

Summary of the House of Commons Health Committee Report on Dental Services

Fifth of the Session 2007-2008

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 1960s 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 Quality Outcomes Framework (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.