Vital Signs' framework contains an indicator in the second tier (national priorities for local delivery) to measure improvements in access to primary dental care. PCTs will therefore be assessed on their performance in terms of access to NHS dental services using data compiled centrally by the Dental Services Division of the NHS Business Authority and the NHS Information Centre. PCTs will be expected to demonstrate improvement in 24-month access to a NHS dentist against a baseline of the two year period ending 31 March 2006, when the new dental contract system was introduced."[23]

In relation to the indicator explained above, PCTs were given one of the following grades:

- Achieved (for an indicator greater than or equal to 99%)
- Under Achieved (for an indicator greater than or equal to 90%)
- Failed (for an indicator less than 90%)

Table 5: Annual Health Check Scores for 'Access to primary dental services' 2008/09[24]

Primary Care Trust	*Quality of commissioning services*	*Access to primary dental services*	
		Performance	*Indicator value*[25]
Eastern and Coastal Kent	Fair	Under Achieved	98.11%
West Kent	Fair	Failed	83.78%
Medway	Fair	Achieved	120.4%

Some Key Organisations

Local Dental Committees – Established in 1948, LDCs became statutory bodies in 1977. "Primary care trusts/health boards consult with LDCs on

[23] Care Quality Commission, Access to primary dental services, http://www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/annualhealthcheck2008/09/qualityofservices/exis/accesstoprimarydentalservices.cfm

[24] Annual Health Check information for specific organisation can be accessed from the Care Quality Commission website, http://2009ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm

[25] The indicator is the numerator divided by the denominator, expressed as a percentage. The numerator is the number of patients seen in the 24 month period ending 31 March 2009 and the denominator is number of patients seen in the 24 month period ending 31 March 2006.

matters of local dental interest and, following the NHS reforms in 2006, local commissioning and developments in the provision of NHS dental services."[26]

British Dental Association – Founded in 1880, the BDA is the professional association and trade union for dentists in the United Kingdom. It has a voluntary membership of around 23,000[27].

General Dental Council – "Anybody who wants to work in the UK as a dentist, dental nurse, dental technician, dental hygienist, dental therapist, clinical dental technician or orthodontic therapist must be registered"[28] with the GDC.

Care Quality Commission – From April 2010, all NHS Trusts must be registered with the CQC. "From April 2011, primary care services that directly provide dentistry (NHS and private) must be registered."[29]

[26] British Dental Association, Local Dental Committees, http://www.bda.org/dentists/representation/gdps/ldcs/index.aspx
[27] For further information, see http://www.bda.org/.
[28] General Dental Council, Who we regulate, http://www.gdc-uk.org/About+us/Who+we+regulate/
[29] Care Quality Commission, Who needs to register?, http://www.cqc.org.uk/guidanceforprofessionals/registration/newregistrationsystem/whoneedstoregister.cfm

Appendix: Executive summary and key recommendations of *NHS dental services in England An independent review led by Professor Jimmy Steele, June 2009*[30]

"Oral health should be for life. The two common dental diseases, dental decay and gum disease, are chronic and the damage they cause is cumulative and costly. The NHS in 2009 is still dealing with, and paying for, the consequences of disease that developed more than 50 years ago. The trends in disease prevalence and the way it has been managed are visible in the oral health of different generations. We still need to deal with this burden of the past and manage the demands of the present, but keep a very clear focus on the future so that we can minimise the risk, discomfort and costs for future generations.

Almost everyone in the population is a dental patient at some time and, for many, a dental visit is a regular occurrence. But not everyone is the same and providing for the varying needs and aspirations of all of the consumers of dental care is a particular challenge. Clarifying what it is that NHS dentistry offers, what the NHS commissions, what dentists provide and what patients get is an essential step in this process.

Much NHS dentistry is already outstanding, reflecting the quality of the workforce. The basic structures we have in place now provide the opportunity to move on to the next, and most challenging, stage.

Just as health is the desired outcome of the rest of the NHS, so health should now be the desired outcome for NHS dentistry, while good oral health and the quality of the service should be the benchmarks against which success is measured. Through the NHS, dentistry could take a huge step forward but in order to do that, one concept is critical. So long as we see value for taxpayers' money as measured by the production of fillings, dentures, extractions or crowns, rather than improvements in oral health, it will be difficult to escape the cycle of intervention and repair that is the legacy of a different age.

Making the transition from dental activity to oral health as the outcome of the NHS dental service will be a challenge for everybody, but it is essential if NHS dentistry is to be aligned with the modern NHS. In this review we have tried to set out a framework for care and we have tried to provide a rationale for that framework.

In doing so we were also mindful of the current economic circumstances. Ensuring an efficient and well-aligned service was an underpinning principle in the way we approached our task.

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[30] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Executive Summary, Department of Health, June 2009, pp.2-5, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101181.pdf

A better service for patients: accessible and high quality

Access to care is a problem, but not a universal problem, as it tends to be concentrated in particular areas of the country. The Department of Health (DH) access team is working alongside the review team to address these issues. **We recommend the continuation of this process but that the access programme uses the opportunity for new procurement to pilot some of the key components of our recommendations.**

However, perceptions of problems with access are compounded by simple problems of information. People are uncertain how to find a dentist and the information they require is often not available in the right places, is not co-ordinated or is not kept up to date.
PCTs and the NHS should communicate clearly how people might find a dentist through the most appropriate media and what to expect from a dentist when they get there. This is much more a matter of organisation than resource and would make a big difference to patients and their perceptions of access. People have a right to access an NHS dentist; the NHS now needs to work to make this a reality and to extend this to a meaningful oral health service.

Good oral health depends on more than just access: prevention and high-quality provision are also essential. These are related concepts which depend on the dental profession and the dental team working towards a common oral health goal. The clarity of that goal is important.

We have identified an approach to allow the NHS offer to dental patients to be based on some basic national priorities. **We recommend that NHS primary care dentistry provision should be commissioned and delivered around a staged pathway through care which supports these priorities.** The proposed pathway allows and encourages continuity of the relationship between patients and dentists, for those who want it, built around the most appropriate recall interval for the patient and uses oral health as an outcome.

Continuity of care matters to patients and to dentists. It is important in building a relationship of trust and a philosophy of lifelong care. This is at the heart of the pathway, but a continuing care relationship implies responsibilities and rights on both sides. **We recommend that patients registered in a continuing care relationship with a practice have an absolute right to return to that practice for both routine and urgent care.**

Not everyone wants to have a continuing care relationship with a dentist and it is important that their needs are met too. Provision of urgent care is a fundamental responsibility for the NHS and for PCT commissioners and **we recommend that urgent care services should be accessible and commissioned to a high and consistent level of quality**.

While meeting local need is important, the level of variation in the quality of care is too great. The basics of good practice are well understood. **We recommend that strong clinical guidelines are developed to support dentists and patients through specific pathways of treatment.** These would allow determination of thresholds for treatment, ensuring that some of the costly and complex care can be targeted to the patients where it will provide greatest benefit.

As dentists are paid as professionals to perform high-quality services, neither the patient nor the taxpayer should bear the cost of unnecessary premature failure of restorative care. **We recommend that the free replacement period for restorations should be extended to three years and that the provider should bear the full cost of replacement rather than the PCT or the patient.**

Aligning the contract to improve access and quality

The incentives for dentists are not as precisely aligned as they could be to a goal of oral health and consequently there are inefficiencies within NHS dentistry. The pathway we describe should be supported by an altered contractual structure for dentists.

We therefore recommend that dental contracts are developed with much clearer incentives for improving health, improving access and improving quality.

The basic structure of the existing contract is quite flexible and we suggest that much could be achieved within existing regulations or with relatively minor adjustments.

We recommend that the current contract is developed specifically to allow payments for continuing care responsibility, blended with rewards for both activity and quality. We further recommend that these are piloted and then nationally applied.

There are limited incentives for dentists to see patients and to take on new patients. As part of the blended contract system **we specifically recommend introducing an annual per person registration payment to dentists within the contract** to provide greater security for dental practices, and greater accountability on all sides.

For the 60 years that NHS dentistry has been in existence the focus of the service has been mainly on treatment rather than prevention or quality. This means that there is little visible reward for good dentists who are improving oral health and providing a service that patients like, and little sanction for poor ones. **We recommend that the quality of a service and the outcomes it achieves are explicitly recognised in the reward system of the revised contract.**

To do this there will need to be robust measures of quality. These will need continuous development and should concentrate on oral health outcomes and patients' perceptions of quality. This process has started and **we recommend that a high priority is given to developing a consistent set of quality measures**. Local PCTs should not need to develop their own quality measures – this represents a waste of resource that could be used elsewhere.

What the NHS has to do

The process and skills in commissioning dental services have been highly variable. There are excellent examples but the standard of all commissioning needs to be brought to the level of the best. In the best there are structures and processes in place to ensure good communication with the profession and advice from specialists in dental public health. **We recommend that PCTs should be required to demonstrate good organisation and structures, including in senior leadership in the PCT and strong clinical engagement, and that strategic health authorities (SHAs) and DH oversee this process.**

There is relatively little information available about what is happening in NHS dentistry, who wants and gets NHS care, what happens when they receive it and, crucially, whether the services they receive are making a contribution to oral health. A rich body of information is critical to our ability to monitor progress, reward quality and learn what works best for patients and what does not. **We recommend that DH develops a clear set of national data requirements for all providers.**

Technology can help to facilitate the collection and organisation of data. Software systems are available to record what happens chair-side and link it to national datasets. Around 25% of practices do not even have the very basic computer hardware that can allow this to happen. **We recommend that PCs are used in all dental surgeries within three years and are, ultimately, centrally connected to allow clinical data to support shared information on quality and outcomes.**

Historically, money has followed activity, not patients' needs. The process of reallocation of the resource to align it with need has already begun. **We recommend that this process continues and we have proposed a basis for a funding formula that can allow that to happen.**

Implementation challenges

While it may seem relatively easy to set out a vision and possibly even to get agreement on high-level principles, achieving change and remembering why we need it is much more difficult. The real task now is to implement that vision and this will require dedicated work and commitment across the dental profession and the NHS."